THE IMPACT OF ADVERSE CHILDHOOD EXPERIENCES ON ADULT MONETARY BEHAVIORS

by

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DISSERTATION

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This dissertation, by Patricia C. Michaels, has been approved by the committee members signed below who recommend that it be accepted by the faculty of Antioch University, Santa Barbara in partial fulfillment of requirement for the degree of DOCTOR OF PSYCHOLOGY.

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Abstract

Financial stressors such as unemployment and unexpected expenses are difficult for the general population, but for adults who experienced an adverse childhood, financial stressors may have a serious negative impact on their motivation, well-being, and interpersonal relationships. In addition, life stress may lead people with adverse childhood experiences to exhibit dysfunctional money behaviors. The primary hypothesis of this study is that adults who had adverse childhood experiences, as measured by the Adverse Childhood Experiences Questionnaire (ACE-Q), will show a positive association between the severity of their childhood adverse experiences and the extent of dysfunctional money behaviors they report, as measured by the Klontz-Money Behavior Inventory (K-MBI). Out of 187 random participants in this research project, the average number of adverse childhood experiences was 2.11 out of a possible 10. Using the Pearson Correlations, the K-MBI's scales as related to the total number of ACE-Q items statistically varied in significance from the weak to the moderate range. Future researchers in this area are encouraged to stratify those people who had four or more adverse childhood experiences to allow these potentially causal dysfunctional money behaviors to show their dominance.

Keywords: *Adverse Childhood Experiences (ACE), Klontz-Money Behavior Inventory (K-MBI), child abuse, child trauma, financial stress, money issues, well-being, depression, anxiety, dysfunctional money behaviors, maladaptive money behaviors, money behaviors are diagnostic*.

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Chapter I: Introduction

When people's financial resources are limited, especially for an extended period of time, their mental and physical well-being are negatively affected (Atzaba-Poria, Pike, & Deater-Deckards, 2004). There is significant research evidence to substantiate that for many people having adverse childhood experiences (ACEs) is associated with lower educational attainment, antisocial behaviors, frequent absences from work, and poor job performance (Dong, Anda, Dube, Giles, & Felitti, 2003). Financial stressors, such as unemployment and unexpected expense, are difficult for the general population, but for adults who experienced an adverse childhood, financial stressors may dampen a person's motivation, decrease their sense of well-being, and harm their interpersonal relationships (Conger & Dogan, 2007; Furnham & Lewis, 1986). In addition to financial stressors, there may be another component that perpetuates people's financial instability, namely dysfunctional spending behaviors. With the exceptions of pathological gambling and hoarding, little research has been done to explore the etiology of disordered money behaviors. The purpose of this study is to determine if there is an association between dysfunctional money behaviors, such as overspending, compulsive buying and pathological gambling, and adults who experienced adverse childhood experiences.

The American Psychological Association's Stress in America Survey (APA, 2009), reported that money has been the number one stressor in the United States since the 2008 financial crisis (Financial Crisis Response, 2011). The findings from the APA survey documented that even though most people reported their health to be good (80% said their health is excellent, very good, or good), the younger generation parents, and people living in lower-income households (making less than $50,000 per year), had a different experience. The lower-income households reported higher levels of stress than did other Americans overall, especially

people with money. The lower-income households experienced greater degrees of money stressors (such as foreclosures, homelessness, and loss of income) and were more likely to engage in unhealthy behaviors to manage their stress. The survey concluded the gap between people who appeared to do well by managing their stress and the percentage of people who were not, was growing rapidly. The scope of the present study is to explore if dysfunctional money behaviors are prevalent within a specific population. The main hypothesis examined in this study is adults who experienced adverse childhood experiences (as measured by the Adverse Childhood Experience Questionnaire, ACE-Q), will be positively associated with their tendency to engage in maladaptive money behaviors (as measured by the Klontz-Money Behavior Inventory, K-MBI).

Statement of the Core Problem

Despite the significant impact financial stressors have on people's mental health, there is a lack of empirical data addressing this hypothesis (Furnham & Argyle, 1998; Kreuger, 1986). Even though money is the number one stressor in the United States, very few money-related psychotherapeutic assessments exist. The irony is that even though the APA conducted a survey that distinguished money as the number one stressor in the United States, mental health professionals have sadly neglected to inquire about their patients' money behaviors and financial well-being (Klontz, Bivens, Klontz, Wada, & Kahler, 2008). It would seem to make sense that patients' money behaviors would be an important criterion to include in the clinical interview and used for diagnostic information within psychotherapy sessions. The intent of this study is to stimulate rethinking about how emotions related to financial stress can cause debilitating emotional strain. How patients learn to understand money, and form their beliefs and practices

regarding financial resources, deserves a thorough behavioral analysis since money is a key factor in everyone's life.

The results of this study can introduce information to assist psychologists in identifying dysfunctional money behaviors that may interfere with patients' daily functioning. It may also contribute to a greater understanding of the importance of integrating the psychology of money into therapeutic sessions. This may deepen not only patient awareness, but aid psychologists in examining their own money behaviors, thereby alleviating possible countertransference. This study aims to establish a benchmark and spark interest in future research examining how dysfunctional money behaviors can undermine patients' daily lives, lead to mental health issues, and even sabotage the psychotherapeutic process.

Adverse Childhood Experiences Within the United States

Adverse childhood experiences (ACE) are a pervasive health concern across many disciplines. An immense quantity of research demonstrates that exposure to physical, sexual, and emotional adversity in childhood places people at greater risk for mental and physical difficulties (Anda et al., 2006; Lanis, Vermetten, & Pain, 2010). The reported incidences of adverse experiences have quadrupled from 1986 to 1993 (Sedlak & Brodhurst, 1996; Hall, 2000). By 2014, over six million children in the United States were reported as abuse victims. Unfortunately, the United States has the worst record among industrialized nations, losing between four and seven children every day because of child abuse and neglect (Children's Bureau, U.S. Department of Health & Human Services, 2014). The estimated cost of child abuse and neglect in the United States based on data drawn from a variety of courses was $103.8 billion in 2007 (Wang & Holton, 2007). Even though ACEs impact more than 50% of the U.S. population and are recognized to have powerful adverse effects on health at all life stages and on

victims' socio-economic well-being in adulthood (Liu et al., 2013; Schusseler-Fiorenza Rose et al., 2015), psychological researchers have not examined if dysfunctional money behaviors may be a key construct that adds to the disempowering after effect of ACEs. Since the number one stressor in the United States is financial instability, it may be important to explore dysfunctional money behaviors in every patient's history. Examining money behaviors is especially relevant for adults who had adverse childhood experiences, as it may help define interventions that can lessen the life stress they experience. If this study's hypothesis holds true, a link between money behavior and adverse childhood experiences could open up new approaches for improving prognosis, treatment, and research.

Financial strain and difficulties may have an adverse effect on parents' emotions, behaviors, and beliefs, which can negatively influence their parenting practices and socialization strategies (Conger & Dogan, 2007). The family environment is how, when, and why children come to understand the economic world (Furnham and Argyle, 1998; Furnham & Okamura, 1999; Strauss, 1952). This notion is of theoretical importance because children are subject to the influence of their parents' beliefs and practices around money. Therefore, when money stressors significantly impact the family's homeostasis, this disruption is likely to have a negative effect on the children.

Background

The 2008 financial crisis caused an estimated decline amounting to trillions of dollars of middle-class wealth in the United States. The financial market provided access to almost unlimited amounts of consumer credit. American money issues such as high debt, unemployment, increased health costs, mortgage debt, and students' loan debts were at an all-time high. During the crisis, home foreclosures climbed and by late 2008 one out of every five-

mortgage owners owed more than their home was worth (Financial Crisis Response, 2011). Whether measured by the unemployment rate, the reaction to the economic bailout, effects of the increase in home foreclosures, or the rationing of money to pay for medication or food, the 2008 financial crisis had a significant cultural influence on many individuals and families (National Alliance on Mental Illness (NAMI), 2008).

According to the American philosopher, author, and religious scholar Jacob Needleman (1998), money has entered more aspects of life in the United States than in any other nation. In some cultures, honor and self-respect are the focus, but in the United States, money often constitutes the central purpose of life. The United States population is vulnerable to sophisticated marketing campaigns that influence spending habits, such as buying a home a family cannot afford. Money is often used to buy items for outward appearances and material acquisitions that superficially soothe psychological problems and enhance self-worth (Burroughs and Rindfleisch, 2002; Wang, Cheng, Chiou, & Kung, 2012; Christopher, Marek, & Carroll, 2004; Troisi, Christopher, & Marek, 2006). The United States population is vulnerable to consumerism. Those more at risk may be adults who experienced child abuse are those left with a legacy of psychological vulnerability are at greater risk of succumbing to the allure of unnecessary spending. This spending may have masked negative feelings of loneliness, anxiety, tension, and/or depression for the short term, but may lead to financial instability (Cambron, Gringeri, & Vogel-Ferguson, 2014).

A 2010 survey published by the National Council of La Raza (formerly named: UnidosUS.org; is the United States' largest Latino nonprofit advocacy organization) reported foreclosures that brought about the Latino/Hispanic community financial instability, also led to increased domestic violence, disintegration of marriages, family dislocation and changed social

networks. Financial providers for these families experienced feelings of shame and humiliation due to their inability to support their families (National Council of La Raza, 2010). Unemployment caused many Americans to encounter foreclosures. A study by Yong et. al. (2013) concluded individuals who had ACE, especially men, were twice as likely to experience unemployment because of impaired cognitive ability during childhood resulting in lower educational achievement, social isolation, and less resilience to adversity. The effects of unemployment can quickly diminish income and jeopardize a family's basic security, their home. The effects of a family losing their monthly income and/or home can be emotionally devastating; for some families, it led to separation and/or divorce. These life-changing events can also cause anxiety, insomnia, depression, and even suicide (O'Neill, Sorhaindo, Xiao, & Garman, 2005). Financial instability not only contributes to distressing emotions for the providers, but it also significantly affects children. Data compiled by the Third National Incidence Study of Child Abuse and Neglect indicate that children from families with annual incomes below $15,000 were over 22 times more likely to experience maltreatment than children from families whose income exceeded $30,000. These children were almost 56 times more likely to be educationally neglected and over 22 times more likely to be seriously injured. Cumulative evidence of studies shows that financial stress during childhood is the one most powerful predictor of childhood neglect (Lieberman, Zeanah, & McIntosh, 2011).

Dr. Alex Crosby, an epidemiologist at the Centers for Disease Control and Prevention, discovered that suicide was high when the economy was weak (Tavernise, 2016). In the years before the onset of the 2008 financial crisis, the suicide mortality rate in the United States was rising an average rate of 0-12 per 100,000/person per year. During 2008-2010, the suicide rate accelerated to 0-51 deaths per 100,000/person per year (Correspondence, 2012). After the 2008

financial crisis, for the first time in history the number of suicides in the United States surpassed motor vehicle deaths (Anderson, Belar, & Breckler, 2015). Another interesting statistic from the Correspondence Report (2012) is that as unemployment increased from 5.8 to 9.6% between 2007 and 2010, the rate of suicides increased by 3.8%. Suicide of a family member or a friend is a traumatic experience and especially traumatic for children. In 2014, the American Association of Suicidology reported that there were 838,373 suicides between 1990 and 2014. The number of survivors of a suicide in the family is 15.09 million (one of every 21 Americans in 2014). This number grew by 769,914 in 2014. Many survivors of suicide are children. A loss due to suicide of a caregiver or close relative during childhood is an adverse childhood experience.

The APA's 2010 Stress in America Findings Survey reported most parents were grossly unaware of the impact financial stress had on their children. Katherine Nordal, Ph.D., APA's executive director for professional practice reported that one key to children's mental health is for parents to communicate with their children about how to identify stress triggers and manage stress in healthy ways. If children do not learn these lessons early on, it could significantly impact their emotional well-being as they move into adulthood (American Psychological Association, Stress in America Findings Survey, 2010).

Money stress contributes to a vicious cycle of unhealthy behaviors (e.g., emotional, verbal, and physical abuse) and unhealthy coping mechanisms (e.g., making impulsive purchases, gambling, abusing alcohol, using illicit drugs such as heroin and methamphetamines, etc.) among United States citizens (Cambron et al., 2014). It is critically important to explore the financial stability of a patient to identify all underlying trigger sources, especially when unhealthy behaviors, and/or unhealthy coping mechanisms, are presented within a therapy session.

Summary

Financial stress appears to have a significant impact on many American's lives. Money and finances remain a substantial stressor, as noted by the APA's stress survey beginning in 2007. Effects of deteriorating finances can be subtle, so subtle that the emotional impact of financial issues is seldom addressed within psychotherapy sessions. While the emotional impact of financial distress is widely ignored, this study examines a particular population (people who experienced adverse childhood experiences), to explore how a person's emotional well-being is associated with their current money behaviors.

The results of this study will examine if adverse childhood experiences (as measured by the Adverse Childhood Experiences Questionnaire, ACE-Q) are related to an individual's financial behavior (as measured by the Klontz-Money Behavior Inventory, K-MBI). This research hypothesizes that higher scores on the ACE-Q (more adverse childhood experiences) will correlate to higher scores on the K-MBI (more dysfunctional money behaviors). The demographic categories are listed on Appendix I. Questions and the hypotheses are:

Research Question 1. Are any of the 10 ACE-Q experiences individually related to any of the 10 K-MBI subscale scores?

