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# Clinicians' Reports of the Impact of the 2008 Financial Crisis on Mental Health Clients

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This study investigated the impact of the 2008 economic crisis on mental health clients. One hundred and three mental health providers (101 being psychologists) from California, Colorado, and Arizona completed an online survey. Following Lazarus' stress theory, social identity theory, and the finances-shame model, several moderator variables were evaluated for impact of financial crisis: gender, age group, previous mental health, lifestyle threat, and sources for support. As predicted, male and female clients were generally described as equally stressed, but stress responses differed. Financial role responsibilities and previous mental health were noted as predictors of stress. Men—as well as clients earning a "moderate" income (i.e., $50–100,000 annually) and who faced greater instability in social identity/status—described finance shame. Implications for further research, clinical competence, and public health are discussed.

**Keywords:** *clients, clinicians, finance shame, financial recession, gender, mental health, mixed methods social identity, stress*

## Introduction

Economic crises, whether at an individual or global level, can have far-reaching social and personal impact (Catalano & Dooley, 1977; Davis & Mantler, 2004; World Health Organization, 2007). Indeed, the 2008 Stress in America Survey by the American Psychological Association (2008) documented the immediate impact the first few months of the recession beginning January 2008 had on the mental health of the general population ("Economic Report of the President," 2010)—fully 80% of the American respondents noted the economy as a significant cause of stress, up from 66% only 6 months earlier. Gender differences were also noted: "More women are feeling additional pressure as a result of the recent economic crisis and are reporting that financial considerations are more often significant sources of stress" (American Psychological Association, 2008, p. 8).

Several factors are known to affect an individual's experience of financial well-being. These include objective resources, such as liquidity, savings, asset allocation, inflation protection, tax burden, housing expenses, and insolvency/credit (Greninger, Hampton, Kitt, & Achacoso, 1996), as well as knowledge and skills for managing such resources (Sherraden, 2010). In addition, social, emotional, and psychological factors play critical roles in determining the experience of and responses to financial stress (e.g., Ervasti & Venetoklis, 2010; Lincoln, 2007); however, there is no known study to date of the impact of financial stressors on individuals who may be most at risk emotionally: clients receiving mental health services.

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## Coping With Financial Stress

In the general population, those with limited financial resources often are considered the most vulnerable to financial stress. Frequently, individuals with limited financial resources are living on the edge financially and are typically found among the underemployed or those in low-income jobs, the undereducated, and/or minorities—groups that often lack accessibility to resources and/or financial capability for planning for and managing financial security (Hoynes, Page, & Stevens, 2006; Sherraden, 2010). In addition, financial resources and/or financial capability may be affected by a host of factors, such as medical and mental health problems, addiction, citizenship status, criminal record status, single parenthood and other caretaker obligations, or gender (Center for Immigration Studies, 2012; Floro & Dymski, 1990; Freid, Bernstein, & Bush, 2012; Heflin & Iceland, 2010; She & Livermore, 2009; Lynch et al., 2004; Stoll & Bushway, 2007). Financial crises also affect children, both physically (e.g., risks of malnutrition) and emotionally, often in concert with the coping responses of their parents/caretakers (Davis & Mantler, 2004; McLoyd, 1990; Mistry, Lowe, Benner, & Chien, 2008).

*Financial strain* refers to distress that results from subjective evaluations of financial challenges (e.g., Ervasti & Venetoklis, 2010; Lincoln, 2007). Financial strain and coping during financial hardship may be understood through Lazarus and Folkman's (1987) transactional theory of stress: cognitive appraisals moderate the emotional impact of situational stressors; elements of cognitive processing may include values, attitudes, commitments, goals, expectancies, beliefs, attributions, social identity and self-schemas, and behavioral scripts for coping that are developed through experience (e.g., Folkman & Lazarus, 1998; Lazarus, 1999, 2006; Skinner & Brewer, 2001). For example, decades of research support cognitive factors, such as expectations of self-efficacy, self-esteem, and motivation (e.g., employment commitment during financial need); perception of social support; and locus of control and optimism expectancies as predictors of job seeking behaviors (Kanfer, Wanberg, & Kantrowitz, 2001; van Hooft & Crossley, 2008) and/or stress during unemployment (Davis & Mantler, 2004; Wiener, Oei, & Creed, 1999).

## Social Identity and Financial Stress

In addition to the threat of unemployment and diminished income, other risks of the recent financial crisis have included loss of liquidity, savings, and assets through investments, including the risk of losing the ability to meet mortgage or rent payments, and even foreclosure on mortgages (Kingsley, Smith, & Price, 2009). Along with financial status, individuals' lifestyles and social identities have been threatened (Belk, 1988; McLoyd, 1990). The psychosocial meaning of financial status can be understood through Tajfel and Turner's (1986) social identity theory, as well as the more recent finances-shame model (Rantakeisu, Starrin, & Hagquist, 1999; Starrin, Aslund, & Nilsson, 2009) and Gilbert's (1998) discussion on internal and external shame. Each of these approaches emphasizes how one's sense of identity and worth is intricately tied to group identity, culture, and the attendant meanings of the social roles and social status one occupies. Social identity is group-dependent in that identification with social roles also involves expectations one internalizes and assumes are shared with others. Indeed, possessions and consumption behaviors become extensions of self (Belk, 1988; Belk, Sherry, & Wallendorf, 1989), are associated with life satisfaction (Johnson & Krueger, 2006), and are additional indicators of social roles and social status (Jost, Banaji, & Nosek, 2004; Richins, 1994).

