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Financial Struggles and Contributing Factors Among Individuals with Psychotic Disorders: Three Perspectives

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Abstract

Financial difficulties and mental health are closely interlinked, with each influencing the other. Managing finances poses a major challenge for individuals living with psychosis. To better understand these challenges, it is important to adopt a qualitative approach that captures perspectives from all members of the therapeutic triad. This study explores how people with psychosis, their family members, and mental health professionals perceive financial problems and the factors contributing to them. Using purposive sampling, we recruited 14 individuals with psychosis, 15 family members, and 16 professionals. Participants took part in semi-structured, individual interviews. Data were examined through an iterative thematic analysis. Analysis revealed five main themes related to financial problems: managing daily expenses, financial skills and performance, housing and living conditions, interpersonal conflicts and vulnerability to exploitation, and challenges tied to regulations and legislation. Additionally, five categories of associated factors emerged: psychotic symptoms, indirect consequences of psychosis, substance use and addiction, financial socialization and life events, and broader societal influences. Across the therapeutic triad, participants described overlapping and often interrelated financial difficulties, highlighting the risk of reinforcing cycles of hardship. Breaking these cycles requires increased awareness and joint action among all stakeholders involved in the care and support of people with psychosis.

Keywords: Psychotic disorders, Mental health professionals, Family members, Therapeutic triad, Financial difficulties

Introduction

Financial difficulties are closely linked with mental health, creating a reciprocal relationship where one can worsen the other [1-3]. For individuals with psychotic disorders, managing money represents a particularly complex challenge [4, 5]. Beyond finances, psychosis can disrupt other life domains, including work [6], education [7], and social engagement [8, 9]. Many people with psychosis are unemployed [10] and rely primarily on government benefits, which often provide only minimal income [11]. Compounding this, a substantial proportion of discretionary funds may be spent on substances [12], and gambling issues are more common than in the general population (around 5.7% versus 0.5–1.0%; Haydock *et al*. [13]), often generating additional financial strain. Reports from the Netherlands show that 20–33% of people with psychosis feel dissatisfied with their financial situation, a figure far higher than the general population [14].

Central to financial independence is financial capability, which refers to the ability to manage one's finances in ways that protect one's best interests [15]. Financial capability encompasses both financial competence—knowledge of financial concepts and the ability to make goal-directed decisions—and financial performance, the

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practical handling of daily financial obligations. Performance is influenced by contextual factors such as social support, substance use, and the availability of resources, meaning competence and performance do not always align [15-17]. Strong financial capability is essential for independent living, and deficits can have serious consequences, including debt or poverty.

Existing quantitative research suggests that individuals with schizophrenia often perform worse on measures of financial skills and management than healthy controls [18-22], especially when under legal financial guardianship [23]. Only one study has examined financial competence directly, showing lower performance across all domains in people with schizophrenia compared to controls [24]. However, these studies largely ignore contextual factors such as social support, personal finances, or substance use, and focus narrowly on schizophrenia rather than the broader spectrum of psychotic disorders.

Understanding financial challenges requires considering the perspectives of all key actors in the therapeutic triad—patients, family members, and mental health professionals [25-29]. Qualitative approaches are particularly valuable, as they can reveal not just the scope of financial difficulties but also the underlying reasons and contextual dynamics that quantitative studies might miss [30-31]. Although the burden on caregivers is well documented [32, 33], financial strain is a consistent component, arising from both direct costs, such as covering medical expenses, and indirect **costs**, like lost income due to caregiving responsibilities [34-43]. Only one study has explicitly focused on family perspectives regarding financial issues in five European countries, highlighting financial concerns as a prominent source of worry among caregivers [44].

Mental healthcare professionals often play a role in assessing and supporting the financial management of individuals with psychosis. For instance, clinicians may evaluate a patient's financial capability and document any impairments [45, 46]. In legal contexts, these evaluations can serve as admissible evidence to appoint a representative payee, a practice observed in roughly 35% of individuals with psychosis in the United States [47, 48]. Many professionals acknowledge the importance of routinely addressing broader financial issues—such as financial difficulties, caregiver burden, or financial abuse—during patient interactions [49], including for those with psychosis [12, 50]. The emerging field of financial therapy, which combines mental health care with financial guidance, also highlights the growing relevance of this domain [51, 52]. Nonetheless, discussions about finances are not consistently integrated into clinical practice [53, 54], likely due to the sensitive nature of personal finances, time constraints during consultations, or prioritization of symptom management and recovery [50, 53, 55]. These considerations underscore the value of examining mental healthcare professionals' perspectives on the financial challenges faced by people with psychosis.