$H_0$1. None of the 10 ACE-Q experiences are related to any of the ten K-MBI subscale scores.

H_a1. At least one of the 10 ACE-Q experiences is related to at least one of the ten K-MBI subscale scores.

Statistical Approach: Point Biserial Correlations

Research Question 2. Is the ACE-Q abuse, neglect, household dysfunction, and/or total experiences score related to any of the 10 K-MBI subscale scores?

$H_0$2. None of ACE-Q abuse, neglect, household dysfunction and total experiences scores are related to any of the 10 K-MBI subscale scores.

H_a2. At least one of the ACE-Q abuse, neglect, household dysfunction, and total experiences scores are related to at least one of the 10 K-MBI subscale scores.

Statistical Approach: Pearson Correlations

Research Question 3. Are any of the 10 ACE-Q experiences individually related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics

$H_0$3. None of the 10 ACE-Q experiences are related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

H_a3. At least one of the 10 ACE-Q experiences is related to at least one of the ten K-MBI subscale scores after controlling for the respondent's demographic characteristics.

Statistical Approach: Partial Correlations

Research Question 4. Is the ACE-Q abuse, neglect, household dysfunction, and/or total experiences scores related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics?

$H_0$4. None of the ACE-Q abuse, neglect, household dysfunction, and total experiences scores will be related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

H_a4. At least one of the ACE-Q abuse, neglect, household dysfunction, and total experiences scores will be related to at least one of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

Statistical Approach: Partial Correlations

Chapter II: Literature Review

Introduction

The powerful influence of money, combined with its neutrality, yields a perfect object of transference (and countertransference) (Klontz et al., 2008). A notable psychological definition of money by Trachtman (1999) is that money is a projection of people's emotional concerns. When money is in scarce supply, this relationship to money can cause anxiety and unhappiness (Furnham, 1996). A person's beliefs around money contain various mental concepts; money can have a significant emotional effect relating to one's security, stability, and well-being, for money is necessary to acquire a home, transportation, and food. However, within the United States money means more than just the basics, it is difficult to participate in society without money. Trachtman (1999) wrote of " . . . our projection onto coins, bills, and financial instruments of our beliefs, hopes, and fears about how those things will affect who we are, what will happen to us, and how we will be treated by others or by ourselves" (p. 287). Money is powerful, as our relationship to it can influence our well-being and cognition (Mills, Grasmick, Morgan, Wenk, 1992) and our acceptance within the American culture.

The research literature has shown increasing interest in studying the psychology of money psychology since the 2008 financial crisis, yet some mental health professionals avoid integrating money behaviors into their therapeutic sessions. Money is an essential part of daily life, and inquiring about money behaviors and beliefs can provide important diagnostic information. Money questions such as: what a patient believes and thinks about money; how a patient spends; whether a patient saves or does not save; and what concerns a patient has and feels about debt, should be an important part of the clinical interview. Answers to these questions are essential to an individual's mental health. Yet, according to Krueger (1986), money is

perhaps the most ignored subject in the practice, literature, and training of psychotherapy: "Psychotherapists are embarrassed or conflicted about discussion of money" (p. 7).

Financial satisfaction and a sense of well-being involves being financially "healthy, happy, and free from financial worry," (Joo & Grable, 2004, p. 27). Persons who are chronically anxious about money may perceive their financial situation to be inescapable and ill fated. Anxious people tend to complain more frequently about money and are less satisfied with their jobs (Zalewska, 2011), their relationships (Mikulincer & Shaver, 2007), and their lives (Guney, Kalfat, & Boysan, 2010). The impact of money anxiety may be connected to materialistic traits frequently endorsed by persons with low self-esteem (Chaplin & Roedder, 2007; Shafer, 2000). People with materialistic traits may ruminate between what they want vs. what they can not afford. These people may become hopeless about satisfying their materialistic desires (Solberg et al., 2001) leading them to deny themselves from purchasing what they desire or to overspend. Awareness of money behaviors and understanding what drives those behaviors can assist patients' financial stability, especially when financial stability is a key factor for a sense of well-being in consumer-based nations such as the United States.

The understanding of money behaviors is important not just for psychologists, but also for marketers, policy makers, sociologists, and anthropologists. Social scientists from many of these different disciplines have studied peoples' attitudes about and behavior toward money. Within the United States, the population not only depends on money for basic needs, but the culture is also greatly influenced by large corporations which implement highly sophisticated advertising campaigns to convince American citizens their products are necessary and will help solve their problems. Often, in reality, buying unnecessary products may cause financial stress and economic instability. Lester and Spinella (2005) questioned why national suicide rates

increase when the stock market crashes, even though those committing suicide might still have ample money. Tang and his colleagues (2004) noted, "Rich or poor is a state of mind. People may be financially poor but psychologically rich and vice versa" (p. 119). Put differently, two people with the same wealth are likely to have different perceptions about their financial situation. As mental health professionals, it is important to be aware of the control and power that money may have over a patient's state of mind; one person may take a financial crisis in stride, while another may present with severe depression. A patient's relationship to money is an important factor to integrate into the clinical interview.

There was no literature that this researcher ascertained that directly related to this study, but a few did relate indirectly, such as in Chong-Hwan Son's (2016) study. Son noted that male, married, and White non-Hispanic individuals have less exposure to ACEs than other adults, as the ACE scores rose for those who had less than a high school education and household income less than $20,000. The literature review is divided into three parts. In the first section, theories and research regarding money are explored; in the second part, studies relating to how childhood abuse may affect money behavior in adulthood are examined; and in the third part, studies regarding existing money measures are reported.

Theoretical Background

Sigmund Freud, the founding father of psychoanalysis, recognized that a style of money management is one of the most obvious ways in which people differ. He observed a range of reactions to money in his patients, from loathing to compulsion to appreciation. One of his descriptions of the different personality styles, as noted in his Rat Man case (Freud & Rieff, 2008) was that of an anal personality. Freud's Rat Man case presented with obsessional thoughts and behaviors he felt compelled to carry out; this was precipitated by losing the Rat Man's

reading glasses and his increased anxiety on how he would pay for them. Freud documented how the anal personality simulates the subconscious alter ego's obsession with feces. A later psychoanalyst, Ferenczi (Rachman, 2007), who enhanced Freud's idea, stated the different individual behaviors and attitudes toward money (the misers hoarding to the spendthrift's self-destructive carelessness) represented varieties of anal eroticism. Several theories have since been developed to explain patients' money behaviors and how money magnifies mental health issues.

Many of these theories describe how significant the concept of money can be in relation to a person's mental health. Kraepelin was the first to describe impulsive-compulsive buying (CB) disorder. He called the disorder *oniomania* and affected patients were labeled "buying maniacs" (Dell'Osso, Allen, Altamura, Buoli, & Hollander, 2008). Kraepelin mentioned compulsive buying leads to senseless debt. Shopping experiences provide pleasure and relaxation, but for some, excessive shopping is a costly way of life. These are compulsive buyers whose lives are organized around many shopping experiences and whose behavior, untreated, can lead to complications (Shepherd, 1995).

Spending money may also fulfill a psychological need. Karl Abraham proposed that money is used to counterbalance anxiety related to separation issues (Freud, S & Abraham, K 2002). He also asserted lack of money is a threat to one's safety and contributes to depression and emptiness—an important concept for this study. Fenichel (Michels, 1996) also identified that depression is often associated with compulsive neuroses, and he asserted that poverty and a fear of money loss repeatedly plays a role in clinical depression. For some people, the attainment of money may be necessary to sustain their feeling of worthiness in society. When money is believed to be mandatory for one's safety and then becomes scarce, the lack can cause stress in daily functioning.

Many psychologists suggested that money is often used to enhance self-esteem. Murray (1938) stated money behavior reflects needs for achievement, acquisition, and recognition. Adler (1964) believed the need to collect and hoard money stems from feelings of inferiority. Fenichel (Michels, 1996) stated the drive to become wealthy is when one seeks a sense of power and respect to recapture childhood feelings of omnipotence. Krueger (1986) observed emotionally deprived persons unconsciously replace what is missing with objects to "fill the emptiness of depression and the absence of self-regulation" (p. 582). A chronic inability to self-regulate emotions may be associated with high levels of impulsivity among adults who experienced childhood trauma (Music, 2014). The emotional significance attributed to certain types of purchased objects may address personal and social identity needs. Buying objects one cannot afford may temporarily regulate emotions and provide a short-term positive reinforcement, but given time, the negative reinforcement of anxiety and depression may become acute when money scarcities surface.

Well before the 2008 financial crisis, psychological theories explored peoples' relationships to money and how the power of money influences behavior. Those who originated theories of money behavior included Lindgren (1980) and later Gurney (1988), who examined the relationship between self and money; these writers explored through observation how attitudes and feelings about money integrated into people's lives and how attitudes motivated behavior in subtle ways. Lindgren and Gurney noted these beliefs were personal, subjective, and connected to images of the self within a modern consumer society. Krueger recognized that: "Money is probably the most emotionally meaningful object in contemporary life; only food and sex are its close competitors as common carriers of such strong and diverse feelings, significances, and strivings" (Krueger, 1986, p. 3). According to Goldberg and Lewis (1978),

"[People] have become so indoctrinated with the idea that having money is important, that they no longer question why. They are unaware that perhaps what they are truly seeking is an increase in self-respect, or security, or freedom, or love, or power" (p. 14).

American culture is money-oriented, as money is a superior means for the exchange of value. The United States imbued with the values of a capitalistic economy where people seem to have lost sight of other aspects of life and are driven into a lifetime of money enslavement. Large corporations promote advertising campaigns to shape audience's values and preferences, convincing consumers by subtle manipulation that their products are necessary. Marketing techniques saturate their audience and cause them to over identify with image and material possessions; when these influences are combined with easily acquired credit, many people are driven to spend beyond their means. This contributes greatly not only to the nation's financial instability, but also to the style of life internalized by a significant element of the nation's people. Fromm (1976) described Western industrial society as possessing an orientation in which greed for money, fame, and power became dominant themes of life. He believed if economic, social, and political conditions deprive man of freedom (of family, spontaneous activity, love, passion for work, and belonging to nature), life will lack meaning and direction, and powerful tendencies to escape from the submission to cultural norms will arise.

These theories validated the powerful influence money has on the dominant culture of the United States. Even though money is an abstract object, it has a subconscious hold on human behavior. According to earlier psychological theories, money can give a false sense of well-being, it can seem to soothe psychological problems, to increase self-respect, and to enhance feelings of security, love, and power. It is easy to understand how money can be a controlling factor in mental and physical well-being and an important aspect to explore within therapy.

Studies of the Effects of Adverse Experiences in Childhood in Relation to Money Behaviors

Financial matters were identified as a significant source of stress for individuals and their families. People learn about money (how to manage it, how to come to understand it, and how to react when financial stress occurs) during childhood (Furnham, 1996; Kirkcaldy & Furnham, 1993). The following studies explored how financial instability can affect a person's sense of well being, can affect a family's homeostasis, can cause depression and anxiety, and how child abuse can affect an adult's financial stability.

One of the most painful side-effects of financial hardship is the rise of child abuse and neglect (Price, 2009). Childhood abuses are well-established risk factors for developing acute and chronic mental illness. (Anda, et al., 2006; Anda, et al., 1999; Felitti, et al., 1998). During economic hardships, problems with marital, parent-child, and sibling relationships become aggravated. Economic pressures can lead to hostility between spouses, which can advance into exaggerated disciplinary practices with children (Conger et al., 1994). The Iowa Project (Conger et al., 1994) is an example of a research study that demonstrated how a financial crisis can upset a family's homeostasis. The Iowa Project was a qualitative study still widely considered the richest archive of life-record data on rural families and children in the United States. This project analyzed experiences of over 400 Iowa families who lived through the great farm crisis of the 1980s. These families lived on farms or in small rural communities financially dependent on an agricultural economy. Trained observers and family members' self-reports measured theoretical constructs in the model. The study's data came from both the observations, by trained observers, as well as self-report data from four members of each family: the father; the mother; an adolescent child; and the sibling closest in age to the adolescent. Interviewers documented behavioral vulnerabilities of these family members during that economic crisis. Family members

described the sense of hopelessness that can overtake those who suffer severe financial hardship. Feelings of depression among the parents were more prevalent in families with lower incomes, higher debt-to-asset ratios, and/or unstable work patterns. Some people noted that in families with social and family reinforcement (a solid support system), the adults' depressive symptoms were mitigated. Overall, economic stress took a toll on marital quality and parent-child relations. Tragic circumstances happened during these times. For instance, a farmer in Hills, Iowa, shot and killed his banker, his neighbor, his wife, and then himself. In South Dakota's Union County, a Farmers Home Administration administrator murdered his wife, daughter, son, and dog before committing suicide. Surveys revealed cases of child abuse and neglect rose by 10% in a nine-county rural area in southern Iowa during this period. Studies also showed an alarming rise in divorce rates and alcohol abuse in farm families. Economic hardship can lead to hostility within a family. Tension between spouses led to severe disciplinary practices with children. This well documented project demonstrates that economic hardship can have a severe adverse influence on the psychological well-being of each family member and on the quality of family relationships.

An intriguing discovery within this study showed how psychological vulnerabilities in parents, traced to their childhoods, further undermined their ability to secure social-support systems in the hard times of the 1980s (Conger et al., 1994). Children who experienced the great 1980s farm crisis were greatly influenced by their family's economic hardships, and in turn may have influenced their adulthood money behaviors.

