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## Solution Focused Financial Therapy: A Brief Report of a Pilot Study

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## **Solution Focused Financial Therapy: A Brief Report of a Pilot Study**

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## **Solution-focused Financial Therapy: A Brief Report of a Pilot Study**

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*The financial counseling, financial planning, and financial therapy fields are hampered by a conceptual and empirical paucity of clinical and experimental evidence-based research. In an attempt to decrease this gap in the literature, a pilot study was developed to test the implementation of a solution-focused financial therapy client intervention approach, in which solution-focused therapy techniques were applied in a financial counseling setting. This paper reports findings from a clinical intervention study of college students (N = 8) who presented a variety of financial issues related to budgeting, investing, and debt repayment problems. Data were gathered prior to the start of treatment, after treatment ended, and three months later. Participants' psychological well-being and financial behaviors improved, while financial distress decreased. The solution-focused financial therapy approach used is discussed.*

*Keywords: financial therapy; solution-focused therapy; solution-focused financial therapy; financial counseling; financial planning*

Training the next generation of practitioners is a growing concern among financial therapists, counselors, and planners, as well as the researchers in these communities

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(Archuleta & Grable, 2010; Britt, Klontz, & Archuleta, 2015; Britt, Archuleta, & Klontz, 2015; McGill, Grable, & Britt, 2010). A key issue of concern is related to the intervention techniques new therapists, counselors, and planners are incorporating into their practices. Not unlike other emerging fields of study and practice, many of the behavioral change techniques taught to novice financial therapists, counselors, and planners are based on experiential opinion rather than clinically documented effectiveness. It is difficult to discern what the most effective modalities are, how practitioners coherently conceptualize client cases, or why practitioners choose certain types of interventions over others based on the current literature.

Approaches rooted in theory can provide some insight to these uncertainties. Theory provides a way to look at a problem by applying a framework to explain phenomena. Theoretically informed modalities in financial therapy, counseling, and planning can help a practitioner frame how to think about an issue, predict what will happen next, and provide interventions for how to treat an issue (Britt et al., 2015a). Connecting theory, research, and practice is important in any professional field of practice, but it is especially important for financial therapists, counselors, and planners. Moving beyond opinion towards evidence-based practice is an important step in the establishment of credibility among clientele, colleagues, and policy makers. It is especially important when educating a new generation of practitioners.

Multiple modalities—documented best practices for performing tasks—exist in the mental health and personal finance fields that can be directly applied to financial therapy (Archuleta & Grable, 2010). In addition, there are modalities that are unique to financial therapy. Interestingly, very few models of client interaction and intervention exist that have been tested in either a clinical or experimental sense (Britt et al. 2015a). There is limited evidence of the effectiveness of the most widely used approaches. Some research exists on experiential and cognitive behavioral therapies (e.g., Benson, Eisenach, Abrams, van Stolk-Cooke, 2014; Ford, Baptist, & Archuleta, 2011; Klontz, Bivens, Klontz, Wada, Kahler, 2008) as applied to financial issues. Additionally, the Collaborative Relational Model (Kim, Gale, Goetz, & Bermúdez, 2011) has been tested in a limited fashion and been shown to be unique to the emerging field of financial therapy. Similarly, Archuleta, Grable, and Burr (2015) described solution-focused therapeutic techniques that may provide a mechanism for financial behavioral change.

Solution-focused therapy is a theoretically informed approach traditionally used by mental health practitioners to help clients utilize their strengths to focus on future-oriented goals and tasks (de Shazer, Dolan, Korman, McCollum, Trepper, Berg, 2007). In the financial counseling profession, practitioners have typically focused on their client's financial problems and the negative behaviors that lead to these problems (Archuleta & Grable, 2010). In general, financial counselors have placed attention on a client's history and how the client developed financial problems and negative behavior. Rarely are financial counselors trained to promote a client's positive characteristics in order to build self-identified solutions to financial issues. Solution-focused therapy is considered to be a brief therapeutic approach that provides a lens, in which practitioners believe clients can change and are willing to make changes using their personal strengths. In the mental health

field, solution-focused therapy outcome studies have consistently shown evidence that the technique produces positive behavior changes in a shorter period of time by creating a higher autonomy in clients as compared to other therapeutic approaches (Bannink, 2007; Corcoran & Pillai, 2009). In a review of effectiveness research including solution-focused therapy, Corcoran and Pillai (2009) showed that solution-focused therapy demonstrated a 50% effectiveness rate compared to receiving no treatment or alternative conditions. These types of studies indicate that solution-focused therapy can be a successful way to work with clients.