Applying social identity theory, one might expect the negative impact of financial hardship to differently affect those whose membership in a particular valued social group depends on obtaining and maintaining stable financial assets. Psychologically, individuals with histories of successful

outcomes develop enhanced beliefs and expectations for continued success, that is, self-efficacy, in similar situations (Bandura, 1997). More specifically, financial self-efficacy involves personal beliefs and expectations regarding one's talents, choices, and strategies for control over financial situations (Caplan & Schooler, 2007; Danes & Haberman, 2007; Dietz, Carrozza, & Ritchey, 2003). When circumstances thwart the effectiveness of one's skills and efforts, however, there is the risk that those who expect such personal efficacy become particularly vulnerable to internalized shame and guilt (Gilbert, 1998), emotional distress, and decreased motivation (Bandura, 1997; Lazarus, 1999). Those with the additional threat to their social identity and status may have more difficulty reaching reappraisal and acceptance, while turning to avoidance and self-blame (Folkman & Lazarus, 1998). Turner (1995) discussed greater damage to self for victims of job loss who also have higher social and occupational status. A 2009 study by the University of Pennsylvania School of Medicine found that 37% of homeowners confronted with foreclosure reported symptoms of major depression, higher than the 12.8% usually noted among people living in poverty ("More Than One Third," 2009). Further, one may expect that those who are already more psychologically and emotionally vulnerable may also experience even greater impact of these assaults on status, identity, and self-efficacy.

One's social identity, self-categorization, and related group norms can also increase the risk of stigma during financial crises. Kelvin and Jarrett (1985) found that when individuals function in groups in which financial loss is the norm among other members of that group, they are less stigmatized than when they function in groups in which financial loss is less commonplace among their peers. As Hogg and Reid (2006) noted, "in high-salience groups, low-prototypical in-group members are marginalized and evaluatively downgraded—they are often treated more negatively (as 'black sheep') than out-group members holding a similar position" (p. 21). Thus, individuals in groups with histories of relative financial success and security may have fewer formal and informal social supports (such as in the family or community)—and may be less likely to seek support due to fear and shame—during financial crises than those in social groups comprised of others who experience financial vulnerability (Falconier & Epstein, 2011).

In summary, the theoretical and research literature suggests that personal factors interact with environmental pressures to influence one's coping and well-being in the face of financial crises (e.g., Davis & Mantler, 2004). We do not, however, have any data to date on the impact of financial crises on individuals who are already known to be at additional risk to stress: clients receiving mental health services. For example, the same cognitive-emotional risks described for financial strain are also known to be common among those receiving mental health services for depression, anxiety, substance abuse, and other diagnoses (e.g., Gotlib & Joorman, 2010; MacLeod & Mathews, 2012; Substance Abuse and Mental Health Services Administration, 1999).

The purpose of this study is to clarify the types of challenges that impact clients during financial crises. Although limited discussion may be found on the possible impact on financial stressors on couples in counseling (Falconier & Epstein, 2011), mental health providers need more information to help them understand specific risks, and to support resilience, among their clients facing fiscal crises (e.g., Javors, 2010).

The design of this study allows for direct comparison of clinicians' observations of their clients' functioning—both in the months prior to and following January 2008, the onset of the recession of 2008–2009 in the United States. This recession was generally characterized by increased unemployment, underemployment, loss or reduction of income, threats to housing (e.g., foreclosure and difficulty getting mortgage loans), and/or loss or reduction of investment funds ("Economic Report of the President," 2010). Following theory and research reviewed here, several hypotheses are tested regarding variables that may serve as moderators (Baron & Kenny, 1986) of the impact of

financial stressors on psychosocial well-being among clients receiving services from mental health professionals.

**H1:** Level of mental distress prior to the increase in financial stressors will moderate the impact of the financial stressors on mental health status following the increase in financial stressors.

**H2:** Females will respond to increased financial stress with more anxiety and worry than will males (APA, 2008), but males will respond with more self-blame, guilt, and depression than will females.

**H3:** Children and adolescents will be impacted in ways that mirror their parents/caretakers' responses (McLoyd, 1990; Mistry et al., 2008).

**H4:** The relationship between financial loss and psychological health will be moderated by perceptions of threat to social status and by related experiences of financial shame (Starrin et al., 2009). Clients facing financial loss who belong to groups where membership depends on financial stability and related lifestyle will experience greater perceptions of threat to social status, greater shame, and more negative impact on their psychological health than those who face financial loss but belong to groups where financial loss is more commonly experienced by others in the social group. Relatedly, both availability of and willingness to seek support will be moderated by social identity: clients in social groups where financial instability is less common will find fewer sources of support (Hogg & Reid, 2006) and will be less willing to reach out for support than those in groups where financial instability is more normative (Kelvin & Jarrett, 1985).

## Method

This study employed a cross-sectional design that included both closed-ended and open-ended questions to gather information on clinicians' perceptions of the impact of the onset of the 2008 recession on their clients.

### Participants

A total of 103 clinicians (98% of whom were licensed psychologists) from Colorado, California, and Arizona participated in this study. These states were selected as they showed high financial distress, both in foreclosure rates and unemployment during 2007–2008 (www.realtytrac.com/trendcenter for 2007–2008; Southern Regional Education Board, 2012). Clinicians were intended as the informants (Barker, Pistrang, & Elliot, 2002) for several reasons: (a) due to their professional relationship, clinicians would have specific and detailed information about the client's stressors and coping responses across a period of time; (b) their professional training and experience would allow them to assess and report client status using familiar diagnostic and descriptive conventions; and (c) clinicians can track changes in intake characteristics of new clients (e.g., reports of current stressors) across time.

### Target Information

The author developed an online survey that presented both closed- and open-ended questions. Length, readability, face and content validity, presentation format, and ease of use of the online site

(Netemeyer, Bearden, & Sharma, 2003) were reviewed and evaluated by the author and a psychology graduate student (LH). After review, some errors in typing were corrected and formatting of the survey webpages was improved for readability.

### *Clinician and Client Demographics*

Demographic items were adapted from the National Counselor Questionnaire, which was used to survey professional counselors regarding their practices and characteristics of their clients (Smith, Sexton, & Bradley, 2005). Respondents were asked to report their "field(s) of practice (e.g., psychology, social work, PC, etc.)," percent of caseload seen in private practice (solo or group) and/or in an agency/hospital, percent of payments received from "private insurance-based clientele (including Medicare)" and/or from "Medicaid/publicly funded clientele," percent of clients offered a sliding payment scale, percent of clients seen during the previous 6 months who fall into eight categories for annual income ($0–$25,000, $25,001–$50,000, $50,001–$75,000, $75,001–$100,000, $100,001–$150,000, $150,001–$200,000, $200,001–$300,000, $300,001 or more, and "Don't know" was added as an option), approximate number of clients seen per week, the zip code(s) where they practice with the percent of the total caseload in each zip code, and finally, the "special focus of your services (e.g., CD, children, general, adults, etc.)."