Many studies have documented how difficult it is for adults who were abused as children to regulate their emotions. For many abuse survivors, one after effect of childhood abuse is an inability to function in adulthood tasks such as working, money management, and parenting (Hall, 2000). In 2000, J. M. Hall completed a qualitative study involving 20 urban, African-

American, low-income women survivors of abuse. This study documented the participant's stories about their lives, including their adverse childhood experiences. Information given by participants was paraphrased; for example, having an abusive current male partner, could be paraphrased as: "I stay because he pays the bills." Paraphrases were indexed for later reference and then linked to the participant's direct quotes. Paraphrases were matched with similar demographic information as a way of comparing individual participant profiles to search for patterns. Direct quotes were then separated into themes and organized within five broad domains. The Hall study revealed the obstacles experienced by adults who have had adverse childhood experiences. Those obstacles are:

1. Lack of education regarding money management, time management, and parenting skills;
2. Emotional instability with an early onset of depression, anger, and difficulty trusting others;
3. Financial instability due to a lack of healthy money-management role models.

For women in the study, illiteracy and opposition from male partners prevented success at any level. Their financial instability triggered the emotional instability, often causing a downward-spiral effect and increasing difficulty in meeting daily needs. The emotional instability triggered the onset of mood disorders, thus causing a decreased ability to earn income. This study's findings demonstrate the need for mental health providers to integrate money-management skills through a workbook or refer the patient to someone who can provide money-management education.

Childhood adversities are empirically associated with self-regulation difficulties in adulthood, although a relationship between childhood trauma and compulsive buying was not explored until a study conducted by Sansone, Chang, Jewell, and Rock (2013). This appears to

be one of the first psychological studies to explore dysfunctional money behaviors as they relate to childhood trauma. Compulsive buying (CB) is recognized as a problem, as stated earlier in Kraepelin's oniomania (Shepherd, 1995). Sansone, Chang, Jewell, and Rock (2013) examined various types of childhood trauma and compulsive buying behavior in adulthood. A self-report survey methodology was conducted using a sample of 370 obstetrics/gynecology patients. Five types of childhood trauma with an onset before the age of 12 years were examined (i.e. witnessing violence, physical neglect, emotional abuse, physical abuse, and sexual abuse) in relation to compulsive buying as assessed by the Compulsive Buying Scale (CBS). Using a hierarchical linear regression analysis, Sansone and his associates found that two forms of trauma were particularly related to compulsive buying: witnessing violence and emotional abuse. The study found a statistically significant association between all forms of trauma and people's scores on the CBS. The data also indicated that the race of the subject was unrelated to the degree of the association between childhood trauma and compulsive buying.

In 2011, Yong et. al. conducted a study to assess the relationship between adverse childhood experiences and unemployment among adults. This study employed the 2009 Behavioral Risk Factor Surveillance System (BRFSS) survey and the Adverse Childhood Experiences Questionnaire (ACE-Q), it also provided socio-demographic and social-support data for 17,469 respondents (ages 18-64 years). The data used in this study's analysis was drawn from five states: Arkansas, Louisiana, New Mexico, Tennessee, and Washington. The study determined that more than half of adult respondents reported experiencing an event from at least one ACE category during childhood. Overall, the results showed childhood experiences of abuse were associated with an increased risk of unemployment among both men and women. The study also pointed out that the estimated direct and indirect cost of these abuse experiences might be

more than $57 billion, based on approximately 3.3 million maltreated or neglected children reported by state and local child protective services in the United States in 2008. This study suggested that the cognitive ability of adults who had experienced childhood trauma might be impaired. Impaired cognitive ability would cause lower educational attainment and greater financial instability.

A study conducted by Caballero, Johnson, Buchanan, & DeCamp (2017) examined the prevalence of child and family characteristics associated with ACEs in children in Hispanic immigrant families compared with Hispanic children who lived in families where the parents were born in the U.S. Caballeros, et al.'s study demonstrated how strong family relationships decrease the likelihood of ACEs. The 2011 and 2012 National Survey of Children's Health (NSCH), whose data was collected using phone interviews, included questions asking parents about their exposure to ACE. These surveys found that Hispanic children make up a quarter of all children in the United States and that they are projected to remain the largest ethnic minority group among children (Passel & Cohn, 2008); Hispanic children in immigrant families comprise over half of all immigrant children in the U.S. Hispanic children in immigrant families are more likely to be uninsured, to live in poverty, and to experience food insecurity than Non-Hispanic White children (Woods, Hanson, Saxton, & Simms, 2013; Wildsmith, Alvira-Hammond, & Guzman 2016; Capps, Horowitz, Fortuny, Bronte-Tinkew, & Zaslow, 2009). Further, the survey data revealed that ACE exposure among Hispanic children was lower than among African American children, despite similarly high rates of childhood poverty (Child Trends Databank, 2016). The prevalence of high ACE exposure was significantly higher in children in US-native families compared with children in immigrant families. Parental divorce and economic hardship were the most prevalence ACE exposures. Despite higher poverty, lower education, and

decreased health care access (ACE-Q was initially used to show correlations with health issues), Hispanic immigrants have similar or better health outcomes than whites and US-born Hispanics (Caballero, Johnson, Buchanan, & DeCamp, p. 5 (2007);Mendoza (1986); Markides & Coreil (1986), Vaughn, et al. (2017). Further, the lack of a supportive family environment was significantly associated with increased odds of high ACE exposure in children in immigrant families. It is likely that emotional consequences of an absent parent are universal among children. Within the immigrant families, death, divorce, and incarceration are not the only reasons for parental absence, but immigrant children may experience an extended separation from parents related to parental deportation, complicated and often discriminatory immigration policies, and financial limitations (Suarez-Orozco, Todorova, & Louie, 2002; Enchautegui & Menjivar, 2015; Gindling & Poggio, 2012). For immigrant children, indefinite separations have a powerful negative influence on childhood attachment, and emotional, social, and physical health (Suarez-Orozco, Todorova, & Louie, 2002; Enchautegui & Menjivar, 2015). Literature on immigrant families shows that strong family and community networks can safeguard against some of the effects of ACE exposure (American Psychological Association, 2012; Linton, Choi, Mendoza, 2016; Gallo, Penedo, Espinosa de los Monteros, & Arguelles, 2009; Javier, Festa, Florendo, & Mendoza, 2015). In addition, the religious and spiritual values of Hispanic immigrant parents, and a positive cultural identity among Hispanic youth correlate with positive self-rated health and ability to cope with mental health issues, discrimination, and stressful life events including financial stress (Krause & Bastida, 2011; Escobar, et al. 2013; Finch & Vega, 2003).

Money Behavior Studies

Various child development research projects have been devoted to studying how children learn about money. For example, Sato (2011), using data from interviews conducted by The Money and Child Project, gave pocket money to children to investigate how they negotiate spending the money to respond to social demands, activities with peers, and needs and wishes of their parents (Sato, 2011). The Money and Child Project (Oh et al., 2005; Yamamoto et al., 2003; Yamamoto and Pian, 2000; Yamamoto and Takahashi, 2007) was conducted in China, Korea, Japan and Vietnam. Sato reviewed an interview with a Korean family that demonstrated how children acquire their money behaviors from their parents. A set amount of pocket money was given to the children. The pocket money was used to negotiate between the children's social interactions such as activities with their peers, and those of their parents. Sato analyzed these negotiations and discovered a pattern in the social ecology of money use, in both children and their parents, that set the stage for the meaning of money. He concluded that the family, social, and economic environment influences children's money behaviors. His case study highlights that children were easily accepted into peer groups with the same money behaviors; in other words, the wish to be accepted by their peers may have had a significant influence leading children to conform to their peer group's money behaviors. That this case study was conducted in another cultural context also demonstrated the phenomenon that money is embedded within a cultural context. The Korean family within this case did not use money to fulfill consumer desires through the purchase of goods. It was determined that this family focused on mutual sharing and not on capitalistic aspirations. Economic activities, such as behaviors and actions, are embedded in the everyday lives of children. This study emphasized that children are influenced in healthy

or unhealthy ways to control desires or not to control desires, and regarding how to participate in a consumer society, and so acquire functional or dysfunctional money-management behaviors.

Hanley and Wilhelm's study (1992) demonstrated the emotional and psychological value of money far exceeds its relative economic value. The purpose of their study was to explore differences in self-esteem and money attitudes and behaviors within a group of self-reported compulsive spenders (n = 43) and a group of normal consumers (n = 100). Rosenberg's Self-Esteem Scale and Furnham's Money Beliefs and Behavior Scale were used to measure these variables. They found that compulsive spenders had lower self-esteem than average consumers and appear to cultivate money beliefs that reflect its symbolic or abstract ability to enhance their self-esteem (Hanley & Wilhelm, 1992). Findings from Hanley and Wilhelm's (1992) study aided marketing goods and services and did not draw attention to how consumption behavior has gone awry. If the emotional and psychological value of money greatly contributes to how people feel about themselves, this study substantiates how spending too much money may enhance one's self-esteem for a short period of time, until excessive spending exacerbates financial instability and in-turn sabotages a person's overall well-being.

Ridge (2011) reviewed 10 years of qualitative research on the everyday lives of low-income and disadvantaged children in the United Kingdom. The review process entailed extensive searches of citation databases from published research studies. A variety of studies that were reviewed, including in-depth interviews, focus groups, group work, case studies, participatory workshops and action research. What appealed to Ridge and what he found valuable were studies that documented the children own descriptions of their experiences and concerns. Ridge became mindful of the profound effect poverty had on the children's voices. They spoke of hardships they felt every day, which included economic, social, and relational

constraints that the children tried to mediate, contain, and often hide. They also expressed the stigma, shame, sadness, and fear of being identified or isolated for being different because of their limited ability to participate in social activities. Fairbrother, Curtis, and Goyder (2012) stated socioeconomic inequalities in childhood are linked to childhood and adult health.

Zhou, Vohs, & Baumeister (2009) examined how the social system works when an individual has enhanced popularity because of having money. The authors examined six studies that tested relationships between reminders of money, social exclusion, and physical pain. Findings indicated that just having money could have benefits: "Thinking about [the presence of] money interacted with social and physical adversity and changed the participants' subjective [negative] experience [to a positive experience]" (Zhou, Vohs, & Baumeister, 2009, p. 704). They discovered that both social rejection and thoughts of physical pain led to an increased desire for money. Researchers noted counting money reduced the suffering induced by Cyberball (an open-source virtual ball-toss game) from ostracism and real physical pain. However, when individuals were reminded they had spent money, an increase in social distress and physical pain was observed. The mere presence or absence of money affects people's mental and physical states. When money is scarce, people need to control what to buy and what not to buy; thoughts of money may trigger weakness instead of confidence. ACE victims may use money for immediate gratification, and then later reap negative consequences of mental health issues, such as depression and anxiety, from having spent money intended for basic living needs.

Englebery & Sjoberg's study further expands on the impact money has on people's emotions (Englebery & Sjoberg, 2006). Englebery & Sjoberg hypothesized emotional intelligence (EI) (decisions based on emotions) affects coping with emotional issues involving money. The study included a sample of 212 respondents who filled out the Money Attitude Scale

(MAS) developed by Yamauchi and Templer (1982), which contained a test of EI performance comprising judging emotions in facial expressions and self-report measures considered subscales of EI. Findings showed achievement, drive, resilience, and emotional stability facilitate the ability to delay gratification of future consumption. Less money-oriented respondents were more stable emotionally, geared toward achievement, and withstood failure better and dealt more efficiently with demanding challenges. ACE adults may unfortunately have acquired some deep-rooted emotional instability during childhood due to the physical and/or mental abuse they endured. This may negatively impact the drive for achievement and resiliency of many ACE survivors. The trigger of financial instability impedes their ability to delay gratification and may cause maladaptive money behaviors.

The emotional effect of financial stress is widely ignored within the psychological literature and yet the APA notes this as an ongoing major stressor in American life. The current study can help bridge the gap of how important it is to assess for money behaviors within the therapeutic process.

Existing Money Measures

Psychologists recognized psychological behaviors interrelated to financial outcomes in the early 1970s (Furnham, 1996), and began to develop assessment tools in the 1980s. The two most commonly used instruments for measuring money behavior over the last 3 decades have been Yamauchi and Templer's (1982) Money Attitude Scale (MAS) and Furnham's (1984) Money Beliefs and Behavior Scale (MBBS).

According to Yamauchi and Templer (1982), some individuals hold the belief that money is a symbol of status or success. The authors also found that for some individuals, money causes anxiety, while for others it is a reliever of anxiety. The MAS comprises 29 items, making up four

money attitude scales, namely: (a) power-prestige (defined as using money to influence others or show status); (b) retention-time (defined as prepared for the financial future); (c) distrust (said to measure a state of not wanting to spend money); and (d) anxiety (defined as a state of worry about money and a desire to spend it; Yamauchi & Templer, 1982).

Furnham (1984) utilized items from the MAS and other sources to structure the MBBS. The MBBS is comprised of 60 items divided among six factors, which Furnham designated as: (a) obsession (defined as preoccupation with money); (b) power (using money to maintain an upper hand); (c) retention (the keeping of money); (d) security (the preservation of money); (e) inadequacy (feelings of not having enough money); and (f) effort/ability (how money is obtained). The difference between these two instruments is Furnham's combined money-belief and behavior statements into his assessment, and Yamauchi and Templer (1982) did not.