Lethem (2002) noted that solution-focused therapy could be easily adapted to meet the needs of clients with different presenting issues and situations. Solution-focused therapy has been applied to variety of contexts and problems, including business, social policy, education, health care, criminal justice services, child welfare, domestic violence, medicine, substance abuse. To date, few attempts have been made to bring solution-focused therapy to the realm of personal finance topics and issues. The purpose of this paper is to report findings from a clinical test of solution-focused therapy principles and techniques applied to money related issues. The paper provides a brief report of the findings of a pilot study that initially sought to address the following question: Can solution-focused therapy techniques be used to work effectively with financial therapy clients?

## METHOD

### ***Manual Development and Implementation***

Prior to conducting the current pilot study, a treatment manual that integrated solution-focused therapy principles and techniques within the context of financial therapy and financial counseling skills and strategies that was developed by a team of researchers was evaluated. The manual was developed by Archuleta et al. (2015) to provide consistency of implementation among financial therapists when incorporating solution-focused techniques into practice. The manual was based on the *Solution-focused Therapy Treatment Manual for Working with Individuals* (Trepper, McCollum, De Jong, Korman, Gingerich, & Franklin, 2010). As part of the development of the manual, mock financial sessions were conducted to enhance the coherency and applicability of the manual. The manual, designed to be implemented over the course of three to five sessions depending on the client's situation, allows for flexibility of length of time each client needs between sessions. Initial work using the manual showed that some clients prefer meeting every two weeks, while others need longer spans of time between sessions. Regardless of the time needed, to keep with solution-focused principles, the focus of each session was on the client's needs rather than completing sessions in a certain timeframe.

Archuleta et al. (2015) noted that in order to use the manual appropriately, financial therapists should have a foundational knowledge in both personal finance topics (e.g., introductory course in personal finance or more advanced personal finance related courses) and counseling skills (e.g., financial counseling course, conflict resolution courses, or more advanced training in marriage and family therapy), as well as training in the

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solution-focused approach. Based on this recommendation, graduate students who met these criteria were recruited to participate as financial therapists in this study. These financial therapists then participated in practice sessions that utilized specific steps outlined in the manual. They were supervised by financial therapists who had previously been trained using the manual. For this study, three financial therapists who received cross-discipline training implemented the manual with the clients. The three financial therapists were female graduate students. One student was a doctoral student in personal financial planning and held the CFP® and AFC® designations, as well as a core conflict resolution certificate. Two of the financial therapists were master's level students in studying marriage and family therapy. For the purpose of this study, each financial therapist was tested and found to have achieved at least an 85% adherence and competency rating on an adapted version of McCollum's (unpublished) *Competency and Adherence Ratings for Solution-focused Therapy* assessment.

The manual provided an outline of solution-focused oriented questions and interventions, as well as a standardized set of mandatory financial homework assignments and other optional homework assignment ideas. During each session, one of the other financial therapists or a supervising faculty member (i.e., the supervising faculty member was trained in both marriage and family therapy and personal finance) observed each therapist's session. Ideally, and when at all possible, someone trained primarily in the opposite field of the therapist observed the session (e.g., if the financial therapist was one of the marriage and family therapists, the observer was a financial counselor or planner). Towards the end of each session, the financial therapist took a break from the session. During the break, the financial therapist met with the observer who shared positive observations of the client and compliments to share with the client. The therapist and observer brainstormed about additional homework ideas to share with the client (beyond the already required homework). Another observer objective was to complete a *Competency and Adherence Ratings for Solution-focused Therapy* form that evaluated the financial therapist's adherence to solution-focused principles and techniques during the session. This evaluation helped to ensure that each financial therapist was implementing the modality similarly by 80% competency and adherence to the solution-focused financial therapy approach. Following the consultation between financial therapist and observer, the financial therapist returned to the session to share with the client positive observations and compliments.

During session one, the following solution-focused techniques were implemented into the session: (a) joining, (b) historical accounts of solutions, (c) pre-session change, (d) the miracle question, (e) scaling, (f) goal setting, and (g) compliments. Homework assigned at the end of the first session consisted of reviewing the client's credit history and tracking expenses. Clients were asked to track expenses over the course of four weeks.