### *Stressors Reported by Clients*

The list that is universally used by clinicians for diagnosing on Axis IV: Psychosocial and Environmental Stressors of the DSM-IV-TR Multiaxial System (American Psychiatric Association, 2000) was administered as part of the survey: problems with primary support group, social environment, education, occupation, housing, economic, healthcare, legal, other. Clinicians were asked to describe the relative frequency of each of the nine stressors as the key reasons for clients seeking services during two periods of time: for part one, "Considering all the clients that you were seeing during the year prior to January 2008, please indicate the relative frequency of each of the following stressors as related to their key reasons for seeking services," and for part two, "Considering all the clients that you have seen during 2008, please indicate the relative frequency of each of the following stressors as related to their key reasons for seeking services." The response scale was 1 = *Never/none*, 2 =*Very infrequent/few*, 3 = *Moderately frequent/50–50*, 4 = *Very frequent/many*, or 5 =*Always/all*.

### *Client Stress Specific to Housing Instability*

Instability in housing is an indicator of instability in income, employment, and other financial resources and a correlate of social status (Belk, 1988; Richins, 1994). For some, housing instability has been the risk of not meeting mortgage or rental payments; for others, instability involves experiencing some stage of the foreclosure process (Kingsley et al., 2009). Clinicians were asked, "During the past 6 months, how many of your clients have been experiencing each of the following?" The list included various types of housing instability (see Table 1). A similar 5-point response scale was used (1 = *None*, 2 = *A few*, 3 = *Some*, 4 = *Many*, 5 = *All*) and an option was included for "I have not seen clients during this time."

**Table 1:** *Changes in Primary Stressors After January 2008*

| Stressor | Pre-January 2008 Mean (*SD*)[1] | Post-January 2008 Mean (*SD*)[1] | *t*-value[2] | Probability | $r^2$ |
|---|---|---|---|---|---|
| Economic | 2.6 (.78) | 3.17 (.93) | 5.76 | $p < .000$ | .25 |
| Housing | 1.85 (.79) | 2.26 (.91) | 5.66 | $p < .000$ | .24 |
| Healthcare | 2.21 (.91) | 2.51 (.97) | 4.06 | $p < .000$ | .14 |
| Occupation | 2.77 (.78) | 3.03 (.86) | 3.88 | $p < .000$ | .13 |
| Primary support | 3.48 (.81) | 3.60 (.76) | 2.24 | $p < .05$ | .05 |
| Social environment | 3.07 (.88) | 3.15 (.81) | 1.72 | *n.s.* | |
| Education | 2.31 (.85) | 2.34 (.89) | .54 | *n.s.* | |
| Legal | 2.17 (.87) | 2.20 (.86) | .69 | *n.s.* | |
| Other | 2.68 (.95) | 2.76 (.99) | 1.27 | *n.s.* | |

*Note:* [1] Ratings: 1 = *Never/none*, 2 = *Very infrequent/few*, 3 = *Moderately frequent/50–50*, 4 = *Very frequent/many*, or 5 = *Always/all*; [2] $df = 102$, dependent samples *t*-test. *SD* = standard deviation.

### *Symptoms Related to Financial Stressors*

Using the same response scale, clinicians were then asked, "Of those who have presented with the financial issues mentioned in the previous questions, how many have presented with the following symptoms as a result of (or magnified by) these financial stressors?" Respondents were also cautioned, "If the symptoms are present, but you do not feel that they have been affected by financial stressors, do not count these." The list of symptoms they were presented to rate (see Figure 1) included those that have been reported elsewhere to be associated with financial crises (e.g., Catalano & Dooley, 1977; Catalano, Dooley, Wilson, & Hough, 1993; World Health Organization, 2007) and/or among clinical clients.

### *Open-Ended Questions*

In order to evaluate variables specified in the hypotheses for the study, clinicians were asked to describe ways that various demographic and environmental support characteristics were related to the impact of financial stress on their clients (e.g., Davis & Mantler, 2004). The list included gender, age (young children, adolescents), income/lifestyle prior to financial problems, mental health prior to financial problems, and support systems (family, community). Clinicians were instructed not to answer questions for which they did not have sufficient knowledge through their experiences with their actual clients.

## Procedures

Following certification by the campus institutional review board, requests to participate were emailed between November 2008 and February 2009 to a purposeful sample of 600 licensed psychologists from zip codes in Colorado, California, and Arizona. As I was limited to those with readily available email addresses, not all psychologists in the zip codes of interest were considered for the recruitment pool. The initial plan was to recruit 500, with an anticipated minimum response rate of 20% (based on previous literature response rates [Sheehan, 2001]). An additional 100 psychologists were solicited in January and February 2009 to meet minimum sample goals. Prospective participants received the initial email informing them of the purpose of the study, requirements, assurance of anonymity, other informed consent information and were provided with a link to the online survey. When the respondent went to the survey website, the initial section provided a detailed description of the study and all information required for informed consent. Electing to complete the online survey constituted informed consent. Email requests were sent

between November 2008 and February 2009. Follow-up requests were sent two times (2 weeks and 1 month after initial request). Most completed surveys were returned within 1 month (77%), although returns continued through May 2009.

### *Analyses of Quantitative and Qualitative Data*

IBM SPSS v.21 software was used for analyzing quantitative data. Narrative responses to the open-ended questions were analyzed first using SPSS Text Analytics for Surveys 4.0.1. Key terms and phrases were highlighted and the relative frequencies of these were compiled. I then reviewed the responses in their original forms to evaluate further for overriding themes and general concepts.

## Results

Approximately 55 emails were returned for bad email addresses, leaving a distribution total of 545 surveys. A total of 103 surveys (19%) were completed and returned. Consideration for the return rate will be provided later in the Discussion section.

### Characteristics of Clinician Respondents and Their Clients' Financial Status

Demographics of the respondents, by state, are summarized in Table 2. As planned, the majority of respondents were psychologists; however, one professional counselor and one marriage and family therapist, who probably were involved in practices with psychologists who received the invitation, also returned the survey. There was a good range and mix on other characteristics: age groups of clients (53.5% reported that they see adults, adolescents, and children; 37.6% saw only adults; 8.9% saw only children and/or adolescents) and place of practice (76% in private practice, 12.8% public institutions/agencies, or 12.2% in a mixture of private and public offices/institutions). Respondents saw an average of 20.5 clients per week ($SD$ = 10.5). Some (26.4%) reported over 50% of clients with incomes less than $50,000 per year, 19% with a majority of clients earning $50,000–$100,000, and 10.7% with a majority of clients with incomes over $100,000. The remainder who provided income information had a mixture of clients from the various income groups (primarily below $100,000). Most clinicians (79.2%) reported private insurance, self-pay, and/or Medicare as their sole source of payment; 15.8% received payment only from public funds (e.g., Medicaid); and the remaining 5% had a mixture of payments from both private and public sources. Sixty-four percent offered some level of sliding scale to clients.

One-way, between-group analyses of variance were used to compare mean ratings across the three states for ratings on remaining quantitative variables. None of the differences was statistically significant. Thus, data were combined across states for further analyses.

**Table 2:** *Characteristics of Responding Clinicians*

| | State (by zip code reported) | | | |
|---|---|---|---|---|
| | Colorado | California | Arizona | *N*[1] |
| Number received | 47 | 37 | 19 | 103 |
| Field of specialty | | | | |
| Psychologist | 46 | 34 | 19 | 99 |
| Professional counselor | 1 | 0 | 0 | 1 |
| Marriage & family therapist | 0 | 1 | 0 | 1 |
| Focus of practice | | | | |
| General/mixed ages | 28 | 15 | 11 | 54 |
| Adults only | 17 | 15 | 6 | 38 |
| Children/adolescents only | 2 | 5 | 2 | 9 |
| Place of practice | | | | |
| Private/solo/group only | 39 | 24 | 13 | 76 |
| Public institution/agency only | 6 | 5 | 2 | 13 |
| Combination private/public | 2 | 6 | 4 | 12 |
| Number of clients per week | | | | |
| Mean | 19.07 | 21.75 | 20.25 | 20.5 |
| *N, SD* | 46, 10.8 | 35, 11.4 | 17, 10.5 | 98, 10.5 |
| Comparison between states: $F(2,95) = .65$, n.s. | | | | |
| Mean percentage of clients by income group[1] | | | | |
| < $50,000 | 37.93 | 37.63 | 51.78 | 38.25[2] |
| $50,000–$100,000 | 38.23 | 38.63 | 36.33 | 32.00[2] |
| > $100,000 | 17.83 | 20.32 | 7.89 | 17.75[2] |
| Source of payment of 50% or more of clients | | | | |
| Self/private institution/Medicare | 38 | 27 | 15 | 80 |
| Medicaid/public funding | 5 | 7 | 4 | 16 |
| Both private & public | 4 | 1 | 0 | 5 |
| Offers sliding scale | | | | |
| No | 16 | 11 | 8 | 35 |
| Yes | 29 | 24 | 11 | 64 |

*Note*: [1] Values shown under N are based on totals collapsed across states and respective income groups.
[2] $N = 84$; with all states combined, mean percentage of clients in each income group was: $0–$24.99K, $M = 18.9$ ($SD = 29.8$); $25K–$49.99K, $M = 19.3$ (22.8); $50–$74.99K, $M = 20.7$ (23.0); $75K–$99.99K, $M = 11.4$ (12.6); $100K–$149.99K, $M = 10.0$ (16.7); $150K–$199.99K, $M = 2.8$ (5.3); $200K–$300K, $M = 275$ (6.5); > $300K, $M =$ 2.3 (8.0); approximately 11.9% of clients were not classified by income as some clinicians omitted information for 1% to 100% of their clients. *SD* = standard deviation; n.s. = not significant.

## Financial Stressors After January 2008 and Impact on Mental Health: Testing Hypothesis 1

### *Changes in Primary Stressors*

Results indicated a direct association between the onset of the 2008 recession and increases in psychosocial and environmental problems that would accompany financial stress. Clinicians reported statistically significant increases for their clients after January 2008 compared to prior months in problems with economics, housing, access to healthcare, occupation, and primary support group (see Table 1).

### *Relationship Between Stressors Reported by Clients and Housing Status for Previous 6 Months*

Clinicians were queried regarding the frequency of five potential housing risks among their clients. Again, response choices ran from 1 (*None*) to 5 (*All*). Frequencies of occurrences, from highest to lowest, were as follows: risk not making mortgage payment ($M = 3.13$, $SD = 1.12$, 97), homeless since foreclosure ($M = 2.10$; $SD = .88$, 102), risk not making rent payment ($M = 2.03$, $SD = .89$, 102), currently in foreclosure process ($M = 1.47$, $SD = .67$, 102), and completed foreclosure and moved ($M = 1.15$, $SD = .43$, $N = 102$; one-way analysis of variance for repeated measures: Wilks' Lambda $F[4,93] = 72.5$, $p = .000$, partial eta squared = .76). Post hoc comparisons between repeated ratings (using Bonferroni corrections, alpha = .05, $k = 5$, adjusted criterion for significance = $p < .01$) indicated that risk of not making mortgage payment was not significantly different from homeless after foreclosure but was statistically significantly higher than all other housing conditions ($p < .001$). Homeless since foreclosure did not differ from risk of not making rent, but both of these were statistically significantly higher than currently in foreclosure process ($p < .001$) and completed foreclosure and moved ($p < .001$).

Correlations between social and environmental stressors reported by clients in 2008 and housing risks are presented in Table 3. Homelessness after foreclosure related statistically significantly to greater frequency of stress due to problems with all five key social and environmental stressors: primary support groups ($r = .25$, $p < .05$, two-tailed), occupation ($r = .34$, $p < .01$), housing ($r = .46$, $p < .01$), economics ($r = .48$, $p < .01$), and access to healthcare ($r = .40$, $p < .01$). Those who are not yet in any stage of foreclosure but are at risk of not making their rent or mortgage payments were experiencing stress in four areas: their work ($r = .31$ and $r = .50$, respectively; $p < .01$), housing ($r = .37$, $r = .49$; $p < .01$), economics ($r = .49$ for both, $p < .01$), and access to healthcare ($r = .42$, $r = .34$; $p < .01$). Those currently in the foreclosure process were still experiencing stress regarding housing ($r = .34$, $p < .01$) and economics ($r = .37$, $p < .01$) plus work ($r = .26$, $p < .01$), but not yet access to healthcare. Finally, those who have completed foreclosure and moved appeared to still experience stress regarding housing ($r = .23$, $p < .05$) and economics ($r = .38$, $p < .01$), but were not experiencing as many problems with primary support, occupation (work), or access to healthcare.

**Table 3:** *Correlation Coefficients Between Clients' Areas of Psychosocial and Environmental Problems That Increased After January 2008 and Housing Status During Previous 6 Months*

| | Housing Status | | | | |
|---|---|---|---|---|---|
| Area of Increased Problems | Currently in Foreclosure | Completed Foreclosure and Moved | Homeless After Foreclosure | Risk of Not Making Mortgage Payment | Risk of Not Making Rent Payment |
| Primary support | .03 | .18 | .25* | .09 | .17 |
| Occupation | .26** | .15 | .34** | .50** | .31** |
| Housing | .34** | .23* | .46** | .49** | .37** |
| Economic | .37** | .38** | .48** | .49** | .49** |
| Healthcare | .11 | .17 | .40** | .34** | .42** |

*Note:* $N = 102$; *$p < .05$, 2-tailed; **$p < .01$, 2-tailed.

### *Housing Status During Previous 6 Months and Client Income Level*

Clinicians were asked to estimate what percentage of their total client load fell into each of eight income ranges. The total percentage estimates for each clinician were collapsed into three income groups: under $50,000, $50,000–$100,000, and over $100,000. The value for the percentage of clients in each of the three income groups was then correlated separately with the rating given for the frequency of clients experiencing each of the five housing stressors during the previous 6 months. Results indicated that the greater the percentage of clients that clinicians served in the under $50,000 income group, the greater the reported frequency of clients who during the previous 6 months had completed foreclosure and moved ($r = .32$, $p = .015$) or were homeless after foreclosure ($r = .31$, $p = .017$). By contrast, the greater the proportion of clients in the $50,000–$100,000 range, the greater the frequency of clients who were at risk of not making rental payments during the previous 6 months ($r = .31$, $p = .011$). As an indicator of the lower risks for those in higher income ranges, the more clients in this range, the lower the frequency of having clients who had been homeless following foreclosure ($r = -.31$, $p = .013$) or had difficulty making rent payments ($r = -.33$, $p = .007$). Frequency of current foreclosure activities and risk of making mortgage payments did not appear to be correlated with income ranges (see Table 4).

**Table 4:** *Correlation Coefficients Between Ratings for Frequency of Housing Status for Previous 6 Months and Proportion of Clients by Income Level*

| | Proportion of Clients in Income Range | | |
|---|---|---|---|
| Housing Status | < $50,000 | $50,000–100,000 | > $100,000 |
| Currently in foreclosure process | .06 | .09 | - .17 |
| Completed foreclosure and moved | .32* | - .18 | - .18 |
| Homeless due to foreclosure | .31* | .03 | - .31* |
| At risk of not meeting rent | .04 | .31* | - .33** |
| At risk of not meeting mortgage | .02 | .13 | - .08 |

*Note.* $N = 58$ to 65 due to missing data regarding proportion of clients in various income ranges. Higher ratings indicate housing stressor seen more frequently. Higher values on income indicate higher proportion of clients in this income range; * $p < .05$, 2-tailed; ** $p < .01$, 2-tailed.

***Psychological Symptoms and Housing Stressors***

Similar to types of stress among the general population (e.g., APA, 2008), the most common symptoms reported by clinicians for their clients who recently were experiencing financial/housing stressors were anxiety with worry, depression, and physical symptoms, followed by increased alcohol use (see Figure 1). A repeated-measures one-way ANOVA indicated a statistically significant difference in ratings for various symptoms ($N = 94$; $F[13,1131] = 102.165$, $p < .000$). Results of pairwise comparisons indicated that the top three ratings were statistically significantly higher than those for other symptoms ($p < .001$).

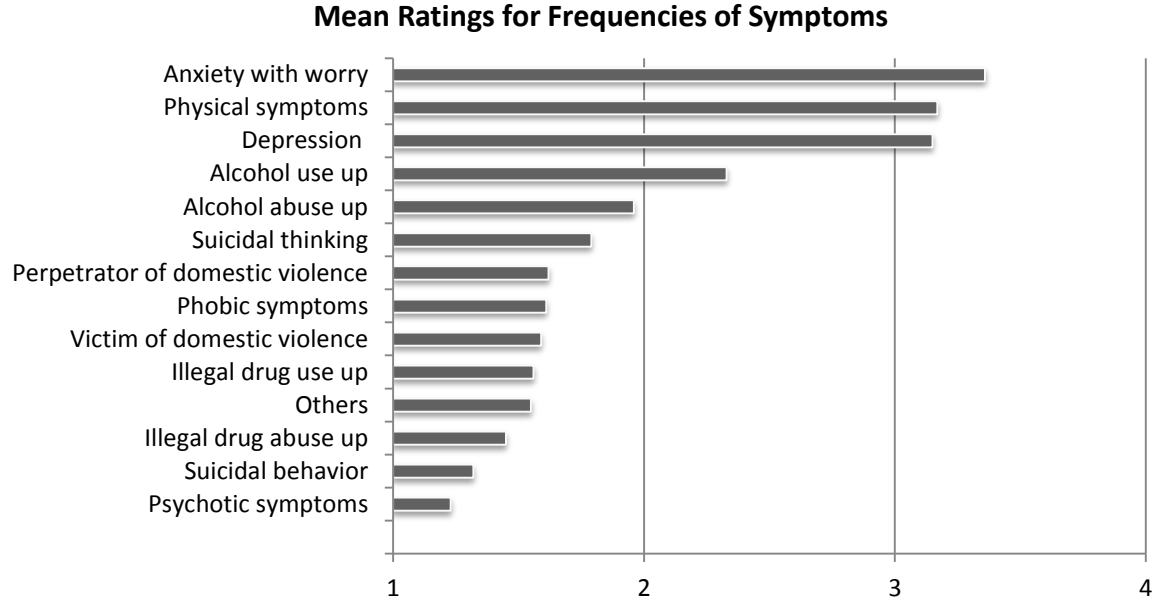


**Figure 1:** *Mean Ratings for Frequencies of Psychological Symptoms Among Clients With Financial Stressors During Previous 6 Months (After Jan. 1, 2008;* N *= 98; Ratings: 1 [*Never/None*], 2 [*Very Infrequent/A few*], 3 [*Moderately Frequent/50–50*], 4 [*Very Frequent/Many*], or 5 [*Always/All*]).*

***Narrative Descriptions Regarding Impact of Previous Mental Health***

Open-ended responses were reviewed in order to evaluate the hypothesis that previous mental health status would predict the degree of impact of financial stressors upon clients' mental health. A majority (69% of 70 respondents) suggested that new financial stressors magnified conditions already present or created new symptoms for those who were already vulnerable: for example, "In general, financial stress compounds emotional, social, and physical issues. Frequently, I have observed increased marital tension and stress and difficulty coping with anxiety, worry, and feelings of helplessness/hopelessness associated with depression." Only 10% described no change in symptoms. A few (4%) respondents indicated that their clients found a gain from the financial hardship: for example, "More likely to develop withdrawal symptoms such as denial, depression or anxiety. But, also more likely to develop positive character traits such as courage, discipline and entrepreneurial spirit."

## Moderator Variables and Financial Stress: Testing Hypotheses 2–4

Clinicians' responses to the remaining open-ended questions were analyzed to evaluate hypotheses 2 through 4, which posited specific moderating effects of demographic and social environment variables on the psychosocial impact of financial stressors. A summary of key themes and percent of responses for each theme are presented in Table 5.

### Open-Ended Responses and Income Levels of Clients

In order to consider possible differences in effects of financial stressors by income level, 85 clinicians who provided responses to some/all of these open-ended questions were subclassified according to the income range of the majority of their clients: Majority Low Income = at least 50% of clients earned less than $50,000 per year ($N = 21$; 24.7% of 85 clinicians); Majority Moderate Income = $50,000 to $100,000 ($N = 22$; 25.9%); Majority High Income = earned over $100,000 ($N = 11$; 12.9%); Mixed Incomes = no clear majority reported in one income range ($N = 19$; 22.3%). The remaining 12 clinicians (14.1%) did not include information about client income. In general, income level of clients was related only to lifestyle changes and social support following the impact of financial stressors.

### Gender

Responses regarding possible gender differences in responses to financial stressors offered no support to previous findings of greater financial stress specific to women (e.g., APA, 2008). Four major themes were noted in the descriptions provided by the clinicians (see Table 5): males and females were both impacted but in different ways (40.6%); gender was not as important as financial responsibilities (e.g., primary breadwinner status; 18.8%); only one gender group is affected (males, 17.4%; females, 7.2%).

#### *Males and Females Impacted in Different Ways*

Across the client income groups, men were described more frequently as angry, depressed (even suicidal), acting out, and ashamed, while women were described more frequently as anxious, anxious with depression, worried, and/or as showing physical symptoms. Representative responses included the following: "Women seem to have more of the responsibility of actually taking care of the family finances and become more depressed/anxious as they watch the finances diminish. The men also become depressed due to their perceived inability to care for their families"; "Men act out, while women worry; lower self-esteem for men"; and "Men seem more humiliated. Women seem more adjusted, but they are very worried."

#### *Gender Not as Important as Financial Responsibilities and Resources*

Some clinicians described one's financial responsibility for the family as more relevant than gender: for example, "Most of my clients, male and female, are the sole breadwinners for their families and feel the stress tremendously"; "With both genders working, almost all adults are worried about how to pay the bills and not get laid off."

#### *Men Specifically Affected*

When effects were mentioned for men only, clinicians across income levels tended also to remark about loss of self-esteem, guilt, and personal failure accompanied by depression and self-destructiveness, generally associating these responses with expectations placed upon men by society: for example, "men may more often interpret financial stress as a personal failure"; "Men tend to be more self-destructive around these stressors."

**Table 5:** *Themes and Frequencies of Responses to Open-Ended Questions Concerning Possible Effects of Moderating Variables*

| Themes | Frequencies |
|---|---|
| **Gender** | *N* = 69 |
| Men and women respond with different emotions and behaviors | *n*= 28, 40.6% |
| Differences not related to gender, but to roles/responsibilities | *n* = 13, 18.8% |
| Men specifically are affected | *n* = 12, 17.4% |
| Women specifically are affected | *n* = 5, 7.2% |
| Other responses describing emotions/behaviors without referencing gender | *n* = 11, 16.0%) |
| **Age** | |
| Children | *N* = 45 |
| Affected | *n* = 38, 84.4% |
| Described symptoms | *n* = 20, 44.4% |
| Anxiety, fear, worry, somatic symptoms, and/or insecurity | *n* = 11, 24.4% |
| Anger, aggression, and/or acting out | *n* = 6, 13.3% |
| Distractibility, difficulty concentrating, sleeplessness | *n* = 3, 6.7% |
| Child's response related to parents' distress | *n* = 16, 35.6% |
| General statement that children are affected other than those mentioned in first two categories | *n* = 2, .04% |
| Unaffected (protected or not aware) | *n* = 7, 15.6%; |
| Adolescents | *N* = 49 |
| Affected | *n* = 47, 96% |
| Described symptoms | *n* = 24, 51% |
| Internalizing | *n* = 12, 25.5% |
| Externalizing | *n* = 12, 25.5% |
| Youths' response related to parents' distress | *n* = 10, 20.4% |
| Youths' concerns about their own financial well-being | *n* = 8, 17% |
| Youths want to help family | *n* = 3, 6.3% |
| Unaffected | *n* = 2, 5% |
| **Lifestyle** | *N* = 70 |
| Lifestyle altered negatively due to finances | *n* = 29, 42% |
| Increased stress and emotional distress | *n* = 11, 15% |
| Those with higher incomes doing worse | *n* = 11, 15% |
| No real challenge to or change in lifestyle | *n* = 7, 10% |
| Increased worries about future finances, such as retirement | *n* = 5, 7% |
| Financial stressors actually brought positive effects on lifestyle | *n* = 4, 6% |
| Other | *n* = 3, 5% |
| **Support** | |
| Within family | *N* = 61 |
| Reduced, lacking, or strained support | *n* = 40, 65.5% |
| Variable across families | *n* = 7, 11.5% |
| Increased support | *n* = 6, 9.8% |
| Adequate support | *n* = 4, 6.6% |
| Same as before | *n* = 4, 6.6% |
| In community | *N* = 62 |
| Has shrunk, is inadequate | *n* = 36, 58% |
| Clients are reluctant to reach out for community support | *n* = 9, 14.5% |
| Clients reach out for community support | *n* = 9, 14.5% |
| Positive support is available | *n* = 3, 4.9% |
| No change in community support | *n* = 3, 4.9% |
| Community support is "fair" | *n* = 1, 1.6% |
| Few clients require community support | *n* = 1, 1.6% |

### *Women Specifically Affected*

When effects were described for women only, clinicians ascribed the stress to women's responsibilities or to discrimination: "Women are financial managers of homes, creating more stress"; "Women who are victims of discrimination or divorce"; "Worse for women with children."

## Age

As predicted, a clear majority of respondents across all income groups described children and adolescents affected by how their parents/caretakers responded to the financial crises (see Table 5).

### *Children*

Clinicians described children as reactive to their parents/caretakers' distress, instability, or reduced availability. They also noted that children demonstrated a variety of symptoms, such as physical illness, aggression, distractibility, anxiety, anger, and feelings of instability.

### *Adolescents*

Symptoms for adolescents generally fell into two categories: internalizing and externalizing. Clinicians with the majority of clients in Low and Moderate income ranges were more likely to mention job loss as a stressor among the adolescents. Clinicians with clients in the Moderate and High income ranges also noted status concerns, such as, "Some anxieties about loss of status, possible opportunities for certain colleges, etc. Resentment aimed at parents," but also proactive responses ("Other teens see it as an opportunity to step up to the plate and play a helpful role through cutting back or part-time work").

## Prior Income/Lifestyle

As predicted, clinicians described ways in which income levels/social status prior to the financial crisis impacted responses. In particular, clinicians with Moderate or Mixed income groups described the specific plights of clients who "had it good" prior to financial crisis, especially those who may have recently moved to middle/upper-middle class status: for example,

> Many people were making a whole lot of money in real estate and enjoying a lifestyle full of shopping, fancy restaurants, boating and traveling. Now people stay home, don't eat out, don't buy unnecessary items and rarely travel. The positive side is that people are learning simpler ways to enjoy themselves and are working less. The negative side is that many people are stressed because they are not taking a break from the grind. Many people are spending their retirement money and will experience even greater stress in the future. People are embarrassed about their poor financial decisions. They are upset about losing their homes and jobs. Even those 85% who are working are generally underemployed or working fewer hours and tightening their belt. Many businesses are failing.

Another clinician with Moderate income clients noticed "loss of previous level of lifestyle causing a grief response." Therapists who could compare across income groups noted, "Lifestyle changes are significant, especially for high income patients. Low incomes have greater level of fear but less loss of lifestyle"; "I've seen those who have been comfortable have a lot of upset. They continue to go into deeper debt to keep up appearances." By contrast, clinicians with primarily Low income clients shared, "The poor get poorer"; "Many of my clients have been poor most of their lives. They are handling things better than those who had more resources." A few clinicians, mostly with clients in the Moderate income range, described possible positive effects of reduced finances: "Lifestyle more

limited, some do well with this"; "People are coming to terms with having less money available…not as superficial and find it easier to get down to basic values."

## Social Support

Descriptions by clinicians suggested that previous lifestyle/social status was related more to differences regarding community support than to support by family (see Table 5).

### *Family Support*

The majority of clinicians with clients in the Low and Moderate income groups described family support as variable, lacking, reduced, or more strained as a function of financial stressors. Family support was limited or problematic before, which only got worse after the increase in financial stressors; for example, "People have had to come together more to support out-of-work family members and sometimes to give each other a place to live. In functional families, this can bring them together. In moderately functional families, this often stresses the family and causes conflict. Dysfunctional families remain dysfunctional." Interestingly, most of those with High income clients did not respond to this question or indicated few and only minor problems in family support.

### *Community Support*

In general, clinicians with Moderate and Low income level clients noted that community resources are inadequate to the new levels of need. One clinician with Moderate income clients noted, "Not much [support], especially if you are seen as 'well off.'" Other clinicians with Moderate income clients focused on clients' willingness to seek support: for example, "Several definitely feel more isolated/alienated or purposefully insulating self and family"; "People hide their problems and feel ashamed. They don't reach out, so they don't get support from the community." One clinician in the High income group observed that community support was "often not pursued" and another noted that isolation was due to no longer being able to afford recreational activities where they could find peer support. A few clinicians described positive community response (e.g., "more organizations popping up to assist families in need of food and assistance with avoiding foreclosure") and clients who "rely on community support more."

# Discussion

This study explored the impact of major financial stressors (in particular, those of the 2008–2009 recession) among a particular subgroup of Americans, clients receiving mental health services. Four hypotheses were advanced, which were derived from Lazarus and Folkman's (1987) transitional theory of stress, Tajfel and Turner's (1986) social identity theory, finance-shame theory (Rantakeisu et al., 1999; Starrin et al., 2009), as well as past research into social, cognitive, and emotional factors in response to financial stress. Each of the hypotheses received general support from the quantitative and/or qualitative responses of the clinicians:

- Similar to the general population, financial stressors did increase after January 2008 and exacerbated clients' mental health vulnerabilities.
- When gender differences were described, clinicians noticed more anxiety and worry among women than men and more self-blame, guilt, and depression among men than women (however, consideration of other findings are discussed below)
- Children and adolescents were impacted and the majority described this as related to their parents' responses

- With some qualifications that will be discussed below, previous income level was related to relative difficulty with adjusting to financial and lifestyle changes; and, again with some qualifications, availability of social support, and willingness to reach out for it, was related to financial status and social identity.

Contrary to previous reports of greater stress for women than for men during financial crises (e.g., APA, 2008; Flora & Dymski, 1990), results argue that differences between men and women, at least those in therapy, lie in type—rather than amount—of stress responses to financial stressors. It is possible that research strategies have systematically underestimated the symptoms or expressions of financial stress among men. For example, results may be biased by women's greater willingness to share their negative emotions. Additionally, questions may focus on emotions such as anxiety and worry and emotional expressions that adhere to American gender stereotypes (Simon & Nath, 2004), while not focusing on emotions and forms of expression more common among men (e.g., anger, acting out, alcohol abuse). It also may be argued, however, that men who are receiving mental health services may not be typical of the general male population. Addis and Mahalik (2003) present a cogent discussion of the issue of help-seeking behavior among men that takes it beyond the simple assumption that men are less emotional or less emotionally expressive in reaction to stressors. Instead, they suggest that social psychological processes moderate help-seeking behavior, including perceptions regarding the normativeness and ego centrality of the problem, characteristics of the social groups to which the person belongs, characteristics of potential helpers, and perceived loss of control over the problem. It would thus appear that some of the same person X situation factors that are suggested in how one responds to financial stress may also play into which males seek mental health services. In addition, the responses by 18.8% of the clinicians that argue that it is financial responsibility and role—not gender—that predicts stress may also suggest that previous findings that more women are stressed during financial crises may not have considered their responsibilities as heads of households, single parents, and the member of a family who manages financial resources, which would differentially predict greater stress. These questions merit further research.

Many of the qualitative descriptions support the finances-shame model (Rantakeisu et al., 1999; Starrin et al., 2009) and Gilbert's (1998) discussions of internal and external shame; however, finance-related guilt and shame seemed to be gender-specific among these clients and particular to the social role expectations for males as family provider and problem-solver. Although women were often described as the family provider and financial problem-solver, descriptions of guilt and shame were not associated with them. Similarly, income level also was related to finance shame, guilt, and outreach for support. Descriptions suggested that it may not be either the Low or High income groups who were most at risk, but rather those in the Moderate income group who became members of a "new" middle or upper-middle class that rose during the boon of various industries, such as construction. Analyses by economists also reveal that this prerecession period was a time when the economic security of the middle class in general was decreasing, positioning many to be at risk of not being able to weather financial setbacks: "The sharp drop in the broadly measured middle class security was followed by a heightened economic anxiety and sharply higher economic distress. For instance, by the third quarter of 2008, one-in-ten mortgages was either delinquent or in foreclosure" (Weller & Logan, 2009, p. 335). Thus, the middle class was economically at peril and, by association, also the most in peril of losing that social status. Further research is needed to understand the relationships between gender, socioeconomic status, and precrisis financial and mental health risks in relation to finance shame, guilt, and other forms of psychological and emotional distress in response to financial stressors.

Finally, findings of this study strongly suggest that the type and number of additional worries and challenges impacting clients (e.g., access to healthcare, housing) change during financial crises. For

example, different combinations of additional psychosocial and environmental concerns were associated with housing status, with homelessness following foreclosure described as a point where all options for support, work, housing, economics, and access to healthcare have been depleted.

## Limitations of the Study

This study contained several limitations. First, the sample size was smaller than desired, with a 19% return rate. Unfortunately, return rate for online surveys has been declining steadily for the past 2 decades. Even the return rate for the 2008 APA Survey of Psychology Health Service Providers (Michalski, Mulvey, & Kohout, 2010), which targeted similar professionals using online surveys, was only 14.8%, and a recent survey of physicians using similar online methods had a return rate of 12.95% (Scott et al., 2011). In fact, in a review of the response rate literature between 1986 and 2000, Sheehan (2001) found that the only significant predictors of email survey response rate were year ($\beta = -.54$, $p < .005$, 24% of variance) and follow-up reminders ($\beta = .46$, $p < .05$, 17%); number of questions, prenotification, and salience did not reach significance and only accounted for 8% of the variance. Thus, more direct contact with participants (e.g., face-to-face, telephone, or video interviews) may improve the response rate and sample size for future research.

Second, the survey questionnaire was designed for this study. While I pretested the measure on key parameters of readability, content validity related to research questions, and online accessibility, further assessment would be ideal (e.g., test-retest evaluations of reliability).

Third, the selection of informants for this study limits the generalizability of the findings: one group of mental health providers (psychologists) with published email addresses and in only three states certainly does not guarantee a truly representative sample of the experiences across mental health clients following the onset of the 2008 recession. Also, clinicians provided overall impressions, but were not asked to verify their estimates with objective information from their case files.

Finally, a study that includes information from additional sources, including the clients themselves, could offer a richer understanding of client needs and experiences in response to financial stress. Also, impact on those with mental health needs who were not in treatment or who were in intensive inpatient treatment at the time was not sampled.

## Conclusions and Implications

To date, this is the first known study of the impact of a major financial crisis on a specific subgroup, clients receiving care by mental health professionals. Findings indicate important implications for clinical application. