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Editorial

Kristy L. Archuleta, Ph.D.

The *Journal of Financial Therapy* would not exist without the time and efforts of our excellent reviewers. You may be asking, "what does a reviewer do?" When a paper is submitted to *JFT*, it goes through a double blind peer review process where reviewers do not know who the author(s) is and the author(s) do not know who the reviewers are. Typically, two to three reviewers are assigned to review each paper and in general, we try to assign at least one scholar and one practitioner. *JFT* is a unique scholarly publication because papers require the rigor of academic standards, but also must be translatable to non-researchers. It is not uncommon for researchers and practitioners to fail to communicate effectively with one another because the two groups speak what seems like different languages. Therefore, it is the goal of *JFT* to publish quality scholarly research and to emphasize the practicality of the research.

This leads to another common question, what are reviewers looking for when they review submissions to *JFT*? As you may already know, *JFT* primarily publishes research that examines the empirical link between personal financial knowledge, attitudes, and behaviors and personal and family well-being, contributing to new knowledge that includes clinical research, cross-sectional survey research, longitudinal and panel study research, case studies, financial therapy practice management tutorials, and literature reviews. Reviewers are assigned to submitted manuscripts based on the reviewers' specific areas of expertise. For example, a manuscript about marriage and money will be sent to a reviewer who identifies that couple relationships is one of their areas of expertise, meaning the reviewer is current on the existing literature on this topic. This is important, as one of the primary objectives of *JFT* is to publish literature that contributes new knowledge to the field. Several objectives of the review process exist, but two other primary objectives I want to mention are evaluating methods and implications. Reviewing the quality and rigor of the methodology used in the development and analysis of the research is imperative to the credibility of the *Journal*. Especially for *JFT*, the implications for how the research or theoretical piece applies to practice, policy development, and future research is a must in aiding the bridge between academia and practice.

We are always looking for individuals who are willing to review manuscripts submitted to the *JFT*. Whether you are a practitioner or an academic, we invite you to become a reviewer. To do so, visit the *Journal's* website at www.jftonline.org, create a login, and then sign up to be a reviewer. Be sure to note your particular areas of expertise. For example, you

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might include a specific population, like couples, millennials, retirees, etc., or a particular area, such as physiological stress, mental health disorders, or financial literacy. Please join us as an author or reviewer in our efforts to communicate across disciplines with both practitioners and academics!

This issue features four articles, two profiles, and one book review. Each article adds a new contribution to the field of financial therapy. First, Lance Palmer, Teri Pichot, and Irina Kunovskaya report on a study about using Solution Focused Therapy techniques in a tax planning setting. Next, D. Bruce Ross, Jerry Gale, and Joseph Goetz provide new insights and raise important questions on the ethical issues in collaborative financial therapy. Third, Chelsey Franz discusses her mixed methods study on the implementation of a financial empowerment curriculum in a community program and stress reduction. Finally, Shinae Choi, Suzanne Bartholomae, Clinton Gudmunson, and Jonathan Fox report findings on the importance of sources of referral in help-seeking.

This issue features a practitioner profile of Syble Solomon and a scholar profile of Jorge Ruiz-Menjivar. Both of these individuals play an important role in the development of financial therapy. Finally, we conclude with a review by Cherie Stueve about a free book entitled, *What It's Worth: Strengthening the Financial Future of Families, Communities and the Nation*. This could be a book that benefits you and your financial therapy work!

To conclude, I am excited to announce the first special issue of *Journal of Financial Therapy*! The special issue will focus on the topic of Stress and Money and is scheduled to be published in Summer 2017. Dr. Sonya Britt, Kansas State University, will be the special guest editor. She brings a wealth of expertise from her research in this particular area. If you would like to submit a manuscript that is related to stress and money, please submit by January 2, 2017. We are looking to solicit quality papers that feature financial therapy practices, experiments, and other research related to stress and money.

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Financial Therapy Network

The following individuals have identified themselves as providing services that promote a vision of financial therapy. The Financial Therapy Association cannot guarantee the services of those listed in the FTA Network. For more information and to view these professionals' profiles, visit http://www.financialtherapyassociation.org.

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Promoting Savings at Tax Time through a Video-Based Solution-Focused Brief Coaching Intervention

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Solution-focused brief coaching, based on solution-focused brief therapy, is a well-established practice model and is used widely to help individuals progress toward desired outcomes in a variety of settings. This papers presents the findings of a pilot study that examined the impact of a video-based solution-focused brief coaching intervention delivered in conjunction with income tax preparation services at a Volunteer Income Tax Assistance location (n = 212). Individuals receiving tax preparation assistance were randomly assigned to one of four treatment groups: 1) control group; 2) video-based solution-focused brief coaching; 3) discount card incentive; 4) both the video-based solution-focused brief coaching and the discount card incentive. Results of the study indicate that the video-based solution-focused brief coaching intervention increased both the frequency and amount of self-reported savings at tax time. Results also indicate that financial therapy based interventions may be scalable through the use of technology.

Keywords: coaching; solution-focused brief coaching; VITA; savings intervention; savings motivation

INTRODUCTION

Most low and moderate-income households in the United States receive large lump-sums of money each year when they file their federal income tax return. For many low to moderate-income households, the tax refund is one of the single largest payments received all year and may not be completely allocated to the household's routine spending patterns because of its once-a-year timing. These factors make tax-time savings programs attractive interventions that could lead to substantial increases in the amount of savings and financial stability among low and moderate-income households. This study presents the structure and effect on self-reported savings behavior of a tax-time savings intervention.

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Tax Time Savings Interventions

The federal government continues to implement social welfare policies through the Internal Revenue Code implying that future tax refunds for low and moderate-income households will grow in size and continue to be a staple of tax policy in the future. Effective interventions that encourage saving at tax time (and throughout the year) among low and moderate-income households can contribute to greater long-term financial stability for households and increase the likelihood that government transfer programs affect permanent, rather than simply temporary, changes in the economic well-being of targeted households.

Some tax-time interventions have focused solely on financial incentives, such as matching contributions to restricted savings accounts or savings bonds and gamification of the savings decision (i.e., Beverly, Schneider, & Tufano, 2006; Doorways to Dreams Fund, 2011; Duflo, Gale, Liebman, Orszag, & Saez, 2005; Jones & Mahajan, 2011). Other interventions have utilized financial coaches to encourage saving among participants, as well as gift cards for those choosing to save (i.e., Empire Justice Center, n.d.). Tax-time savings research-based initiatives during the early 2000s led to policy changes (Beverly et al., 2006) that were designed to make it easier for tax filers to save more of their refunds. Beginning in 2005, the nonprofit organization, Doorways to Dreams Fund (D2D), offered U.S. savings bonds during tax-time and contributed to the introduction of IRS Form 8888, which allows tax filers receiving a tax refund to split that refund across multiple accounts, as well as purchase U.S. savings bonds. D2D also launched Bonds Make it Easy, a creative social marketing campaign that included video games as an instructional media tool designed to promote personal savings through savings bonds, workplace savings accounts, and budgeting (Tufano, Flacke, & Maynard, 2012). For the 2013 tax season, D2D launched a nationwide Save Your Refund Sweepstakes that offered cash prizes to filers who used IRS Form 8888 to commit their refund dollars to U.S. savings bonds or other savings products.

Refund to Savings is the largest savings experiment conducted in the United States. It integrated two behavioral economic interventions, namely prompts and anchors, into Turbo Tax Free File, a free online tax filing software for low and moderate-income households (Grinstein-Weiss et al., 2015). The combination of prompts and anchors led to a statistically significant increase in the percentage of households' saving part of their tax refund, as well as an increase in the amount they chose to save. While the gains were modest (i.e., the percentage of households saving increased from 6.8% to 7.6% of tax filers), the analysis was robust and used split refunds to measure the immediate and long-term impact of anchors and prompts embedded in the tax preparation process.

Many tax-time savings interventions, such as D2D, are initiated and implemented at Volunteer Income Tax Assistance (VITA) sites, or through other free tax filing assistance programs. VITA sites are sponsored by the IRS and are made available in local communities through partnerships with the local entities, such as social service agencies, schools, churches, military installations, credit unions, and other community organizations (Annis, Palmer, & Goetz, 2010). VITA sites offer free income tax preparation and filing services to

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low and moderate-income households. Many types of savings intervention programs are frequently offered at VITA sites. However, evaluations of tax-time saving programs show them to have fairly small incremental effects on motivating savings behavior changes (Grinstein-Weiss, Russell, Gale, Key, & Ariely, 2016).

Insights from social psychology provide help in understanding why people fail to save more of their money and why matching incentives sometimes do not work as expected. Certain external incentives, such as gift cards or matched savings programs, have little influence when they must compete against substantial opposing internal forces. The degree to which an individual desires to satisfy their needs/wants and the congruency of external savings incentives with their internal desires will lead to the avoidance or acceptance of the incentive (Lewin, 1951). Additionally, consumers can interpret interventions and associated stimuli, such as images, short phrases, or incentives, differently than intended depending on their mind-set, thus confounding the effects of the intervention (Cheema & Patrick, 2008).

The present study proposed an innovative tax-time saving intervention, which was designed based on Solution-Focused Brief Coaching (SFBC), to foster in VITA clients an intrinsic motivation to save for their future needs. This intervention utilized key approaches of Solution-Focused Brief Therapy (SFBT). While the financial coaching literature has recently grown significantly, empirical evidence about specific approaches or practice models is still limited. Data presented in this paper show some encouraging results regarding the effectiveness of the SFBC approach.

REVIEW OF LITERATURE

Financial Coaching

Financial coaching was introduced as a promising approach for helping clients to attain their financial goals. It is distinct from financial literacy education, financial planning, or financial counseling (Collins, Baker, & Gorey, 2007; Collins, Olive, & O'Rourke, 2013). Financial coaching is described as a newly emerging and applied sub-discipline of life coaching, which according to Grant and Cavanagh (2011), refers to "a goal-directed activity" (p. 294).

Coaching incorporates many of the clinical, technical, interpersonal, and managerial skills that therapists have been using for years in face-to-face therapy. However, coaches define their work differently than therapists do (Szabo, Meier, & Dierolf, 2009). The primary distinction is that therapy can treat diagnosable disorders or pathologies. While therapists can provide significant help to individuals with or without diagnosed disorders, coaching is focused solely on those individuals who have a functioning ability in the area(s) for which they are seeking support. Coaching presumes one is doing many things well and wants to perform even better. It involves helping clients identify centrally important professional and/or personal goals and taking action toward their deepest vision of who they want to become.

The goals of clients pursuing coaching services similarly set them apart. Clients who pursue personal and professional coaching are generally motivated to reach personal

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wellness, peak performance, and a greater life experience. They are not seeking emotional healing or relief from psychological pain, but rather they are seeking to improve their performance or conduct in specific areas of their lives.

As the financial coaching field has developed, there have been ongoing appeals to place significant emphasis on developing scientifically rigorous and theoretically-informed practices in the field. Collins and O'Rourke (2012) developed a clearer definition of financial coaching which was an important theoretical step forward and defined financial coaching as "a collaborative solution-focused, result-oriented, systematic and strengths-based process in which the coach facilitates the enhancement of personal financial management practices" (p. 42).

This definition highlights that communication between a client and a coach is collaborative and is focused on helping clients articulate their own goals and outcomes. Defining financial coaching also clarified that a financial coach (a) acts as a facilitator of change rather than an expert, (b) facilitates the construction of solutions, (c) focuses on client strengths and emphasizes their resources, (d) highlights how these resources can be used in the attainment of a client's goals, and (e) emphasizes the future more than the present or the past (Collins & O'Rourke, 2012).

Collins and O'Rourke (2012) also analyzed data from financial coaching programs that targeted lower income populations. Results of the analysis suggested that clients who had received financial coaching, compared to those who had not been coached, self-reported higher budgeting self-efficacy, were more likely to have a goal, and had higher confidence regarding achieving the goal.

Solution-Focused Brief Therapy and Solution-Focused Brief Coaching

While financial coaching is generally described as solution-focused, it is important to note that SFBC is a very specific type of coaching that includes the common elements of general financial coaching, but also incorporates additional essential intervention tools pertaining to the SFBC practice model. SFBC is derived from Solution-focused Brief Therapy (SFBT) which has its origin in the field of psychotherapy (Visser, 2011). SFBT was originally developed by Insoo Kim Berg, Steve de Shazer, and a group of colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin, in the early 1980s (Berg, 1994; Berg & Miller, 1992; Berg & Reuss, 1998; de Shazer, 1985, 1988, 1991, 1994; Miller & Berg, 1995). An overview and narrative of model SFBT discussions is presented by Trepper et al. (2010). Bavelas et al. (2013) also provide an in-depth introduction to Solution Focused Therapy.

Since its inception, SFBT has been applied across a range of contexts, such as substance abuse, domestic violence offenders, couples therapy, traditional psychotherapy, and organizational development (Corcoran & Pillai, 2009). SFBT is a future-focused, goal-directed approach based upon principles of focusing on strengths, exceptions to the problem, and future goals. Solution-focused work is also short-term, and may consist of a small number of sessions, or even a single session.

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Certain aspects of SFBT have been incorporated into the general field of financial coaching, but consistent applications of all of the core tools and approaches are not typically followed in general financial coaching interventions (Collins & O'Rourke, 2012).

Archuleta et al. (2015) utilized SFBT techniques to work with college students struggling with financial issues. In contrast to financial coaches' general "solution-focused" orientation, Archuleta et al. monitored counselors' adherence to the specific practice model of SFBT to ensure that the core elements and processes were followed in each counseling session. Across multiple measures of financial well-being, students in the study showed improvements. Archuleta et al. not only demonstrated the efficacy of the SFBT approach for financial counseling, but they also persuasively argued the importance of understanding, applying, and adhering to core elements of specific practice models when working with clients.

Tools and Processes in SFBC

The tools of SFBC, derived directly from the SFBT practice model, begin with identifying and creating a detailed description of the client's desired goals, and continue with assisting them in evaluating their situation in relation to their desired goals, including what they have done successfully in the past that resulted in being closer to their desired goals. The SFBC approach also emphasizes, identifies, and acknowledges small steps that can be taken in the present in order to reach future goals (Pichot & Smock, 2009). In the SBFC approach, the coach helps the client create a well-defined image of their desired future situation. The clients are the experts regarding their desired outcomes and in defining what steps will lead to these outcomes. The coach's role in SFBC is to lead clients in exploring possible solutions. This process allows clients to focus on their goals for the future, while still being aware of, yet not focused on, lessons from the past. The following tools and questions are essential elements of SFBC as derived from SFBT.

Goal formation questions invite clients to consider and develop a clear picture of their situation without their current problem, or to go to a place in their imagination where their desired future state has been achieved. As a result, the client's focus shifts from addressing the despair that results from current problems, to creating an intention to act for an improved future.

A common technique used to help elicit from the client a clear vision of the client's desired future state is to ask the client the *miracle question* (Trepper et al., 2010). The miracle question invites the client to imagine that a miracle has taken place while the client was sleeping and when they wake, the problem is gone or the goal is achieved. The client is then asked to describe this future state. This approach helps the client suspend any disbelief that change is possible, by framing the situation as though the desired change has already taken place. A variation of this technique invites clients to move forward in their imagination to a specific point in time, or fast-forward to a time when the desired state has been achieved (Pichot & Dolan, 2003). The fast-forward variation of the miracle question removes any religious undertones that may confound the discussion and therefore may be better suited to the needs of a larger, more heterogeneous audience.

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Solution-focused scaling questions help clients to orient and understand their current situation in relation to their desired future state. Such scales typically range from one to ten, where ten represents the client having achieved their desired state, and one represents the worst the client is possibly doing in relation to that desired state or outcome. Through scaling questions, clients can better understand the steps between their current situation and their desired situation. When a client's goal is expressed in terms of manageable steps (i.e., half or full increments on a scale), the client can not only understand their situation and plan for realizing their goal, but also can feel motivated to achieve small victories toward their ultimate goal.

Scales also allow identification of situations in which the problem is resolved or is less severe. In other words, scales help clients to become aware of exceptions. For example, a "three" on a ten-point scale, as reported by the client, indicates the client is closer to their desired state than if they had reported a "one" or "two" on the scale. A coach would ask clients to explain why they are at "three," and not at "two" or "one." This helps the client recognize what they have been doing well and provides a positive foundation to build upon. Clients are encouraged to identify steps that will get them one step, or even just a half a step, higher on the scale. Over repeated sessions, the coach and client revisit this scale to recognize progress and identify the next action steps. Through this process clients learn that even in the most difficult times, they are using skills and strategies that work.

Coping questions are questions that help clients to explore what they are doing to prevent their situation from becoming worse. These questions are particularly useful for clients who are not yet ready to advance along the scale but may still feel empowered by identifying something they are doing well, despite their adverse circumstances. These questions include, "What did you do from keeping the situation from getting worse?" or "What are you currently doing to manage the situation?"

Relationship questions ask clients to think from the perspective of others, allowing clients to consider the feelings, needs, and desires of others. These questions increase clients' motivation to take difficult or uncomfortable steps to make a positive difference in the lives of those to whom they feel connected.

SFBC was considered an appropriate intervention tool to use during VITA sessions to engage clients in forward looking savings behavior because it is goal-oriented and well-suited to meet clients' needs who have financial challenges, but can also benefit those who are managing their finances well by reinforcing positive behaviors.

Tax-time Savings Interventions

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Building on previous tax-time interventions, this project developed two interventions designed to encourage individuals to save. One intervention took VITA clients through a SFBC process prior to the completion of their tax return, while the other intervention focused on an immediate benefit if the client chose to save. These two interventions are scalable to reach larger populations with few marginal costs. The SFBC intervention took the form of a standardized internet-delivered video and accompanying worksheet, and was designed to help tax filers develop a clearer and emotionally connected vision of their future. The other intervention offered VITA clients who chose to save a discount card to local businesses. The discount card was intended to reduce the impact of loss aversion to saving by offering a current consumption benefit. The following section describes these two interventions and how they were implemented.

METHODOLOGY

Implementing the application of the SFBC model was a challenge. It was to be delivered by more than 40 different student volunteers organized to provide VITA services to more than 800 households. The volunteers had never practiced SFBC, but the need for consistent SFBC intervention without substantially lengthening the time required to complete the tax preparation process was imperative. To address these concerns, researchers created a SFBC video and accompanying worksheet for clients to watch and complete either while waiting for their tax filing appointment or over the internet prior to arriving at the site.

Developing a Solution-Focused Brief Coaching Video

The "coach" used as the subject for the video was a nationally recognized therapist, trainer, and coach specializing in the area of Solution-Focused Brief Therapy. She also held professional licenses and designations, such as Licensed Clinical Social Worker, Licensed Addiction Counselor, and Master Addiction Counselor. In order to develop a video-based version of SFBC, wherein the video coach could adequately empathize with the clients through echoing some of their concerns, two focus groups were held with tax filers from the previous tax year and the SFBC coach. Findings from the focus groups regarding the client's goals, concerns, desires, and general mindsets regarding their financial situations helped the coach learn about the clients. This allowed her to adapt her language in order to make the video more culturally appropriate and familiar to the audience (VITA clients). Phrases and themes that were commonly heard in the focus groups were then incorporated into the video script. These included: buying the latest smart phone; treating yourself to Jittery Joe's (a local coffee shop); saving to buy your children something special; saving for a future goal (i.e., a house or going back to school); and having a little money left over for the unexpected.

Key elements of SFBC included asking questions of the client, including the miracle or fast-forward (goal formation), scaling, next steps, coping, and relationship questions. A simple worksheet was developed that followed the video. The video coach would ask the client to respond to the questions on the worksheet. Each time the video coach asked a question that the client was to respond to, the video auto-paused to allow the client time to respond to the question. The client then restarted the video once they had written down

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their response. In this manner, the client was given sufficient time to write specific, individualized responses to the video coach's questions.

The SFBC coaching video was outlined as follows: (a) welcome and introduction to the concept of SFBC; (b) introduction of the video coach as a life coach; (c) invitation to take a few minutes to prepare and think about their desired financial future; (d) addressing the possible question of why the video may be helpful; (e) discussion of an analogy (driving in the rain) that showcases the importance of planning for the future; (f) fast-forward exercise, which is the creation of a desired future vision (worksheet response); (g) scaling of current progress toward this desired future state (worksheet response); (h) exploration of current exceptions (i.e., what's working now) (worksheet response); (i) introduction of the ladder analogy and scaling; (j) creation of a clear vision of what or how things would be different if they were just a little bit closer to their desired state; (k) exploration of possible next steps in order to reach that higher place (worksheet response); and (l) an invitation to discuss their goals and possible next steps with the tax preparer. The video can be viewed at http://www.fcs.uga.edu/fhce/outreach-vita-resources-research.

In order to facilitate the transition from video and worksheet coaching to the live tax preparer and maintain the momentum from the video, a four-hour training session was held with the student tax preparers. Training sessions focused on the key elements of SFBC that the video presented to clients and then provided tax preparers with simple strategies to follow-up with the clients in order to encourage clients to take the next steps toward their desired future state. Other research has shown that VITA sites not only provide valuable services to the clients they serve, but also provide influential experiential learning to students that provide the services (Palmer, Goetz, & Chatterjee, 2009).

A Cashless Matching Program

The second intervention administered as part of this project was an incentive based savings promotion. As a substitute for a matched savings program, a cashless savings match program that utilized discounts at local businesses to provide a way of matching funds was developed. The discount card, titled "The 10% Club," was only available to those tax filers who chose to save at least 10% of their tax refund in long-term savings accounts, such as U.S. savings bonds, IRAs, CDs, or other restricted access accounts. The card included varying discounts at restaurants, retailers, auto repair shops, and other basic service providers (i.e., buy-one-get-one-free, 10% off auto repairs, etc.). By choosing to save, clients were purchasing discounts on current consumption; thus, the clients were mitigating the loss aversion that is typically associated with a pure savings decision.

Assignment of VITA Clients to Intervention and Control Groups

On rotating days throughout the tax filing season, individuals coming to the Volunteer Income Tax Assistance site were exposed to different interventions or no intervention (control group). All VITA clients on any given day received the same treatment. Prior to the start of their tax return, randomly selected VITA clients were invited to do one of the following: (a) save part of their tax return (control group—no *10% Club, no video*); (b)

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participate in the *10% Club* by saving 10% of their potential tax refund in a restricted savings vehicle (i.e., CD, IRA, U.S. savings bonds) and receive a 10% Club discount card; (c) view the SFBC video and complete the associated worksheet; or (d) participate in both the *10% Club* program and watch the SFBC video and complete the associated worksheet. Due to different response rates on given days, treatment group sizes were not equal. Table 1 shows the sample sizes for each of the four groupings.

At the conclusion of the tax preparation process, all tax filers were invited to complete an informed consent form and a survey. This research study was approved by the university's Institutional Review Board.

Table 1

Experimental Designs

Intervention	Description / Label	Number of Participants	Number of Usable Surveys with a Refund
Intervention 1	Control Group	56	37
Intervention 2	10% Club card	94	68
Intervention 3	SFBC Video	57	35
Intervention 4	10% Club card & SFBC Video	99	72
Total		306	212

Operations, Staffing, and Target Audience

VITA services were offered to the community in the branch offices of a local credit union after the branch was closed. Hours of VITA operation were Tuesdays and Thursdays from 5:00 PM to 9:00 PM, and Saturdays from 9:00 AM to 1:00 PM. Tuesday and Thursday sessions were by appointment only and Saturday sessions were primarily walk-in sessions. VITA operations began in the first week of February and concluded in the second week of April. Advertisements for the free income tax preparation services were sent via email list-serves to the local school district, university staff, city government, and print advertisements were also in the credit union lobby and on its website.

Staffing for the VITA site was provided by student volunteers from a local state university. Students were also enrolled in a service-learning class that was devoted to tax planning and research. They received a letter grade based on written assignments that included a tax research paper and a reflective essay of their service-learning experience, in addition to their certification, accuracy of tax filing, professionalism, and client's feedback during the filing experience. The class was comprised of students who were either accounting or financial planning majors.

All student volunteers were required to be certified through the IRS Link & Learn education program at the advanced level prior to working on any tax returns. In addition to

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the certification, student volunteers also completed approximately six hours of software, process, and SFBC training, and were required to dress professionally at the VITA site.

RESULTS

Table 2 presents the sample characteristics based on survey data that was collected from tax filers at the conclusion of the tax preparation process.

Table 2

Demographic characteristics of the sample by intervention design

	Total Sample	Control Group	10% Club	SFBC Video	10% Card & Video
Gender					
Male	35.0%	22.2%	33.3%	31.4%	44.4%
Female	65.0%	77.8%	66.7%	68.6%	55.6%
Ethnicity					
Hispanic/Latino	7.8%	2.8%	14.8%	11.4%	2.8%
Non-Hispanic/Latino	92.2%	97.2%	85.2%	88.6%	97.2%
Race					
Asian	9.7%	8.6%	16.4%	6.1%	6.9%
Black/African American	16.4%	20.0%	10.9%	18.2%	18.1%
White	72.8%	71.4%	70.9%	72.7%	75%
Other	1.0%	0.0%	1.8%	3.0%	0.0%
Education					
High School or less	9.8%	10.8%	13.1%	2.9%	9.7%
Some College	20.0%	32.4%	21.3%	11.4%	16.7%
Bachelor's Degree	32.7%	27.0%	27.9%	42.0%	34.7%
Postgraduate Degree	37.6%	29.7%	37.7%	42.9%	38.9%
Last Year's Taxes Prepared					
Paid a professional	16.5%	18.9%	14.7 %	17.1%	16.7%
VITA	54.7%	59.5%	66.2%	54.3%	41.7%
Self-prepared / other	28.7%	21.6%	19.2%	28.5%	41.7%
Will use VITA Next Year	98.6%	100.0%	100.0%	97.1%	97.2%

The total number of VITA clients that had tax returns prepared at the site was 665. There were 306 surveys collected with one survey being completed for each household. Of the 306 surveys, 45 surveys had missing data and were excluded from the analysis and 49 additional surveys indicated that the VITA client did not receive a tax refund, resulting in a final sample size of 212. Based on VITA site administrative data, the average Adjusted Gross Income of the tax filers who participated in this research was $30,733 and the average federal tax refund amount among all VITA clients was $1,156. Among only those receiving a federal tax refund the average federal refund amount was $1,575. Nearly two-thirds of the participants were females, and approximately two-thirds of participants were non-Hispanic White. A high proportion of the sample had college degrees, which was not surprising given the target audience and location of the VITA site.

Over half of the participants had received tax preparation services through VITA in prior years. Nearly 99% of the sample expressed that they planned to return to the VITA site

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the following year. Just over 15% of the sample used a paid preparer in the prior year and about 30% of the sample prepared their own taxes in the prior year.

Savings Behavior by Intervention

The savings response to the various treatments was assessed by the following questions:

- "Did you save part of your refund TODAY?"
- "How did you save part of your refund TODAY?"
- "How much of your refund did you save TODAY?"

Response options to the first question included "Yes," "No," and "Did not get a refund." Response options to second question included: (a) "Opened a new account," (b) "Purchased a U.S. savings bond," (c) "Used an existing account," (d) "Did not save," (e) "Did not get a refund." Table 3 presents the self-reported savings behaviors for the entire sample and for each of the treatment groups.

Table 3

Financial behaviors of the respondents by intervention design

	Total Sample	Control Group	10% Club	SFBC Video	10% Club & Video
Did you save part of your refund today?					
Saved	39.2%	37.8%	33.8%	65.7%	31.9%
Chose not to save	60.8%	62.2%	66.2%	34.3%	68.1%
Mean Amount Saved	$330.84	$309.66	$298.49	$758.26	$164.49
(SD)	($670.93)	($603.63)	($626.59)	(1,066.89)	($343.63)

Approximately 40% of the sample stated they saved part of their refund. The highest percentage of tax filers who chose to save was in the SFBC video treatment group and the lowest percentage was in the 10% Club Card treatment group. The proportion of individuals reporting saving part of their refund in the SFBC video treatment group was nearly twice as high as that found in other treatment groups and the control group. With the exception of the SFBC video treatment group, the proportion of savers was similar in each of the treatment groups. The percentage of individuals who chose not to save was 60.8%.

A Chi-square test was performed to determine whether the differences that were observed in the proportion of participants who chose to save in the various treatment groups was even. The Chi-square test (x^2 = 12.773, 3, p = 0.005) rejected the null hypothesis that proportions were equal, confirming that the proportion of VITA clients in the SFBC video group reporting savings part of their refund was significantly higher than the proportion in other groups.

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The amount of savings for those in the SFBC video treatment group was also substantially higher than the amount saved by those in the other treatment groups. The average amount reported saved in the SFBC video treatment group was $758.26, more than double the average amount reported in any of the other treatment or control groups. A one-way ANOVA was conducted to compare the effect of savings interventions on self-reported savings behavior using the SFBC video, the 10% Club Card, the combination of the SFBC video and the 10% Club Card, and a control group. A significant effect was found for savings interventions on the amount of self-reported savings at the $p < 0.01$ level for the four conditions [$F(3, 208) = 6.79$, $p < 0.001$].

An ANOVA means plot is shown in Figure 1. The mean dollar amount of self-reported savings is illustrated for each of the three treatment groups and the control group.

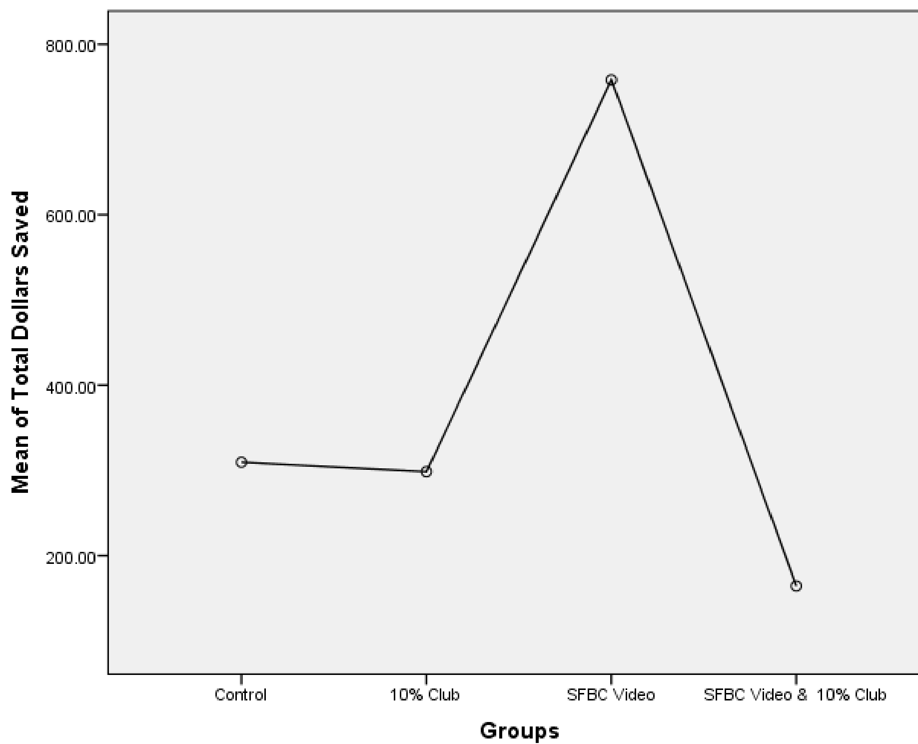

Figure 1. ANOVA means plot of self-reported amount saved for each of the four intervention groups (n = 212).

DISCUSSION

Tax filers' self-reported savings behavior appears to be significantly affected by the SFBC video intervention. Higher proportions of tax filers who viewed only the SFBC video reported saving part of their refund, and the amount of self-reported savings was higher than those who received a different intervention or no intervention. The SFBC video treatment appeared to effectively help clients develop a higher intrinsic motivation to reach their future goals, or desired state, which in turn affected their current self-reported savings behavior. Based on the proportion of clients choosing to save and the amount of self-reported savings,

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intrinsic motivation fostered by the SFBC process appeared to have had a substantially larger impact on clients than the external incentive (10% Club Card).

Perhaps the most significant "result" of this study is that coaching at tax time was found to be scalable through pre-recorded videos, a worksheet, and some limited training with tax preparers. The uses of a SFBC video and worksheet to conduct the main aspects of the coaching process allowed the coaching intervention to be delivered uniformly to all of the VITA clients that received it. This not only added to the robustness of the study, but, more importantly for VITA site coordinators, it also provided a high level of quality control assurance because a professional coach was leading the VITA site clients through the coaching process. While a simple worksheet was used in this study to engage the clients in the video coaching process, other client engagement tools could also be utilized.

Clients also appeared to be receptive to the uniform application of the SFBC video. This is evidenced by the 97% of VITA clients in the SFBC video, and SFBC video and 10% Club Card treatment groups, that indicated they planned to return to the VITA site the following year.

Limitations

The impact of the SFBC video on savings behavior did not appear to be as effective when the treatment was combined with another treatment, namely the 10% Club discount card treatment group. The mean proportion of savers and the amount of savings reported by those participants exposed to both treatments were lower than those reported for the 10% Club only and SFBC video only treatment groups. This suggests that tax preparers, when presented with both options may have overemphasized the 10% Club and underemphasized the SFBC video in their follow-up conversations with participants. This scenario is likely given that the student tax preparers did not view themselves as life coaches, nor did they have experience other than a few hours of training in performing SFBC. In addition, as participant goals may be deeply personal, emotional, or difficult to articulate, when given another option the participant and tax preparer may have chosen the emotionally safer conversation. Discussing the 10% Club card is less personal and required little introspection or questioning. It also may suggest that clients who received both the SFBC video followed by the 10% Club discount card intervention could have been overwhelmed by both interventions simultaneously and chose not to exert the mental effort necessary to focus on both interventions and consequently chose to stay with the status quo decision regarding savings, which is to not save. Additionally, the combination of both interventions may have appeared to the client to be some sort of sales presentation, which in turn may have increased the client's resistance to the presentations.

Implications

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For the SFBC video treatment group only, there was no distraction to divert the client's attention from their goals. This allowed more time for a thoughtful discussion about the participant's experiences with watching the video. Even in the event that tax preparers did not thoroughly discuss the video, the client was not distracted by another savings intervention and had that time to ponder their worksheet responses and the video presentation.

Avoiding an anchor may also improve the amount of savings. Anchoring occurs when an external figure is used as an internal decision heuristic. This project used "10%" as an anchor from which participants could frame the amount they chose to save (i.e., higher or lower than 10%). The selection of 10% as an anchor may have been too low. The SFBC video only treatment group did not receive an anchor; therefore, the perceived financial expense associated with achieving internally-generated goals and aspirations was likely the primary influence on the amount of savings. When no anchor was present, the amount of self-reported savings appears to be much larger. Thus, interventions that can help the client generate and foster their own aspirational goals will likely result in not only a greater willingness to save, but also a greater amount of savings.

Conclusion

Tax time does appear to be a promising time to encourage positive savings behavior and discuss savings opportunities with low and moderate-income individuals. This paper demonstrates that therapy-based interventions, such as SFBC, can be applied in a standardized, brief, and efficient method that can change a client's willingness to save, as well as increase the amount that they choose to save. SFBC and other therapy-based practice models that can be used to promote future goal orientation and financial stability among individuals receiving financial services warrant further study and evaluation.

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Ethical Issues and Decision Making in Collaborative Financial Therapy[1]

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The purpose of this article is to introduce potential ethical challenges that may arise when a financial and mental health professional collaborate to provide financial therapy and recommendations on how to effectively address these concerns. The development of ethical and professional practices requires extensive dialogue from practitioners in the emerging field of financial therapy; however, it is important to first develop an awareness and sensitivity to the ethical and professional issues across disciplines. This article examines the differences and similarities between the codes of ethics of different financial and mental health disciplines, and addresses six core ethical and professional issues: dual relationships, confidentiality, collaborating with other professionals, fee management, use of technology, and attending to federal and state regulatory laws. In working through the complexity of different disciplines' regulatory environments, a discussion of how to address these ethical questions in order to progress the financial therapy field is presented.

Keywords: best practices; family therapy; financial planning; financial therapy; ethics; professional collaboration; professional standards

INTRODUCTION

Although the part that finances play in family conflict has been indicated as a leading reason for divorce for some time (Cleek & Pearson, 1985), the use of mental health therapy techniques within financial planning or the implementation of financial interventions in therapeutic work is a relatively recent concept in both practice and study (Gale, Goetz, & Bermudez, 2009; Kim, Gale, Goetz, & Bermudez, 2011; Klontz, Britt, & Archuleta, 2015). Based, in part, on the wide acceptance that economic factors impact individual and couple's well-being, and that relationship dynamics can impact financial behavior, the field of financial therapy has developed to more effectively address financial issues affecting clients within multiple disciplines (McGill, Grable, & Britt, 2010). The Financial Therapy Association (FTA) defines the practice of financial therapy as "the integration of cognitive, emotional,

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behavioral, relational, and economic aspects that influence financial well-being, and ultimately, quality of life" (Financial Therapy Association, 2016). Although this definition provides a broad description of financial therapy, the practice of financial therapy for collaborating practitioners from different disciplinary backgrounds requires a more nuanced framework. In developing the integration and articulating the intersections of the different fields and disciplines involved in financial therapy, a necessary step is to consider, articulate, and discuss ethical and professional practices and principles to orient practitioners, researchers, and educators to achieve best practices in financial therapy, as well as to demonstrate to the public that clear ethical standards are in place to protect consumers (Gale, Goetz, & Britt, 2012). Establishing ethical and professional standards for the practice of financial therapy is a particularly complex process when two professionals from different fields are collaborating to provide services, as many professionals already follow their own specific ethical codes and professional standards. Although across disciplines these codes and standards have substantial overlap, there are a few important differences.

Licensed mental health practitioners of financial therapy are practicing under the umbrellas of state licensures and professional standards. Financial practitioners of financial therapy may also be working under state and federal financial regulations and professional standards. Due to the variety of practitioners practicing financial therapy, the professional practitioner likely positions his or her practice based upon: (a) how he or she conceptualizes financial therapy and (b) how his or her professional organization or state/federal regulatory boards view his/her work. As the field of financial therapy continues to grow on a national scale, it is important to have a clear and shared understanding of the ethical and professional standards involved across disciplines, particularly when different professional standards are incongruent.

The purpose of this paper is to initiate a dialogue of potential ethical challenges that may arise in the practice of financial therapy and offer suggestions on how to effectively address common ethical and professional issues, which may arise when professionals from different disciplines work together. The development of professional practices requires extensive dialogue across professional disciplines from those practicing financial therapy in order to be not only acknowledged, but addressed. To achieve this, an awareness and sensitivity to the ethical and professional issues is needed. Familiarity with the ethical and professional standards of both mental health and financial disciplines allows practitioners to provide ethically and legally appropriate action plans for their clients, while also protecting their clients' rights. It is not unusual for clients seeking services of financial therapists to be struggling with some or all of these points of intersection: (a) financial issues, (b) making rational decisions when emotions are high, (c) modifying financial behaviors, and (d) working through couple or family relationship dynamics. When practitioners from different disciplines work closely together in financial therapy, the ethical and professional standards of each discipline must be considered to avoid potential conflicts at any of these points of convergence.

A necessary caveat for this paper is that it is primarily focused on a sample of disciplines that have government licensing or regulatory certifications, and therefore have

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their own defined ethical codes from which the paper provides a comparative analysis. Although other disciplines are certainly active in the field, this paper focuses on presenting ethical issues in the context of the distinctions and similarities between existing national ethical codes as a way to start the discussion of professional standards for one form of financial therapy. Every established service discipline adheres to certain codes of ethical and professional conduct in order to maintain a standard of integrity not only for its members, but also for the benefit of those clients the members represent. The emerging field of financial therapy has a unique opportunity in considering the varying codes of ethics from which its members currently practice. Although each member recognizes common ethical standards, there are differences in how each affiliation and individual interprets and applies these ethical standards. Therefore, in order to maintain standards of best practices *for clients' well-being*, it is imperative that professional codes of ethics from the multiple disciplines utilizing financial therapy practices are analyzed and considered. It is the authors' intention to begin to work through a sample of established standards and initiate a dialogue around possible ethical and professional standards to progress the field of financial therapy.

ETHICAL AND PROFESSIONAL STANDARDS

All licensed, registered, and certified professional practitioners have their own ethical and professional standards or guidelines. Ethical and professional standards are explicitly stated and nationally or state regulated. Financial counselors, financial coaches, financial planners, family therapists, life coaches, social workers, counselors all have written and published ethical and professional guidelines to adhere to throughout the course of their work. Although there may be considerable overlap among disciplines (e.g., between social workers and marriage and family therapists), there are also differences, as each discipline still retains its own distinct ethical and professional guidelines. In the case of financial therapy, which requires some level of integration from at least two or more disciplines (either for the individual practitioner or two practitioners working together), potential ethical and professional concerns may arise. The following sections examine the differences and similarities between the codes of ethics of different financial and mental health disciplines.

Codes of Ethics between Financial Disciplines

There are a number of financial service disciplines involved in financial therapy practices. Common financial disciplines include financial planning, financial counseling, financial advising, and financial coaching.[2] For the scope of the paper, only two financial certifications and associated professional standards are evaluated: Certified Financial Planner Board of Standards (Certified Financial Planner Board of Standards, Inc., 2013) and the Association of Financial Counseling and Planning Education (Association for Financial Counseling and Planning Education, 2013).

[2]There certainly may be other financial disciplines, and we do not want to discredit their expertise or involvement; however, currently these are the most common.

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Commonalities. The CFP® (7 Principles) and AFC® (12 Standards) codes of ethics share considerable overlap in what they each discuss and consider important standards. Both entities and associated codes indicate the need for competency, honesty, integrity, promptness, fairness, diligence, and professionalism within their practices, as well as a duty to care for their clients to the best of their abilities. Additionally, both disciplines state the need to maintain necessary knowledge and skills to *practice competently*, but also to recognize any limitations of their knowledge or skills and thus, to know when consultation with or referrals to other professionals is necessary.

Differences. Some differences exist between CFP® and AFC® codes of ethics as well. For instance, although both codes have *standards of fairness*, they are defined differently. The CFP Board discusses the concept of fairness under Principle 4, in regards to being reasonable in all professional relationships and in disclosing conflicts of interest. AFCPE discusses the concept of fairness in relation to accepting reasonable compensation and assisting clients in finding other services if fees are not affordable. The CFP Board's code of ethics does not have any statement that directly refers to a client's inability to pay fees. The AFCPE code does not provide any discussion regarding conflicts of interest.

Codes of Ethics between Mental Health Disciplines

Just as there are multiple financial disciplines and sub-disciplines that may incorporate components of financial therapy, there are also many mental health disciplines that may do so as well. As discussed above, common mental health disciplines are counseling, psychology, life coaching, family therapy, and social work. Generally, there are more similarities within the codes of ethics across the different mental health disciplines than there are differences. Again, considering the scope of the paper, only a comparison of the codes of ethics for licensed mental health practitioners of marriage and family therapy (American Association of Marriage and Family Therapy, 2013), social work (NASW Delegate Assembly, 2013), and psychology (American Psychological Association, 2010) are provided.

Commonalities. Mental health disciplines have much overlap in how they list and explain their ethical guidelines. Mental health professions generally address professional standards about non-discrimination, informed consent, issues of privacy and confidentiality with clients, avoiding conflicts of interest, not furthering one's own interests, having a sense of responsibility toward one's clients, not exploiting services, and treating all clients with respect and integrity.

Differences. Although differences between mental health standards are small, they do exist in the way that concepts are discussed and in terms of their theoretical underpinnings. This is readily displayed in cross-discipline differences in individualistic versus systemic and contextual perspectives of treating client systems. For example, psychology historically has centered on an intra-psychological framework, while couple and family therapy has emphasized an interpersonal perspective, which leads to different considerations for confidentiality. These conceptual frameworks shape the ethical standards each mental health discipline maintains. Although all mental health professions share general similarities in their ethical standards, they differ on certain aspects in how each

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standard is written (e.g., how they are specifically worded, how much they leave to interpretation and what statements are left out).

Codes of Ethics between Financial and Mental Health Disciplines

Nash (2002) defined ethics under three parts. First, a meta-ethical dimension which analyzes concepts such as ought, should, duty, right, wrong, obligation, and responsibility, as well as dealing with the logic of moral justification. Second, it provides a set of operational reference points to resolve potential conflicts of interests. Third, a set of ideals to build a moral life. These three parts combined together generate a code of ethical principles and rules, becoming the theoretical framework from which a discipline can build upon.

It is important to note that ethical codes are not meant to be specific ethical action rules, as it is not feasible to cover every potentially ethical situation. Rather, codes of ethics are meant to be guidelines to understand points of tension or complexity in a discipline and its practices. Codes of ethics are a framework provided to assist practitioners in navigating ambiguous ethical dilemmas and situations. Understanding other discipline's theoretical frameworks and ethical principles will help collaborating professionals providing financial therapy in not only accepting multiple viewpoints concerning ethics, but also in being able to navigate best possible outcomes when differences or ambiguity arises in session.

As noted, differences in ethical and professional standards exist within both financial and mental health disciplines. However, when comparing the ethical codes between financial disciplines and mental health disciplines a few more distinctions are apparent. Although ethical codes across both financial and mental health fields offer general guidelines in how a practitioner should act and have similar standards referring to the concepts of respect, integrity, and professionalism in the practitioners' practices, the behavioral understandings of these concepts may vary greatly. For example, below is a list of common ethical and professional challenges that may arise in the collaborative model of financial therapy.

SIX COMMON ETHICAL AND PROFESSIONAL ISSUES

As previously stated, the purpose of this paper is to facilitate the conversation on ethical and professional guidelines in the collaborative model of financial therapy. Six themes are presented: (1) dual relationships, (2) confidentiality, (3) working with other professionals, (4) fee management and insurance reimbursement, (5) use of technology, and (6) attending to federal and state regulatory laws. This is not an exhaustive list, but rather designed to stimulate discussion within the field of financial therapy. A table that outlines the mental health and financial distinctions and similarities of these six themes is provided in Appendix A.

Dual Relationships

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Mental health relationships. The concept of dual relationships generally refers to when a mental health service provider and client engage in a separate and distinct relationship, either simultaneously with the professional relationship, or during a 'reasonable' time either preceding or following the completion of professional services. A key aspect of dual relationships in mental health codes of practice is that mental health professionals need to be aware of their influential position with their client(s), and that they avoid dual relationships that are likely to impair professional judgment or lead to exploitation. Dual relationships can also arise between the professional and other members of the client system (e.g., having a personal relationship with a relative of the client). Implications of dual relationships for licensed mental health therapists mean that these mental health therapists should limit contact with the client outside of professional services, even to the degree of not acknowledging their client if they see them in public, but to only return a greeting if the client first acknowledges them.

Financial planning relationships. Although there are some dual roles that are seen as inappropriate and even potentially exploitative, such as a separate business relationship with a client wherein there exists a conflict of interest, the personal and professional boundaries between advisor and client are less distinct within the financial planning profession. For example, social activities, such as meals together, attending sporting and cultural events, and attending celebratory events together are generally seen as positive and increasing the professional connections between service provider and client. The planner-client working alliance is assumed to be enhanced by these multiple relationships. Although dual relationships for financial practitioners are allowed, there are still boundaries that must be maintained. For example, financial practitioners are still bound by limits of personal disclosure and/or contact so that it does not become a burden to the client.

The different assumptions and theoretical foundations between mental health relationships and financial advising relationships have a profound effect on how to conceptualize best practices for collaborating financial therapists from these two fields. If there are two practitioners working together providing financial therapy, it is suggested that each provider abides by their own standards about dual relationships. However, it is also important to attend to how the client(s) view the different relationships with the two service providers and make sure they understand the differences. If a person is a licensed mental health therapist, he or she is bound to their professional licensing standards and is required to avoid violating dual relationship standards (e.g., taking clients out to dinner, buying them concert tickets, or attending a sporting event together). What is very important here is both how the service providers and client understand and define financial therapy.

Confidentiality

Mental health confidentiality. Confidentiality is when the mental health service provider respects and guards the confidences and privacy of each individual client. In gathering private information about clients and their reasons for seeking mental health services, information which is not necessary for providing mental health therapy should not be asked by the practitioner. Also no information from the client, or even that the client is receiving services, should be disclosed to another person without client permission. A key

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component of confidentiality is that mental health practitioners are required to disclose the nature of confidentiality as soon as services begin through the process of informed consent. Informed consent outlines the expectations, risks and benefits, processes, and procedures of mental health services in clear and understandable language. Furthermore, licensed mental health therapists are required to cite any possible limitations to the client's right to confidentiality. For instance, rights to confidentiality may be rescinded in the instance of prior abuse towards vulnerable populations (e.g., children, the elderly, and the mentally or physically impaired) or the threat of future harm to self or others as required by the mental health practitioner's legal duty to report. However, in these cases where confidentiality is broken, only the information that is directly relevant to the instance of abuse or harm may be reported.

Additionally, mental health practitioners are required to further protect the client's right to confidentiality through ensuring privacy in the mental health setting for mental health services rendered, as well as for case records. Mental health services should not be performed in public or unsafe arenas where the confidentiality cannot be safeguarded and maintained. Any information referring to mental health services provided (e.g., case notes, demographic information, or assessments) should be protected and stored in accordance with legal and professional standards.

Financial planning confidentiality. Confidentiality is a critical component to financial planning services that is built upon trust and confidence with the client. Financial practitioners are required to ensure that personal client information remains inaccessible, except to those who are authorized. Financial practitioners may disclose private and confidential information only with the expressed informed consent of the client. Thus, with permission from clients, financial practitioners may share with others the identity of clients (e.g., when financial practitioners may have agreed to serve as a reference for other prospective clients). The practitioner-client relationship is built upon an implicit trust that private financial information is not shared without expressed consent.

In contrast to the mental health field, a mandated legal duty or responsibility to report prior abuse or threats if said statements are disclosed during services is not explicitly discussed. Thus, there are no legal requirements to break confidentiality between the service provider and client(s). Additionally, as discussed above in relation to dual relationships, financial practitioners are permitted to meet clients in public settings such as a restaurant, coffee shop, or the client's workplace as long as privacy requirements are maintained. In contrast, licensed mental health professionals cannot meet clients either in public settings or semipublic settings, such as hallways, waiting rooms, elevators, waiting rooms, etc. Furthermore, licensed mental health professionals cannot acknowledge knowing the client in such settings unless initiated by the client in order to not betray confidences. Although both financial and mental health service providers strive to maintain the privacy and confidences of their clients, the distinctions between their professional standards may create operational challenges.

Working with Other Professionals

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Mental health work with other professionals. The mental health standards for working with other professionals fall under the umbrella of confidentiality and informed consent. Written authorization from the client or legal guardian (if the client is under age 18) is a requirement for disclosing personal or identifying information about the client to a third party. In situations where there are multiple people in the client system, practitioners are required to gain written acceptance from all participants before disclosing any private information to a third party. However, licensed mental health therapists are able to consult with other colleagues and referral sources about a client as long as no confidential information is disclosed as to allow identification of said client. Information disclosed about a client may only be discussed to the extent necessary for the consultation's purpose.

In cases where a client is referred to another practitioner for additional services, it is the practitioner's responsibility to ensure that transfer of any private records remains confidential and that the referral's services are in accordance with the client's interests. As such, mental health practitioners should be aware that vast majority of professionals working within financial services are not required to always recommend what is in the best interest of the clients. Most financial professional make recommendations that follow a legal *suitability standard of care*. This standard of client care means that under federal law, those professionals are not required to make optimal recommendations that are in the client's best interest; rather, their recommendations must only be suitable given the clients' investment objectives and financial situation (Goetz, Chatterjee, & Cude, 2014). Thus, when referring clients to financial professionals, mental health practitioners are encouraged to work with those financial professionals under the *fiduciary standard of care.* Fiduciaries make certain recommendations that are legally required to be in the client's best interest. Financial service professionals who are registered with their state or the Securities and Exchange Commission (SEC) as a registered investment adviser/investment adviser representatives (RIA/IAR) must make recommendations that are in the client's best interest and adhere to a fiduciary standard of care when providing investment advice. All members of the National Association of Personal Financial Advisors (NAPFA) must meet this higher standard of always recommending what is in the best interest of the client, and thus may hold a service and regulatory perspective most consistent with mental health practitioners.

Financial work with other professionals. Financial practitioners are responsible for protecting the privacy of their clients as well as providing professional services competently. Financial planners must protect the confidentiality of their clients by safeguarding that all private information is only accessible by authorized personnel. If a service provider deems that services are outside of his/her scope, then referrals to other professionals with the appropriate skills and knowledge is necessary. As with mental health practitioners, information about a client's case can only be shared with authorization from the client.

Work with other professionals and practitioners occurs within both mental health and financial disciplines and there is much overlap in ethical codes. However, working with other mental health professionals is more common for mental health practitioners as they often seek outside aid and services. Mental health practitioners are often encouraged to collaborate with other agencies and other mental health professionals in terms of supervision and referral. It is much less common for competing financial planning firms to

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work together. It is, however, common for financial practitioners to work with accountants, attorneys, or insurance brokers when those professionals offer complementary (but not duplicative) services. Thus, if financial and mental health practitioners are working together, boundaries need to be negotiated so that it is clear in how, or if, other resources are to be brought into the financial therapy practice.

Fee Management and Insurance Reimbursement

Financial arrangements for mental health services. Payment for mental health services provided is collected under fair and responsible standards of practice. Service providers are tasked with charging for only those services that are stated and performed, and consideration should be given to the client's ability to pay. Furthermore, licensed mental health therapists should not engage in bartering for services rendered nor accept kickbacks, bonuses, remuneration for referrals, or gifts from clients. Receiving goods, services, or incentives as payment has the potential for creating a power imbalance or an unfair means of payment that may be detrimental to the mental health relationship.

Mental health services are also in a unique position surrounding fee management, as licensed mental health therapists are able to accept insurance for services provided. In this situation, a client's insurance covers the majority of the cost for services, and clients are only responsible for a significantly reduced portion, or co-pay, of the total payment at the time of fee collection. In these situations, licensed mental health therapists are responsible for demonstrating that appropriate services are being provided and are required to address some psychopathology. Implications of these mental health services are that clients who seek financial therapy may not be permitted to utilize insurance, as services may not directly address psychopathology in the client system.

Financial arrangements for financial services. Financial practitioners are also held to ethical standards of reasonable and appropriate fees for services rendered. If fees are not affordable for a client, then financial service providers have a responsibility to assist in finding other affordable services, as written in principle 7 of the AFC® code of ethics (but not in the CFP® code of ethics). Although fees should be reasonable and appropriate for services, financial practitioners may collect kickbacks, commissions, bonuses, remuneration for referrals, and gifts from clients. Instances where financial practitioners receive these additional forms of payment are considered acceptable practices in the financial services industry. However, as previously mentioned, there is a subset of financial service practitioners held to the higher fiduciary standard of care, as well as the requirements to never accept kickbacks, commissions, remuneration for referrals, etc. (e.g., financial planners who are members of the National Association of Personal Financial Advisors; NAPFA.org).

Theoretical foundation distinctions between mental health and financial services have a substantial effect on financial therapy services with fee management and insurance reimbursement. If two practitioners are working together in providing financial therapy, they may be required or allowed to follow different standards about payment services.

Use of technology

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Technology use for mental health services. The use of technology in mental health settings is already an ethical concern as there are limits and risks to what can be kept confidential and safe. Technological mediums such as phone, email, and now other more advanced web services, such as video conferencing, provides an increased risk to protecting the privacy of client's confidences. Although it is required that clients are to be informed of the risks that may arise in using such electronic media as part of mental health services, it is still the licensed mental health therapist's responsibility to ensure the security of whichever medium is used. This in and of itself presents a possible ethical dilemma as a mental health therapist may be able to provide security and privacy on their end of the electronic communication, but cannot guarantee the security of the client's end, yet the licensed mental health therapist is still the one responsible for the confidentiality rights of the client.

In addition to the protection of a client's confidences, licensed mental health therapists are responsible for determining the appropriateness of utilizing the electronic medium. Licensed mental health therapists are required to consider the emotional, physical, and intellectual needs of the client in deciding to pursue any electronic communication or services. Furthermore, before a mental health therapist can begin to use electronic services, appropriate education and training is required to ensure that the mental health therapist is practicing within the scope of their knowledge and skill set. Licensed mental health therapists are also responsible for ensuring that they are in accordance with all relevant laws in using electronic services. However, a caveat that must be made is that the standards and regulations surrounding technological use is a constantly changing landscape as new standards are developed in response to evolving technologies.[3]

Technology use for financial services. Although financial practitioners ensure the confidentiality of their client's private information, their ethical codes under the presented certifications do not *directly* discuss ethical considerations in the use of electronic mediums; they, however, have strict legal requirements, such as retaining copies of all electronic correspondence. Financial firms and practitioners utilize technology in almost every aspect of their services, from using websites to track spending or check credit reports to sending e-statements about current portfolios to providing tips and updates on a client's mobile device. Financial service practitioners are encouraged to use technological opportunities to enhance the efficacy of their work.

Mental health and financial practitioners come from very different theoretical foundations considering the use of technology in their services. Mental health practitioners derive their guiding beliefs through ethical standards that embrace caution in providing new means of electronic services in order to best provide for the security of their clients. Financial service providers, however, are often encouraged to use all technological services as a means to advance the value of their services. For instance, financial practitioners may at times provide financial advice via email, whereas licensed mental health therapists typically do not

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[3]The state of Georgia is the first state to require continuing education training in telemental health for licensed mental health professionals which includes new limitations, standards, and continuing education hours (Georgia Composite Board, 2016).

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provide specific therapeutic advice via email. If two practitioners are working together to provide financial therapy for a client, it could present a potential ethical dilemma in how each practitioner is guided by their ethical principles. As the accelerated growth of technology continues and becomes more pervasive, managing the ethical considerations surrounding technology usage becomes more essential.

Attending to Federal and State Regulatory Laws

Mental health federal and state laws. Mental health service providers are mandated to not only abide by their codes of ethical conduct, but also federal and state laws. Although federal laws governing mental health services bind service providers, state laws vary depending upon which state a practitioner is working and licensed within. Practitioners are held to ethical codes, which are typically state regulated and connected to licensure codes, such as a duty to report abuse of vulnerable populations and a duty to warn in case of threats to harm self or others. In addition, practitioners' licenses are issued by the state, not nationally. Therefore, practitioners can only work in the states from which they have active licenses.

Financial advising federal and state laws. Although ethical codes are a major factor in providing best outcomes for financial services, financial practitioners are mandated to follow state and federal laws of conduct as well. Many financial disciplines include ethical standards to abide by all relevant criminal laws and furthermore, to report any felony that would bring disrepute to the profession. Financial disciplines involve licensing on both a state and a federal basis when practitioners are providing certain services, such as investment or insurance advice. Thus, financial practitioners are often restricted by state lines in terms of what types of advice can be provided. With other types of financial planning, advice can be provided across state lines.

Given the different assumptions and standards which regulate the behavior and services rendered by mental health and financial practitioners, it can be argued that possible ethical concerns may arise in the management of collaborative financial therapy depending upon which disciplines license is utilized.

INTEGRATING DISCIPLINES IN FINANCIAL THERAPY

In creating professional guidelines, it is suggested that the following configurations of relationships may be useful for presenting best practices, and that the continuum of mental health and financial services is useful for examining professional boundaries and when crossing the line might occur. Due to the fact financial therapy combines aspects from both a mental health and financial perspective, the approach financial therapy may take can vary in how it integrates the two fields. Services and actions provided to the client(s) may be split between financial and mental health perspectives evenly, or may be comprised of mostly financial planning practices with a few therapeutic techniques incorporated, or the services may consist mostly of therapeutic approaches with the incorporation of some financial education or financially-oriented interventions.

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Configurations of Collaboration in Financial Therapy

Considerations arise when financial therapy is conducted by two or more service providers, such as how the service providers work with each other, as well as with the client system. When there are two service providers in financial therapy, often one comes from a financial discipline while the other comes from a mental health discipline. These practitioners may work together or there may be times that either practitioner works alone with the client system. These services are orchestrated and transitioned between the mental health and financial concerns of the client system by the service providers. Consequently, there is need of clear communication between all parties involved, including both practitioners and clients. However, how these service providers work together may happen in different ways (Gale, Goetz, & Ross, 2012; Goetz & Gale, 2014).

There are four distinct models of collaborative work between mental health and financial professionals when conducting financial therapy with two practitioners: (a) professional referral, (b) parallel services, (c) consultation services, and (d) integrative collaboration (Gale, et al, 2012; Goetz & Gale, 2014). Professional referral services occur when one of the practitioners involved with the client system (either the financial planner or the therapist) will refer the client(s) out for the other practitioner's services when needed, often for a specific issue. For instance, if a couple is coming to see a therapist for premarital counseling, and the therapist recognizes the couple may benefit from some financial literacy training in buying their first home together, the therapist may refer the couple to a financial planner to help with that specific component. This approach is considered the least collaborative between the mental health and financial professional disciplines of the four models. However, it does require maintaining good professional boundaries between the two practitioners, as well as good communication so that it is clear for all parties involved what is being addressed.

In contrast, parallel services[4] occur when the financial planner and the mental health provider are both working with the client system, but at different times. For instance, a couple is seeking mental health services from one practitioner, while also seeking financial services from another practitioner. Clients may have similar concerns they are expressing to both providers, and when both the financial person and mental health provider are in communication, these services can be coordinated. The communication between the practitioners should be carefully and professionally established, with confidentiality standards maintained. There also should be a shared paradigm of when and how to intervene where both practitioners are working towards common goals.

Consultation services, also called conjoint services, occur when the one practitioner (either the financial planner or therapist) invites the other professional practitioner to join in on occasional meetings to help facilitate a concern or issue. This consultation arises as needed and can address important issues in multiple meetings or on only a one-time basis.

[4]Parallel services may also occur where there is no communication between practitioners as the client does not inform their service providers about other services they may be receiving. Consequently, clients should be asked about other services they may be currently receiving.

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Parallel services may arise out of this approach where the client system sees both practitioners separately to handle the issue. For instance, a therapist working with a client over obsessive spending habits may bring in a financial planner to discuss how to set up a budget based on the client's income and expenses. This approach requires a business arrangement for a negotiation of how fees are handled, as well as having a shared paradigm of when and how to intervene, maintaining good communication, and working towards common goals.

Lastly, the integrative collaboration model occurs when the financial planner and therapist work simultaneously with the client system. This approach includes aspects of parallel and consultation services as it provides an integrative and systemic collaboration between the service providers. Under this model, there are times the client(s) and two practitioners might be in the same session all together, while other times there may be only one or the other practitioner with the client(s). Similar to consultation services, this approach also requires a business arrangement for negotiating fees, discussing and implementing a shared paradigm of when and how to intervene, maintaining good communication, and working towards common goals for the client.

Depending on how practitioners and client systems negotiate the balance between services when conducting financial therapy, different outcomes can occur. The professional training, knowledge, values, and skill set of a practitioners' primary profession and secondary profession will influence the integration of cognitive, emotional, behavioral, relational, and economic well-being factors to achieve different unified wholes or outcomes. For instance, financial health may be defined differently across practitioners, it may be considered as a secondary outcome for others, or it may be a prerequisite in the process of attaining other goals. Thus, practitioners may approach the practice of financial therapy very differently based upon their own professional orientation and learned skill sets. Additionally, how clients present the request for services or what happens during the course of services may dictate what services are appropriate and therefore provided. Thus, the future of the field of financial therapy requires a focus on decision models to determine the optimal action plan to most effectively address the client's needs while adhering to ethical and professional standards.

Distinguishing Financial and Mental Health Approaches

Another important consideration that multiple practitioners working in collaboration, as well as individual practitioners, face is where to distinguish the financial side from the mental health side of the continuum. The figure below by Goetz and Gale (2014) displays five different points on a scale which illustrates the range of skill and knowledge sets that can be used by a practitioner in financial therapy. The polar ends of the continuum shown in Figure 1, those being primarily mental health (at point E) or primarily financial (at point A) are straightforward services. However, as either side approaches the middle of the continuum (at point C), where the financial therapists are providing an equal split between financial and therapeutic services, financial therapy services may become more vague as ethical and professional considerations may arise. Figure 1 below illustrates this by the shaded area between point B and point D, which encompasses point C, as the area

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in which a practitioner may have difficulty in clarifying the type of services he/she is providing. In this vague area, many questions for the practitioner arise. How is the practitioner supposed to distinguish where that middle line of financial therapy is when providing services? How do two practitioners working in collaboration provide services from their respective sides of the continuum?

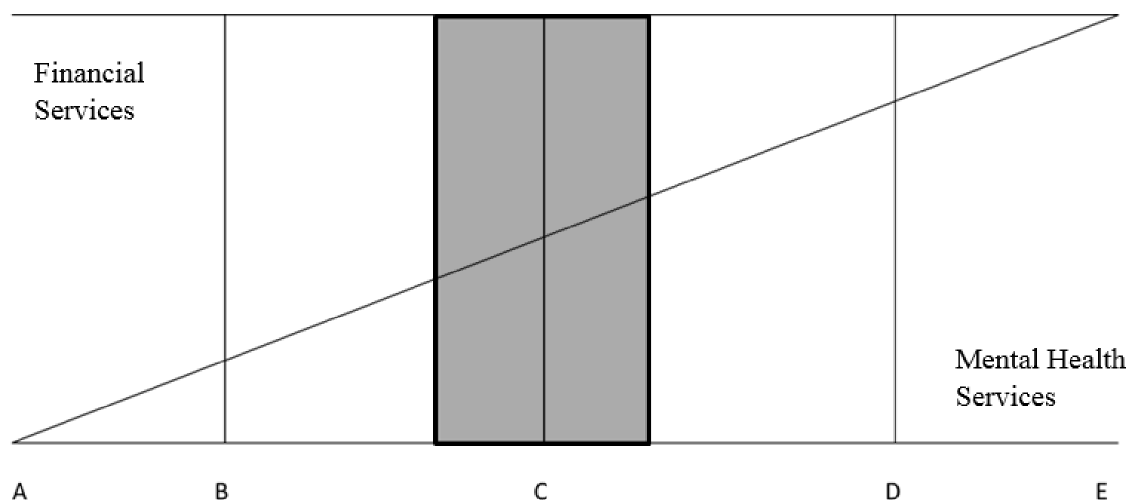

Figure 1. A continuum of financial therapy services (highlighting a vague middle)

The financial therapy process is optimized for the client by having multiple professionals involved in treating the issues on either side of the continuum. For instance, a person practicing from A to B is providing only financial services and using skills of his/her profession in that regard and a person practicing from D to E is providing mental health services and using skills of his/her profession in that regard. However, a person practicing from B to C, or D to C is combining services from both financial and mental health disciplines. If the client enters from the left, they are under the 'service agreement' of financial. If the client enters from the right, they are entering under the 'service agreement' of mental health. Now, if a client is to enter services directly in the middle, C, and seeking 'financial therapy' then the collaborative service providers could be working from either B to C or D to C. In order to practice from an ethical and professional standpoint, practitioners need to be aware of and sensitive to how they engage the client from each of these three areas (e.g., the right, left, and direct middle).

Given the differences in training, knowledge, values, and skill sets of differing disciplines that may participate in financial therapy, how do we bring together a set of values and ethics under a common roof of standards? It is not the intent of the authors to answer this question in the current paper; we are merely proposing these questions to the field as a whole, as well as financial therapists individually, as we believe it is always important to remember how the ethical and professional standards influence our service models. Since different disciplines have differing theories and perceptions about the nature of change which dictates how they approach and treat the clients, financial therapy practitioners must consider these differences such as who the client is, how change occurs, which aspects of context to include, issues of power and social disparities, relationship dynamics between

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practitioner(s) and client(s), how confidentiality is viewed and maintained, the length of service provided, the overall purpose of financial therapy, what to do if the clients are a couple that divorces, and different philosophies and paradigmatic views (Gale, Goetz, & Britt, 2012). Each of these differing issues are potential ethical and/or professional dilemmas that may arise during the course of financial therapy and should be taken into consideration by each financial therapist or practitioner employing some component of financial therapy as they address financial concerns in their own practice.

CASE ILLUSTRATION

The following vignette helps to illustrate the importance of discussing and exploring how to handle bringing together differing standards and value sets under financial therapy. As the vignette is read, it is encouraged to think about how a practitioner from either a mental health or financial discipline, as well as a practitioner from multiple disciplines would deal with the ethical dilemma presented, if there is a right or wrong answer, and if there should be a common set of ethical and professional practices created to resolve such issues.

> *For the past 15 years, a family therapist and a financial planner have been working together with a married couple under the integrative model of collaboration and thus far, have managed a good working balance. Both family therapist and financial planner maintained good communication with each other and were clear about the family's goals. The couple had been primarily seeing the financial planner in dealing with the financial concerns of their company that they co-own and operate together. However, the couple has also met with the family therapist through the years to deal with managing the relational issues that come up in operating a joint business, such as having clear communication skills to express expectations about each other's role in the business and managing the balance between work and the relationship.*
>
> *At present, the couple has a coming-of-age and problematic son who is heir to the company. The goals of the family system are three-fold: first, to feel financially secure in their retirement; second, to increase positive communication between all family members; and third, to "fix" their problematic son.*
>
> *The family therapist has seen the son during a few family sessions, as well as for individual mental health therapy, and believes that the son is not as problematic as he is perceived to be by the parents. Conversely, the financial planner, who is thinking in terms of business succession plans and what is financially best for his clients, does not want the son involved in the family business due to the perceived problems.*
>
> *The integrative model of collaboration between the family therapist and financial planner with the couple began with good intentions and worked very well for the past 15 years; however now there is a conflict of interest as they both have very different goals for their clients.*

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The vignette illustrates how a potential ethical and professional conflict may arise through the course of financial therapy. There may be contextual, emotional, financial, and psychological factors that need to be explored further, but it is clear there is the possibility of conflictual advice being given to the client by each practitioner due to their different standards of values and training. For instance, the family therapist may look to explore and improve the family's interaction patterns. The family therapist may also attempt to increase the level of trust between the parents and their child, as well as promote self-efficacy in the child. Giving the "problematic" child more responsibility with the business may be an intervention to convey trust from the parents, promote self-efficacy for the child, and direct energy towards positive behaviors instead of problematic ones. In contrast, the financial planner may advise the couple to remain in complete charge of the business or bring in another party to help manage the business as they look toward retirement so that income can be maintained, but there is little risk to the health of the business. These are not the only options available, but are realistic ones that may occur and that create opposing differences in services for the client. Moving forward with financial therapy in the case will require a significant amount of clear communication between both practitioners where they each can discuss and lay out their service goals. For the best outcome of the clients, it is essential for the practitioners to come under a common roof from which to work under, so that contradictory or competing messages are not presented to the client system.

Ethical codes, and therefore ethical concerns, may not always be clear, where there is only one beneficial outcome. Often, cases present themselves with a multitude of acceptable outcomes that may benefit the client(s). Creating a common standard of ethical/professional principles for financial therapy would ensure that practitioners are able to reach the best outcome for clients. The current case example highlights how different backgrounds lend themselves to different premises, interpretations and ways to handle an ethical situation. All choices discussed benefit the clients, but how one distinguishes the best possible outcome is still undecided.

Questions adapted from Nash (2002) that may be utilized by a financial therapist to consider the best ethical outcome in the case are as follows: What is the ethical dilemma presented? Why is this an ethical dilemma? What are the choices or directions to choose from in making a decision? Are there any other alternative paths the client(s) or practitioner(s) can take? Who is affected in this dilemma? What codes are directly applicable to the current case? What rules or laws are applied in order to justify a choice? What personal and ethical principles guide a choice? What theory or assumptions does one's work fall under? What are the foreseeable consequences of each choice? Then what conclusions are reached and what predictions can be made about such conclusions? And finally, evaluate after thoughts and the outcome of the decision. These questions are meant to be a guide for which practitioners can start to navigate potential ethical dilemmas.

As discussed above, the purpose of the paper is not for the authors to specify answers to the presented ethical dilemma, but to promote awareness of how these conflicts can occur and how they may influence the field of financial therapy, as well as start a conversation within the financial therapy community to address potential ethical and professional concerns. The authors are raising these issues and questions, so that as a field, and for each

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mental health therapist, financial planner, or financial therapist in their own practice, we can move forward in the profession because we think that it is always important to be informed about and adhere to ethical and professional standards. The vignette is used as an example of how there are still unknowns of how potential situations should be handled when there are competing standards at play in financial therapy. It also illustrates a demand for the consideration of a set of ethical practices that are capable of spanning the divergent disciplines of the financial therapy field.

CONCLUSION

Based on the analysis of professional standards across the more common disciplines contributing to the field of financial therapy, further discussion and consideration is required to fully address potential ethical concerns that may arise in cross-disciplinary client work and the development of best practices in this regard. The topics raised are not exhaustive, but are meant to stimulate professional dialogue in the literature and between practitioners. The challenge of the field of financial therapy is to bring together varied standards and guidelines from separate disciplines. Many financial therapy practitioners are already bound by distinct standards from their respective accrediting or licensing bodies. However, a small subset of these standards may be incongruent within the context of collaborative work. Professionals integrating financial therapy into their service model should work through this complexity to achieve clarity in their responsibility to other practitioners involved and to the clients they serve.

Professional standards and ethical codes are critical to consider when practitioners are providing combined services of financial planning/counseling and mental health therapy, particularly when there are multiple practitioners involved from different disciplines. There is an importance in knowing one's colleagues' ethical and professional guidelines when conducting financial therapy with two practitioners, just as there is importance in knowing one's own standards of ethics and professionalism. Practitioners are bound by their own discipline's standards, as well as by state and federal rules. In order to maintain best practices when integrating financial therapy into their service model, they should become familiar with the regulatory rules of other disciplines. Looking toward the future, mental health and financial professionals who are integrating components of financial therapy into their practice should further address the professional standards and ethical guidelines for the practice of financial therapy to ensure the integrity of the professional standards of all primary professions is maintained.

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APPENDIX A

Table 1

Outline of Mental Health and Financial Distinctions of Six Themes in Financial Therapy

Issue	Mental Health Perspective	Financial Perspective
Dual Relationship	-Limited to no contact outside of professional services -Based upon the avoidance of possible exploitation of the client or impaired judgment of the mental health therapist	-Social events (e.g., meals together, attending events, etc.) can enhance the professional relationship -Personal boundaries are still maintained to the point that the service provider does not burden the client
Confidentiality	-Respects and guards the privacy of each individual client -Does not collect information that is not necessary for providing services -Must disclose the nature of confidentiality through informed consent -May be rescinded in instances of prior abuse to vulnerable populations or threat of future harm -Responsible for safeguarding all records and confidences	-Ensure that personal client information remains inaccessible except to those authorized -No mandated or legal duty to report abuse/threats -Must provide privacy statement -Must have reasonable safeguards in place to protect clients information
Working with Other Practitioners	-Written authorization from the client(s) is required for disclosing personal or identifying information -Mental health therapist can consult with other mental health therapists as long as no identifying information is shared -It is the responsibility of the mental health therapist that any referral made is in accordance with the client's interests	- Written authorization from the client(s) is required for disclosing personal or identifying information -Only authorized providers may share private information -Referrals must be made to other providers with appropriate skills and knowledge
Fee Management	-Fees are to be collected under fair and responsible standards of practice, only charging for services provided, and within the client' ability to pay -Mental health therapists cannot barter for services, nor except kickbacks, bonuses, remuneration for referrals, or gifts -Insurance may be considered and used for addressing psychopathology in the client(s)	-Reasonable and appropriate fees for services rendered -If fees are unaffordable, then there is a responsibility to assist in finding other affordable services -May accept and collect kickbacks, bonuses, commissions, remunerations for referrals, unless working under a fee-only compensation model. -Insurance is not available

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Usage of Technology	-Mental health therapists are responsible for ensuring the security of whichever technology based medium that is used, as well as informing the client(s) of the risks that may arise to using electronic media -Mental health therapists are required to consider the emotional, physical, and intellectual needs of the client when using electronic mediums -Practice within the scope of knowledge and skillset -Be in accordance with all relevant laws in using electronic services	-Although required to ensure the confidentiality of the client's private information, ethical codes do not discuss electronic mediums explicitly -A major component of financial services, as providers utilize technology in almost every aspect of financial services to enhance the efficacy and convenience of their work
Federal & State Regulatory Laws	-Bound by federal laws for mandated reporting -States issue mental health licenses, however, and therefore mental health therapists are bound to practice only in the state in which their license is issued	-Must abide by all state and federal criminal and regulatory laws -Report any felony that would bring disrepute to the profession -Financial-related licenses are issued at the national and state level

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Financial Empowerment and Health Related Quality of Life in Family Scholar House Participants

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Research demonstrates an association between poverty and health. Populations in poverty suffer from poor mental and physical health, and thus, poor health-related quality of life. Research also indicates people living in the lower socio-economic categories experience higher levels of stress that are associated with these health declines. Family Scholar House, a local community intervention designed to alleviate poverty and improve socio-economic status by providing college education and support to single parents, combats these health outcomes by addressing the five social determinants of health (economic stability, education, social and community context, health care, and neighborhood and built environment). Quantitative analysis indicates an improvement in mental health among Family Scholar House participants: 0-12 month participants reported significantly more mentally unhealthy days than a control group; however, this difference is no longer significant at the end of participant's time in the program. Qualitative analysis suggests this improvement may be due to stress reduction related to increased economic stability and financial security gained through an intentional implementation of a financial empowerment curriculum within the Family Scholar House program. Implementation of financial empowerment into community programs designed to alleviate poverty may improve mental health and thus health-related quality of life.

Keywords: *quality of life; financial empowerment; mental health; poverty; community support*

In the United States, one of the wealthiest countries in the world, an alarming 50 million Americans are living below the federal poverty line; sixteen million are children (United States Census Bureau, 2012). The Family Scholar House (FSH) in Louisville, Kentucky, works to alleviate poverty with an aim "to end the cycle of poverty and transform our community by empowering families and youth to succeed in education and achieve life-long self-sufficiency" (Family Scholar House, 2014, para. 1). Established in 1995 as Project Women, the organization was formed with the purpose of assisting single mothers in breaking their cycle of poverty. Initially providing housing and educational assistance to one single mother, the program has grown considerably over the past 20 years and now serves hundreds of families each year. The intent of the program is to assist clients with achieving a Bachelor's degree. With this degree and the education, support, and empowerment provided by Family Scholar House, the participants hope to secure self-sufficiency and

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reduce reliance on public assistance. Since the program began, 347 families, including 528 children, have lived in the Family Scholar House residential program. The participants have completed 93% of the college credits attempted and 75% have exited the program to stable employment. In addition, 100% of the participants exited the program into stable housing, a key factor of success, considering 100% of the participants entered the program homeless or with unstable housing (Family Scholar House, 2014).

The Family Scholar House is one of several community interventions designed to reduce poverty. People living in poverty situations face several barriers to achieving optimal health-related quality of life (HRQoL), which includes mental, physical, and emotion well-being (Adler et al., 1994; Backlund et al., 2007; Baker, Sudano, Albert, Borawski, & Dor, 2001). For example, an individual living in poverty more often lacks money to pay for physical therapy services, lives in an area where physical therapy clinics are few, and lacks the opportunity to drive or take public transportation to an alternative form of therapy, such as an outdoor walking trail. Resources, access, and opportunities that improve health-related quality of life are afforded to some members of society, but not to all (Wilson, 2009). When examining poverty and socio-economic status and the role they play in health outcomes, researchers have conducted studies on the disparities related to these specific factors. However, only within the last decade has an effort been made to collaborate among professionals from multiple disciplines to design, implement, and evaluate interventions through a lens that considers the complexity of the social determinants of health and how these factors influence health-related quality of life.

The social determinants of health include "the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness" (World Health Organization, 2008, para. 11). Specifically, Healthy People 2020 describes social determinants of health as economic stability, education, social and community context, health and health care, and neighborhood and built environment. These five determinants affect a person's health-related quality of life in a variety of different, and often intersecting, ways (U.S. Department of Health & Human Services, 2014a). For example, research indicates that in the U.S., individuals in lower SES categories live in neighborhoods with higher crime rates (neighborhood and built environment) and are provided sub-par schooling (education). These components lead to a life trajectory commonly ending in either the prison system (social and community context) or a lower paying job (economic stability). The combination of these determinants ultimately creates poor health-related quality of life (Alexander, 2012; Guggenheim, 2010). Thus, in an effort to alleviate poverty and improve health-related quality of life, community programs, clinicians, and state agencies working with populations in poverty must address each of the social determinants of health. Support systems often focus on housing or health care, yet long-term economic stability, attained through financial empowerment, is still a new concept within the state and local agencies and community programs designed to assist populations in poverty. Thus, the specific aim of this article is to explore the relationship between financial empowerment and health-related quality of life in a community program designed to alleviate poverty by addressing the various social determinants of health, which includes economic stability.

LITERATURE REVIEW

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Poverty, socio-economic status, and health

Health-related quality of life (HRQoL) is defined by the CDC as "an individual's or group's perceived physical and mental health over time" (Centers for Disease Control and Prevention, 2000, p. 5). Health-related quality of life is affected by both mental and physical health outcomes. Although a newer measurement of an individual's health, studies indicating poor physical and mental health outcomes would also indicate poor health-related quality of life. Thus, studies examining health outcomes are also indicative of health-related quality of life. For the purpose of this article, physical and mental health outcomes are viewed as health-related quality of life outcomes.

Research has long shown the relationship between poverty, socio-economic status (SES), and physical and mental health (Adler et al., 1994; Backlund et al., 2007; Centers for Disease Control and Prevention, 2010; Nesbitt, Harris, Hall, & Pallam, 2012; Nobles, Ritterman Weintraub, & Adler, 2013; U.S. Department of Health & Human Services, 2014b; Wilson, 2009). The most commonly cited systematic review on socio-economic status and physical and mental health, by Alder et al., indicates a graded association of health at all levels of SES. Examining multiple variables associated with socio-economic status and health including psychological effects (hostility, depression), social ordering effects (one's position in the SES hierarchy), and health behaviors (alcohol, smoking, physical activity) the authors found that as one's SES improves, so does one's health; as one's SES declines, so does one's health (Adler et al., 1994). Research also supports indirect associates between socio-economic status and health. Gallo and Matthews (2003) examined the role of low SES, negative emotions and cognitions, and physical health related outcomes providing evidence for an association between low socio-economic status and hostility, hopelessness, anxiety, and depression.

A complementary way to examine the role of socio-economic status in health is to consider income inequality (Lynch et al., 2005; Pickett & Wilkinson, 2007, 2015). Building on several previous studies that found that higher inequality relates to poorer population health (Lynch et al., 2000, 2004, 2005; Wilkinson & Pickett, 2006, 2007, 2008, 2009), researchers provided evidence to support a causal relationship between income inequality and poor physical and mental health outcomes (Pickett & Wilkinson, 2015). They utilized an epidemiological causal framework that considers evidence as a whole, rather than identifying individual study findings, to determine if exposure (income inequality) caused an outcome (poor health and well-being). The researchers found that 94% of the studies showed at least one association between income inequality and poor health, citing an inverse relationship between inequality and health and direct relationship between inequality and violence (Pickett & Wilkinson, 2015). Furthermore, they cited multiple studies that supported the role of chronic stress and poor health outcomes to demonstrate the effect of income inequality on health. The authors found evidence to suggest a causal connection between income inequality and physical and mental health (Pickett & Wilkinson, 2015).

Interventions

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With substantial evidence citing disparities in health among those in poverty situations, governmental programs to improve health-related quality of life of those in poverty have been in effect for several years. The supplemental nutrition assistance program (SNAP) and women, infant, and children program (WIC) were designed to improve physical health outcomes for U.S. citizens (United States Department of Agriculture, 2012, 2014). Other interventions, including housing assistance, tax relief, job training, and income assistance have also been implemented at both the state and federal levels (The White House, 2014). Brooks and Wiedrich (2012) used a ranking system to compare states based on policies designed to financially assist individuals and families living below 150% of the federal poverty level (e.g., providing funding for individual development accounts, protection from payday lenders, removal of asset limits on TANF and SNAP). The authors demonstrated that states with multiple and strong policies have individuals and families who are better suited to handle financial crises (e.g., The Great Recession) which may carry over into improved health-related quality of life (Brooks & Wiedrich, 2012).

Financial Empowerment Interventions

Another intervention to alleviate poverty is through financial empowerment. Financial empowerment increases economic stability, which may reduce stress and improve health. Studies suggest that long-term economic stability may be achieved by providing the necessary knowledge for one to make sound financial decisions (Clark, Morrill, & Allen, 2012; Collins & O'Rourke, 2010; Danes, 2012; Gale, Harris, & Levine, 2012; Letkiewicz & Fox, 2014; van Rooij, Lusardi, & Alessie, 2012).

At the community level, a successful financial empowerment program to note is in New York (NYC Department of Consumer Affairs Office of Financial Empowerment, 2013). In 2006, with the creation of the Office of Financial Empowerment (OFE), New York City started a program to improve the financial health of its residents. The OFE set three over-arching goals: "Empower individuals with low incomes by ensuring that they have sufficient knowledge to make financial decisions in their own best interest; increase financial stability in low income households by increasing assets, decreasing debts, and boosting incomes to help families meet their present and future needs; make NYC's financial marketplace safer by diminishing predatory practices and increasing access to appropriate and affordable products and services" (NYC Department of Consumer Affairs Office of Financial Empowerment, 2013, p. 10). Recognizing the need to make financial empowerment part of the many services available to low-income populations, OFE dictated financial empowerment be integrated into the existing social services. The Office of Financial Empowerment fostered strong partnerships with city agencies to ensure an understanding of the importance of financial empowerment of low-income families and individuals and then utilized pilot studies to demonstrate the positive impact of financial empowerment across the levels of social services. Data were collected via social service providers from client meetings and verified through bank statements, loan statements, and credit score print outs. Outcomes included, among others, debt reduction, increased savings, and improved credit scores (NYC Department of Consumer Affairs Office of Financial Empowerment, 2013).

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Following the lead of NYC, Louisville, KY, joined the Cities for Financial Empowerment (CFE) Coalition and began implementing financial empowerment training at the social service provider level across multiple city government agencies and local community partnerships, including the Family Scholar House. The Family Scholar House training included educating the case managers on approaches to working with their clients on budgets and cash-flow analyses. In addition, the case managers received training on behaviors of people in poverty, banking practices, lending institutions, and investment opportunities. Pre- and post-surveys given at financial empowerment trainings noted improvements in social service provider's financial knowledge, as well as confidence in discussing finances with their clients, both common barriers to assisting clients with financial empowerment (T. Lentz, personal communication, January 12, 2014).

At the Family Scholar House, this training was added to an existing curriculum designed to provide various support systems to the single parents as they work towards completion of a Bachelor's degree. Support provided by the program includes safe, affordable housing in a community of like-minded families, assistance with academics, and education on health, wellness, parenting, and finances. Residents are provided Section 8 housing, which reduces their rent to 30% of their income. To assist with educational costs, the campuses provide internet, computers, printers, and resources for scholarships and grants. Moreover, at no cost, the residents have access to apartment furniture, clothing for themselves and their children, and food.

In addition, Future Funds, a savings program where residents are required to put $10 per month into an FSH saving account, provide the residents with a "safety net" when leaving the program. This money is returned upon graduation and can be combined with the Family Scholar home ownership program. With this program, residents save money towards purchasing a new home; this money is matched (or more) upon graduation (Family Scholar House, 2014).

Family Scholar House addresses each of the social determinants of health in an effort to reduce poverty and improve health-related quality of life. Research indicates multiple factors influence both individual and population health-related quality of life, and social determinants demand consideration when developing interventions designed to improve health-related quality of life. Specifically, little information is available on the role of financial empowerment within the social determinants of health and the impact on poverty reduction. Therefore, this current study contributes to the research gap by evaluating the Family Scholar House program within the framework of the social determinants of health, and exploring the role of financial empowerment on health-related quality of life.

METHOD

In an effort to understand the effects of financial empowerment on health-related quality of life in a program that addresses the social determinants of health, the current study

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utilized a cross-sectional survey and focus group discussions. By better understanding the role of financial empowerment concerning health-related quality of life, social service providers can design and implement programs and interventions to serve individuals and populations living in poverty situations.

Sampling Procedure

The population for the current study consisted of six sub-groups: pre-residential, residential (year 1, year 2, year 3, and year 4), and graduate Family Scholar House participants in Louisville, Kentucky. The survey and focus group discussions were approved by the University of Louisville's Institutional Review Board and endorsed by the Family Scholar House Program. At the time of data collection, there were 28 families in the pre-residence stage, 215 families in the FSH residential program, and 132 graduates. Utilizing Survey Monkey, a Scholar House administrator sent out a health-related quality of life survey, via email, to all the members of the categories listed above. To be in the program, participants must have a high school diploma or GED, thus the researcher assumed all participants could read and understand the survey. The Scholar House administrator also gathered demographic information on all the above participants. This information allowed the researcher to determine if the sample was descriptive of the Family Scholar House population.

In addition, the researcher examined data from the Behavioral Risk Factor Surveillance System (BRFSS) for single female parents in Louisville, Kentucky to serve as a control. BRFSS is a national telephone-based health survey utilizing, among other questions, the health-related quality of life survey.

The population for the focus group discussions consisted of the same FSH participants. In the emails sent to the participants, volunteers were requested, on the email and on the survey, to attend a focus group. The researcher offered an incentive of a $20 gift card, dinner, and free childcare for focus group participation. A Family Scholar House administrator chose the dates and times for the focus group discussions. A doctoral candidate trained in the implementation of iterative thematic of qualitative analysis put forth by Bradley, Curry, and Devers (2007) led the discussion.

Respondent Characteristics

Ninety-two single female parents responded to part or all of the online survey. Of these respondents, nearly 90% were in the residential program. The average age of the respondent was 27, with ages ranging from 18-45 years. The average number of children in each household was just under two. The majority of participants were in the Family Scholar House program for 13-24 months. Thirty-eight single female parents took part in the focus group discussions. Residents from each of the Louisville campuses were represented. Based on demographics of the full Family Scholar House population, the sample populations were representative of the full FSH population.

Instrumentation

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For the online survey, the researcher utilized four core questions from the Centers for Disease Control and Prevention's health-related quality of life survey. The CDC and partners developed an assessment tool to measure HRQoL (Centers for Disease Control and Prevention, 2000; Moriarity, Zach, & Kobau, 2003). Criterion validity testing shows the HRQoL to be valid when compared to the "gold standard" of quality of life scales: the SF-36 (Moriarty & Zach, 1999). Test-retest reliability scored moderately to excellently reliable (i.e., 0.58-0.75; Andresen, Catlin, Wyrich, & Jackson-Thompson, 2003).

Anonymity of survey respondents was preserved through utilization of an online survey tool. Responses were anonymous. Confidentiality was preserved as no identifying information was given to the researcher. The Family Scholar House administrators emailed to FSH participants a link to the online survey.

Focus group discussions consisted of 10-15 participants for each group. These groups were held in a community room on a Family Scholar House campus and were recorded by the researcher. At the beginning of the discussions, the researcher explained the goal of hearing any and all viewpoints, re-assuring that there was no right or wrong answers to the questions posed, and that no identifying information would be utilized in the research study. To ensure representation from all campuses for the focus groups, discussions were held at three different Family Scholar House locations.

Measurements

Health-related quality of life questions. The HRQoL measure consisted of the following four questions:

1. Would you say that in general your health is *excellent, very good, good, fair*, or *poor*?
2. Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health *not* good?
3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health *not* good?
4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Financial empowerment questions. The following questions were asked in the focus group discussions: From your perspective, what are some of the more important parts of the Family Scholar House program? What is different about your life after entering the Scholar House program? What do you do differently than you did before entering the Family Scholar House program? Has the program affected your ability to take care of yourself financially? How? Have the financial success classes changed how you deal with your money? How? When you think about your health, what would you consider to be "good health"? Has your health changed since you've entered the program? How?

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Analysis

The data were positively skewed and therefore non-normal (failing an assumption of the tests used in this study). Thus, the data were transformed utilizing a log + 1 transformation (Howell, 2013). Analyses were computed with SPSS 21.0 (2012).

The researcher used a one-way analysis of variance (ANOVA) to test for statistical differences between the means of multiple groups. Participants were divided into five groups according to time in the Family Scholar House program (0-12 months, 13-24 months, 25-36 months, 37+ months, graduate) and a sixth matched Behavioral Risk Factor Surveillance System (BRFSS) group. Marital status (single), number of children in the household (≥1), gender (female), age (18-49 years) and location (Jefferson Co. Kentucky) matched the BRFSS group. There were only two participants from the pre-resident group; no quantitative analyses were conducted with this sub-sample. The analysis tested for differences between the means of the six groups regarding the core four HRQoL questions.

The researcher transcribed, verbatim, the focus group discussions. Following the iterative thematic analysis methods put forth by Bradley et al. (2007), these transcripts were reviewed, coded, and organized into groups based on the support systems in place at the Family Scholar House (i.e., housing, academics, finances, community, health and wellness). Within these groups, the researcher organized specific quotes from the discussion group transcription into related themes. After this initial coding, a secondary coding process occurred. During the secondary coding process, the researcher looked for common themes among the data already present on the table. This process moved from a micro to a macro look at the data. A final thematic coding was presented to a Family Scholar House administrator for clarity and understanding, thus affirming and validating the data analysis (Bradley et al., 2007).

RESULTS

Health-related quality of life

A statistically significant difference was found in the number of mentally unhealthy days per month for the six groups, $F(5, 137) = 3.4$, $p = .006$, $\eta^2 = .11$ (see Table 1). Pair-wise post-hoc comparisons using the Bonferroni test indicated that the log transformation of mean days of mental health score for the 0-12 month group ($M = .84$, $SD = .53$) was significantly different from the mean days of mental health score for the BRFSS group, $M = .43$, $SD = .51$, $t(5) = 1.77$, $p = .003$) (see Table 2). A second statistical difference was found in health ranking, *Excellent* (5) to *Poor* (1), for the six groups, $F(5, 137) = 2.36$, $p = .04$, $\eta^2 = .08$] (Table 1). Pair-wise post-hoc comparisons using the Bonferroni test failed to find significant differences between the means. The mean health ranking score for the 13-24 month group ($M = .66$, $SD = .11$) was not significantly different from the mean health ranking score for the BRFSS group, $M = .57$, $SD = .13$, $t(5) = 1.54$, $p = .067$ (see Table 3).

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Table 1

One-way Analysis of Variance for Differences in Group Means

		df	Sum of Squares	F	Sig.
Physcal Health	Between Groups	5	0.321 (0.064)	0.274	0.926
	Within Groups	136	31.864 (0.234)		
	Total	141	32.185		
Mental Health	Between Groups	5	4.564 (0.913)	3.41	0.006*
	Within Groups	137	36.669 (0.268)		
	Total	142	41.233		
Activity Restriction	Between Groups	5	1.634 (0.327)	1.505	0.193
	Within Groups	116	25.18 (0.217)		
	Total	121	26.814		
Overall Health	Between Groups	4	0.054 (0.011)	0.247	0.941
	Within Groups	136	5.952 (0.044)		
	Total	141	6.006		
Health Rating	Between Groups	5	0.184 (0.037)	2.364	0.043*
	Within Groups	137	2.132 (0.016)		
	Total	142	2.316		

Note. Sig. at p<.05 level.

Table 2

Mean Scores, by Group, of Mental Health Days

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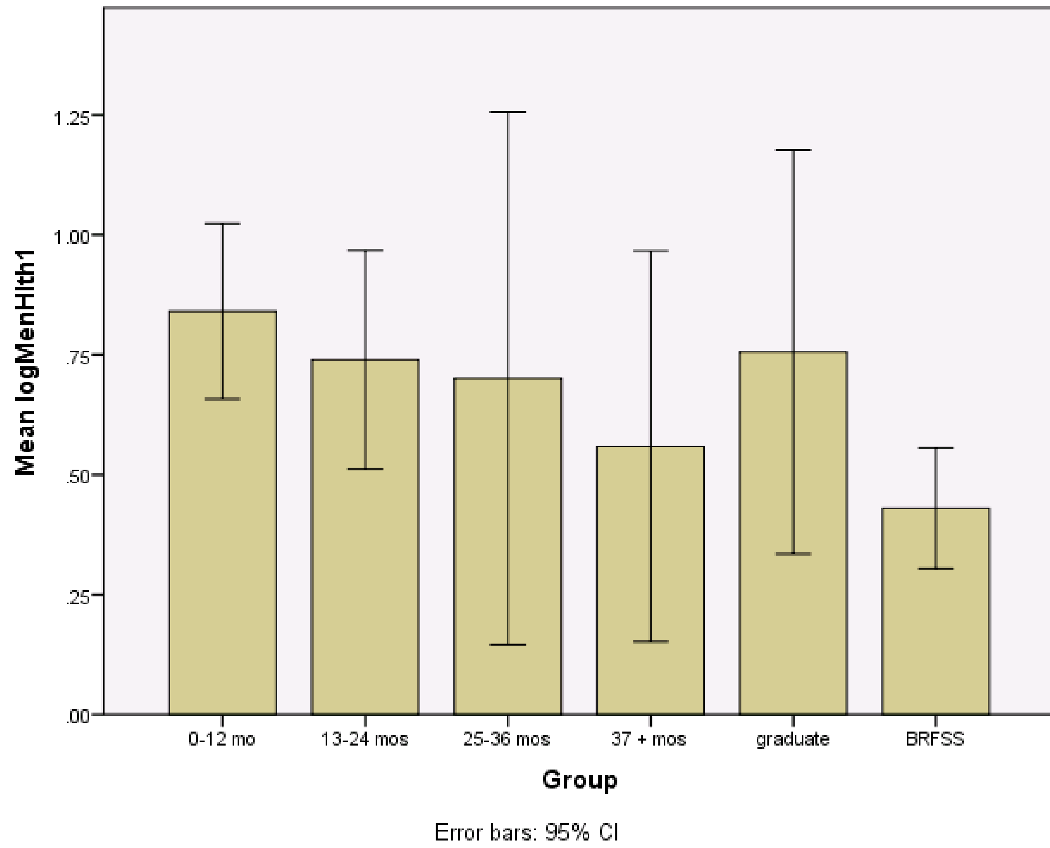

Table 3

Mean Scores, by Group, of Health Rating

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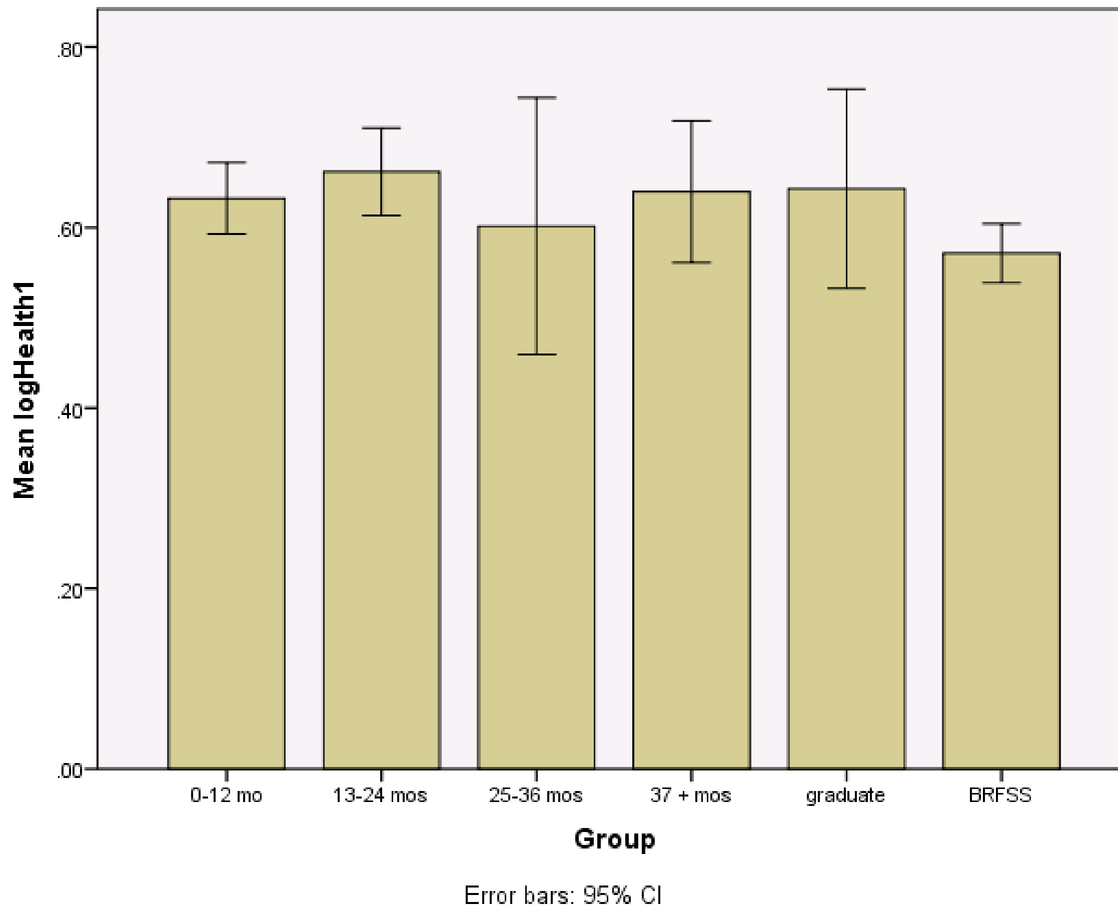

Financial Empowerment and health-related quality of life

Utilization of the Cumulative Inequality Theory (CIT; DiPrete & Eirich, 2005) assisted with understanding the resulting themes from the focus group discussions. Primarily, the main ideas of inequality leading to risk exposure and cumulative inequality leading to higher mortality rates provided a theoretical framework to explore the relationship between financial empowerment and the themes found in the discussion.

The primary theme to arise from the focus group discussions was stress reduction. The different components of the Family Scholar House program reduced stress in the participants' lives in a variety of ways. The following individual participation quotations (noted by italics) were a sample of the responses given for each question. Quotes were chosen based on their representativeness of the average responses of the participants.

> *"Just being in this program alone has lifted a lot of stress. I mean, I still have my daily stress, everyone does. But I feel like this program has just lifted a lot off of my plate so I don't have to worry about stuff all the time. Because of their support, I don't have to worry."*

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"Being in Family Scholar House kind of takes the edge off. You're not so angry all the time, or bitter or frustrated with being in a situation you are."

The above quotations explained the stress reduction and subsequent mental health benefits provided by the Family Scholar House program. As stress of housing, finances, and money for school were relieved, participants noted mental health improvements in themselves. This finding follows the CIT model, demonstrating that the disadvantages faced by people in poverty situations may contribute to poor health-related quality of life. With the reduction of stress, mental health, a contributor to health-related quality of life, improved.

In addition, as the focus group questions became more directed towards finances, a secondary theme of being able to save money emerged. This contributed towards the reduction in stress and improved mental health of the participants.

"I've been saving money and making better choices with my money. Family Scholar House has helped me with that a lot."

"I've been able to save money for when I move out."

Several residents also cited the future funds program. With this program, participants were required to give Family Scholar House ten dollars per month that is placed into a fund for the resident. Upon leaving the program, this money is returned to the resident. Knowing that this money will be available upon graduation, residents commented on feeling secure and less apprehensive (noted as advantages in the CIT) about leaving the program, again improving the mental health of the participants.

Besides the future funds, residents had the ability to increase short and long-term savings within their overall budget due to lower rent and bills. With the monthly savings, residents paid cash for vehicles, saved money for homes, paid off debt and were able to stop living on credit cards.

"They pay our internet and show you that you don't have to have cable. That's $40 a month. You can do Netflix for $8. They always make sure you know your options so you don't put a financial strain on yourself."

"Instead of always struggling, Family Scholar House showed me how to manage my money so I can pay for stuff that I need, like LG&E. I can get caught up and not be behind all the time or in debt."

Residents felt empowered by paying for big purchases (car) in full and noted security in having money set aside for unexpected bills such as car repairs or medical bills. These factors contributed to improved mental health afforded to populations with financial security. According to the cumulative inequality theory, advantages (seen in FSH as debt elimination, increased savings and financial security) improve opportunities for events that contribute to positive mental health and health-related quality of life. Residents were able to save money (advantage) and thus no longer faced significant financial risk with purchases

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or bills (opportunity). As a result, their mental and emotional stress decreased and their mental health improved.

In addition, several residents mentioned the support of Family Scholar House through “the basement” and holiday support. The basement contains food, clothing and furniture that are available to all participants. Some residents were able to get full living room sets, desks, and dressers as well as clothing for themselves and their children. The food pantry provided essentials towards the end of the month when money was scarce. Family Scholar House sponsors provide holiday family meals and gifts, alleviating the stress of proving extras and reducing debt accumulation commonly seen during the holiday season.

> *“The food pantry is a very nice program. If I am low on food, I can go get cereal, canned goods, and things like that. It all helps a lot. Saves you money if you need to go grocery shopping.”*

> *“At Thanksgiving, they will have free turkeys and free meals that you can come and pick up. And Christmas is one of the biggest things for people who celebrate Christmas and they can’t afford to get their kids anything. Somebody else provides everything for them. Just about anything you want.”*

The inability to provide necessities or holiday extras for themselves or their children was stressful. The Family Scholar House program provided these items (noted in the CIT as an advantage), improving the resident’s financial security, reducing stress, and improving mental health. Though residents did not improve their socio-economic status, the advantages provided by the Family Scholar House did allow them opportunities (holiday celebrations with minimalized financial stress) afforded to higher SES populations.

Finally, discussion arose regarding how the financial classes may have changed participant’s money management knowledge and skills. The ability to understand finances, including credit, banking, budgeting, and taxes was a common theme that surfaced.

> *“They point out a lot of expenses that you don’t realize how much you’re spending until it’s pointed out to you. Like how much I spend on coffee. It adds up.”*

> *“They have classes that teach you how to manage your finances which help you balance your rent and the utilities you have. These are things that maybe your parents didn’t teach you.”*

Residents, many for the first time, learned how to live on a budget, the difference between needs (LG&E bills) and wants (cable TV), and the different banking and credit card options. Being knowledgeable regarding their finances improved their financial empowerment, as they felt confident in their financial decisions. This, again, reduced stress due to unpaid bills or unexpected fees. As the participants better understood their options, they made wise financial choices. Thus, their financial struggles were better controlled, empowering the residents and improving their mental health.

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DISCUSSION

Using a health-related quality of life survey, the current study noted improvements in mental health days, a contributor to health-related quality of life outcomes, and the general health rating among Family Scholar House participants. Upon graduation from the Family Scholar House program, resident's mental health and general health rating were no longer significantly different from a comparison group. In focus group discussions, a common theme of stress reduction emerged. People living in the lower SES categories experience higher levels of stress that are associated with poor mental and general health (Backlund et al., 2007; Gallo & Matthews, 2003; Myers, 2009). More specifically, mothers report fatigue and chronic mental and physical health problems resulting from financial strain, parenting stress, and lack of support (Oyserman, Bybee, Mowbray, & Kahng, 2004; Schwartz, Bybee, Spang, Rueda-Reidl, & Oyserman, 2000). Following the Cumulative Inequality Theory, the Family Scholar House support alleviated several inequalities previously faced by the residents (i.e., housing, education, health and wellness, community support, economic stability). This reduction of inequality may have contributed to stress reduction, financial security, financial empowerment, and thus, an improved state of mental health.

Focusing primarily on the stress reduced due to economic stability (one of the social determinants of health), the residents were not as anxious about life during or after the program. The advantages provided by FSH reduced the stressors commonly noted among populations in poverty. First, the resident knew they had money put aside in their Future Funds account and trusted that these funds would support them as they transitioned out of the Family Scholar House apartments and into a new career and possibly a home of their own. Second, saving money outside of these funds also reduced stress by giving residents the opportunity to purchase larger items with cash, eliminating the monthly credit card bills. One resident paid cash for her first car; other residents commented on the ability to buy items for their apartment, their children and themselves without having the worry of debt accumulation. Third, residents noted the stress reduction that would normally arise from unexpected bills. Car repairs or medical bills were not as devastating. As one resident noted, "I didn't want to spend the money on getting my car fixed, but I had it to spend." Fourth, with money saved and debt paid off, residents could use tax returns for something other than bills; again, a first for many of the residents.

The saving of money came not only because of the financial support provided by the Family Scholar House, but also because the financial success classes enabled the residents to manage their money, ensuring that bills were paid on time and expenditures were prioritized and stayed within the monthly budget. As one resident commented, "I had no idea how much money I was spending on buying coffee each morning. Now I own a travel mug and a coffee pot. And that saves me money each month." Multiple components of the Family Scholar House program work to address the social determinants of health, including economic stability, and alleviate stress caused by limited finances. These findings support research on financial literacy where behavior changes, such as increased savings and decreased debt, are seen as positive financial health outcomes (Grimes, Rogers, & Smith,

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2010; NYC Department of Consumer Affairs Office of Financial Empowerment, 2013; Phillips & Stuhldreher, 2011; Rothwell & Han, 2010; Willenbrink, 2015).

This study adds to the current literature regarding social determinants of health, as well as financial empowerment. Health improvements were found in a program that addressed each of the social determinants of health, with a specific curriculum related to economic stability. Due to improved financial stability, residents had reduced stress and anxiety levels related to their financial circumstances. Thus, at the clinical and programming level, education and guidance on financial security and the subsequent financial empowerment needs consideration. Social workers assisting clients with food stamps or housing vouchers need to provide education on budgeting, debt reduction and other concepts of financial security. In addition, programs designed to work with impoverished populations, such as the various city and state agency programs, must consider and address all the social determinants of health if true reform is expected. As demonstrated by the mental health improvements seen in the Family Scholar House participants, financial education, empowerment, and security are essential to improving the overall health of impoverished populations.

Limitations

This study is not without limitations. Primarily, the design of the study limits the generalizability of the findings. As the participants were all from one intact group and voluntarily chose to be in the study, random selection was not utilized therefore the results cannot infer causation nor be expected in other populations. Resources may inhibit researchers' abilities to address this limitation. Therefore, other programs designed to alleviate poverty should be examined to note similar findings.

A second limitation is due to cross-sectional data collection. This method may fail to give a true reflection of participants' state of health. Future studies should address this limitation by tracking the participants from program entry to exit, collecting data at specified periods over the long-term to note possible trends and ensure results truly reflect the population.

Conclusion

The Family Scholar House program, with a mission of alleviating poverty by increasing self-sufficiency, addresses each of the five social determinants of health, including a curriculum that focused on economic stability. Findings from this study suggest that the various supports put in place by the Family Scholar House program reduce stress, which may improve the mental health of the residents. Specifically, data suggests that the increased financial knowledge, empowerment, and stability reduced stress levels and improved mental health among the Family Scholar House residents. State agency programs and social workers in clinical environments educating and guiding people in poverty need to address all the social determinants of health if poverty is to be reduced and health improvements noted. Minimally, community support programs, clinicians and caseworkers should include

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financial empowerment curriculum as a component within the resources currently being provided to populations in poverty.

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Sources of Referral in Student Financial Counseling

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This study evaluated sources of referral to financial counseling and varied declines in financial stress across the financial counseling process. College students came to counseling most often through self-referral. Younger students and women were more likely to respond to institutional referrals. There were two clearly discernable periods of decline in financial stress, smaller interim declines occurring after requesting appointments and larger declines that occurred in counseling sessions. The interim declines, however, were only operative for those who were self- or institutionally-referred and not for those who entered on a social-referral. A possible explanation is that social-referrals have already had "someone to talk to," whereas other referrals may only begin to feel a psychological burden lifted after making an appointment. Total declines in financial stress were mostly impervious to individual differences and sources of referral lending support to the notion that financial counseling itself contributed to aggregate declines in financial stress.

Keywords: financial counseling; sources of referral; financial stress; college students

Financial stress among college students has been on the rise in recent decades (Northern, O'Brien, & Goetz, 2010) with finances cited as the second largest source of stress, ranking just behind academic performance (Groux, 2012). Durband and Britt (2012) described the pivotal financial decision points faced by the developing college student, "choosing a major, financing an education, establishing credit, renting an apartment or home, paying for major purchases, reviewing job offers, and choosing health-care coverage or a retirement plan" (p. 2) and noted the opportunity for colleges and universities to provide financial support through financial education and counseling.

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It is during these pivotal financial decisions that financial literacy is important, yet college students demonstrate low rates of literacy. Inceptia's (2013) National Financial Capability Study of undergraduate students found 67% surveyed scored either a "D" or "F" on a 50 question knowledge test and not one student scored in the "A" range. Higher One (2011) administered a nine-question financial knowledge quiz to 5,488 college students and found seven in ten students received a failing score and less than 30% answered six or more questions correctly. This evidence is disconcerting because it is during young adulthood that financial attitudes and behavior are being developed, and financial independence is eventually established (Durband & Britt, 2012; Xiao, Chatterjee, & Kim, 2014).

The growing interest in the financial well-being of college students is linked to new economic realities such as rising tuition costs, increasing student loan debt, and uncertainties in the job market. For university administrators, these conditions have amplified the importance of addressing student financial needs. During the Great Recession, Bushong (2009) found that students more often sought financial counseling. Financial counseling is an important component of addressing student financial needs. Yet, according to a recent nationwide search, only five universities have a full-service financial counseling program (Eades, Fox, Keown, & Staten, 2013). In the last five years, colleges and universities have increased services and efforts to help students with financial literacy and financial struggles (Durband & Britt, 2012; Eades et al., 2013). There are multiple possible university-based interventions, and a variety of routes for students to obtain help with financial issues. Among researchers and practitioners, little is known about college students' preferences for help when it comes to their financial issues. In the context of increased interest on the part of universities who want to play a more supportive role in the health and well-being of college students, we were interested in how college students sought help for financial challenges.

Given college students' new economic reality, in hand with developmental decision points, this study investigated financial stress and the financial help-seeking behavior of young adults who obtained financial counseling from a university-based clinic. As college students become financially independent from their parents or guardians, they assume responsibility for determining and directing their own financial well-being. This self-monitoring includes seeking help when feeling overwhelmed by financial stress and/or being confronted with a financial problem. Important questions exist about where students will go to find help and how universities assist in connecting these students to university support services. To be successful there needs to be a fit between the avenues that students travel to find financial support and the outreach and services that happen on or near college campuses. While there are many routes to find financial counseling services, the counseling experience itself can differ by the route taken. Deciding to seek counseling on the advice of a friend could be part of a process that includes disclosure of one's financial situation and emotional support from members of a social network. Self-referrals may be preceded by some amount of search and comparison shopping. Institutional-referrals could bolster student's confidence that service providers will have been well-trained and adhere to professional practices. This is an area of investigation that has not been often researched,

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but at least one study suggests that the source of referral is crucial, as it has been shown to predict whether someone follows through and attends their first session of therapy (Hampton-Robb, Qualls, & Compton, 2003). If a referral source is inappropriate, unavailable, or unknown to young adults then financial stress and challenges will go unaddressed. Source of referral may also be linked to the characteristics of a client that seeks help with financial issues and, as a result, university administrators and financial counselors might adjust their approach to addressing financial stress based on students' particular needs.

A robust literature exists on the sociodemographic variables that predict financial stress, but little is known about the potential predictors in the treatment of financial stress. Furthermore, in the financial help-seeking literature, little is known about source of referral and whether it relates to outcomes, such as stress levels, recurrence of the problem, or motivation to change among those who seek help. The current study addressed financial stress and counseling by examining: (a) individual and financial characteristics associated with the source of referral (e.g., self-referral, institutional-referral, or social-referral) utilized by college students involved in the financial counseling process, (b) the association that type of referral had on the rate of decline in financial stress during the financial counseling process, and (c) factors that predict the total decline in financial stress across the student financial counseling process. To date, no other study has examined source of referral in relation to financial stress in the context of college student financial counseling.

LITERATURE REVIEW

College Students and Financial Stress

Rising college costs and subsequent student loan debt have been identified as primary contributors to the elevated financial stress and anxiety experienced by college students (Andruska, Hogarth, Fletcher, Forbes, & Wohlgemuth, 2014; Archuleta, Dale, & Spann, 2013), with students leaving college with an average of $23,000 in student loan debt (Federal Reserve Bank of New York, 2013). Studies have indicated that more than half of people with student loans are concerned that they may not be able to pay off their debt (Baum & O'Malley, 2003; Ratcliffe & McKernan, 2013). Furthermore, diminished labor market opportunities for young borrowers during the Great Recession significantly amplified student loan defaults (Ionescu & Ionescu, 2014).

Investigation of the inroads to student financial counseling is important because financial stress is a prominent obstacle for college students (Staats, Cosmar, & Kaffenberger, 2007; Serido, Shim, Mishra, & Tang, 2010). Nearly 35% of students described their financial situation as either "traumatic" or "difficult to handle" (American College Health Association, 2011). In another study of university students, 71% indicated financial stress was a significant problem (Heckman, Lim, & Montalto, 2014). College students who have sought financial counseling from a university-based service typically report high levels of financial stress as their reason for seeking services (Britt et al., 2011; Eades et al., 2013).

Financial stress, anxiety, and concern among college students have been linked to a variety of consequences. Financial stress has been found to diminish academic performance

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(Hossler, Ziskin, Gross, Kim, & Cekic, 2009; Joo, Durband, & Grable, 2008), with researchers showing an association between working and lower grade point averages (Stinebrickner & Stinebrickner, 2003). Financial stress has been shown to impact college students' expected time-to-degree, graduation rates, and their dropout rates (Bozick, 2007; Joo et al., 2008; Heckman et al., 2014; Letkiewicz et al., 2014, 2015). Joo et al. (2008) linked financial stress to lower grades and increased incidences of leaving college prior to finishing a degree.

Other research has suggested that anxiety is a more likely outcome for college students than depression in situations involving students working while going to school (Mounsey, Vandehey, & Diekhoff, 2013). College students who feel financial-related anxiety have lower financial satisfaction and larger student loan debt balances (Archuleta et al., 2013). Extremely stressful financial situations have even been associated with increased suicidality for some college students (Westefeld et al., 2005). The consequences of financial stress on college students' welfare is of great concern to university professionals and policy makers, so too are effective strategies to help reduce and/or relieve student stress and anxiety.

Financial Counseling

Financial counseling is a promising intervention as evidenced by some studies (Britt, Canale, Fernatt, Stutz, & Tibbetts, 2015; Collins & O'Rourke, 2010). Based on a meta-analysis of impact evaluations of financial education and counseling programs, Collins and O'Rourke (2010) suggested that one-on-one financial counseling and financial coaching is a more promising remedy than traditional financial education. Young adults who have the support of a coach or counselor are more likely to reach financial goals and achieve positive changes in their financial behaviors. Examining the effectiveness of a university-based financial counseling center, a recent study found that financial counseling improved subjective financial knowledge and attitudes (Britt et al., 2015).

Financial Help-Seeking Behavior

Help-seeking behavior has been shown to vary by the source of the problem, for example, young people tend to seek out friends for relationship problems and family for personal problems (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Help-seeking has been defined as:

> the behaviour of actively seeking help from other people. It is about communicating with other people to obtain help in terms of understanding, advice, information, treatment, and general support in response to a problem or distressing experience. Help-seeking is a form of coping that relies on other people, and is therefore often based on social relationships and interpersonal skills (Rickwood et al., 2005, p. 4).

Less is known about the source of referral used by college students who seek help when confronted by financial stress and/or a financial issue during their college careers. More specifically, financial help-seeking has been operationalized as "an action by an

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individual to seek and use the assistance of a secondary source when dealing with a personal finance issue, problem or objective" (Grable & Joo, 2003, p. 89). Research on patterns of help-seeking behavior remains somewhat inconsistent, and little is known about seeking financial help (Rickwood et al., 2005).

To elaborate the process of financial help-seeking, Grable and Joo (1999) developed the personal finance help-seeking theoretical framework, based on Suchman's (1966) health care help-seeking framework. The five stage personal finance help-seeking theoretical framework is conceptualized such that individuals: (a) exhibit poor financial behaviors or habits, (b) evaluate the financial behavior(s), (c) analyze the root cause of the financial behavior(s), (d) decide to seek help with the financial behavior(s), and (e) choose to get financial help. The current study focused on the final steps in the Grable and Joo model. As noted by Grable and Joo (2001), it is the final step that is of interest to financial counselors because an individual who decides against seeking help will drop out at the fourth step and the cause of financial stress is never addressed with professional help such as financial counseling or financial therapy (Klontz, Britt, & Archuleta, 2015).

Initial research tested the financial help-seeking framework with a community sample and found younger people, people with poor financial behaviors, and people with multiple financial stressors were more likely to seek financial help (Grable & Joo, 1999). Further, Lim, Heckman, Letkiewicz, and Montalto (2014) examined the factors related to college students' financial help-seeking behavior, utilizing Grable and Joo's (1999) framework. Their findings indicated that students who were Black, have had a financial education course, have larger current student loan debt, experience higher levels of financial stress, and have high financial self-efficacy tend to seek help from professionals. In contrast to students, research based on a sample of university faculty and staff found that those who sought help from financial services professionals were more likely to be female, have higher incomes, have higher levels of financial risk tolerance, and a positive mental outlook, as well as exhibiting healthier financial behaviors such as monitoring spending, spending less than income, setting money aside for savings or retirement, having a plan to reach financial goals, and having a weekly or monthly budget (Grable & Joo, 2001).

The existing literature demonstrates that sociodemographic variables predict who seeks help when experiencing financial stress. Britt et al. (2011) modeled who is likely to seek financial counseling from a university-based service. The study found help-seekers tended to be older and had higher perceived net worth, lower mental health (measured by elevated stress levels and rates of depression), lower financial knowledge, and lower income satisfaction. A Canadian study identifying factors that propel people to seek professional financial planning help found that individuals with high self-efficacy were more likely to seek help and those with high subjective financial stress were less likely to seek help (Letkiewicz, Robinson, Domian, & Uborceva, 2015).

Financial help-seeking is largely influenced by individual characteristics, such as age, gender, education, income, and personality (Britt et al., 2011; Grable & Joo, 2003), but these may primarily serve as markers of more proximal financial situations (Gudmunson & Danes,

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2011). Younger individuals who had more education and higher income were more likely to seek advice and help from professionals (Britt et al., 2011; Collins, 2010; Joo & Grable, 2001), whereas individuals who had lower income and lower self-esteem tended to seek help from non-professionals (du Plessis, Lawton, & Corney, 2010). While a fairly robust literature exists on the sociodemographic variables that predict financial stress, limited research has examined the paths to treatment of financial stress, such as source of referral.

Sources of Referral

Referrals play an important role in the financial stress and counseling process. Without a referral, many individuals would be left to tackle issues on their own and problems might remain unresolved. In the financial help-seeking literature, little is known about the source of referral and whether it relates to outcomes, such as financial stress and willingness to change. However, there is evidence from the mental health literature that source of referral is related to both (Brent et al., 1998; Mataix-Cols, Cameron, Gega, Kenwright, & Marks, 2006). One study found that clients who self-referred were more motived to change and had a lower incidence of problem reoccurrence compared to individuals referred to treatment by a mental health professional (Mataix-Cols et al., 2006). Another study found that adolescents treated for major depressive disorder who were recruited via advertisements showed more optimism compared to adolescents from other referral sources; outcomes at the end of treatment also varied by source of referral (Brent et al., 1998). Further study into source of referral and financial counseling may uncover links between specific client characteristics and those who seek help with financial issues.

Informal sources include family or friends, whereas formal help includes a financial counselor or planner (Grable & Joo, 2003). A study of individuals suffering from debt burdens who sought advice found women to be more likely to seek informal advice from friends and formal advice from a community-based service, whereas men were much less likely to talk about their debt issues informally or formally (Dearden, Goode, Whitfield, & Cox, 2010). In a study of help-seeking behavior of university faculty and staff, Grable and Joo (2003) identified the most popular sources of financial information as non-professional sources like friends, relatives, the internet, and magazines. However, professional sources of help, like financial planners, were found to be the most useful source of help.

For most people, regardless of their presenting problem, barriers exist to seeking help. Financial help-seeking barriers that were identified in a sample of unemployed blue-collar men included a lack of knowledge about professional sources, shame, and embarrassment (du Plessis et al., 2010). Typically, young people do not seek help from professionals, and tend to search out informal help before turning to formal help (Rickwood et al., 2005). One observation is clear from the literature, help-seeking can come from a variety of sources.

Source of information has been identified as a critical factor for understanding the financial information search (Cho, Gutter, Kim, & Mauldin, 2012; Loibl & Hira, 2006, 2011). In one typology, Loibl and Hira (2011) categorized information sources into four categories: internet-based sources, mass-media sources, interpersonal sources, and workplace sources.

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Internet-based financial information sources and mass-media sources were used more often by men whereas women tended to use interpersonal information sources, such as family and friends, to seek for information (Loibl & Hira, 2006). In other research, Cho et al. (2012) identified friends and financial planners as significant sources of financial information.

Current Study

Our research sought to connect the literature on information search to the literature on financial counseling with an eye on the impact search has on financial stress. Specifically, we examined intake surveys of college students who sought help at a university-based financial counseling center. We sought to identify common factors associated with the decision to initiate a financial counseling appointment in a university setting and what actually brings student clients into a counseling relationship. In addition, we assessed whether the sources of referral for seeking financial counseling is a factor in reducing college student financial stress. The proposed relationships to be examined are shown in Figure 1 and the major components of the model are supported by our review of the literature.

RQ1: What types of students respond to various sources of referral for financial counseling?
RQ2: Does the source of referral contribute to changes in financial stress at various stages of student financial counseling?
RQ3: Do individual characteristics and sources of referral predict total declines in financial stress across the financial counseling process?

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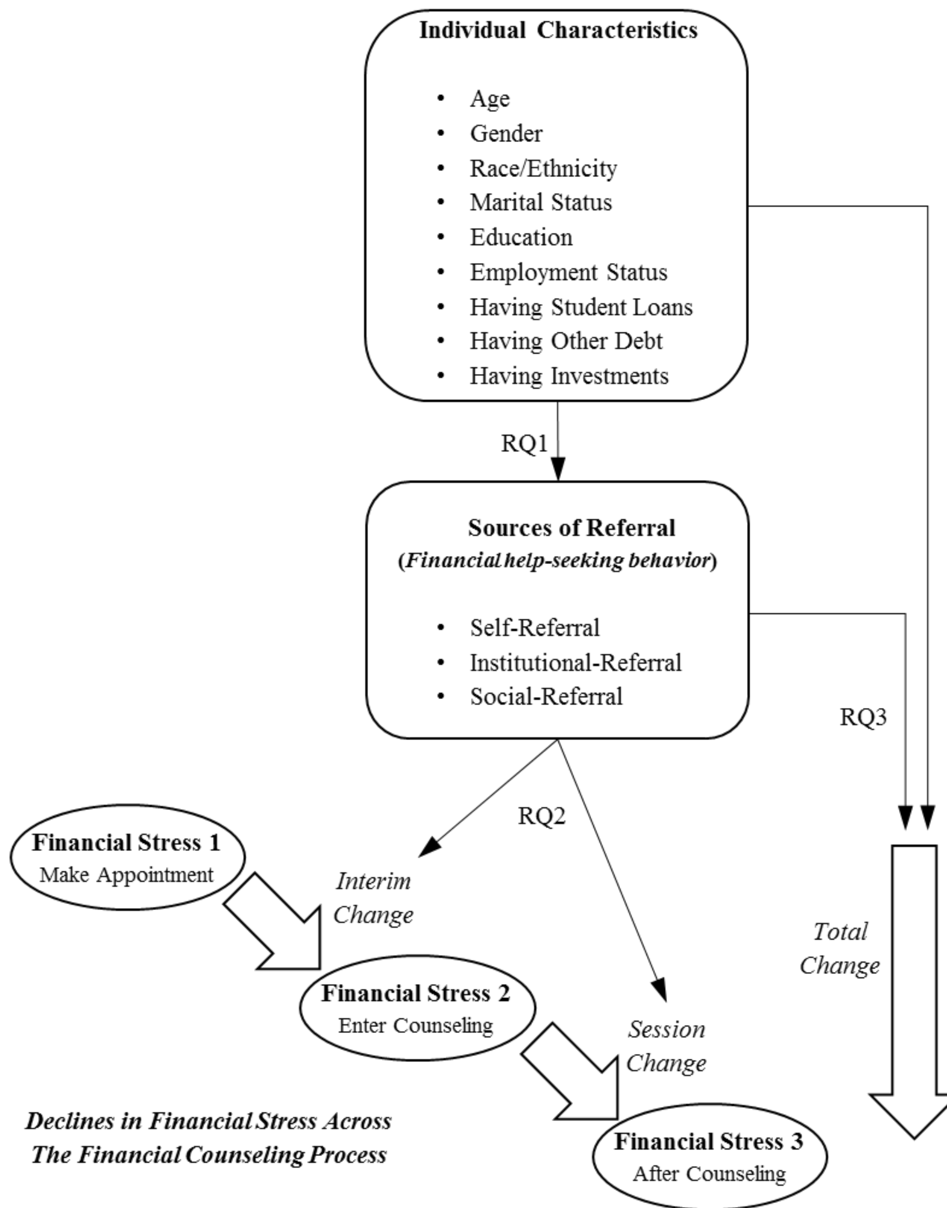

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Figure 1. Conceptual model of factors impacting decline of financial stress in the student financial counseling process.

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METHOD

Data Collection and Participants

The data were obtained from intake and exit surveys completed by clients during scheduling and at the time of counseling in a university financial counseling center. Each client completed an intake survey online before making an appointment at the center. The intake survey was designed to inform the financial counselor about the client's financial situation, financial stress level, demographic background, reasons for seeking counseling, counseling preferences, and availability for scheduling an appointment. Exit surveys were completed on site immediately following counseling sessions and were designed to assess the satisfaction of the client with counseling services. Thus, we were able to track changes in financial pressure during the interim time between setting an appointment and starting the financial counseling appointment, which could include a wait time of several days or more. This study also utilized data on client issues from a checklist created by counselors during the counseling sessions. Client issues on the checklist included client goals, agreed-upon client and counselor tasks, and other counselor notes taken during counseling sessions. Student information was redacted prior to sharing with researchers, which was a requirement for approval obtained from the Institutional Review Board at the researchers' university.

Altogether there were 1,075 client cases from those who visited a Midwestern university-based financial counseling center between 2005 and 2012. The final sample was composed of 554 student clients; 174 non-student cases and 347 incomplete exit survey cases were omitted.

Measures

Sources of referral for seeking financial counseling. Intake surveys included the following question, "How did you learn about our service?" Response options were listed which included websites, email, brochure, workshop, financial aid office, friend, community agency, student organizations, community agency (i.e., extension), or courses. There was also a fill-in-the-blank option to capture other less common options. These options were categorized into three sources of referrals for seeking financial counseling, *self-referral* (emails, websites, brochures, and campus advertisements), *institutional-referral* (workshops, financial aid office, classes, student counseling services, advisors, and community agencies), and *social-referral* (friends, family members, and student organizations).

Perceived financial stress level. Clients were presented with three repeated measures of financial stress. Each question was altered slightly to ensure that there was clarity about the point of timing in which the measure was being assessed. Responses for all three questions were measured on the same 10-point scale. Levels of perceived financial stress ranged from 1 (the lowest level of stress) to 10 (the highest level of stress). At intake, when the appointment was made, student clients indicated their perceived financial stress

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levels by answering the question, "How would you rank your current level of financial stress?" Two remaining financial stress-related questions were asked at the conclusion of the counseling session. The first asked for a retrospective rating of financial stress, "On a scale of 1 to 10, where would you say your financial stress level was when you came in today?" The follow-up question was an assessment of how the client felt at the conclusion of the session, "On a scale of 1 to 10, where would you say your financial stress level is now after discussing your situation?" Ratings at the appointment-making time and after the appointment were each completed alone, via computer.

Individual characteristics. Several individual and financial characteristics were collected. Age, income, total federal student loan balance, total financial debt, and total investment balance were measured as continuous variables. Binary variables included gender (male = 0, female = 1), race (non-White = 0, White = 1), marital status (married, divorced, separated, or engaged = 0, single = 1), employment status (not employed = 0, employed = 1), student loans (do not have student loans = 0, have student loans = 1), other debt (do not have other debt = 0, have other debt = 1), and holding investment accounts (do not have investments = 0, have investments = 1).

Analysis

We conducted a number of chi-square and ANOVA tests to examine differences across sources of referral for key demographic and financial characteristics. To test for declines in stress levels across the points in time in the counseling process and between sources of referral, we conducted a series of paired sample *t*-tests. Finally, regression analysis was used to identify independent factors (including sources of referral) related to declines in stress levels.

Results

A detailed description of the total sample and across referral types is displayed in Table 1. Most of the clients who made an appointment for financial counseling through the center website were single (76.9%), White (81.6%), and in an age range between ages 18 and 25 (84.3%). The participants included more female students (58.3%) than male students (41.7%). In terms of employment, 73.8% were employed earning a median income of $700 monthly.

Regarding student loans, 86.8% had student loans, whereas 13.2% indicated no student loan debt. The median total federal student loan balance for the participants was $26,833. Median total consumer debt, including credit card, car loan, and other loan balances, was $2,760 for those students who had debt. About one in five (20.2%) students indicated they held investments, with a median total investment balance of $3,000. Based on the intake survey, 96.6% of clients preferred to meet face-to-face with a counselor instead of by email (2%) or phone (0.7%).

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Table 1

Student Client Characteristics

Category	Full Sample (n=554) Percent/Median	Self-Referral (n=288) Percent/Median	Institutional-Referral (n=144) Percent/Median	Social-Referral (n=122) Percent/Median
Age (*years*)				
18-21	13.9	11.1	22.2	10.7
22-25[a]	70.4	71.5	65.3	73.8
26-29	9.6	9.7	8.3	10.7
30 and older	6.1	7.6	4.2	4.9
Gender				
Male	41.7	46.5	34.0	39.3
Female[a]	58.3	53.5	66.0	60.7
Race/Ethnicity				
White[a]	81.6	78.8	85.4	83.6
Hispanic	13.0	16.0	9.7	9.8
Asian	2.5	2.4	2.8	2.5
African American	1.6	1.0	2.1	2.5
Hawaiian/Pacific Islander	1.1	1.4	-	1.6
Other/Multiethnic	0.2	0.3	-	-
Marital Status				
Single[a]	76.9	77.8	75.7	76.2
Engaged (*includes cohabiting*)	12.1	11.1	14.6	11.5
Married	9.2	9.0	8.3	10.7
Separated	0.5	0.7	1.4	0.8
Divorced	1.1	1.0	-	0.8
Widowed	0.2	0.3	-	-
Education Attained				
High School	2.0	1.7	2.1	2.5
Some College	61.7	63.2	61.8	58.2
Bachelors	22.6	20.5	25.7	23.8
Masters	7.9	8.3	7.6	7.4
Doctorate	5.8	6.3	2.8	8.2
Employment Status				
Employed (Income)	73.8 ($700)	73.6 ($800)	71.5 ($600)	77.0 ($950)
Not Employed	26.2	26.4	28.5	23.0
Having Student Loans				
Yes (Amount)	86.8 ($26,883)	85.8($27,163)	91.0 ($25,000)	84.4 ($30,462)
No	13.2	14.2	9.0	15.6
Having Other Debt[b]				
Yes (Amount)	54.2($2,760)	52.8 ($2,500)	57.6 ($3,000)	53.3 ($2,500)
No	45.8	47.2	42.4	46.7
Having Investments				
Yes (Amount)	20.2 ($3,000)	19.4 ($2,500)	20.1 ($3,750)	22.1 ($2,550)
No	79.8	80.6	79.9	77.9

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[a]*Used as reference categories in later analyses as dichotomized variables.* [b]*Other debt includes credit card debt and past-due bills.*

Table 2 shows the types of referrals that fit into three categories (self-referral, institutional-referral, and social referral). Over half (52%) of the student clients learned about financial counseling services through self-referral sources. In particular, emails and websites were major sources of referral for seeking financial counseling among college students. About 26% of clients utilized institutional-referral resources, such as workshops, financial aid office, classes, student counseling services, advisors, and community agencies. Many clients acquired information about financial counseling services from classes. Twenty-two percent of the student clients learned about financial counseling services from social-referrals including friends and family members, or student organizations. Referrals from friends and family members were the main source of social-referral for seeking financial counseling.

Table 2

Sources of Referral for Seeking Student Financial Counseling (N = 554)

Referral Category	Sources	Frequency	Total (Percent)
Self-Referral	Email Contact	187	288 (52%)
	Website or Online Search	91	
	Repeat Visit	6	
	Brochure	3	
	Campus Advertisements	1	
Institutional-Referral	Academic Course	89	144 (26%)
	Financial Aid Office	23	
	Workshop	20	
	Advisor	8	
	Student Counseling Service	2	
	Community Agency	2	
Social-Referral	Friend or Family	79	122 (22%)
	Student Organization	43	

What type of students respond to various sources of referral for financial counseling?

Table 3 presents the results of difference tests of individual characteristics on source of referral. It helps to address the question about what type of students respond to various sources of referral for financial counseling (RQ1). Demographic and financial differences

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among students may predispose them to become aware of financial counseling services via different sources of referral.

We used chi-square tests to assess whether dichotomous variables including gender, racial/ethnic minority status, marital status (i.e., being single), employment status, and having student loans, other debt, or investments increased the likelihood of accessing financial counseling via certain sources of referral. Among these factors, only gender was significantly linked to differences in sources of referral ($\chi^2 = 6.526$, $df = 2$, $p = .038$). Post-hoc tests revealed that the percentage of self-referred clients who were female (53.5%) was lower than the percentage of institutional-referral clients who were female (66.0%). It should be pointed out, however, that 58.3% of all clients were female. Thus, females are somewhat more likely to sign up for counseling via institutional-referrals versus being self-referred. Correspondingly, male clients are most likely to be self-referred and least likely to be institutionally-referred.

ANOVA tests were used to examine whether differences in the levels of our continuous variables (e.g., age, educational group, income, student loan amounts, other debt amounts, and investment amounts) predicted the type of referral source used by students for seeking help through financial counseling. For the financial measures, we did not include those having no income, debt, or investments in our significance tests. The only significant differences observed in the levels of any of these variables was for age group ($F = 3.923$, $df_b = 2$, $df_w = 551$, $p = .020$). The institutional-referral group was significantly younger ($p<.05$) on average ($M = 1.94$; coded 1 = *ages 18-21,* and 2 = *ages 22-25*) than either the self-referral group ($M = 2.14$) or the social-referral group ($M = 2.10$).

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Table 3

Difference Tests of Individual Characteristics on Source of Referral (N = 554)

Variables	Source of Referral	*Chi-Square Tests (χ^2)*			*ANOVA Tests*			
		Percent	χ^2 *(df)* *p*-value	Post-Hoc (*p*<.05)	Mean	*n*	*F* (df_b, df_w) *p*	Post-Hoc (*p*<.05)
Age	Self				2.14	288		> Inst.
(*group*)[a]	Institutional				1.94	144	3.923 (2, 551)	< Self, Social
	Social				2.10	122	.020	> Inst.
	Combined				2.08	554		
Gender	Self	53.5%		< Inst.				
(*percent female*)	Institutional	66.0%	6.526 (2)	> Self				
	Social	60.7%	.038					
	Combined	58.3%						
Race/Ethnicity	Self	78.8%		--				
(*percent White*)	Institutional	85.4%	3.206 (2)	--				
	Social	83.6%	.201	--				
	Combined	81.6%						
Marital Status	Self	77.8%		--				
(*percent single*)	Institutional	75.7%	0.274 (2)	--				
	Social	76.2%	.872	--				
	Combined	76.9%						
Education	Self				2.54	288		--
(*group*)[b]	Institutional				2.47	144	0.754 (2, 551)	--
	Social				2.61	122	.471	--
	Combined				2.54	554		
					Income Amount			
Employment Status	Self	73.6%		--	$1,089	165		--
(*percent employed*)	Institutional	71.5%	1.056 (2)	--	$942	77	1.980 (2, 308)	--
	Social	77.0%	.590	--	$1,300	69	.140	--
	Combined	73.8%			$1,100	311		
					Student Loan Amount			
Having Student	Self	85.8%		--	$34,644	226		--
Loans (*percent yes*)	Institutional	91.0%	3.062 (2)	--	$30,740	107	0.665 (2, 426)	--
	Social	84.4%	.216	--	$31,836	96	.520	--
	Combined	86.8%			$33,042	429		
					Other Debt Amount			
Having Other Debt	Self	52.8%		--	$4,652	152		--
(*percent yes*)	Institutional	57.6%	0.962 (2)	--	$5,991	83	1.001 (2, 297)	--
	Social	53.3%	.618	--	$4,992	65	.369	--
	Combined	54.2%			$5,096	300		
					Investment Amount			
Having Investments	Self	19.4%		--	$5,177	45		--
(*percent yes*)	Institutional	21.5%	0.486 (2)	--	$10,052	26	1.495 (2, 86)	--
	Social	22.1%	.784	--	$11,364	78	.230	--
	Combined	20.6%			$7,852	89		

Note. The chi-square tests are based on the full sample (self-referral = 288; institutional-referral = 144; social-referral = 122) whereas the dollar amounts in the ANOVA tests are only based on those being employed or having student loans, other debt, or investments; thus, the subgroup numbers vary in these tests.

[a]Age groups were as follows: 1 (*18-21*), 2 (*22-25*), 3 (*26-29*), 4 (*30 and older*). [b]Education groups were as follows: 1 (*High School*), 2 (*Some College*), 3 (*Bachelors*), 4 (*Masters*), 5 (*Doctorate*)

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Does the source of referral contribute to changes in financial stress at various stages of student financial counseling?

Two of our research questions (RQ2 and RQ3) pertained to changes in financial stress occurring at select time-points during the financial counseling process. These time-points included the time between making an appointment and the beginning of the counseling session, as well as the change before and after the counseling session. Before these questions could be addressed, however, it was important to establish that there was a change (i.e., decrease in financial stress). Figure 2 shows financial stress level by source of referral (e.g., self-, institutional-, and social-referral) for the three measures of financial stress reported at the time the appointment was made, the period just before counseling, and the point immediately following. The graph depicts declines in stress levels over time. It is also apparent from Figure 2 that there were much larger overall declines in financial stress levels corresponding to the counseling session (from the retrospective measure of stress at start of the counseling session to the end of the counseling session) compared with more minor declines in financial stress in the interim between making an appointment and starting a financial counseling session. Next, we conducted further statistical tests to examine which of these apparent differences were statistically meaningful, with a focus on comparisons between groups.

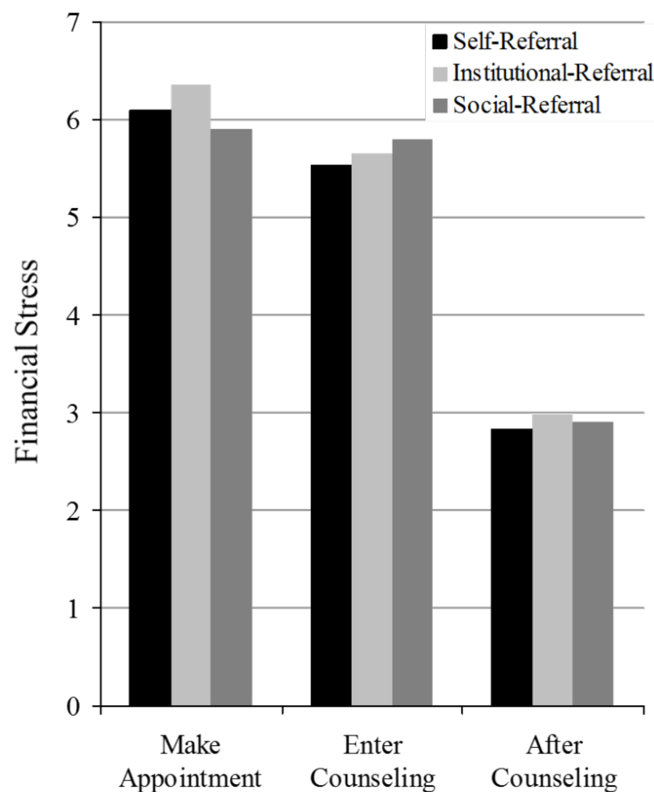

Figure 2. Decline of financial stress across the financial counseling process.

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Table 4 shows the statistical differences in mean changes in financial stress by referral group using a variety of comparisons (the raw means can be visualized in Figure 2). First, we used a series of *t*-tests (six comparisons in the center of the table) to examine whether there was a significant amount of interim change and session change within each of the three referral groups. The self-referral (Δ = -0.57, t = 4.895, p = .000) and institutional-referral (Δ = -0.70, t = 3.798, p = .000) groups experienced significant declines in financial stress during the interim period, but the social-referral group did not (Δ = -0.10, t = 0.482, p = -.631). All three referral groups experienced a significant decline (p<.001) in financial stress during the financial counseling session period. Second, in the bottom row of Table 4 are results of tests, which compared periods of change to examine if session-related declines in financial stress were greater than declines occurring in the interim period. In all three cases, there were greater session-related declines versus interim changes among all three groups. These session versus interim related changes were greatest for the social-referral group (Δ = -2.79, t = 9.064, p = .000), followed by the self-referral group (Δ = -2.14, t = 10.992, p = .000), and smallest for the institutional-referral group (Δ = -1.96, t = 6.189, p = .000). Finally, we compared across the referral groups to examine whether there were significant differences in the slopes between the groups for interim change and again for session change using ANOVA tests. The first test showed that there were significant differences in the slopes (i.e., rates) of interim change (F = 3.042, df_b = 2, df_w = 551, p = .049), and post-hoc tests (results not shown) revealed that decreases in financial stress in the interim period were significantly sharper for self-referral (Δ = -0.57) and institutional-referral (Δ = -0.70) than they were for the social referral group (Δ = -0.10). There were no significant differences between referral groups, however, in the slopes of change (F = 0.494, df_b = 2, df_w = 551, p = .610) (i.e., declines of financial stress) during the session period.

Table 4

Comparing Rates of Decline in Financial Stress in the Financial Counseling Process (N = 554)

Periods of Change	Self-Referral			Institutional-Referral			Social-Referral			Comparing Slopes of Change (F, df_b, df_w, p)
	Δ	t	p	Δ	t	p	Δ	t	p	
Interim Change	-0.57	4.895	.000	-0.70	3.798	.000	-0.10	0.482	.631	Self, Inst > Social (3.042, 2, 551, .049)
Session Change	-2.71	23.189	.000	-2.66	14.547	.000	-2.89	16.398	.000	No Differences (0.494, 2, 551, .610)
Comparing Periods of Change (Δ, t, p)	Interim < Session (-2.14, 10.992, .000)			Interim < Session (-1.96, 6.189, .000)			Interim < Session (-2.79, 9.064, .000)			

Note. Results from paired sample t-test results. Interim change is the period between making an appointment and entering counseling; session change is the period between entering counseling and after counseling.

From these findings, it appears that interim change was a discernable phenomenon, but that it was a less beneficial period of change than the session-related declines in financial stress. Furthermore, the social-referral group did not benefit from interim declines in financial stress to the extent that the other referral groups did. This suggests at least one important difference in the experience of declining financial stress across the financial

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counseling process for the social-referral group, with more uniform declines in financial stress for all others.

Do individual characteristics and sources of referral predict total declines in financial stress across the financial counseling process?

To address our final research question (RQ3), we used regressions with demographic variables and sources of referral to predict overall declines in financial stress (see Figure 1). There are several important points we emphasize regarding this research question. First, the dependent variable in the analysis represents aggregate group change in financial stress, which we refer to as declines, because of what happened for the majority of sample. We observed 90.4% of clients experienced "declines" in financial stress, but 6.3% of the sample experienced no change in financial stress, and 3.2% of the sample experienced increased financial stress across the financial counseling process. All of these students are modeled in the analyses and higher numbers represent greater declines. Second, because this analysis examines change scores, it does not take into consideration differences in financial stress that existed prior to contact with the financial counseling clinic. Finally, by having a sample of financial counseling clients, we have a single group before-and-after assessment of change, but no control group who did not experience financial counseling. Thus we cannot make a direct assessment of the effectiveness of counseling services—although non-significant factors in the model do help to rule out possibilities that could mask the effectiveness of financial counseling.

The results of the analysis are shown in Table 5. In the first model, we included only demographic variables as predictors. Only one factor predicted overall declines in financial stress. Having investments was associated with less decline in financial stress across the total financial counseling process, i.e. interim plus session declines, (B = -.750, SE = .243, β = -.133, p = .002).

In model 2, we added sources of referral as predictors of change in total financial stress with the demographic predictors. Sources of referral, however, were not significant predictors and contributed virtually nothing to altering the impact that having investments had on predicting changes in financial stress (B = -.748, SE = .243, β = -.133, p = .002). With some factors in the regressions, multicollinearity was a potential concern. In particular, including age and education in the model were assessed for multicollinearity, but these variables were only modestly correlated, r = .334, and collinearity diagnostics indicated no problems (i.e., variance inflation factors ranged from 1.037 to 1.638).

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Table 5

Factors Related to Total Declines in Financial Stress across the Student Financial Counseling Process (N = 554)

Variables	Model 1 Individual Factors				Model 2 Individual Factors and Sources of Referral			
	B	**SE**	***β***	***p***	**B**	**SE**	***β***	***p***
Intercept	2.662	.590	--	.000	2.425	.620	--	.000
Individual Characteristics								
Age	.129	.154	.039	.403	.136	.155	.039	.381
Gender (*female)*	.217	.201	.047	.280	.217	.202	.047	.283
Race/Ethnicity (*minority*)	.242	.252	.041	.336	.238	.253	.041	.346
Marital Status (*single*)	.079	.239	.015	.742	.081	.239	.015	.734
Education	-.007	.117	-.003	.955	-.003	.118	-.001	.977
Employment Status (*employed)*	-.209	.224	-.040	.351	-.197	.224	-.038	.379
Having Student Loans (*yes*)	.298	.199	.057	.189	.281	.293	.042	.338
Having Other Debt (*yes*)	.262	.199	.057	.189	.257	.200	.056	.198
Having Investments (*yes*)	-.750	.243	-.133	.002	-.748	.243	-.133	.002
Sources of Referral								
Self-Referral					.257	.246	.056	.295
Institutional-Referral					.338	.281	.065	.229
Social-Referral (*omitted*)					--	--	--	--
	R^2=.031				R^2=.034			
	F=1.965, p=.041				F=1.753, p=.059			

Discussion

This study examined the relationship among specific sources of referrals to counseling to perceived financial stress in the context of a university financial counseling center. Results identify individual and financial characteristics of college students associated with an approach to and preference in seeking help with finances. Differences between sources of referral, with declines in financial stress across the financial counseling process were identified.

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We found that college students come to counseling most often through self-referral, indicating self-reliance and self-efficacy as an important factor, similar to other studies that directly measure self-efficacy and mastery (Britt et al., 2015; Letkiewicz et al., 2015; Lim et al., 2014). In our study, a greater proportion of students were self-motivated to seek help, in particular, websites and emails were effective strategies to link students with financial counseling. One in four students in our study relied on institutional-referral sources, demonstrating the importance of cross-marketing and collaborative efforts among campus student support offices. Furthermore, initial stress levels in the institutional-referral group were greater and it may be that they were triaged from other student counseling services. Word-of-mouth in the form of social-referral was also effective, with referral in classes and from friends and family accounting for a significant portion of clients served in the university counseling center.

There are two clearly discernable periods of decline in financial stress within the financial counseling process, smaller interim declines occurring after requesting appointments and larger declines that occur in counseling sessions. The interim declines, however, were only operative for those who were self-referred or institutionally-referred and not for those who entered on a social-referral. A possible explanation is that social-referrals have already had "someone to talk to," whereas other referrals may begin to feel a psychological burden lifted once they make an appointment.

Similar to other studies of financial behaviors, the current analyses uncovered gender differences. As compared to female students, male clients in this study were less likely to use social-referral sources when coping with financial stress. This finding is in line with previous research in the general help-seeking literatures (Ang, Lim, Tan, & Yau, 2004; Leong & Zachar, 1999; Vogel & Wester, 2003) and the financial help-seeking literature (Grable & Joo, 2003). In contrast, female clients were more likely to use social and institutional sources when dealing with financial stress.

Younger clients tended to use institutional-referrals, whereas older student clients relied more on self-referral sources to seek help with their financial stress. This finding suggests that younger students are still impressionable to the influences of university personnel. These findings have important implications for the outreach plans of college student financial services and campus-based counseling services, namely getting the word out to women is relatively more effective through friends and family or classes, whereas men are more likely to explore options on their own. When trying to reach freshmen and sophomore students, classes and workshops appear more effective than with older students.

Overall, a decrease in financial stress occurred across the financial counseling process, regardless of how the students came to discover the campus-based counseling service. The one individual difference that impacted overall change in financial stress was having investments, and this was negatively related to declines. This means that having investments actually dampened reductions in financial stress across the financial counseling process. Clearly, having investments is a positive financial factor, and it is likely that lower initial levels of financial stress explain this finding (i.e., "regression to the mean") was

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occurring. There were no significant differences between the three sources of referral across changes in levels of perceived financial stress. The findings suggest that the financial counseling process had a significant effect on reducing financial stress, supporting the value in the financial counseling services provided to students, regardless of the path taken to the services.

Implications for Financial Counselors and Therapists

Even though financial counseling appears effective when found through all three paths, financial counselors and educators should consider the source of referral as part of the financial counseling process. Both university-based financial counselors and community financial educators can apply the current findings in their marketing and educational efforts. Source of referral notwithstanding, the evidence in this study suggests the positive impact that a university-affiliated financial counseling service can have on the quality of life and well-being for students, adding further support for university administrators who are considering adding financial counseling as a student support service or program. The current study also speaks to the importance of cross-campus collaboration in promoting financial counseling, with the importance of efforts being coordinated through multiple referral sources such as financial aid, student life, health and wellness, and student services.

The model in the study did not include individual and financial characteristics that were particularly meaningful as predictors of reduced financial stress after financial counseling, highlighting a limitation of the current study. Factors that drive a student to seek help were not included in the current study, such as self-reflection, degree of financial independence, future employment prospects, future social ties (e.g., marriage prospects), financial knowledge, and measures of efficacy and mastery (Britt et al., 2011; Durband & Britt, 2012). Further, based on limited amount of variance accounted for in our regression models, it is evident that future studies need to include other meaningful predictors of financial stress in campus-based financial counseling. Control variables, such as other campus supports, the availability and utilization of financial education courses, mental health counseling, debt counseling provided by offices of financial aid, and other student support services, would be important to include. The data from the current study is from a public university; future studies might yield differences in private universities.

The findings of this study identified a decrease in financial stress occurred across the financial counseling process. It is possible that the behavior of making an appointment for financial counseling decreased the financial stress level in anticipation that some support or possible solution was forthcoming. This suggests that more research is needed to examine whether there is behavior change happening within the help-seeking process itself.

The current study highlights the value of examining the sources of referral that students use when seeking help to reduce stress caused from financial issues. The analysis presented highlights differences in gender and age as being related to referral sources and these are easy characteristics to identify for marketing purposes. Regardless of source of referral, the use of financial counseling services reduced stress levels among college students

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and university administrators and policy makers considering such a service should note the effectiveness of campus-based financial counseling.

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Practitioner Profile

An Interview with Syble Solomon

Syble Solomon is a speaker on the psychology of money and the founder and president of LifeWise Strategies. She is best known for Money Habitudes® a deck of cards (and now an online version) that makes it easy to talk about money and discover what motivates our financial behaviors. Before becoming interested in why people manage money as they do, she had careers in early childhood special education, gerontology and executive coaching. Seemingly unrelated, they all provided experience training, developing educational material and empowering people at all socio-economic levels to work through challenging times and transitions. An excellent background for helping people work through money-related issues!

She has been an adjunct faculty member at SCSU, UNR, and UNCG where she was honored with an award by the Association of Higher Education in Gerontology for developing the course "Planning for the Third Age." Her work with the psychology of money has been recognized with awards such as the North Carolina Jump $tart Outstanding Contributor to the Financial Education of Youth, The Smart Marriages Impact Award and The Institute for Financial Literacy Excellence in Financial Literacy Education (EIFLE) Award. Money Habitudes was a Washington Post book of the month selection by financial columnist Michelle Singletary. The cards have been endorsed by The Institute of Socio-Financial Studies and the Institute of Consumer Financial Education. Syble has served on the Board of the Association of Financial Counseling and Planning Education and was also honored to receive their Educator of the Year Award. She has been quoted in USA Today, Bankrate.com, MSN Money and other national publications.

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Q. Define what you do professionally.

A. I wear three hats.

- As the founder and president of LifeWise Strategies, I speak on the psychology of money and facilitate training using our materials (Money Habitudes and The Good Credit Game). I have been an invited speaker at universities for staff development events and student financial aid events as well being the keynote speaker for very diverse audiences. They have including couples' events, independent financial planners' conferences, the NFL, women's conferences, faith-based conferences and the asset building community conferences. Those speaking engagements have taken me throughout the US and from Aruba to Australia as well as many places in Europe.
- Wearing my creative hat, I develop game-like, educational materials and guides that make learning and teaching about money fun, easy, engaging and effective. Besides *Money Habitudes*®, I co-created *The Good Credit Game*™ with my colleague, Lee Gimpel. The six hands-on activities quickly teach participants how to use credit responsibly. It was developed in response to how often credit card debt came up as an issue and how difficult (and often boring) it was to teach. Our goal was to make it fun to learn about credit scores and the myths, marketing, and misunderstandings that typically lead to debt. I also co-authored *Bringing Money into the Conversation: a quick start for therapists* with Amanda Mills to provide therapists with ways to initiate and become comfortable with money conversations. All of my materials and writing intend to help people help themselves so they can become comfortable with money, talk about money more easily and take control of their money and their life. The cards grew into a business that now also has versions for teens and young adults plus guides and a new online version. The Dibble Institute partnered with me to develop the teen curriculum for high school age students and a guide for working with at-risk youth.
- As an executive coach since 1995, I continue to work with clients attending leadership programs at the Center for Creative Leadership, The National Leadership Institute (UMD) and NEW, a women's executive training program. My coaching clients include high potential managers to executive leaders in corporations, government and the military attending leadership programs. In this role I facilitate small groups, interpret 360 feedback and assessments and provide on-going coaching.

Q. What activities encompass your professional responsibilities?

A. My professional responsibilities include:

- Building relationships with our customers and my coaching clients.
- Speaking and training.
- Developing and updating materials.
- Coaching individual clients.
- Business and administrative responsibilities from financial oversight and marketing to working with contractors, vendors, technology consultants, etc.

Q. How long have you been engaged in your professional activity?

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A. My focus on the psychology of money became official when I introduced Money Habitudes in 2003. I have been an executive coach since 1995 and have developed and provided a wide range of educational training and training materials since the late sixties.

Q. How are you compensated?

A.

- By clients who personally pay for one session of financial coaching to determine a client's real issue(s) and what professional(s) would be the best to serve that individual's immediate and long-term needs. That could be a financial planner, a financial educator/counselor, a lawyer, social worker, counselor, coach, therapist, or a specific support group.
- As a keynote speaker at conferences and events and to provide train-the-trainer workshops for professionals.
- Sales of Money Habitudes® and The Good Credit Game™.
- By organizations who contract for executive coaching services for their clients.

Q. Do you work alone or do you have a team? Please explain.

A. I have a team of four part-time contract people and I hire multiple vendors and professionals for other services as needed (IT, graphic design, etc.).

Q. What needs to happen so that 10 years from now we can say that financial therapy is a respected field of study?

A. This is still a developing concept for me. Financial advising requires staying on top of changing regulations, legal and tax issues, and consumer rights. Therapists may be working with clients who have profound psychological challenges. Combining the necessary depth of knowledge and skills for both fields into one profession seems daunting. I'm more likely to be looking for a therapist or counselor who has an additional certification in financial education or a financial professional who has an additional certification in counseling/coaching. In each case, I would expect that person to be able to cover the basics of financial education, ask good questions, listen effectively, and know when to refer to another professional who has the additional expertise needed for more complex situations.

Q. What benefits can the Financial Therapy Association provide to others doing work that is similar to your professional activities?

A. Thanks for what you are already doing to help us network and grow professionally! I'm always asked for resources when I speak and would appreciate a list of professionals that have met a standard for professionalism that FTA has established through a certification process and a list of resources others value. Continue to encourage people to develop resources and help them share them through FTA channels. Implement an educational awareness campaign to educate the public about what to look for in professionals who claim they are financial therapists/counselors.

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Q. If others are interested in finding out more about you personally and professionally, where can they obtain this information?

A. Visit my website at www.moneyhabitudes.com or contact me at 406-361-8012 or syble@lifewise.us.

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Researcher Profile

An Interview with
Jorge Ruiz-Menjivar, Ph.D.

Jorge Ruiz-Menjivar is originally from San Salvador, El Salvador, but has had the privilege to live in several Latin American countries (e.g., Nicaragua, Costa Rica, among others), and to travel through many other regions in the world. He obtained a Bachelor's degree in Accounting at the University of New Orleans-Louisiana State University. Then, he went on to earn a Master's degree in Personal and Family Financial Planning at the University of Florida under the supervision of Drs. Michael S. Gutter and Martie Gillen. Recently, Jorge finished his Doctoral degree in Financial Planning, Housing and Consumer Economics from the University of Georgia under the supervision of Drs. John E. Grable and George Engelhard, Jr.

Q. Define what you do professionally.

A. I am an assistant professor of Family and Consumer Economics at the University of Florida.

Q. What activities encompass your professional responsibilities?

A. As part of a land grant university, my job has three main components: research, teaching and outreach (extension). Research-wise, my current research focuses on financial risk tolerance and other financial constructs and their measurement using modern psychometric theory (e.g., Rasch Measurement Theory and Item Response Theory), along with cross-cultural and transnational applications for the same. My other projects include research efforts on financial well-being and financial education with researchers in Latin America and Asia. In terms of classes, I teach courses in financial counseling and quantitative research methods for social sciences. And finally, I am a state specialist in family financial management.

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Currently, we are working on projects and initiatives that deal with financial literacy, youth financial education, money management, alongside other projects. Ultimately, our goal is to help Floridians improve their financial well-being.

Q. How long have you been engaged in your professional activity?

A. I started my appointment with the University of Florida in May 2016. Prior to that, I served as faculty for the University of Georgia-Costa Rica campus for 3 years.

Q. How are you compensated?

A. I am provided a salary for my work as a faculty member.

Q. Do you work alone or do you have a team? Please explain.

A. I work with teams at both the University of Georgia (what we like to call the "Risk Team," which includes Dr. John Grable, as well as other faculty and graduate students), and the University of Florida. In addition, I am currently collaborating with researchers in Latin America, Turkey, and Asia.

Q. What theoretical framework guides your work when dealing with clients and/or conducting research?

A. My current research focuses on the application of modern psychometric to the development of scale of financial planning constructs. In particular, I utilize Item Response Theory (IRT) and Rasch Measurement Theory to analyze and improve scales used in research and in the financial planning arena.

Q. What needs to happen so that 10 years from now we can say that financial therapy is a respected field of study?

A. This is an innovative crossroad field of study that combines two important practical aspects for households and individuals: therapy and finance. I believe novel methodologies that allow for the exploration and simulation of human behaviors (rational and irrational) in a more pragmatic manner would be groundbreaking. Additionally, I think more experimental studies with actual intervention could lend further insight into our understanding of financial behaviors.

Q. If others are interested in finding out more about you personally and professionally, where can they obtain this information?

A. Feel free to contact me at jhruiz@ufl.edu or visit my faculty webpage at http://fycs.ifas.ufl.edu/faculty/jorge-ruiz-menjivar/

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Book Review

What It's Worth: Strengthening the Financial Future of Families, Communities and the Nation

Cherie Stueve, MBA
Kansas State University

Federal Reserve Bank of San Francisco & Corporation for Enterprise Development (2016). *What it's worth: Strengthening the financial future of families, communities and the nation.* 393 pp., $0.00, ISBN: 978-0-692-53170-9.

In early 2016, the Federal Reserve Bank of San Francisco and Corporation for Enterprise Development (CFED) compiled 35 essays on financial well-being written by experts and advocates in government, nonprofit, and academic sectors. The free book is available in paperback (multiple unit orders available), iBook, Kindle, ePub, and .pdf. A nice feature in the digital formats is hyperlinks to referenced essays for easy movement if the reader wants to read a more developed article on a mentioned topic.

Although many will point to the Great Recession as the tipping point in declining financial health of Americans, the problems of income and asset inequality started decades ago. Financial inequality can be linked to uncontrollable factors that strongly influence the potential for upward mobility; age cohort, race, ethnicity, gender, and family background. A family's financial capacity influences early childhood experiences, mental and physical health, educational opportunities, employment, and housing and neighborhood options. How can a young adult emerge from these conditions and be financially healthy?

Current financial wellness programs have moved from a classroom delivery model of objective financial information to an interactive model of coordinated delivery of relevant financial information with partner social service agencies. Descriptions of financial capacity programs ranged from basic elements only, to details on past experiences and research influences on program content and execution. Technology advances are incorporated in some programs, like financial literacy games. But overwhelming support is voiced for creating a trusting relationship through one-on-one financial coaching. Access to a physical

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person at a financial institution is shrinking, but that face-to-face interaction is important for the unbanked and underbanked to be served and matched to optimal products and services.

Empirical data has revealed common characteristics of successful programs. Creating a future-oriented perspective helps motivate savings and career development investments. Starting with an attitude that everyone has possesses positive attributes removes the bias associated with culture or socioeconomic levels. One-on-one financial coaching in a trusted advising relationship builds financial confidence and the ability to make future financial decisions. Multi-generational strategies address both the basic needs of children and parents' ability to provide a stable home life. The use of incentive savings accounts for post-secondary education expenses, future home purchases, and retirement income may require significant public and private funding, but even the smallest investment of $50 or $100 can create lifelong economic benefits.

Current tax policies that benefit already well-served and economically strong populations are examined for changes that can contribute to financial wellness without any increase in total taxation. Financially responsible behaviors of paying rent on time and participating in cultural lending circles need to be part of credit reporting systems to improve credit scores and recognize credit-worthy individuals.

The book's overview of financial challenges of vulnerable Americans and creative programs that look beyond income as a metric of financial health is divided into four sections. The first section, "Where We Are," describes the current financial statistics of households by demographic and economic era. The second (and largest) section, "Why Financial Well-Being Matters for All," is broken into four topics: the economy, financial services system, and community; employment and business; health and social services; and education. Each illustrates the strong role financial well-being plays in other systems at the individual and community level.

The third section, "Who is Being Affected," focuses on the uncontrollable demographic factors of age, race and ethnicity, and gender that impact access to economic opportunities. Specific programs that hinder or assist the African American, Latino, Native American, Asian American, and Pacific Islander communities demonstrate the need for greater cultural understanding in the creation of programs and financial products. In addition, researchers are challenged to better measure financially fragile ethnic groups instead of presenting national aggregate ethnic data that hides the struggles of many people.

The fourth section, "What To Do Next," starts with a summary of the first three sections and the remaining essays in the fourth section. The success of understanding and increasing financial well-being is a function of increased collaboration in all sectors. Advocacy for building financial capacity will increase as all society members learn more about the interrelationship of financial health and everyone's economic future.

In conclusion, this book serves as a brief historical summary of key financial challenge factors, descriptions of current dynamic programs improving financial health, and

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recommendations for future programs and policies to support building financial capacity. Practitioners and financial-oriented community programs will find detailed examples of holistic approaches at organization, city, and state levels. Social advocates and businesses will see how double bottom line partnerships can be a profitable win-win for ethically serving the underserved. Academics and researchers will embrace the emphasis on empirical measurements of programs' success and may answer the call for improved metrics for understanding long-term outcomes in future research studies.

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