Sessions two through four were similar in format, where the financial therapist asked questions to elicit each client's perceived and actual strengths as a way to increase accountability and help the client begin taking responsibility for making changes in his/her life, even if minor changes were made. Examples of questions asked during these sessions included:

1. What is different about this week than last week?
2. What did you do differently?
3. How did you manage to do this?
4. What would be the signs that you were doing more of the things that are good for you?

Scaling questions (e.g., “On a scale of zero to 10, where zero means ...”) were also used to assess commitment to change, confidence to change, and motivation to change. For example, the financial therapist would ask, “On a scale from zero to 10, with zero representing that you know that you would not be willing to do anything differently to resolve this situation and 10 being that you know that you would do whatever it takes to sort this out, where do you see yourself right now?” A scaling question, such as this, was followed up with questions like:

1. What number on the scale from 0 to 10 will let you know that you are willing to be committed to the change process?
2. How will you know that you are willing to be committed to the change process?
3. What about yourself or what will you be doing that indicates that you are committed to the change process?

The financial therapist then followed up with the client’s homework assignment from the previous session. Mandatory homework assignments for session two consisted of creating a net worth statement; for session three, the homework was to identify income sources and evaluate all debts; finally, homework for session four involved developing a budget. While these assignments resemble work that might also be required of someone going through traditional financial counseling, the key difference was the manner in which solutions to homework assignments were developed by the client and financial therapist.

The final session (most typically session five) included: (a) reviewing the client’s homework assigned in session four, (b) evaluating the goal(s) the client set at the beginning of the process by asking scaling questions in addition to complimenting the client for his/her achievements, and (c) focusing on the progress the client made and what they learned about themselves throughout the process. In addition, the financial therapists asked questions to help develop a maintenance plan. They also identified potential setbacks in the future and brainstormed ways to deal with these setbacks.

### ***Participant Profiles***

Participants in this pilot clinical study came from university students who were seeking financial advice and counseling through a Midwestern university’s financial counseling clinic. Criteria to participate in the study included the following: (a) over the age of 18, (b) a university student (i.e., undergraduate or graduate), (c) non-clinical levels of distress, (d) no red flag issues present, such as suicidal ideation, alcohol abuse, or clinical depression, and (e) allowing sessions to be recorded (video and audio). All clients

participated in an initial assessment session prior to beginning the solution-focused financial counseling process to screen for potential clinical mental health problems. This step was taken to avoid working with someone whose primary issues were best served by a mental health practitioner and to ensure that all clients were similar in terms of mental health functioning. Participation in the research study was voluntary and those who completed the series of sessions, plus a pre-test taken at the initial assessment session, post-test taken at the final session, and a three-month follow-up survey were compensated \$75 in cash. A total of nine participants began the study. One participant dropped out after attending three sessions. The university's Institutional Review Board approved the study and all applicable testing and evaluation procedures were followed.

### **Measures**

Each measure selected for this study was a standardized self-report instrument developed for use in clinical and/or research settings. Demographic information, which included gender, race/ethnicity, age, marital status, and employment status, and financial information were collected. Financial information included student loan debt, car loan debt, credit card debt, monthly housing costs (i.e., rent/mortgage), and annual pre-tax income. This information was assessed at the initial screening or pre-test. Measures to assess clinical distress, depressive symptoms, financial well-being, financial behaviors, and financial knowledge were included at the pre-test, post-test, and three-month post-post test.

**OQ.45.2 Outcome Questionnaire (OQ.45.2).** The OQ.45.2 is a self-report instrument containing 45-items. The questionnaire was designed to measure clinical distress and change in distress over time (Lambert et al., 1996). The OQ.45.2 measures three psychological domains, including symptomatic distress, interpersonal relations, and social role. Each item is scored on a 5-point Likert-type scale, ranging from zero to four. Total scores can range from zero to 180. Scores above 63 indicate that the individual is so distressed that mental health services are needed. One reason the OQ.45.2 was used in this study was to screen out anyone who presented at a clinically distressed level, meaning a referral to the university's psychotherapy clinic would have been warranted. The second reason the OQ.45.2 was to assess each client's overall progress in managing overall distress. Both test-retest ( $\alpha = .84$ ) and internal consistency ( $\alpha = .93$ ) reliability has been shown to be good to excellent; in addition, the instrument's concurrent validity has also found to be excellent (Lambert et al., 1996).

**Patient Health Questionnaire (PHQ-9).** The PHQ-9 is a brief measure that contains 10-items. The questionnaire is used to screen, diagnose, monitor, and measure the severity of depression (Kroenke, Spitzer, & Williams, 2001). Item responses for the first nine items ranged from 0 (*not at all*) to 3 (*nearly every day*). To score the PHQ-9, the first nine items are summed. Summed scores can range from 0-27 with scores of 1-4 indicating minimal depression, 5-9 demonstrating mild, non-clinical depression, 10-14 representing moderate depression, 15-19 signifying moderately severe depression, and 20-27 suggesting severe depression. It is important to note that clients can have depression symptoms and not be clinically depressed. In this study, clients who were moderately to

severely depressed or who scored 10-27 on the first nine items were not included in the study. Item 10 is evaluated separately to gauge severity of symptoms. Internal reliability and test-retest reliability have been shown to be excellent (Kroenke et al., 2001). In this study, the PHQ-9 was used as a supplemental tool to screen for clinical depression, as well as to monitor progression of depression symptoms.

**InCharge™ Financial Distress/Financial Well-Being (IFDFW) Scale.** The IFDFW Scale is an eight-item instrument that measures the present state of a person's financial well-being (Prawitz, Garman, Sorhaindo, O'Neill, Kim, & Drentea, 2006). Response items range from 1 (*lowest level*) to 10 (*highest level*). To score the IFDFW, item responses are totaled and then divided by eight. Scores range from 1 to 10, with higher scores indicating increased levels of financial well-being. Reliability has been shown to be excellent ( $\alpha = .96$ ) for the IFDFW.

**Financial Stressors.** Financial stressors were measured by asking participants to identify financial events that occurred to them over the past year. This summated variable was used to predict the respondents who had experienced an extreme amount of financial stress. The list of 24 financial stressors was adapted from Joo (1998) and Joo and Grable (2004). Examples of stressors included: (a) becoming seriously ill, (b) having a major house repair, and (c) paying serious medical bills.

**Financial Behaviors.** Financial behaviors were measured using a five-item scale that asked participants to grade themselves in the following areas: (a) spending control, (b) paying bills on time, (c) planning for financial future, (d) providing for self and family, and (e) saving money (Perry & Morris, 2005). Scores ranged on a scale from 1 (*poor*) to 5 (*excellent*). Total scores could range from 5 to 25, with higher scores indicating more positive perception of financial behaviors. Perry and Morris (2005) reported high reliability ( $\alpha = .83$ ) for the financial behaviors scale.

**Financial Knowledge.** Subjective financial knowledge was measured using a five-item scale in which clients were asked how much they knew about the following: (a) interest rates, finances charges and credit terms, (b) credit ratings and credit files, (c) managing finances, (d) investing money, and (e) what is on their credit report. Items were scored on a five-point Likert-type scale, ranging from 1 (*nothing*) to 5 (*a lot*). Total scores could range from 5 to 25 with higher scores suggesting an increased level of self-perceived financial knowledge. This scale has historically shown good reliability with Cronbach's alpha of .87 (Perry & Morris, 2005).

### **Data Analysis**

Descriptive statistics describing the participants prior to and after the intervention were calculated. A Wilcoxon signed ranks test was used to test for both the magnitude and direction of changes in clinical distress, depression, financial well-being, financial behavior, and financial knowledge between the pre-test and two subsequent post-tests. These tests were used to evaluate the hypothesis that median scores of participants on these measures would change from pre-test to post-test (Pett, 1997). Specifically, it was hypothesized that

clinical distress and depression might fall, whereas well-being, behavior, and knowledge might increase.

## **RESULTS**

The final sample included eight participants in which three were male and five were female. Seven of the eight (87.50%) of participants were undergraduate students and not married. On average, one-third of participants lived at home with their parents. One client was married. This client's spouse attended all of the sessions. However, the spouse's data was not included in the study because the partner did not meet the participant criteria. Participants initially reported seeking financial advice and counseling for a variety of reasons, including: (a) debt repayment, (b) budgeting, (c) increasing financial knowledge, and (d) developing and implementing financial goals. Debt repayment and budgeting were the most reported reasons for seeking financial counseling help.

Participants were predominately White (87.50%) and ranged in age from 18 to 34 years ( $Mdn = 23.50$ ,  $SD = 5.81$ ). In regards to employment status, one participant reported being self-employed, three reported being employed part-time, one was employed full-time, and three were not employed. Fifty percent of the sample reported pre-tax household income under \$15,000, 25% reported having an income between \$15,000 and \$24,999, and the remaining 25% reported having income above \$25,000 (see Table 1). Participants were asked how much they paid in housing per month, including rent and renter's insurance or, if they owned a home, mortgage and insurance. The median monthly housing costs were \$341.50. Student loan debt, car loan debt, and credit card debt were measured. The median student loan debt was \$10,000; the median car loan debt was \$0.00 ( $M = \$4,250$ ;  $SD = \$6,633$ ), and the median debt carried on credit cards per participant was \$750.00. The median number of financial stressors experienced by participants during the past year was 3.50.

**Table 1**  
**Participant demographic characteristics**

Sample characteristic	%	Range	<i>Mdn</i>	<i>M</i>	<i>SD</i>
Age		18-34	23.50	24.00	5.81
Relationship status					
Single	87.50				
Married	12.50				
Gender					
Female	62.50				
Male	37.50				
Primary ancestry					
White	87.50				
Other	12.50				
Employment Status					
Full-time Employment	12.50				
Part-time Employment	37.50				
Self-Employed	12.50				
Not Employed	37.50				
Gross Annual Household Income					
Under \$15,000	50.00				
\$15,000 - \$25,999	25.00				
\$25,000 - \$34,999	12.50				
\$35,000 - \$44,999	0.00				
\$45,000 - \$54,999	0.00				
\$55,000 - \$64,999	0.00				
\$65,000 - \$74,999	12.50				
Over \$75,000	0.00				
Auto Loan		0.00-18000	0.00	4250.00	6633.25
Student loans		0-50000	10000	20250.00	18061.40
Credit Card Debt		0-20000	750.00	3500.00	6871.27
Monthly Housing Costs		0-600	341.50	309.13	178.85
Financial Stressors		0-4	3.50	2.88	1.45

Scores on the assessment instruments nominally improved in all areas between initial assessment (i.e., pre-test) and the initial post-test, and the three-month follow-up (post-post test). The median score for the OQ45.2 and PHQ-9 decreased between the pre-test (*Mdn* = 44.50), post-test (*Mdn* = 27.50), and three-month follow-up (*Mdn* = 35.00). Results from the Wilcoxon signed ranks tests were mixed. Scores were not significantly different on the PHQ-9 scale; however, scores were significantly different on the OQ45.2

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scale. These results suggest that depressive symptoms and overall mental health functioning improved nominally upon completion of the solution-focused financial therapy treatment, but showed signs of regression at the three month follow-up, although scores did not revert to their initial state. The change was meaningful in terms of mental health functioning scale. It is important to note that the treatment was not designed to be used as an anxiety or depression intervention. Results simply confirm that the treatment method did not adversely impact participants. Descriptive statistics, including score ranges, medians, means, and standard deviations, are reported for the pre-test, post-test, and post-post tests in Table 2.

Scores for financial well-being, financial behaviors, and financial knowledge nominally increased between the pre-test ( $Mdn = 5.38$ ;  $Mdn = 12.00$ ;  $Mdn = 14.00$ , respectively), post-test ( $Mdn = 6.94$ ;  $Mdn = 19.50$ ;  $Mdn = 16.50$ , respectively), and three-month follow-up ( $Mdn = 6.94$ ,  $SD = 3.70$ ;  $Mdn = 19.50$ ,  $SD = 3.94$ ;  $Mdn = 17.50$ , respectively). As shown in Table 2, the change in well-being, while increasing as hypothesized, was not statistically significant. However, changes in financial behavior and financial knowledge were significant.

**Table 2**  
**Pre-test, post-test, and three month follow-up statistics**

Assessment	Range	<i>Mdn</i>	<i>M</i>	<i>SD</i>	<i>Sig.</i>
PHQ-9					
Pre-Test	0.00-6.00	3.50	3.50	1.93	
Post-Test	1.00-5.00	2.00	2.37	1.50	n.s.
Post-Post Test	0.00-6.00	2.50	2.50	1.77	n.s.
OQ.45.2					
Pre-Test	16.00-58.00	44.50	40.75	14.42	
Post-Test	11.00-59.00	27.50	31.00	18.84	**
Post-Post Test	10.00-51.00	35.00	31.38	14.99	**
IFDFW (Financial Well-being)					
Pre-Test	1.38-9.25	5.38	5.48	2.29	
Post-Test	4.13-9.38	6.94	6.77	1.90	n.s.
Post-Post Test	3.88-9.38	6.94	6.92	1.85	n.s.
Financial Behaviors					
Pre-Test	9.00-20.00	12.00	13.50	3.70	
Post-Test	14.00-23.00	19.50	19.12	3.27	**
Post-Post Test	13.00-24.00	19.50	18.88	3.94	**
Financial Knowledge					
Pre-Test	8.00-18.00	14.00	13.62	3.42	
Post-Test	12.00-23.00	16.50	17.12	4.12	*
Post-Post Test	15.00-24.00	17.50	17.87	2.80	**

Note: n.s. = not significant; \* $p < .05$  \*\* $p < .01$

## DISCUSSION

The literature has suggested for a number of years the need to develop specific practice models and approaches for use by financial therapists, financial counselors, and financial planners. For example, Langrehr (1991) noted that financial counselors and planners would benefit from using counseling techniques derived from psychological approaches. More recently, Archuleta and Grable (2010) and Britt et al. (2015b) called for the investigation of theoretically informed practice models that can be applied to clients seeking financial counseling or financial therapy. Solution-focused is easily adaptable to different presenting issues and situations (Lethem, 2002). The current study on solution-focused financial therapy (SFFT) is one of the few financial therapy modalities to be tested with any kind of data, utilizing rigorous methods.

Results from this study show the potential of SFFT as being an effective approach when working with clients facing financial stress. Nominal scores improved in all areas between pre-test and three-month follow-up, however clinical distress or mental health functioning, financial behaviors, and financial knowledge were the only areas that showed significant changes. One reason that depressive scores (PHQ-9) may not have been significant is due to the low levels of depressive symptoms that clients presented at the outset of the study as this was a requirement of the study. One may expect that mental health distress may have had similar results, but in this study the decrease in mental health distress significantly lowered. However, the OQ.45 that measured mental health covers a broad set of mental health functioning items and does not measure the same symptoms as the PHQ-9.

Another interesting finding is that although financial well-being scores improved, they were not significant. These results may be due to two different issues. First, well-being scores were not extremely low at the pre-test. If scores would have started lower, then there may have been more room to increase well-being. Second, as clients become more knowledgeable about their finances and began improving financial behaviors, they may have become more financially distressed because they learned what they needed to do and keep doing to improve their financial situation.

### ***Implications***

Several implications for practitioners and educators can be made as a result of these findings. First, utilizing a theoretically grounded approach to client intervention provides a lens for viewing how clients function related to finances. Working within such a framework allows practitioners to provide services that are more coherent and consistent. As a result, clients achieve positive outcomes more regularly. Not only is the solution-focused approach a way of working with clients in practice, it is also a way of thinking. Practitioners who employ a solution-focused approach often adopt the principles and assumptions of the model, allowing them to think in a way that naturally evokes solution-focused strategies and interventions. This process does take time and practice, but therapists, counselors, and planners will find that such a model gives them tools they can use, especially when they come to a point when they are not sure what to do next with a client. The approach is

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unique and effective because it moves a client from dwelling on past mistakes to focusing on solutions that have worked in the past as a guide to future behavior.

Second, teaching financial therapy skills to financial counselors and planners can be a difficult task as there are few, if any, theoretically informed approaches that are currently taught in most financial counseling and planning programs. It is not that programs are not interested in teaching these methods, but rather, very few evidence-based models exist. Having an approach that is rooted in a theory, which provides assumptions, principles, and strategies, can easily be taught. In fact, in marriage and family therapy programs, solution-focused therapy is widely used because students can easily grasp the concepts, principles, and assumptions. However, the art of implementing the approach requires practice. The same holds true when adapting Archuleta et al.'s (2015) manual.

Third, this particular pilot study used university students as participants. Although this strategy was for convenience, and to ensure that clients shared a similar attribute, the results suggest that SFFT can be used effectively with university students. This may be ideal for colleges and universities that have a financial counseling center on campus. Counseling staff and/or peer counselors can be trained to use SFFT to help clients not only with their financial issues, but to lower distress related to experiencing financial problems.

As described in this study, the SFFT model, as conceptualized by Archuleta et al. (2015), utilizes a team approach, which is consistent with traditional solution-focused therapy modalities. In solution-focused therapy, a team of observers, typically comprised of more than one therapist, observes the therapist working with the client(s). The objectives for the solution-focused therapy team are much the same as the objectives of the SFFT observer as described in the methods section. In this study, a financial therapist or faculty member trained in the opposite field, when possible, acted as the observer. The observer was not in the room with the financial therapist but viewed the session in the next room through a live video feed. This way, the observer was able to provide immediate feedback when the financial therapist took a break. At break time, the observer and financial therapist had the opportunity to brainstorm interventions and homework ideas that might best help the client in addition to discussing the client's strengths. The use of an observer from an opposite field was particularly helpful when providing insights about the client in regards to their financial situation and psychological, emotional, and relational states because often the financial therapist was either not aware of or had not thought of the issues presented by the observer. This helped the financial therapist maintain a solution-focused stance and utilize solution-focused interventions.

Finally, SFFT promotes mental health and personal finance fields joining forces. Based on results from this study, it is reasonable to believe that SFFT provides promise not only for financial therapists, but also for professionals who primarily identify themselves as financial counselors and mental health therapists who work with clients facing financial issues. Since clients often experience depression, anxiety, and distress as a result of financial issues, treating financial stress and clinical distress concurrently may be another area in which to implement solution-focused therapy. Recent literature (e.g., Archuleta & Grable, 2010; Durband, Grable, & Britt, 2010; Klontz, Britt, & Archuleta, 2015) supports the

revolutionary promise of financial therapy, which is defined as the integration of cognitive, emotional, behavioral, relational, and economic aspects that promote financial health (Financial Therapy Association, 2014). The teaming of mental health and financial professionals in an approach like SFFT could be well suited for those interested or practicing financial therapy.

In addition to financial counselors and mental health therapists, financial planners may also find this approach useful. Although the client concerns in this study dealt primarily with budgeting and debt management issues, more traditionally linked to financial counseling types of topics, SFFT can most likely be successful when employed with the clients whose major focus is learning about investments and developing financial goals, which are areas that financial planners address in practice.

### ***Limitations and Future Directions***

While the results from this study are noteworthy, certain limitations do exist. Generalizability is a limitation. However, generalizability is a common limitation in pilot studies like this one where only university students who were predominantly similar in demographic and socioeconomic status were involved. As a small clinical pilot study, the number of participants was limited. Also, no control group was used. While these are limitations, it is important to note that this is among the first studies to attempt to validate a financial therapy manual approach to client intervention. Results do indicate that a larger scale study is warranted (Leon, Davis, & Kraemer, 2011). Specifically, results show that participant nominal scores improved from pre-test to three-month follow-up in all areas, while scores significantly improved in the following areas: distress, financial behaviors, and financial knowledge. It will be important for future studies to further these results by conducting a true experimental design study, using a control group with a larger, more diverse sample that encompasses a broader population beyond university students.

### ***Conclusion***

It is the opinion of the authors that SFFT is not the only approach that can be used with financial therapy clients; however, to the authors' knowledge, SFFT is one of the few approaches in financial therapy that has had any testing to date (see Klontz et al. 2015). One of the difficulties in testing existing financial counseling and planning approaches is that these modalities are not theoretically informed and largely vary from one practitioner to another. In short, these approaches have been developed over time and based on individual practitioner experiences. As a result, very few models have been articulated in a way that can be replicated by another practitioner, which limits testability. This is discouraging as many of these methods may be very effective and be useful in training future and current financial therapists, counselors, and planners.

In conclusion, this study is the first test of Archuleta et al.'s (2015) SFFT manual. Results from this pilot test suggest positive results for those who participated in the study. The pilot data indicate that the SFFT model can be a useful tool when helping clients achieve successful outcomes. However, and as noted previously, larger scale studies are

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needed to confirm the effectiveness of SFFT as a financial therapy approach. In the meantime, SFFT may be an approach that financial therapists, counselors, planners, and educators, as well as mental health professionals working with financial issues, may want to utilize in their work with clients. It is also a modality that can be implemented in academic programs offering financial therapy, counseling, and planning courses as a technique that has been manualized. With each client's goal(s) at the center of the approach, SFFT principles, assumptions, and strategies can be implemented in multiple financial settings.

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