Another money measure scale is the Money Ethic Scale (MES) (Tang, 1992). Tang identified six major beliefs about money, namely: (a) money is good; (b) money is evil; (c) money represents achievement; (d) money is a sign of respect; (e) budgeting is important; and (f) money is power. Tang (1992) concluded the six beliefs represent areas of affective, cognitive, and behavioral attitudes toward money. A common thread in these three money-belief scales is that some people hold very strong attitudes toward money that lead them to retain or dispose of financial resources quickly.

Klontz, Bivens, Klontz, Wada, and Kahler's (2008) Money Script Inventory provided updated terminology in the identification of money beliefs and included additional demographic characteristics within the analysis. This enhancement ties in the theory that certain individual demographic characteristics relate to certain types of money beliefs. Klontz, Britt, Mentzer, and Klontz (2011) utilized a sample of 422 individuals who identified their level of agreement on 72

money-related beliefs to identify four distinct money-belief patterns. Three of these were associated with income and net worth. Results of this study contributed to the literature by providing a measure that can identify money beliefs quickly and accurately that may have a negative impact on financial health.

Klontz et al. (2008) developed a series of money script subscales that are used by psychologists who suspect self-limiting or destructive money scripts, or both, may be interfering with a client's financial health. Klontz, Kahler, and Klontz (2006) hypothesized that money scripts, defined as beliefs individuals hold about money, are: (a) developed in childhood; (b) often passed down from generation to generation in family systems; (c) typically unconscious; (d) contextually bound; and (e) drive much of one's financial behavior.

In this same study, Klontz et al. (2008) obtained scale items directly from clients in need of assistance for a disordered money belief. Scale items were collected over a decade through clinical observation, using exercises designed to evoke beliefs regarding money from financial therapy clients (Klontz et al., 2008). A Delphi group of nationally recognized financial therapists evaluated the face validity of items. Seventy-two money concepts were identified. These concepts were grouped by the research team into eight hypothesized money script factors, including: (a) money worship (eight items); (b) anti-rich (six items); (c) money is bad (five items); (d) a scale from money mistrust to money openness (12 items); (e) a scale from frugality to fiscal responsibility (12 items); (f) money anxiety (eight items); (g) money status (18 items); and (h) money is unimportant (3 items).

The Klontz-Money Behavior Inventory (K-MBI) is modeled after a study by Klontz, Britt, Archuleta, and Klontz (2012) about developing a money script inventory. The K-MBI is used in clinical practice to screen clients who present with financial concerns and show

disconcerting financial behavior. Awareness of these money behaviors may lead to an underlying diagnosis from a psychologically deeper issue, such as adverse childhood experiences.

Financial behavior items are coded on a six-point Likert-type scale where 1 = strongly disagree, 2 = disagree, 3 = disagree a little, 4 = agree a little, 5 = agree, and 6 = strongly agree. There are 11 financial behavior scale items: (a) compulsive buying disorder (11 items; α =.92), which showed a high reliability (α=.92); (b) pathological gambling (7 items; α=95); (c) workaholism (11 items; α=.89); (d) compulsive hoarding (8 items; α=.91); (e) underspending (3 items; α not disclosed); (f) financial denial (3 items; α=.84); (g) overspending (4 items; α not disclosed); (h) financial enabling (6 items; α=.79); (i) financial dependence (7 items; α=.79); (j) financial rejection (5 items; α not disclosed); and (k) financial enmeshment (3 items; α=.81). Of the 11 hypothesized scales, ten scales emerged from the factor analysis within this study's research.

Gender, race, marital status, and use of revolving credit were binary variables; so, men were coded as 1 and women were coded as 2, non-Hispanic Whites were coded as 2 and all others as 1, married respondents were coded as 1 and all others were coded as 2, and respondents who carried credit card balances from month to month were coded as 1 and all others were coded as 2. Age was measured using five categories: 1 = 18-30 years of age; 2 = 31-40 years of age; 3 = 41-50 years of age; 4 = 51-60 years of age; and 5 = 61-80 years of age. Education was coded categorically, where 1 = less than a high school diploma; 2 = a high school degree; 3 = some college; 4 = an associate's degree; 5 = a bachelor's degree; and 6 = a graduate or professional degree in the original data. Since a small percentage of respondents had less than a high school degree (less than 1% of the sample), categories 1 and 2 were combined.

Background Study of the Adverse Childhood Experiences (ACE) Score Calculator

The Adverse Childhood Experiences (ACE) study is a major American research project that investigates how adverse childhood experiences affected adult health. The ACE study is an ongoing collaborative study involving researchers from the Centers for Disease Control and Prevention (CDC) in Atlanta and Kaiser Permanente in San Diego. The ACE research would have never happened without the co-principal investigators Rob Anda, MD, MS, with the CDC and Vincent Felitti, MD, with Kaiser Permanente. Dr. Felitti gave undisputed credit to his colleague, Robert F. Anda, MD, "who skillfully designed the Adverse Childhood Experiences (ACE) Study in an epidemiologically sound manner" (Felitti, 2003).

The original ACE study, a longitudinal collaborative effort between the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente, grew out of study examining a weight-loss program in California during the 1990s. While adult participants who completed the program successfully lost weight, Dr. Felitti and his colleagues discovered through life story interviews that many individuals were subconsciously using obesity to protect themselves against unwanted sexual attention or as a form of defense against physical attacks. The study did not stop there. Other compelling ACE study findings demonstrated that: 1) Adverse childhood experiences are surprisingly common, although distinctively concealed and unrecognized. 2) ACEs still have a profound effect 50 years later, although now transformed from psychosocial experience into organic disease, social malfunction, and mental illness. 3). Adverse childhood experiences are the main determinant of the health and social well-being within the United States. The overall despairing finding was that ACEs lived a poor quality of life in the United States (Chapman et al., 2004; Felitti, 2003; Felitti, et al., 1998; Moeller, 1993).

The ACE study has proven to be important medically, socially, and economically; it documented the powerful relationship between emotional experiences as children and physical and mental health as adults, and is referenced in over 10,000 published scientific articles, conferences, and workshop presentations. The ACE study is used in public health, medicine, nursing, social services, and criminal justice to improve our understanding of the ACE impact on individuals, families, and communities.

Participants in the study complete a confidential survey containing questions about childhood abuse and family dysfunction, and items that detail their current health status and behaviors. This information is combined with results of a physical examination to form baseline data for the study. The ACE Score Calculator was adapted from three other questionnaires: (a) The Conflict Tactic Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996), which selected physical abuse, witnessing inter-parental violence, and emotional abuse; (b) the Child Trauma Questionnaire (Bernstein et al., 2003), which selected emotional and physical neglect; and four questions from (c) the Wyatt Sexual History Questionnaire (Wyatt, 1985), which focused on sexual abuse during childhood.

The ACE-Q consists of 10 questions. The scoring system is simple: exposure during childhood or adolescences to any category of the ACE-Q was scored as one point. The ACE conditions used in the ACE survey reflect only a selective list of experiences. Multiple exposures within a category were not scored (the study does not capture the frequency or severity of any given ACE in a person's life). According to Dr. Felitti, "if anything, this tends to understate our findings," (Felitti, 2003, p. 3). If a person experienced none of the conditions in childhood, the ACE score is zero. Points are then totaled for a final ACE score.

A population-based analysis of over 17,000 middle-class American adults underwent comprehensive, biopsychosocial medical evaluations and were strongly related in a proportionate manner to three types of adverse experiences during childhood (Felitti, 2003). The ACE Score Calculator's three types of adverse experiences are defined as: (1) childhood abuse, which included emotional, physical, and sexual abuse; (2) neglect, included both physical and emotional neglect; and (3) household dysfunction, which included growing up in a household where there was substance abuse, mental illness, violent treatment of a mother or stepmother, parental separation/divorce or had a member of the household go to prison. Below are the questions that were designated within each type of abuse:

Abuse. Subsections on abuse include emotional abuse, physical abuse, and sexual abuse. Emotional abuse is measured based on this statement: "Often, or very often, a parent or other adult in the household swore at you, insulted you, or put you down, and sometimes, often, or very often acted in a way that made you think that you might be physically hurt." Physical abuse is measured based on this statement: "Sometimes, often, or very often a parent or other adult in the household pushed, grabbed, slapped, or had something thrown at you or ever hit you so hard that you had marks or were injured." Sexual abuse is measured based on this statement: "An adult or person at least 5 years older ever touched or fondled you in a sexual way, or had you touch their body in a sexual way, or attempted oral, anal, or vaginal intercourse with you or actually had oral, anal, or vaginal intercourse with you."

Neglect. The subsection on neglect includes only emotional neglect. Respondents were asked whether their families made them feel special and loved, and if their families were a source of strength, support, and protection. Emotional neglect was defined using scale scores that

represented moderate to extreme exposure on the Emotional Neglect subscale of the Childhood Trauma Questionnaire (CTQ) short form.

Household dysfunction. Subsections on household dysfunction include mother treated violently, household substance abuse, household mental illness, parental separation or divorce, and an incarcerated household member. The section pertaining to violent treatment of the mother is measured with this statement: "Your mother or stepmother was sometimes, often, or very often pushed, grabbed, slapped, or had something thrown at her or sometimes, often, or very often was kicked, bitten, hit with a fist, or hit with something hard, or ever repeatedly hit over at least a few minutes or ever threatened or hurt by a knife or gun." Household substance abuse is measured with the statement: "Lived with anyone who was a problem drinker or alcoholic or lived with anyone who used street drugs." Household mental illness is measured through the statement: "A household member was depressed or mentally ill or a household member attempted suicide." Other statements included parental separation or divorce and inquiring whether a household member was incarcerated.

Respondents are given an ACE score between 0 and 10, with each point indicating an affirmative answer to one of the 10 ACE questions.

The ACE study exposed a major public health problem, which was the discovery of sub-conscious, or occasionally conscious, counterbalanced negative behaviors, such as smoking, overeating, and alcohol and drug use, that were used to numb effects of the patient's childhood abuse. These unhealthy behaviors were resorted to as solutions to the patient's problems dating to their earliest years, but hidden by time, by shame, by secrecy, and by social taboos against exploring certain areas of life experience (Anda et al., 1998). The findings of the current study will attempt to expand on Dr. Anda and Dr. Felitti's ACE study to explore whether there exists a

relationship between adults who have had adverse childhood experiences and acquired dysfunctional money behaviors.

Literature Summary

The lack of recognition by mental health clinicians of their patients' money stress is surprising (Furnham & Argyle, 1998; Klontz et al., 2008). It was determined by the APA that money has been a major stressor in American culture since 2007. There is a need for greater recognition and understanding of how fundamental money issues are within psychotherapy and how deeply they can affect our emotional and psychological stability. A literature gap exists regarding how childhood abuse may contribute to dysfunctional money behavior in adulthood. This gap is addressed by this dissertation's research question: Are adverse childhood experiences (as measured by the ACE questionnaire, ACE-Q) related to an individual's financial behavior (as measured by the Klontz-Money Behavior Inventory)? This study hypothesized that higher scores on the ACE-Q (more adverse childhood experiences) are related to higher scores on the K-MBI (more dysfunctional money behaviors).

The current study's approach could increase an understanding of the relationship between ACEs and mental health and expand the ability of psychologists to treat presenting symptoms from a financial behavioral exploration. When financial stress occurs within a patient's life, it may be helpful to educate them about how financial stress can create negative feelings and discord within the family's homeostasis. It is important to understand the differences within cultures and how social and family support can decrease money anxiety, thus lessening the onset of depression and hopelessness. Encouraging patients to reach out for support and to help identify specific social needs that might mitigate the effects of immediate financial adversity, such as housing and food insecurity. Connecting families to resources, thus addressing their

immediate needs, and recommending local organizations that can assist with financial adversity could provide a safety net that might allow clients to focus on the underlining psychological issues that may have contributed to maladaptive money behaviors. There is a vast amount of literature about child abuse prevention, but a gap remains on how financial instability may contribute to childhood adverse experiences.

Chapter III: Methods and Procedures

Introduction

The purpose of this research project is to determine if there are relationships between adverse childhood experiences and dysfunctional money behaviors. A quantitative research design was followed, using statistical tests to describe or measure the degree of association or relationship between two or more variables (Collins, Onwuegbuzie, & Jiao, 2007). The demographic characteristics are listed in Appendix I.

Research Questions and Hypotheses

Research Question 1. Are any of the 10 ACE-Q experiences individually related to any of the 10 K-MBI subscale scores?

$H_0$1. None of the 10 ACE-Q experiences are related to any of the 10 K-MBI subscale scores.

H_a1. At least one of the 10 ACE-Q experiences is related to at least one of the 10 K-MBI subscale scores.

Statistical Approach: Point-Biserial Correlations

Research Question 2. Are the ACE-Q abuse, neglect, household dysfunction, and total experiences scores related to any of the 10 K-MBI subscale scores?

$H_0$2. None of ACE-Q abuse, neglect, household dysfunction and total experiences scores are related to any of the 10 K-MBI subscale scores.

H_a2. At least one of the ACE-Q abuse, neglect, household dysfunction, and total experiences scores are related to at least one of the 10 K-MBI subscale scores.

Statistical Approach: Pearson Correlations

Research Question 3. Are any of the 10 ACE-Q experiences individually related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics (Appendix I)?

$H_0$3. None of the 10 ACE-Q experiences are related to any of the e10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

H_a3. At least one of the 10 ACE-Q experiences is related to at least one of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

Statistical Approach: Partial Correlations

Research Question 4. Are the ACE-Q abuse, neglect, household dysfunction, and total experiences scores related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics?

$H_0$4. None of the ACE-Q abuse, neglect, household dysfunction, and total experiences scores will be related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

H_a4. At least one of the ACE-Q abuse, neglect, household dysfunction, and total experiences scores will be related to at least one of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics.

Statistical Approach: Partial Correlations

Research Design and Methodology

Description of research design. A quantitative correlational research methodology was employed to quantify the problem and understand its prevalence by looking for results that could be projected to a larger population. Knowledge stemming from results of a quantitative study could point to later useful qualitative work for a deeper understanding.

Correlational studies are used to determine the relationships between stated variables (adverse childhood experiences and dysfunctional money behaviors) (Creswell, 2009). Explanations of the relationship between variables lead to the description of trends. Correlational analysis determines whether there exists a significant positive or negative linear relationship between two or more variables (Burns & Grove, 2005). Point-biserial correlations (the Pearson correlation between a dichotomous variable and a continuous variable), Pearson product-moment correlations and partial correlations were used to address research questions. This study was based on statistical results and any insights gained could be objective and accurate enough to satisfy the research questions of the study.

Selection of Participants

The sample of participants included persons over 18 years of age. The sampling methodology included purposive sampling. Purposive sampling was chosen to gather a subject population that provided focused information and saved time and money (Patton, 2002). This type of sampling can be useful for a situation where there is a need to reach sampling quickly and sampling for proportionality is not the primary concern. However, data collected from purposive sampling is not generalizable to the entire population.

To determine the needed sample size for the multiple regression models expressed as partial correlations, the G*Power 3.1 software program (Faul, Erdfelder, Buchner, & Lang, 2009) was used. With six predictors (gender, age, race/ethnicity, level of education, and household income as control variables plus the ACE-Q score) based on a medium effect size (f^2 = .15), an alpha level of $\alpha = .05$, the needed sample size to achieve sufficient power (.80) was 98 respondents. The final sample of $N = 187$ demonstrated adequate levels of power.

Descriptions of Instruments

Adverse childhood experiences questionnaire (ACE-Q): The initial study using the ACE questionnaire was conducted within the Department of Preventive Medicine at Kaiser Permanente in San Diego from 1995 to 1997; this was in collaboration with the U.S. Centers for Disease Control and Prevention. The ACE-Q has 10 questions and each question was weighted equal. Dr. Anda, co-founder of the ACE study, distributed these 10 questions into three types of adversities: abuse, neglect, and household dysfunction (Appendix A; refer to Appendix B for a detailed description of the ACE-Q items used to score abuse, neglect, and household dysfunction scales).

The ACE-Q scoring system is simple. An occurrence of any one category of adverse experience before 18 years of age was scored as one point. There was no further scoring for multiple incidents within a category; for example, an alcoholic and a drug user within a household were scored the same as one alcoholic, and multiple sexual molestations by multiple individuals were totaled as one point. Each of the individual ACE-Q items (0 = *absent* or 1 = *present*) and the aggregated total ACE-Q score were correlated with each of the 10 K-MBI scores. The elicited response from the participant is: 0 = *absent* or 1 = *present*. This scoring approach does not address any other relevant clinical information about the adverse condition such as chronicity, frequency, severity, meaning, or context.

Klontz-Money Behavior Inventory (K-MBI) (Appendix C) has 55 questions and is a Likert scale assessment that covers ten money behaviors: (1) pathological gambling, (2) overspending and (3) compulsive buying disorder, (4) underspending, (5) compulsive hoarding, (6) workaholism, (7) financial dependences, (8) financial enabling, (9) financial denial/rejection, and (10) financial enmeshment. All financial behavior items were coded on a six-point Likert-

type scale where 1= strongly disagree, 2= disagree, 3= disagree a little, 4= agree a little, 5= agree, and 6= strongly agree. Scoring was done based on the K-MBI manual (Author, 9999). As an example, the first seven items were related to compulsive buying. Those seven items were added together and divided by seven to retain the original six-point metric. The K-MBI is used within a clinical practice to screen clients who present with financial concerns and show disconcerting financial behavior. Awareness of these money behaviors may lead to an underlying diagnosis of a deeper psychological issue.

Procedures

A recruitment letter was announced via social media for potential participants. The letter directed participants to click on a link taking them to a specific page at the SurveyMonkey website. SurveyMonkey ensured anonymity and easy access to information. Participants were not asked to give their names, and as only minimal identifying details were provided, the survey is confidential.

Once at the Internet site, participants were given these instructions. First, they read a statement that discussed informed consent and explicitly stated that their participation was voluntary (see Appendix G). Participants were then given directions on how to participate in the survey. Third, they were asked to answer the two survey instruments, the ACE-Q and K-MBI (see Appendix B and C). Upon completion of the questionnaires, participants submitted their answers and were given the option to receive the results of the study.

Data Processing Techniques

After data were collected, scores for each of the subscales for abuse, neglect, household dysfunction and total experiences (ACE-Q Scores) and money disorders (K-MBI) were

calculated. Descriptive statistics of mean and standard deviations were also obtained to summarize the data of the study variables.

Data was analyzed using the latest version of Statistical Package for the Social Sciences (SPSS). For research questions 1 and 2, Pearson product-moment correlations were conducted to determine relationships between each subscale for the variables of adverse childhood events and money disorders. Pearson's Correlation test is a bivariate measure of the effect size or strength of the relationship between variables. This relationship is quantified by an *r* coefficient that ranges from -1 to +1, with a higher value indicating a stronger relationship. The nature of the relationship is denoted by the positive or negative value of the correlation, with a positive value indicating a direct relationship between variables and a negative value indicating an inverse relationship between variables. The p-value of the *r* coefficient indicates whether the observed relationship between variables is statistically significant. Results found significant at a .05 level or lower are examined to clarify which aspects of the relationship are significant. For research questions 3 and 4, partial correlations were used to examine relationships between each of the ACE-Q items and scale scores with each of the K-MBI scores while controlling the respondent's demographic characteristics (gender, age, race/ethnicity, level of education, net worth, childhood SES and household income, Appendix I).

Methodological Assumptions and Limitations

The focus of the study was about how money issues may exacerbate psychological problems (Furnham & Argyle, 1998; Krueger, 1986). Some limitations of this study included the following: the instruments used in this study involve self-report, and the researcher assumed participants answered questions honestly; the sample size was modest for this study; some volunteers may not want to take the time to complete the three instruments within the study,

which may result in losing valuable participants who could enrich the understanding of the topic under study; questionnaires used for this study were available only via the SurveyMonkey website, and a population with money issues may not have access to the Internet. Another limitation was that individuals with money issues do not want to participate in a money survey if they feel it could put them at risk of judgment.

It was assumed the two-survey questionnaires used would accurately measure numbers of adverse experiences, if any, during childhood and types of money behaviors in adulthood. It was also assumed study participants would provide honest responses to survey questions (Mitchell & Jolley, 2010). Researchers found participants are generally honest in social science research, particularly when their responses are confidential (Lelkes, Krosnick, Marx, Judd, & Park, 2012). This assumed the subjects in the study would participate in the study, minimizing the bias from data and making findings reliable. One of the limitations of the ACE-Q was that the elicited response from the participant is only (0 = *absent* or 1 = *present*). This scoring approach does not address any other relevant clinical information about the adverse condition such as chronicity, frequency, severity, meaning, or context.

Participants within this study included both adults who had no adverse childhood experiences and adults who had adverse childhood experiences. Based on the G*Power calculation, the ideal minimum number of participants to complete the study is approximately 98 respondents over 18 years of age. The actual sample size of $N = 187$ was deemed sufficient.

This research will include two assessments: the Klontz-Money Behavior Inventory (Klontz, Britt, Archuleta, & Klontz, 2012) (Appendix A), the Adverse Childhood Experiences Score (Chapman et al., 2004; Felitti et al. 1998; Moeller et al., 1993) (Appendix B), and the demographic questionnaire (Appendix I). Social media such as Facebook was the link for this

study's recruitment. Individuals from diverse cultures and community social groups were invited to respond, including friends and family members of participants, by connecting to the SurveyMonkey website where the survey was hosted. All survey results remained anonymous, and SurveyMonkey did not release specific participant data to the researcher.

Participants were instructed to answer all questions but they may not answer questions if they so choose per Antioch University IRB guidelines. The survey was open to potential participants until the 98 suitable respondents were collected.

Ethical Assurances

One potential source of risk was that participants could experience some emotional disturbance due to memories of their adverse experiences. A list of resources was included to support participants who experienced emotional disturbances related to this study (Appendix I). To minimize this risk, participation was voluntary and participants could remove themselves from participation at any time, with no pressure to remain in the study. Some potential benefits to their participation included increased awareness of the impact traumas may have had on their financial situation, which might lead them to seek out further education from parents, teachers, and their community regarding the psychology of money.

To protect the privacy of respondents, no names were used at any point from data collection through data analysis to the final write-up of the study's results. Similarly, all data were stored in paper and electronic formats. Hard copies of data were stored in a locked filing cabinet accessible to only the researcher. Electronic copies of all data, including spreadsheets used for data analysis, were stored in the researcher's personal computer, and secured by a password known only to the researcher. Backup copies of all electronic files were saved in a password-protected flash drive locked in the filing cabinet with hard copies of data. Hard and

electronic copies of data will be stored for 5 years following the conclusion of the study, after which all hard copies will be shredded and all electronic files will be permanently deleted.

Chapter IV: Results

Introduction

The purpose of this study was to determine if there were associations between dysfunctional or maladaptive money behaviors such as overspending, compulsive buying, pathological gambling, etc., and adverse childhood experiences of the adult respondents. There were 187 participants.

Table 1 (p. 94) displays the frequency counts for selected variables. The majority of the participants was female (80.2%) and was either married (47.1%) or single (29.9%). The participants ranged in age from 18 to 80, with 24.6% falling between the ages of 18-30, and 26.2% between the ages of 61-80, with a median age of 35.50 years. Many of the participants' highest level of education was a graduate degree (32.1%), 28.9% highest level of education was a high school diploma, with a median education level of a Bachelor's degree. Most of the participants were either Caucasian/White (65.2%) or Hispanic/Latino (25.7%). Household income ranged from less than $30,000 (13.9%) to $100,000 or more (35.8%), with a median income level of $80,000. The childhood socioeconomic status for the participants ranged from poverty (8.0%) to wealthy (2.7%) with a median of $53,000.

Table 1

Frequency Counts for Selected Variables (N = 187)

Variable	Category	*n*	%
Gender			
	Male	37	19.8
	Female	150	80.2
Marital Status			

	Single	56	29.9
	Married	88	47.1
	Divorced	22	11.8
	Significant other	21	11.2
Age [a]			
	18-30	46	24.6
	31-40	48	25.7
	41-60	44	23.5
	61-80	49	26.2
Highest Level of Education [b]			
	High School degree	54	28.9
	GED	2	1.1
	Neither High School or GED degree	4	2.1
	Associate's degree	23	12.3
	Bachelor's degree	44	23.5
	Graduate degree	60	32.1
Ethnicity			
	Asian	2	1.1
	Black/African American	3	1.6
	Caucasian/White	122	65.2
	Hispanic/Latino	48	25.7
	Native American	3	1.6
	Other	9	4.8

[a] Age: *Mdn* = 35.5 years
[b] Education: *Mdn* = Bachelor's degree.

Variable	Category	*n*	%
Household Income [c]			
	Less than $30,000	26	13.9
	$30,000-$59,999	42	22.5
	$60,000-$99,999	52	27.8
	$100,000 or more	67	35.8
Childhood Socioeconomic Status [d]			
	Poverty ($17,000 and under/annual income)	15	8.0
	Lower middle-class ($17,001-$26,000)	31	16.6
	Middle-class ($26,001-$80,000)	95	50.8
	Upper middle-class ($80,001-$250,000)	41	21.9
	Wealthy ($250,001+)	5	2.7

[c] Household Income: *Mdn* = $80,000.
[d] Childhood Socioeconomic Status: *Mdn* = $53,000.

Table 2 displays the frequency counts for other historical financial information sorted by the highest frequency. The frequency counts were based on the number of respondents with various types of financial history. Two-thirds had "source of income from one job (*n* = 125, 66.8%)." The lowest endorsement was "Receive income solely from a trust fund, alimony, and/or non-earning (non-work) source (*n* = 11, 5.9%)."

Table 2
Frequency Counts for Other Financial Information Sorted by Highest Frequency (N = 187)

Rating	*n*	%
18. Source of income from one job	125	66.8
13. Carry credit card debt	84	44.9
19. Source of income from more than one job	52	27.8
17. Social Security	51	27.3
14. Filed for bankruptcy	24	12.8
15. Social Security Insurance	22	11.8
16. Social Security Disability Insurance	12	6.4
20. Receive income solely from a trust fund, alimony, and/or non-earning (non-work) source	11	5.9

Note. Respondents could endorse multiple answers so frequencies total more than 100%.

Table 3 displays the frequency counts for ACE-Q experiences sorted by the highest frequency. The frequency counts were based on the number of respondents who endorsed any of the 10 negative childhood experiences. The most common experience was "Divorce (*n* = 74, 39.6%)." The least common experience was "Lack basic needs (*n* = 10, 5.3%)."

Table 3

Frequency Counts for ACE-Q Experiences Sorted By Highest Frequency (N = 187)

Rating	*n*	%
6. Divorce	74	39.6
8. Substance abuse	55	29.4
1. Verbal abuse	52	27.8
9. Mental abuse	51	27.3
4. Neglect	45	24.1
2. Physical abuse	35	18.7
3. Sexual abuse	34	18.2
10. Incarceration	21	11.2
7. Domestic violence	17	9.1
5. Lack basic needs	10	5.3

Note. Respondents could endorse multiple experiences so frequencies total more than 100%.

Table 4 displays the descriptive statistics for the four ACE-Q Scales. Scores were based on summing the number of negative childhood experiences. The mean numbers for childhood negative experiences per category were abuse ($M = 0.65$, $SD = 0.93$ out of three possible experiences), dysfunction ($M = 1.17$, $SD = 1.29$ out of five possible experiences), neglect ($M = 0.29$, $SD = 0.52$ out of two possible experiences), and total ACE-Q experiences ($M = 2.11$, $SD = 2.20$) out of 10 possible experiences).

Table 4

Descriptive Statistics for ACE-Q Scales (N = 187)

Scale	*M*	*SD*	Low	High
Abuse	0.65	0.93	0.00	3.00
Dysfunction	1.17	1.29	0.00	5.00
Neglect	0.29	0.52	0.00	2.00
Total ACE-Q	2.11	2.20	0.00	10.00

Note. ACE-Q scores were based on summing the number of negative childhood experiences endorsed from ten possible separate experiences. The abuse category had three possible

experiences, dysfunction had five possible experiences and neglect had two experiences.

Table 5 displays the descriptive statistics for the 10 K-MBI Scales. These ratings were based on a 6-point scale: 1 = *Strongly Disagree* to 6 = *Strongly Agree*. The lowest rated scale was pathological gambling (M = 1.30, SD = 0.71) and the highest rated scale was underspending (M = 2.78, SD = 1.39).

Table 5
Descriptive Statistics for K-MBI Scales (N = 187)

Scale	*M*	*SD*	Low	High
Compulsive Buying	2.46	0.90	1.00	5.09
Pathological Gambling	1.30	0.71	1.00	6.00
Compulsive Hoarding	2.49	0.98	1.00	5.25
Underspending	2.78	1.39	1.00	6.00
Workaholism	2.61	0.97	1.00	5.50
Financial Dependence	1.91	0.90	1.00	6.00
Financial Enmeshment	1.73	0.91	1.00	6.00
Financial Enabling	2.77	1.28	1.00	6.00
Financial Denial	2.59	1.27	1.00	6.00
Other Financial Problems	2.23	1.05	1.00	6.00

Note. Ratings based on a 6-point metric: 1 = *Strongly Disagree* to 6 = *Strongly Agree*.

Answering the Research Questions

Cohen (1988) suggested some guidelines for interpreting the strength of linear correlations. He suggested that a weak correlation typically had an absolute value of r = .10 (r^2 = one percent of the variance explained), a moderate correlation typically had an absolute value of r = .30 (r^2 = nine percent of the variance explained) and a strong correlation typically had an absolute value of r = .50 (r^2 = 25 percent of the variance explained). For the sake of parsimony, this chapter will primarily highlight those correlations that were of at least moderate strength to minimize the potential of numerous Type I errors stemming from interpreting and drawing

conclusions based on potentially spurious correlations. However, due to the exploratory nature of this study, those correlations that were statistically significant but weak in size based on the Cohen (1988) criteria will be noted to suggest possible avenues for future research

Research Question 1. Research Question 1 asked, "Are any of the 10 ACE-Q experiences individually related to any of the 10 K-MBI subscale scores?" The alternative hypothesis stated, "At least one of the 10 ACE-Q experiences is related to at least one of the 10 K-MBI subscale scores," and the related null hypothesis stated, "None of the 10 ACE-Q experiences are related to any of the 10 K-MBI subscale scores." To answer this question, Table 6 displays the Pearson correlations for the 10 money behaviors (K-MBI Scales) with each of the 10 childhood trauma (ACE-Q) experience variables. It should be noted that the ACE-Q experience variables are dichotomous ((0 = *absent* or 1 = *present*). With that, point-biserial correlations (the Pearson correlation between a dichotomous variable and a continuous variable) were used. Out of the resulting 100 correlations, 14 were significant at the $p < .05$ but none were of moderate strength using the Cohen (1988) criteria. The three leading correlations by chance finding were: workaholism with mental abuse ($r = .28$, $p = .001$), financial dependence with verbal abuse ($r = .26$, $p = .001$), and financial dependence with physical abuse ($r = .23$, $p = .001$). Based on these findings, the null hypothesis was rejected and the alternative hypothesis was supported (Table 6).

Table 6

Pearson Correlations for Money Behaviors (K-MBI Scales) with Childhood Trauma (ACE-Q) Experience Variables (N = 187)

Childhood Trauma Experiences (ACE-Q)

K-MBI Scale	Verbal Abuse		Physical Abuse		Sexual Abuse		Neglect		Lack of Needs	Divorce
Compulsive Buying	.00		.09		-.03		.04		-.03	.02
Pathological Gambling	.09		.12		.09		.01		-.02	.09
Compulsive Hoarding	.20	**	.10		.20	**	.13		.02	-.05
Underspending	.13		.13		.01		.18	**	.03	.00
Workaholism	.15	*	.12		.11		.14		.02	.05
Financial Dependence	.26	****	.23	****	.12		.19	**	.12	.07
Financial Enmeshment	.06		.05		-.06		.06		-.09	-.06
Financial Enabling	.03		.04		.12		.02		.02	.08
Financial Denial	.06		.02		-.04		.13		-.05	.01
Other Financial Problems	.11		.03		.10		.16	*	-.05	.04

*$p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$.

Childhood Trauma Experiences (ACE-Q)

K-MBI Scale	Domestic Violence		Substance Abuse	Mental Abuse		Incarceration
Compulsive Buying	.04		.05	.00		.03
Pathological Gambling	-.04		-.03	-.01		-.04
Compulsive Hoarding	.03		.07	.18	*	-.05
Underspending	.06		.04	.16	*	-.07
Workaholism	.20	**	.14	.28	****	-.03
Financial Dependence	.14		.05	.20	**	.02
Financial Enmeshment	.10		.00	.09		-.09
Financial Enabling	.03		.08	.20	**	.01
Financial Denial	-.03		.06	.14		-.10
Other Financial Problems	.05		.00	.13		-.04

* $p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$.

Research Question 2. Research Question 2 asked, "Are the ACE-Q abuse, neglect, household dysfunction, and total experiences scores related to any of the 10 K-MBI subscale scores?" The alternative hypothesis stated, "At least one of the ACE-Q abuse, neglect, household dysfunction and total experiences scores are related to at least one of the 10 K-MBI subscale scores" and the related null hypothesis stated, "None of ACE-Q abuse, neglect, household dysfunction and total experiences scores are related to any of the 10 K-MBI subscale scores."

To answer this question, Table 7 displays the Pearson correlations for the 10 money behaviors (K-MBI scales) with the four number of childhood traumas (ACE-Q statistic scales). Out of the resulting 40 correlations, 10 were significant at the $p < .05$ but none of the correlations were of moderate strength based on the Cohen (1988) criteria. The five highest correlations were financial dependence with abuse ($r = .28$, $p = .001$), financial dependence with ACE-Q total score ($r = .25$, $p = .001$), compulsive hoarding with abuse ($r = .22$, $p = .002$), workaholism with ACE-Q total score ($r = .22$, $p = .003$), and financial dependence with neglect ($r = .21$, $p = .004$). Based on these findings, the null hypothesis was rejected and the alternative hypothesis was supported (Table 7).

Table 7
Pearson Correlations for Money Behaviors (K-MBI Scales) with Number of Childhood Traumas (ACE-Q Statistic Scales) (N = 187)

	Childhood Experiences (ACE-Q Scales)			
K-MBI Scale	Abuse	Household Dysfunction	Neglect	Total ACE-Q
Compulsive Buying	.03	.04	.02	.04
Pathological Gambling	.13	.00	.00	.06
Compulsive Hoarding	.22 ***	.06	.11	.16 *
Underspending	.12	.06	.16 *	.13

Workaholism	.17	*	.20	**	.12		.22	***
Financial Dependence	.28	****	.15	*	.21	***	.25	****
Financial Enmeshment	.03		.01		.02		.02	
Financial Enabling	.08		.14		.03		.12	
Financial Denial	.02		.04		.09		.05	
Other Financial Problems	.10		.06		.11		.11	

* $p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$.

Research Question 3. Research Question 3 asked, "Are any of the 10 ACE-Q experiences individually related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics (Appendix I)?" The alternative hypothesis stated, "At least one of the 10 ACE-Q experiences is related to at least one of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics" and the related null hypothesis stated, "None of the 10 ACE-Q experiences are related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics."

To answer this question, Table 8 displays the partial correlations for the 10 K-MBI Scales with the 10 individual ACE-Q experience variables controlling for selected demographic variables. Out of the resulting 100 correlations, 18 were significant at the $p < .05$ level with one correlation of moderate strength using the Cohen (1988) criteria. The five highest partial correlations were workaholism with mental abuse ($r_{ab.c} = .30$, $p = .001$), financial dependence with verbal abuse ($r_{ab.c} = .28$, $p = .001$), financial dependence with physical abuse ($r_{ab.c} = .26$, $p = .001$), compulsive hoarding with sexual abuse ($r_{ab.c} = .22$, $p = .003$), and financial dependence with mental abuse ($r_{ab.c} = .22$, $p = .004$). Based on these findings, the null hypothesis was rejected and the alternative hypothesis was supported (Table 8).

Table 8
Partial Correlations for K-MBI Scales with ACE-Q Experience Variables Controlled for Selected Demographic Variables (N = 187)

	Childhood Trauma Experiences (ACE-Q)											
K-MBI Scale	Verbal Abuse		Physical Abuse		Sexual Abuse		Neglect		Lack of Needs		Divorce	
Compulsive Buying	-.01		.08		-.04		.04		-.06		-.04	
Pathological Gambling	.11		.11		.17	*	.00		-.04		.08	
Compulsive Hoarding	.21	***	.13		.22	***	.14		.02		-.06	

Underspending	.16	*	.11		.05		.18	*	.01	-.04
Workaholism	.14		.11		.11		.15	*	.01	.02
Financial Dependence	.28	****	.26	****	.15	*	.20	**	.12	.07
Financial Enmeshment	.08		.08		-.03		.08		-.09	-.06
Financial Enabling	.02		.05		.11		.03		.02	.09
Financial Denial	.07		.04		-.02		.14		-.06	-.01
Other Financial Problems	.11		.06		.10		.16	*	-.06	.04

* $p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$.
Note: Controlled for gender, marital status, age, highest level of education, race, household income, and child socioeconomic status.

Childhood Trauma Experiences (ACE-Q)

K-MBI Scale	Domestic Violence		Substance Abuse		Mental Abuse		Incarceration
Compulsive Buying	-.01		.04		-.02		-.06
Pathological Gambling	-.07		-.03		.02		-.10
Compulsive Hoarding	.04		.06		.16	*	-.07
Underspending	.03		.03		.20	**	-.09
Workaholism	.18	*	.15	*	.30	****	-.04
Financial Dependence	.16	*	.05		.22	***	.05
Financial Enmeshment	.13		-.01		.09		-.07
Financial Enabling	.02		.06		.18	**	.01
Financial Denial	-.02		.05		.14		-.12
Other Financial Problems	.08		.00		.13		-.05

* $p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$.
Note: Controlled for gender, marital status, age, highest level of education, race, household income, and child socioeconomic status

Research Question 4. Research Question 4 asked, "Are the ACE-Q abuse, neglect, household dysfunction, and total experiences scores related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics?" The alternative hypothesis stated, "At least one of the ACE-Q abuse, neglect, household dysfunction and total experiences scores will be related to at least one of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics" and the related null hypothesis

stated, "None of the ACE-Q abuse, neglect, household dysfunction and total experiences scores will be related to any of the 10 K-MBI subscale scores after controlling for the respondent's demographic characteristics."

To answer this question, Table 9 displays the partial correlations for the 10 K-MBI scales with the four ACE-Q statistic scales controlling for selected demographic variables. Out of the resulting 40 partial correlations, 11 were significant at the $p < .05$ level with one correlation of moderate strength using the Cohen (1988) criteria. The five highest correlations were financial dependence with abuse ($r_{ab.c} = .31$, $p = .001$), financial dependence with ACE-Q total score ($r_{ab.c} = .28$, $p = .001$), compulsive hoarding with abuse ($r_{ab.c} = .24$, $p = .001$), financial dependence with neglect ($r_{ab.c} = .22$, $p = .22$), and workaholism with ACE-Q total score ($r_{ab.c} = .21$, $p = .005$). Based on these findings, the null hypothesis was rejected and the alternative hypothesis was supported (Table 9).

Table 9
Partial Correlations for K-MBI Scales with Select ACE-Q Statistic Scales Controlled for Selected Demographic Variables (N = 187)

	Childhood Experiences (ACE-Q Scales)							
K-MBI Scale	Abuse		Household Dysfunction		Neglect		Total ACE-Q	
Compulsive Buying	.01		-.02		.00		-.01	
Pathological Gambling	.17	*	-.01		-.02		.06	
Compulsive Hoarding	.24	****	.05		.12		.16	*
Underspending	.14		.05		.15	*	.13	
Workaholism	.16	*	.19	**	.13		.21	***
Financial Dependence	.31	****	.17	*	.22	***	.28	****
Financial Enmeshment	.06		.02		.02		.04	
Financial Enabling	.07		.13		.03		.11	
Financial Denial	.04		.03		.09		.06	
Other Financial Problems	.12		.06		.11		.11	

* $p < .05$. ** $p < .01$. *** $p < .005$. **** $p < .001$.

Note: Controlled for gender, marital status, age, highest level of education, race, household income, and child socioeconomic status.

Summary

In summary, this study gathered data from 187 participants to determine if there were associations between dysfunctional or maladaptive money behaviors such as overspending, compulsive buying, pathological gambling, etc., and adults' report of adverse childhood experiences. Hypothesis one (adverse childhood experiences and money behaviors) was supported (Table 6). Hypothesis two (adverse childhood experiences and money behaviors) was supported (Table 7). Hypothesis three (adverse childhood experiences and money behaviors controlling for demographics) was supported (Table 8). Hypothesis four (adverse childhood experiences and money behaviors controlling for demographics) was supported (Table 9). In the final chapter, these findings will be compared to the literature, conclusions and implications will be drawn, and a series of recommendations will be suggested.

Chapter V: Discussion and Conclusions

This study's primary hypothesis was confirmed, that is, adults who had adverse childhood experiences revealed a positive relationship with dysfunctional money behaviors. All four-research questions were modestly supported by the alternative hypothesis; the four null hypotheses were rejected. Out of 187 participants, the average number of adverse childhood experiences was 2.11 out of a possible 10. Using the Pearson Correlations, the K-MBI's scales as related to the total number of ACE-Q items statistically varied from weak to the moderate range.

Discussion of Key Findings

There were three partial correlations of the K-MBI scales with the 10 individual ACE-Q variables. (1) Financial dependence with verbal abuse ($p < .001$; .28), physical abuse ($p < .001$;

.26), neglect ($p < .05$; .15), and mental abuse ($p < .005$; .22). (2) Workaholism with mental abuse ($p < .001$; .30). (3) Compulsive hoarding with sexual abuse ($p < .005$; .22 and verbal abuse ($p < .005$; .21).

Financial dependence showed significant results in all three of the ACE-Q categories: it correlated with verbal abuse ($p < .001$; .28), physical abuse ($p < .001$; .26), neglect ($p < .05$; .15), and mental abuse ($p < .005$; .22). abuse (verbal and physical), neglect, and household: mental abuse. Klontz defined financial dependence as a feeling that money comes with strings attached, resentment, fear of being cut-off from non-work income, and acknowledgment that their non-work income suppresses their motivation, passion, creativity, and drive to succeed. Klontz presumed "less educated and lower income non-married individuals are 'most likely' to identify with financial dependence" (Klontz, Britt, Archuleta, and Klontz, 2012, p. 28). Within Klontz's development study of the K-MBI, the financial dependence scale had "good reliability" (a=.70, p. 28). The current study presented differently; its sample consisted of highly educated, higher income participants, 47% of whom were married. In this case, the participants may be dependent on their extended family for financial support even though they were highly educated due to the increased costs over the years of advanced education. College, professional, and graduate schools currently cost more since government aid that once came as grants have transitioned to student loans. Educational loans can represent the second to largest debt a student may have in their life (first being a home loan); of course, educational debt can be viewed as an investment in their future. It is understandable when money comes with strings attached and a deep fear of being cut-off can produce an overwhelming sense of dependence that can intensify anxiety.

In reference to financial dependence, a study by Serido, Shim, Xiao, Tang, & Card (2014) addressed financial issues among college students. The basis of the study identified

patterns between "financial stain" and financial coping behaviors among college students. Lazarus, 1999, used the term "financial strain", defined as "financial demands" that sabotages one's ability to manage those demands can be a source of burdensome stress among college students. Serido, et al. (2014) demonstrated that "perceived" change in financial stress (that means the change may or may not occur), but no change in "objective" financial debt (the debt did not change) initiated change in financial coping behaviors. The perceived financial stress was associated with increased use of reactive behaviors and decreased use of proactive behaviors. When perceived financial stress decreased, so did the reactive behaviors and increased proactive behaviors. The pattern that surfaced suggested that when financial demands increased, the students resorted to hasty financial behaviors, such as cost cutting and borrowing. These may not be the best choices to adopt in the moment. Janis (1993) indicated, the cognitive impairment associated with high levels of stress may lead to "narrowing the range of perceived options, overlooking long-term consequences, inefficient searching for information, erroneous assessing of expected outcomes, and using oversimplified decision rules that fail to consider the full range of values implicated by choice" (p.57). Specifically, experiencing high levels of stress is not the time to make an acute and hasty financial decision. Serido and his associates conceptualized three types of financial coping behaviors to 1) reactive behaviors to manage immediate changes in financial conditions (e.g., cost cutting), 2) preventive behaviors to minimize future financial stain (e.g., spending within budget), and 3) proactive behaviors to promote future goals (e.g., savings). The final result from Serido, et al.'s study was that preventive behaviors were the most effective coping behavior as compared to reactive steps and proactive behavior.

The second highest correlation of Klontz's subscales was workaholism; workaholism correlated with mental abuse ($p < .001$; .30). Workaholism is defined when individuals feel an

overpowering urge to work long hours and have difficulty savoring time away from work. K-MBI's workaholism subscale measured high reliability (a=.89). A measure is said to have high reliability when it produces similar results under consistent conditions. Within this study workaholism exhibited significant results in all three categories: household dysfunction, verbal abuse, and neglect (Table 3, p. 97). Divorce was the highest frequency as compared to the other nine ACE-Q experiences; out of 187 participants, 74 or 39.6% endorsed divorce to be the most pervasive adverse experience during childhood under household dysfunction. Under the same category substance abuse was second with 55 endorsements or 29.4%. Verbal abuse was third; 52 or 27.8%, and neglect positioned itself as fifth in-line, 45 or 24.1%. Klontz noted that workaholics are inclined to be younger men with higher income who take-on credit card debt. It seems contradictory that a high earning individual would carry credit card debt, but on the contrary the debt may serve to further rationalize their compulsive need to work. The relenting unconscious compulsive behavior, such as compulsive buying that can lead to high debt, which leads to working long hours to pay off the credit cards, and then comes full circle by justifying the buying as a reward "to self" might give a person temporary relief from worry until the month end bill arrives. It could be that workaholism associates with Serido, et al.'s first financial coping behavior: "reactive behavior." A debtor works longer hours or two jobs when, as an example, credit cards were used to pay the mortgage or other monthly payments and the debt became overwhelming. Moreover, Klontz indicated that workaholism may stem from a critical parent, verbal abuse, who had high expectations that were instilled in their children (Klontz, Britt, Archuleta, & Klontz, 2012, p.28) or the parent may have been, in general, critical about most anything.

The third highest correlation was with compulsive hoarding; compulsive hoarding correlated with sexual abuse ($p < .005$; .22) and verbal abuse ($p < .005$; .21). Klontz's development of K-MBI's scales' study confirmed a high reliability coefficient of a = .91. A compulsive hoarder was identified as a person who has trouble throwing items of little value away, has a living space cluttered with things that are not used, and who feels emotionally attached to possessions. Clinical and psychometric work gives some support to the Freudian notion that miserliness and hoarding are components of obsessive-compulsive disorder, and both seem to have some connection to compulsive shopping (Frost, et al. 2002; Grilo, 2004). Behrendt (2006) contributed that hoarding and the "spendthrift's self-destructive carelessness" are both ways of dealing with interpersonal anxieties around rejection. Peer rejection and peer victimization are categories that fit into childhood adversities. Behrendt, Klontz and associates reported that compulsive hoarders tend to be men with lower levels of net worth (Klontz, Britt, Archuleta, & Klontz, 2012, p.28). This study's findings stand in contrast to Klontz's findings as there were 80% more women than men and net worth was not taken into account in this study.

This study's overall hypothesis, based on limited evidence, set forth that higher scores on the ACE-Q (more adverse childhood experiences) would correlate to higher scores on the K-MBI (more dysfunctional money behaviors). This study's population had a disproportionate substructure since the majority of the participants had favorable childhoods. The more favorable childhoods as compared to disadvantaged childhoods compelled the statistical overall results to range between weak to moderate.

Limitations

This study was not without limitations. In general, the participants in this study were well educated, over 100 participants out of the 187 were within the median range of a bachelor's

degree, and 32% had graduate degrees. The overall household income and childhood socioeconomic status were in the upper middle-class range. More women (150 or 80%) than men (37 or 20%) completed this study. There was little racial or ethnic diversity; the ethnicity was 65% Caucasian/White, almost 26% Hispanic/Latino, approximately 9% were Asian, Black/African American, Native American, and other. In relation to ethnic diversity, there may have been variability in cultural perception of adversity. For example, there is some evidence that African Americans and Hispanic/Latino underreport racism and discrimination as a significant stressor, because these experiences may be perceived as commonplace in some segregated communities (Wade, Shea, Rubin, & Wood, 2014). It is possible that individuals who responded to this web-based survey differed from those who chose not to respond, such as being more educated and more financially astute. Another limitation is the demographic region was primarily located in the United States' Central Coast region of California. The study was limited by its reliance on self-report, which made it susceptible to individual attempts to fake or who may be in denial of their money behaviors and adverse childhood experiences. The existing ACE-Q had its limitations, as well; the questions could be expanded to include racial and/or ethnic discrimination, prejudice, and prolonged separation that includes deportation.

Summary and Conclusion

The purpose of this study was to determine if there was an association between dysfunctional money behaviors and adults who had adverse childhood experiences and that was established. The aim of this study was to establish a benchmark and interest for future research on how dysfunctional money behaviors can undermine patients' daily lives. The ACE population was chosen for this study to assess their vulnerability to money, and how money may trigger a variety of unwanted feelings and behaviors. The bigger picture of this study was to convey a

better understanding of how important money may play a role in the causation of childhood adversities, and how those adults who experienced childhood adversities can sabotage their financial stability. A preoccupation with money is nothing new in our culture. Not only do we rely on money for our basic needs, but also money can be at the center of our thoughts, decisions and activities.

Financial behaviors should not be ignored within therapy especially in the aftermath of the U.S. 2008 financial crisis, the mounting educational loan debt, and the uncertainty of job stability, etc. Money psychology studies are still in their early stages. The awareness of personal responsibility for securing a secure financial future to adapt to a changing environment is crucial. The current lack of support for mental health professionals not addressing money issues within sessions is an oversight on the part of this profession. Money behaviors can be seen as diagnostic. A patient's relationship to money and money behaviors are areas that should not be bypassed within the clinical interview. Integrating money psychology into diagnostic and therapeutic practice may help patients to become aware of how money issues can evoke unwanted emotions leading to dysfunctional family dynamics, anger, depression, anxiety, substance abuse, or other psychological issues. Financial education could include "stress-based" case studies that reflect how personal finances may be disrupted by internal and external conditions, i.e.: such as divorce and/or an economic recession. Scenarios may be created for alternative approaches on how to manage financial stressors, such as contrasting desirable and undesirable parenting skills in various stressful financial situations, role-play situational experiences, and strategies for coping. Asking within these scenarios: if there is anger involved: "Where does the anger go?" A proactive approach to incorporate money education may alleviate

the stress families experience. Mitigating a family's financial strain could lead to improve family homeostasis.

Due to the paucity of research in this area, there was limited literature directly related to this study's hypotheses. This research appears to be the first study to compare adverse childhood experiences with dysfunctional money behaviors. An interesting interpretation of the study's results was that even the adults who had only a few adverse childhood experiences also demonstrated dysfunctional money behaviors. Among those who were exposed to poverty, discrimination, and violence it was noted in the literature that the Latino/Hispanic culture substantiated resilience through strong family ties, community networks, religious and spiritual values, and cultural identity that correlated with positive self and the ability to cope with life's stressful events. Even in adversity family and community support can ease the mental anguish that may come with financial strain. A future research project is encouraged to search out people who had more adverse childhood experiences to allow these potentially causal dysfunctional money behaviors to show their dominance.

In regard to future research, to design effective interventions, strategies, evidence-based practices for the ACE population would not only assist in our patients' welfare but could save billions in government spending on child abuse and neglect. Now more than ever, it is crucial for health care professionals to understand how money and money behaviors play a major role not only with our security but also in our overall wellbeing. Development of a beneficial and an acceptable entry into the closed realm of personal and family financial experiences may lead health care professionals to restructure treatment programs to help our patients deal with their underlying money stress before it is displaced onto the next generation.

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Appendix A: Adverse Childhood Experience Questionnaire

While you were growing up, during your first 18 years of life (the word "often" defines as frequently):

1. Did a parent or other adult in the household often . . . swear at you, insult you, put you down, or humiliate you? Or act in a way that made you afraid that you might be physically hurt?

If yes, enter 1 _____

2. Did a parent or other adult in the household often . . . push, grab, slap, or throw something at you? Or ever hit you so hard that you had marks or were injured?

If yes, enter 1 _____

3. Did an adult or person at least 5 years older than you ever . . . touch or fondle you or have you touch their body in a sexual way? Or attempt or actually have oral, anal, or vaginal intercourse with you?

If yes, enter 1 _____

4. Did you often feel that . . . no one in your family loved you or thought you were important or special? Or that your family didn't look out for each other, feel close to each other, or support each other?

If yes, enter 1 _____

5. Did you often feel that . . . you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? Or that your parents/or guardians were too drunk or high to take care of you or take you to the doctor if you needed it?

If yes, enter 1 _____

6. Were your parents ever separated or divorced?

If yes, enter 1 _____

7. Was your mother or stepmother often pushed, grabbed, or slapped, or did she often have something thrown at her? Or was she sometimes or often kicked, bitten, hit with a fist, or hit with something hard? Or was she ever repeatedly hit at least a few minutes or threatened with a gun or knife?

If yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

If yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt or commit suicide?

If yes, enter 1 _____

10. Did a household member go to prison?

If yes, enter 1 _____

Please add up your "Yes" answers. Write in 0 if there were NO "Yes" answers:

"Yes" answers: _____

****

Appendix B: ACE-Qs three Categories: Abuse, Household Dysfunction, and Neglect

All ACE questions refer to the respondent's first 18 years of life.

Abuse

Emotional abuse: A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.

Physical abuse: A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.

Sexual abuse: An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you**.**

Household Dysfunction

Mother treated violently: Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.

Household substance abuse: A household member was a problem drinker or alcoholic or a household member used street drugs.

Mental illness in household: A household member was depressed or mentally ill or a household member attempted suicide.

Parental separation or divorce: Your parents were ever separated or divorced.

Criminal household member: A household member went to prison.

Neglect

Emotional neglect: Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.

Physical neglect: There was someone to take care of you, protect you, and take you to the doctor if you needed it, you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.

Appendix C: Klontz-Money Behavior Inventory

#	Klontz's Money Behaviors Assessment: Likert scale: Strongly disagree, Disagree, Disagree a little, Agree a little, Agree, Strongly Agree
1.	My spending feels out of control
2.	I obsess about shopping
3.	I buy more things than I need or can afford
4.	I feel irresistible urges to shop
5.	I shop to forget about my problems and make myself feel better
6.	I feel guilt and/or shame after making purchases
7.	I often return items because I feel bad about buying them
8.	I have tried to reduce my spending but have had trouble doing so
9.	I hide my spending from my partner/family
10.	I feel anxious or panicky if I am unable to shop
11.	Shopping interferes with my work or relationships
12.	I have trouble controlling my gambling
13.	I gamble to relieve stress or make myself feel better
14.	I have to gamble with more and more money to keep it exciting
15.	I have committed an illegal act to get money for gambling

16.	I have borrowed money for gambling or have gambled on credit
17.	My gambling interferes with other aspects of my life (e.g. work, education, relationships)
18.	I have hidden my gambling from people close to me
19.	I have trouble throwing things away, even if they aren't worth much
20.	My living space is cluttered with things I do not use
21.	Throwing something away makes me feel like I am losing a part of myself
22.	I feel emotionally attached to my possessions
23.	My possessions give me a sense of safety and security
24.	I have trouble using my living space because of clutter
25.	I feel irresponsible if I get rid of an item
26.	I hide my need to hold on to items from others

27.	I avoid spending money even though I can afford to
28.	I have money saved but refuse to spend it out of fear
29.	I often feel an irresistible drive to work
30.	My family complains about how much I work
31.	I feel guilty when I take time off of work
32.	I feel a need to constantly stay busy
33.	I often miss important family events because I am working
34.	I have trouble finishing projects because I feel they are never quite perfect enough
35.	I have trouble falling or staying asleep because I am thinking about work

36.	I have made promises to myself or others to work less but have had trouble keeping them
37.	It is hard for me to enjoy time off of work
38.	People close to me complain that I am so focused on my "to-do" lists that I ignore them or brush aside their needs or concerns
39.	I feel like the money I get comes with strings attached
40.	I often feel resentment or anger related to the money I receive

41.	A significant portion of my income comes from money I do nothing to earn (e.g. trust fund, compensation payments)
42.	I have significant fear or anxiety that I will be cut off from my non-work income
43.	I talk to my children (under 18) about my financial stress
44.	I ask my children (under 18) to pass on financial messages to other adults
45.	I feel better after I talk to my children (under 18) about my financial stress
46.	I give money to others even though I can't afford it
47.	I have trouble saying "no" to requests for money from family or friends
48.	I sacrifice my financial well-being for the sake of others
49.	I lend money without making clear arrangements for repayment
50.	I often find myself feeling resentment or anger after giving money to others
51.	I avoid thinking about money
52.	I try to forget about my financial situation
53.	I avoid opening/looking at my bank statements

54.	I hide my spending from my partner/family
55.	I have hid my gambling from people close to me

Appendix D: Ten Money Behaviors as They correspond to the 55 Questions

1. Compulsive Buying

My spending feels out of control.

I obsess about shopping.

I buy more things than I need or can afford.

I feel irresistible urges to shop.

I shop to forget about my problems and make myself feel better.

I feel guilt and/or shame after making purchases.

I often return items because I feel bad about buying them.

I have tried to reduce my spending but have had trouble doing so. I hide my spending from my partner/family.

I feel anxious or panicky if I am unable to shop.

Shopping interferes with my work or relationships.

2. Pathological Gambling

I have trouble controlling my gambling.

I gamble to make relieve stress or make myself feel better.

I have to gamble with more and more money to keep it exciting.

I have committed an illegal act to get money for gambling.

I have borrowed money for gambling or have gambled on credit.

My gambling interferes with other aspects of my life (e.g. work, education, relationships).

I have hid my gambling from people close to me.

3. Workaholism

I often feel an irresistible drive to work.

My family complains about how much I work.

I feel guilty when I take time off of work.

I feel a need to constantly stay busy.

I often miss important family events because I am working.

I have trouble finishing projects because I feel they are never quite perfect enough.

I have trouble falling or staying asleep because I am thinking about work.

I have made promises to myself or others to work less but have had trouble keeping them.

It is hard for me to enjoy time off of work.

People close to me complain that I am so focused on my "to-do" lists that I ignore them or brush aside their needs or concerns.

I have trouble saying "no" when asked to work extra hours or take on extra projects.

4. Compulsive Hoarding

I have trouble throwing things away, even if they aren't worth much.

My living space is cluttered with things I do not use.

Throwing something away makes me feel like I am losing a part of myself. I feel emotionally attached to my possessions.

My possessions give me a sense of safety and security. I have trouble using my living space because of clutter. I feel irresponsible if I get rid of an item.

I hide my need to hold on to items from others.

5. Underspending

I avoid spending money even though I can afford to. I have money saved but refuse to spend it out of fear.

I deny myself basic things, even though I can afford them.

6. Overspending

I buy things even though I can't afford them.

I spend more money than I make.

I can't stick to a budget.

I am too broke at the end of the month to save for retirement. I avoid opening/looking at my bank statements.

7. Financial Enabling

I give money to others even though I can't afford it.

I have trouble saying "no" to requests for money from family or friends. I sacrifice my financial well-being for the sake of others.

People take advantage of me around money.

I lend money without making clear arrangements for repayment.

I often find myself feeling resentment or anger after giving money to others.

8. Financial Dependence

I ask others for money when I am financial stressed.

I couldn't make ends meet with receiving non-work income.

I feel like the money I get comes with strings attached.

I often feel resentment or anger related to the money I receive.

A significant portion of my income comes from money I do nothing to earn (e.g. trust fund, compensation payments).

I have significant fear or anxiety that I will be cut off from my non-work income.

The non-work income I receive seems to stifle my motivation, passion, creativity, and/or drive to succeed.

9. Financial Rejection

I seem to avoid accumulating wealth.

I charge/get paid less than I am worth.

I feel guilty about getting paid for the work I do.

I have received a large sum of money (e.g. from an inheritance, lottery win, settlement, etc.) and have given away or spent most or all of it.

I have lost substantial amounts of money through poor investment decisions.

10. Financial Enmeshment

I talk to my children (under 18) about my financial stress.

I ask my children (under 18) to pass on financial messages to other adults. I feel better after I talk to my children (under 18) about my financial stress.

Appendix E: Support Resources for Adult Survivors of Child Abuse

Adult Survivors of Child Abuse: http://ascasupport.org

Bullying Recovery Helping People Thrive After Bullying Trauma: https://bullyingrecovery.org

Childhelp Prevention and Treatment of Child Abuse: https://www.childhelp.org
Hotline: 1-800-4-A-Child (1-800-422-4453

CrisisLink: https://prsinc.org/crisislink/

Dream Catchers For Abused Children: dreamcatchersforabusedchildren.com

Hope for Healing: http://hopeforhealing.org

Moving Victims of Violence from Crisis to Confidence: https://www.safehorizon.org
Hotline: 1-800-621-4673 (HOPE)

National Association of Adult Survivors of Child Abuse: http://www.naasca.org
NAASCA Facebook: www.Facebook.com/groups/NAASCA

National Coalition Against Domestic Violence: http://www.ncadv.org

Way2Hope Home-Help with Family and Life Problems: http://way2hope.org

Appendix F: Resources to Improve Money Behaviors and other Financial Support

Bureau of Consumer Protection: https://www.ftc.gov/about-ftc/bureaus-offices/bureau-consumer-protection

Debtors Anonymous: http://debtorsanonymous.org

Financial Psychology Institute: https://financialpsychologyinstitute.wildapricot.org

Kids.gov: https://kids.usa.gov/play-games/money/index.shtml

Klontz Consulting Group: http://www.yourmentalwealth.com

Money Behavior Mindset: http://www.cfinancialfreedom.com/resources/behavior/

Money Management International, Inc. (Improving lives through financial education): https://www.moneymanagement.org/Community/Blogs/Blogging-for-Change/2015/September/15-emergency-resources.aspx

MyMoney.Gov: https://www.mymoney.gov/Pages/default.aspx

Smart About Money: https://www.smartaboutmoney.org/Tools/LifeValues-Quiz

Appendix G: Informed Consent Form

Antioch University Santa Barbara

Antioch University is committed to the ethical protection of participants in research. This form will provide you with information about the study so that you can decide whether you wish to participate. You may back out of this study at any time. Participation in this study is voluntary and anonymous. The answers and results, within this study, are identified only by a number code, not by your name.

The study is about money behaviors as compared to adverse childhood experiences. This study will require approximately 20 minutes of your time. Participants will need a computer and be able to log onto Surveymonkey.com. There will be two questionnaires that will ask about your money behaviors and if you experienced any adverse children experiences.

If you decide to participate, your results may help researchers understand the deeper issues regarding dysfunctional money behaviors. While it is unlikely, the possibility may exist while participating in this study adverse childhood or unpleasant money experiences may surface. Be assured that if this happens, you may contact the licensed psychologists by using the American Psychological Association's website to locate a licensed psychologist close to where you live: http://locator.apa.org. Also there are attached two resource lists if a participate many need reference for support: (1) support resources for adults of child abuse as well as (2) resources to help improve money spending behaviors.

Appendix H: Copyright Use Permission Obtained for Klontz-Money Behavior Inventory and the Adverse Childhood Experience Questionnaire

Permission to Use: Klontz-Money Behavior Inventory and the Adverse Childhood Experience Questionnaire's Permission

Klontz, B., Britt, S. L., Archuleta, K. L., & Klontz, T. (2012). Disordered Money Behaviors: Development of the Klontz Money Behavior Inventory. *Journal of Financial Therapy, 3* (1) 2.https://doi.org/10.4148/jft.v3i1.1485
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a. Proquest Dissertations and Theses Database and that Proquest is a Print on Demand Publisher http://www.proquest.com/products-services/pqdt.html
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c. AURA: Antioch University Repository and Archive and that AURA is an open access archive. http://aura.antioch.edu/

Please let me know how to fulfill this requirement to graduate.
Thank you,
Patti Michaels

From: "DVP Inquiries (CDC)" <dvpinquiries@cdc.gov>
Date: May 21, 2018 at 10:33:39 AM PDT
To: Patti Michaels <pattimichaels@me.com>
Subject: Re: ACE Questionnaire (10 questions) copyrights

Thank you for your inquiry about using our Adverse Childhood Experiences information.
General text information, publications available for download, and graphs developed by CDC and presented on CDC's website are works of the United States Government and are in the public domain. This means that they are meant for public use and are not subject to copyright law protections. Permission is not required for use of public domain items. But we do ask that you credit CDC as the original source whenever the items are used in any publicly distributed media.
It is important to note that CDC does not endorse the use of the ACE score in any sort of diagnosis process. Many organizations use ACE study questions and other screening tools at their discretion.
Again, thank you for your inquiry and we hope you find this information helpful.

Appendix I: Demographics

I. Gender
1. Male
2. Female

II. Marital Status
1. Single
2. Married
3. Divorced
4. Significant other

III. Please state your age:
1. 18-30
2. 31-40
3. 41-60
5. 61-80
6. 80-90
7. 90-100

IV.. Highest level of education:
1. High School Degree
2. GED
3. Neither High School or GED degree
4. Associate's degree
5. Bachelor's degree
6. Graduate degree

V. Ethnicity
African
African-American
Asian
Asian American
Black
Caucasian/White
Chicano
Hispanic
Indian
Latino
Native American
Other

VI. Please state your household income:
1. Less than $30,000
2. $30,000-$59,999
3. $60,000-$99,999

4. $100,000 or more

VII. Net Worth
1. Do not know
2. 0 or less
3. $1-$50,000
4. $50,000-$100,000
5. $100,001-$250,000
6. $250,001-$500,000

VIII. Childhood Socioeconomic Status
1. Poor ($12,000 and under/annual income)
2. Lower middle-class ($12,001-$26,000)
3. Middle-class ($26,001-$70,000)
4. Upper middle-class ($70,001-$250,000)
5. Wealthy ($250,001+)

IX. Carry Credit Card Debt
1. Yes
2. No