To date, only a few qualitative studies have explored patients' own views on financial functioning. A Canadian and Australian study found that late-onset first-episode psychosis disrupted participants' employment histories and financial stability, with income generation serving as a stronger motivator to return to work than symptom recovery [50]. Similarly, a Swedish study indicated that while participants managed their financial difficulties, these challenges remained a persistent source of stress, influencing social interactions and self-perception [56].

In summary, financial problems represent a significant challenge for individuals with psychosis, often carrying serious consequences. However, there is a notable lack of qualitative research examining and comparing the experiences of all members of the therapeutic triad—patients, family members, and mental health professionals. Understanding these perspectives together is essential for gaining a nuanced view of the financial difficulties faced by this population. Addressing this gap, the present study aimed to qualitatively explore both convergences and divergences in the views of people with psychosis, their families, and healthcare professionals, providing a comprehensive understanding of (1) the financial problems encountered by individuals with psychosis and (2) the factors contributing to these challenges.

Participants

Participants were selected using purposive sampling to include three key groups: individuals with psychosis, their family members, and mental healthcare professionals. People with psychosis were recruited through a mental health institution and a foundation in the northern Netherlands that provides occupational daytime programs for adults with long-term psychiatric conditions.

To participate, individuals with psychosis had to meet the following requirements: a diagnosis of a schizophrenia spectrum or other psychotic disorder according to the

DSM-5 [57], a stable medication regimen for at least four weeks prior to the study, age 18 or older, and sufficient spoken Dutch to engage in a one-on-one interview. Participants were excluded if they experienced significant distress due to ongoing psychotic symptoms or had indications of severe neurological conditions, as determined during a pre-interview screening or by their treating clinician.

The study aimed to include participants varying in age, gender, diagnosis, and duration of illness to capture a broad range of experiences. Data collection continued until saturation was reached—that is, until interviews no longer yielded new meaningful information. The final sample comprised 14 individuals with psychosis, with a mean age of 41.1 years (SD = 13.9, range 24–64) and an average illness duration of 13.1 years (SD = 13.3, range 1–39) **(Table 1)**.

Table 1. Participant details of people with psychosis, family members and mental healthcare professionals

People with psychosis	Gender	Diagnosis	Primary working situation	Net monthly income[a]
P01	Male	Schizophrenia	Student	€1000 - €2000
P02	Male	Delusional disorder	Work experience placement	€1000 - €2000
P03	Male	Psychotic disorder NOS	Labor-based daytime activities	€1000 - €2000
P04	Female	Schizophrenia	Labor-based daytime activities	< €1000
P05	Male	Schizoaffective disorder	Labor-based daytime activities	€1000 - €2000
P06	Male	Schizophrenia	Labor-based daytime activities	€1000 - €2000
P07	Male	Schizophrenia	Labor-based daytime activities	€1000 - €2000
P08	Male	Delusional disorder	Unemployed	€1000 - €2000
P09	Female	Brief psychotic disorder	Disabled to work	< €1000
P10	Female	Brief psychotic disorder	Employed	> €2000
P11	Male	Schizophrenia	Labor-based daytime activities	€1000 - €2000
P12	Male	Schizoaffective disorder	Labor-based daytime activities	€1000 - €2000
P13	Male	Psychotic disorder NOS	Employed	< €1000
P14	Male	Psychotic disorder NOS	Employed	€1000 - €2000
Family members	Gender	Diagnosis relative	Gender relative	
F01[b]	Female	Schizophrenia, schizoaffective disorder	Female, Male	
F02	Female	Drug-induced psychotic disorder	Male	
F03[b]	Female	Schizophrenia, schizophrenia	Male, Male	
F04	Female	Schizophrenia	Male	
F05*	Male	Schizophrenia	Male	
F06*	Female	Schizophrenia	Male	
F07	Female	Psychotic disorder NOS	Male	
F08	Female	Schizophrenia	Male	
F09	Female	Schizophrenia	Male	
F10	Female	Schizophrenia	Female	
F11	Female	Schizoaffective disorder	Male	
F12	Male	Psychotic disorder NOS	Male	
F13	Male	Delusional disorder	Male	
F14	Female	Bipolar disorder	Male	
F15	Male	Delusional disorder	Male	
Healthcare Professional	Gender	Profession	Work experience	
MHP01	Male	Psychiatrist	20 years	
MHP02	Male	Mental health nurse	41 years	
MHP03	Female	Psychologist	2 years	
MHP04	Female	Social worker	6 years	
MHP05	Male	Mental health nurse	10 years	
MHP06	Female	Mental health nurse	26 years	

MHP07	Male	Job coach/counsellor	8 years
MHP08	Female	Job coach/counsellor	10 years
MHP09	Female	Psychiatrist	2 years
MHP10	Male	Medical doctor	2 years
MHP11	Female	Nurse practitioner	24 years
MHP12	Male	Psychiatrist	27 years
MHP13	Female	Psychologist	7 years
MHP14	Male	Mental health nurse	16 years
MHP15	Female	Nurse practitioner	Non-disclosed
MHP16	Female	Mental health nurse	10 years

p = Person with psychosis; NOS = Not Otherwise Specified. F = Family member, MHP = Mental Healthcare Professional.

[a]The net modal monthly income in the Netherlands at the time of data collection was approximately €2,300 [58].

[b]Participant has multiple family members with psychosis.

*Participants are a couple.

Family members

Family members were recruited through a mental healthcare institution in the northern Netherlands and a national association for relatives of people with psychosis. Eligibility criteria included being a family member of someone diagnosed with a schizophrenia spectrum disorder [57], being aged 18 or older, having sufficient spoken Dutch for the interview, and not having a self-reported diagnosis within the schizophrenia spectrum. Participants did not need to be related to the people with psychosis recruited for this study. Efforts were made to include a diverse group with respect to the duration of the relative's illness and the type of familial relationship. Data collection continued until no new insights emerged. The final sample consisted of 15 family members (mean age 67.5 years, SD = 9.4, range 44–82). The average illness duration of their relatives was 18.4 years (SD = 12.8, range 2–42). Among the family participants were 10 mothers, 3 fathers, 1 brother, and 1 sister-in-law **(Table 1)**.

Mental healthcare professionals

Professionals were recruited from several mental healthcare institutions in the northern Netherlands. Selection aimed for variation in age, gender, professional role, and years of experience. Saturation was reached after interviewing 16 professionals, with a mean age of 43.7 years (SD = 9.4, range 32–65) **(Table 1)**.

Materials and Methods

Interview guide

A semi-structured interview guide was developed based on existing literature on financial capability (e.g., Appelbaum *et al.* [15]; Niekawa *et al.* [24]) and the researchers' practical experience. An advisory panel comprising individuals with lived experience, family members, and professionals provided feedback to refine the guide, including recommendations to illustrate abstract questions with concrete examples (e.g., "How do you manage large expenses like holidays?"). Example questions included: "Have you ever experienced financial problems? Can you provide an example? What factors contributed to these financial difficulties?" The semi-structured format allowed flexibility for the interviewer to probe further, enabling participants to share detailed personal narratives [59].

Demographic information

All participants provided their age and gender. Individuals with psychosis additionally reported their diagnosis within the schizophrenia spectrum, illness duration, primary employment status, and net monthly income (six categories: <€1000, €1000–2000, €2000–3000, €3000–4000, €4000–5000, >€5000). Family members reported their relationship to the person with psychosis, as well as the relative's gender, diagnosis, and illness duration. Professionals provided information on their profession and years of work experience.

Procedure

Interested individuals with psychosis could contact the first author directly or be referred by mental healthcare professionals, who obtained verbal permission for contact. Participants received an information sheet and took part in a phone-based pre-interview to clarify study details and confirm eligibility. Family members and professionals contacted the first author directly and received the same information. After a minimum reflection period of two weeks and signing written informed consent, in-depth, face-to-face interviews were conducted, lasting between 45 and 90 minutes at

locations chosen by participants. Interviews began with introductions and an overview of the study, and confidentiality was assured. Demographic questions were collected first. All interviews were audio-recorded and transcribed verbatim. A narrative summary of each interview was sent to participants for verification (member checking). The study was approved by the local Central Ethical Committee (Research no. 202100079).

Data analysis

The qualitative data were analyzed using the Qualitative Analysis Guide of Leuven [60] as a framework. This approach is guided by two key principles: 1) a case-oriented strategy that balances within-case and cross-case analyses (e.g., Ayres *et al.* [61]), and 2) a constant-comparative method, involving iterative verification of emerging codes, concepts, and themes against the original data (e.g., Frogatt [62]). The analysis proceeded in two main phases across six steps [63].

In the preparatory coding phase, which was more narrative and case-focused, the first and last authors repeatedly read and annotated each transcript to familiarize themselves with the data and generate initial codes (Step 1). Each transcript, alongside the participant-provided narrative summaries, was then discussed within the research team. These discussions informed the development of a conceptual interview framework, in which descriptive narratives were organized into higher-level conceptual categories (Step 2). The transcripts were re-examined in light of these frameworks to refine and adjust the conceptual scheme. Finally, concepts were further developed and compared both within and across cases to produce a more coherent set of preliminary categories (Step 3).

The coding phase involved detailed thematic analysis. Each transcript was coded line by line in Atlas.ti 23.2 using an inductive, data-driven approach (Step 4). To enhance methodological rigor, an independent researcher (the second author), who had not participated in the study design or data collection, reviewed and contributed to the coding process. Codes were then organized into overarching themes (Step 5). Theme development was iterative, moving back and forth between codes and transcripts, with extensive team discussions to ensure accurate representation of participant experiences. Themes were finalized and refined after peer debriefing, and each theme was labeled descriptively and illustrated with representative participant quotations (Step 6).

To ensure the quality of the analysis, we applied the criteria of credibility, dependability, confirmability, and transferability [64, 65]. Credibility was enhanced through member checking, allowing participants to review narrative summaries and confirm alignment with their experiences; nine of 14 people with psychosis, 12 of 15 family members, and 11 of 16 professionals provided feedback, which was reviewed and incorporated by the first and last authors. Dependability was supported by independent coding of a sample of transcripts by the second author and by regular team discussions to resolve coding discrepancies. Careful and transparent documentation of all analytic procedures further reinforced dependability. Confirmability was addressed by tracing the analytic process from raw data through data reduction and synthesis in Atlas.ti. Transferability was facilitated by providing a detailed account of participant selection, demographics, data collection procedures, findings, and study context.

Reflexivity

Throughout data collection, the first author maintained reflective memos to consider personal assumptions and biases regarding finances and financial problems. A recurring reflection concerned her own privileged background as a highly educated woman with financial stability, which could introduce bias in interpreting participants' experiences [66]. The first and last authors regularly discussed these potential biases to foster empathetic engagement during interviews. Prior to each interview, the first author practiced bracketing [67] by noting her initial thoughts and expectations, helping to approach each interview with openness and minimize the influence of preconceptions.

Results and Discussion

Analysis of the interviews produced themes related to two main research questions: 1) the financial problems experienced by people with psychosis, and 2) the factors contributing to these problems. From the data, five distinct themes emerged describing the financial challenges faced by participants. Additionally, five themes were identified as factors associated with these financial difficulties, encompassing both psychosis-specific influences and broader contextual factors **(Figure 1)**.

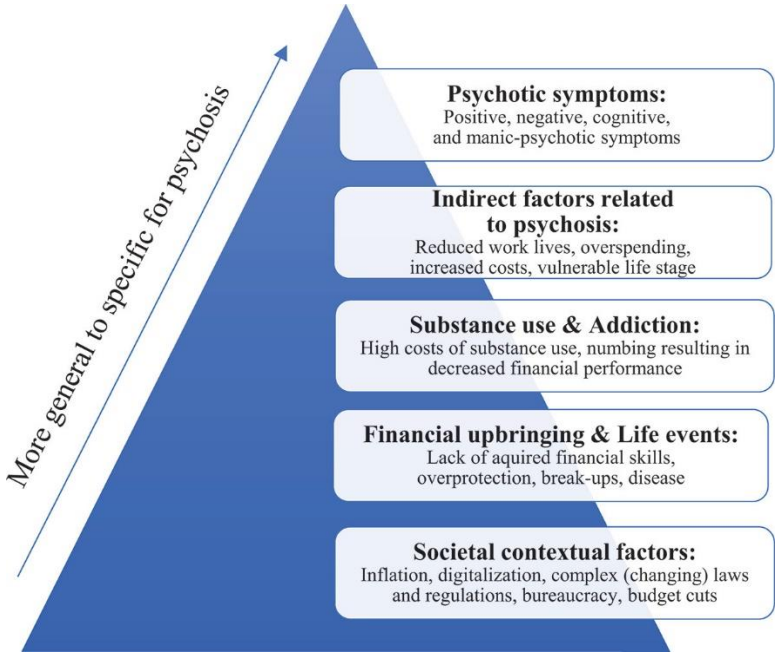

Figure 1. Visual representation of the factors associated with financial problems of people with psychosis according to people in the therapeutic triad.

Research question 1: Financial challenges for people with psychosis

Participants from all three groups frequently described multiple, overlapping financial difficulties that tended to reinforce each other. One participant summarized this cumulative effect: "It actually turned into a sort of mishmash of things piling up. Finances piling up, and problems piling up." (P03). At the same time, periods without financial stress were occasionally reported, often when risk factors were absent or protective factors, such as supportive social networks, were in place.

Managing basic expenses

A recurring problem highlighted by participants was the struggle to meet everyday costs. Many individuals lacked sufficient resources to purchase essential items such as food or toiletries. One participant stated, "I once stole a [personal hygiene essential] because I didn't have any left." (P04). Comparisons with peers also contributed to feelings of inadequacy and exclusion, as some individuals were unable to participate in social activities: "Accepting it. Yes, that's definitely a good one. But I find it really difficult because … I just want so badly to do what other people do too." (P09). Financial limitations sometimes interfered with access to treatment; for example, some therapeutic programs required the purchase of materials that participants could not afford (MHP03).

Debt accumulation was another common concern. When financial obligations mounted, participants reported heightened stress, shame, and stigma: "Just piling up, piling up, bailiff, bailiff, higher costs, another bailiff, even higher costs." (F03). This financial strain could negatively affect the individual's ability to manage money effectively. As one participant described: "… Bills were left unpaid. And I didn't open my mail either, so my mailbox was [full], and I would empty it into a trash bag and store it under my bed … To avoid being confronted with payment reminders and such" (P06).

Financial management skills

Another frequently cited issue was difficulty managing finances. Common challenges included poor oversight, missed or late payments, not opening correspondence, and short-term financial planning: "Within two years, that money was completely spent, when he was in the clinic … He couldn't say 'well, now I can use this for the next ten years… and I won't have financial problems anymore'." (F01).

Participants also noted that some individuals avoided necessary financial steps, such as applying for benefits or addressing loans, even when psychotic episodes

prevented them from working or studying: “For example, even with their studies, not attending for whatever reason, but still borrowing [student loans] heavily … They don’t have the idea that, ‘Hey, this has to be paid back’.” (MHP05).

The relationship between financial performance and expense management was often cyclical: difficulties in monitoring finances could worsen the ability to cover costs, while limited resources could impede financial planning. More broadly, participants highlighted that some individuals with psychosis relied on structured support, such as family assistance or representative payees, to manage their finances: “I think they might not have the cognitive ability for it, so they don’t plan … But then they receive weekly allowances. Some get daily allowances. So, that’s how it’s compensated for.” (MHP13).

Living conditions and housing

Participants from both the psychosis and professional groups highlighted that financial difficulties often affected everyday living conditions. They reported reduced self-care, neglected household maintenance, and unclean or unsafe living spaces. As one professional described: “This lady, living in a concrete space in her apartment, has nothing on the floor (…) she doesn’t have much money, and then we requested if she could get a washing machine and carpet.” (MHP14). Family members also noted reduced self-care but generally did not comment on maintenance or household hygiene issues.

Some participants experienced homelessness as a direct consequence of financial mismanagement or substance use: “I was homeless for three years, yeah, I spent all my money to buy drugs and alcohol.” (P12). Others described the risk of eviction due to unpaid rent: “My mother also provided financial assistance because otherwise he wouldn’t have been able to pay his rent, and it wouldn’t have been long before he would have been evicted.” (F13). In some cases, individuals would leave home without informing family, particularly during psychotic episodes.

Personal conflicts and vulnerability to exploitation

Family members and professionals frequently discussed conflicts arising over money. Tensions often occurred when a caregiver or representative payee had to balance financial oversight with personal relationships, which sometimes resulted in considerable stress for the family. One participant recounted: “He kept coming back to me for money, and ultimately … I said I won’t do it anymore. You can end up on the streets, I don’t care anymore … but I had to do it, otherwise I would have been ruined myself.” (F07). Many family members expressed the need for emotional or mental health support to cope with the pressures of managing both caregiving and financial responsibilities: “Parents also need emotional support … it’s already so difficult to deal with your psychotic family member in daily life, and finances make it harder. There should be more support.” (F10). Interestingly, people with psychosis themselves rarely reported awareness of these conflicts or the burden on relatives.

All participant groups noted that individuals with psychosis can be particularly vulnerable to financial exploitation. Examples included being deceived in transactions or mismanagement of funds by family members or representative payees: “The representative payee didn’t advocate well for my child, left old bills unpaid while paying new ones, which resulted in him accumulating very high debts.” (F02). Such experiences often intensified emotional distress and, in some cases, worsened psychotic symptoms.

Regulations and legal issues

Only people with psychosis and their family members mentioned financial difficulties stemming from legal or regulatory frameworks. Participants reported challenges such as repaying subsidies or security deposits, which could create significant financial strain: “I still have my children living with me, and my son earns enough that I had to repay my rent subsidy last year. I had money in the bank, but it all went back there.” (P09).

Participants also mentioned engagement in financially motivated illegal activities, including theft, burglary, or drug-related offenses. Although such occurrences appeared rare, some individuals faced legal consequences, including fines, imprisonment, or placement in a custodial psychiatric facility: “At one point, he got arrested and sent to prison … he had to pay damages because he had assaulted someone.” (F04).

Research question 2: factors linked to financial problems

All participant groups described a range of factors contributing to financial difficulties, which often interacted and reinforced one another. For example, major life events could trigger psychotic episodes or substance use, while substance use might exacerbate psychiatric symptoms. Participants also recognized that

financial problems can exist independently of a psychotic disorder and are shaped by individual circumstances and broader social conditions. Across all groups, financial stress was reported to negatively affect mental health, sometimes intensifying psychotic experiences: "When people genuinely worry about their finances, it can, of course, make them more mentally unstable in terms of psychosis." (MHP09).

Psychotic symptoms

All participant groups—people with psychosis, family members, and professionals—highlighted that positive symptoms can directly contribute to financial difficulties. Disorganization was frequently mentioned as a factor that undermines financial oversight. Additionally, participants described financial issues arising from hallucinations, such as hearing voices that prompt spending, and from delusions, including grandiosity or paranoia. One family member shared: "He started filling out my mother-in-law's tax forms because he believed he was a tax advisor … she suddenly received a tax bill, and her housing subsidy was revoked." (F03). A professional noted: "Someone felt they needed to escape 5G to an island, and every ferry and taxi ride caused expenses that overwhelmed his mother." (MHP10).

Negative symptoms, particularly avolition, were also reported as contributing to financial problems by impairing financial performance: "I knew I had to pay it, I wanted to pay, but I just couldn't manage it. It wouldn't happen." (P10). Family members and professionals, but not participants with psychosis, additionally described cognitive difficulties, such as poor concentration, as factors affecting financial management: "There's also cognitive decline, which impacts how someone handles money." (MHP04). Cognitive challenges were attributed both to the disorder itself and, in some cases, to antipsychotic medication. Furthermore, family members and professionals reported that manic-psychotic episodes could drive overspending, particularly affecting the ability to cover basic expenses: "During a manic-psychotic episode, people may believe everything will be fine and start spending money they don't have." (MHP14).

Indirect factors related to psychosis

Participants also identified indirect ways in which psychotic disorders contribute to financial problems. Psychotic symptoms often disrupt employment, causing people to lose jobs or work at lower levels, which can lead to reliance on government benefits and feelings of inequality compared to peers. One participant noted: "I have a diploma and attended university, but if I hadn't gotten sick, I might have had a well-paying job. Comparing myself to classmates, I feel I missed out." (P05). Professionals noted that returning to work may not substantially improve income due to loss of benefits: "She's hesitant to work because previous attempts left her worse off financially." (MHP08).

Overspending was highlighted as another indirect factor, often functioning as a coping mechanism to alleviate symptoms, boost self-esteem, or gain social recognition: "When your life is hard and full of negative feedback, spending money on small things that give positive reinforcement feels rewarding." (F05). Participants also pointed to higher costs associated with having a psychotic disorder, especially unexpected healthcare expenses: "My deductible was 800 euros, and after a hospital stay, I still had to pay that." (P01).

Professionals emphasized that psychosis often begins in early adulthood, a period when financial independence is particularly important, increasing vulnerability to financial difficulties: "Young adults want to live normally—they want cars, jobs, weekends out, vacations—but if psychosis starts then, it can seriously disrupt financial stability." (MHP11).

Substance use and addiction

All participant groups consistently highlighted that substance use and addiction can contribute to financial difficulties. The primary substances mentioned were cannabis and alcohol, though tobacco, harder drugs, and gambling were also noted. The main pathway to financial problems was the high cost of these habits: "With that addiction, it was like a snowball—expenses kept piling up." (P02).

Substance use was also linked to impaired financial performance, as it reduces people's ability to manage money effectively. A professional explained: "Often, realizing something is wrong triggers marijuana use to numb themselves. Then they get so dazed that managing mail or bills is no longer a priority." (MHP07).

Financial upbringing and life events

Participants consistently pointed out that limited financial skills learned in childhood can contribute to later difficulties. One person reflected: "I only had a mother. She didn't teach me anything about money, just basics like food and drink." (P12). Contributing factors

include traumatic experiences, single-parent households, or having parents with mental health challenges. On the other hand, excessive financial support from family—providing money without setting boundaries—was also seen by professionals as potentially fostering financial problems: “Constantly giving money without limits, like €100 every month, isn’t real support. Setting boundaries shows more involvement.” (MHP06).

Life events, such as divorce, breakups, or serious illness, were described as triggers for financial problems, especially when occurring alongside psychotic episodes or vulnerabilities: “After my divorce, I relied on social welfare. I wanted to improve my life, but then psychosis interfered.” (P09).

Societal and contextual factors

Only family members and professionals highlighted societal influences on financial problems. Inflation was mentioned as increasing financial strain. Professionals also noted challenges related to growing digitalization, particularly for older individuals with psychosis. Complex, frequently changing laws and bureaucratic procedures regarding benefits and social security in the Netherlands were described as obstacles to managing finances: “You have to go in person and fill out forms just to block a debit card—it’s cumbersome, especially when confused.” (MHP16).

Participants further pointed to broader societal changes that reduce access to financial support, such as budget cuts in the healthcare sector that limit the availability of social workers.

Financial difficulties are a major challenge for people with psychosis, yet few studies have examined this in depth, particularly from the perspective of all members of the therapeutic triad. This study is the first to qualitatively compare experiences of people with psychosis, family members, and mental healthcare professionals regarding financial problems and their contributing factors.

Results indicate that participants across all groups identified similar financial issues, including difficulties covering expenses, financial performance, living conditions and housing, and personal conflicts and victimization. People with psychosis and family members also noted challenges with regulations and legislation, which professionals did not emphasize. The shared recognition of financial difficulties suggests that members of the therapeutic triad generally have a solid understanding of these problems and their own roles. People with psychosis can reflect on their financial behaviors, and family members recognize their contributions to financial conflicts.

However, people with psychosis rarely acknowledged the burden financial conflicts place on family members, and professionals overlooked legal and regulatory issues. Greater recognition of these aspects could improve collaboration and support, helping to prevent or address financial problems more effectively.

Although many of the financial challenges identified are not unique to people with psychosis, this study provides a thorough overview of co-occurring, often severe financial issues that can amplify one another. For instance, limited financial resources, such as difficulty covering basic expenses, can reduce cognitive and emotional capacity, potentially leading to poor financial management (e.g., failing to open mail, focusing on short-term spending; Mullainathan and Shafir [16]). This, in turn, may worsen financial difficulties over time or even increase the risk of homelessness, illustrating the potential for self-reinforcing cycles of financial problems. Addressing these cycles is crucial, as they can have far-reaching consequences for social participation, leisure, mental health, and access to healthcare.

The financial problems identified in this study partially reflect previous findings on people with psychosis. Difficulty covering expenses aligns with studies reporting low annual earnings in this group [11]. Problems with financial management are documented among individuals with schizophrenia [18- 23, 68], and in the U.S., about 35% of people with psychosis rely on a mandatory representative payee [47, 48]. Homelessness risk in this population is well-established, often linked to the absence of income [69-73]. Limited evidence also suggests that financial dependency on caregivers can provoke personal conflicts and aggression [26, 37]. Additionally, people with psychosis are at higher risk of legal violations, sometimes driven by economic survival needs, with low socio-economic status, unemployment, and low income acting as key risk factors [74-77]. Less explored financial challenges highlighted in this study include compromised living conditions (e.g., reduced self-care, household neglect) and vulnerability to financial victimization (e.g., scams or fraud). Dutch research indicates that people with psychosis experience victimization four to six times more than the general population, though prior studies primarily examined violent or sexual crimes, often neglecting financial exploitation [78, 79]. Thus, our findings both corroborate

and extend previous research. Raising awareness among key stakeholders about the co-occurrence and compounding nature of these problems could help in identifying and mitigating financial difficulties earlier, potentially breaking negative cycles.

Participants across all groups also identified similar factors associated with financial challenges, spanning psychosis-specific and more general influences: psychotic symptoms, indirect effects of psychosis, substance use and addiction, and financial upbringing and life events. Family members and professionals additionally noted societal and contextual factors, such as inflation and bureaucratic complexity, which people with psychosis did not mention. The shared recognition of these factors suggests a reasonably strong understanding within the therapeutic triad—for example, people with psychosis reflected on substance-related spending, while professionals recognized the impact of healthcare costs. However, increasing awareness among people with psychosis about societal and structural influences could reduce self-blame and stigma, helping them attribute less personal responsibility for financial difficulties.

Although themes were similar across groups, the lived experiences varied. People with psychosis reported daily struggles but sometimes expressed relative satisfaction, partly due to financial support that provided greater freedom and reduced stress. In contrast, family members frequently conveyed strong negative emotions, emphasizing the considerable burden of supporting their loved ones financially—an impact that participants with psychosis rarely acknowledged. Professionals observed these issues from a more removed perspective and noted that financial challenges are not routinely addressed in clinical practice. They also expressed uncertainty regarding whether addressing financial matters falls within their professional responsibilities, a situation influenced by short consultation times and a focus on symptom management [50, 53, 55].

Considering the factors associated with financial problems, it is unsurprising that manic-psychotic episodes were identified, as excessive spending is recognized as a diagnostic feature in schizoaffective disorders (DSM-5; APA [57]). Likewise, indirect psychosis-related factors, such as unemployment [10, 50] and elevated healthcare costs [28, 36, 80], have been documented in previous research. In this study, substance use—primarily cannabis and alcohol—was repeatedly mentioned across all participant groups as contributing to financial difficulties. Previous studies on people with psychosis also note the role of substance use and addiction [12-14, 81, 82], though many focused mainly on gambling disorders. In contrast, participants in the present study emphasized the impact of substance use over gambling-related issues. Other identified factors, including financial upbringing, life events, and broader societal influences, as well as psychotic symptoms themselves, have received relatively limited attention in the literature.

Most previous research has primarily viewed psychiatric symptoms as indirectly linked to financial problems [83]. For example, studies in the general population categorize causes of financial difficulties into survival (fixed expenses exceed income), compensation (coping through spending), adaptation (life-event-related income changes), overspending (living beyond means), and bureaucracy (administrative barriers) [83, 84]. While these categories partially overlap with our findings, psychiatric symptoms are often only considered as indirect stressors leading to increased spending or income loss. In contrast, our study suggests that psychotic symptoms can also have a direct impact on finances, with positive, negative, manic-psychotic, or cognitive symptoms leading to challenges in covering expenses or managing money. Therefore, although not all associated factors are unique to people with psychosis, certain factors—particularly psychotic symptoms—may heighten vulnerability to financial difficulties.

Financial stressors, however, are not exclusive to those with mental health conditions. Disadvantaged social circumstances can affect anyone [85], and financial difficulties are closely linked to the onset or worsening of mental health problems [1, 5, 86], especially among those in marginalized or low-income contexts [1, 3, 87]. Our results indicate that financial stress can exacerbate suffering, which participants sometimes interpreted as psychotic symptoms. This bidirectional relationship between finances and mental health highlights the risk of vicious cycles and the need to avoid pathologizing behaviors that may instead reflect broader socioeconomic vulnerability [5, 56, 88].

Reflecting on our role as researchers with a background in (mental) healthcare, peer debriefing highlighted a potential psychiatric bias in our study. There was a tendency to over-attribute maladaptive financial behaviors, such as ignoring bills, to psychotic symptoms while underestimating the impact of financial stress on behavior and mental health. This reinforces the importance of adopting a holistic perspective,

recognizing the interplay of psychosis-specific factors with broader contextual influences, and timely addressing financial stressors to prevent exacerbation of both financial and psychiatric difficulties.

This comprehensive perspective aligns with the financial capability model [15]. Participants in the study described financial problems across multiple levels of the model. Financial performance emerged as a key challenge, while issues related to financial competence were also noted, including limited skills acquired during upbringing (financial knowledge) and spending on substances (financial judgment). Many problems were linked to contextual factors such as homelessness, legal regulations, social conflicts, victimization, life events, and societal influences. Accordingly, mental health professionals are encouraged to adopt a holistic approach when assessing financial issues in people with psychosis. This involves evaluating both financial performance and competence while also identifying external contextual factors that may contribute to financial difficulties, beyond the direct effects of psychosis.

The results of this study should be interpreted with certain nuances and limitations in mind. First, when discussing "associated factors" or "vicious cycles," it is important to note that causal relationships cannot be directly inferred [89]. These terms reflect participants' perceptions and experiences rather than objectively proven causality. The qualitative approach allowed us to capture the depth and variability of personal experiences, which is often overlooked in quantitative research and highlights potential avenues for further investigation. Second, participants who volunteered for the interviews may have experienced more pronounced financial challenges, possessed stronger opinions, or had greater insight into these issues than non-participants, potentially intensifying the reported experiences. Third, the majority of family member participants were women, primarily parents, reflecting the typical involvement of mothers in managing the finances of people with psychosis. Other family members might have different experiences that were less represented. Fourth, people with psychosis included in this study had widely varying illness durations. Consequently, those with longer illness histories may have shared experiences influenced by past social and economic conditions (e.g., earlier Dutch social security policies), which may not fully reflect contemporary contexts. While generalizability is not the goal of qualitative research, these findings still offer valuable insights for stakeholders across different settings. Lastly, engaging in continuous team reflexivity regarding potential biases [90] and peer debriefing throughout the research process, rather than only at the conclusion, could have further strengthened the comprehensiveness of the study's perspective.

Conclusion

In conclusion, people with psychosis, family members, and mental healthcare professionals largely reported similar and broad-ranging financial challenges faced by individuals with psychosis. Several associated factors were also identified, often co-occurring and encompassing both general and psychosis-specific elements. This combination underscores the heightened vulnerability of people with psychosis to financial difficulties. Moreover, financial problems and their associated factors often reinforce one another, forming potential vicious cycles that can negatively affect mental health. Such cycles may have serious consequences, including reduced social participation, limited engagement in leisure activities, and compromised treatment adherence. Although financial issues are a shared concern within the therapeutic triad, the perceived burden and impact vary considerably depending on individual perspectives and the type of support provided. This study represents an important step toward recognizing and understanding financial difficulties and their associated factors in people with psychosis. Exploring the issue from multiple perspectives is both complex and essential, as it encourages awareness and fosters a more nuanced understanding of the challenges this population faces. Our reflections on the research process further emphasize the importance of considering multiple viewpoints. Building on these findings, our forthcoming study will investigate the perspectives of the therapeutic triad on the support people with psychosis receive or require for financial challenges. Promoting collaboration within the triad and ensuring early identification of financial difficulties may help disrupt these vicious cycles and mitigate their adverse effects.

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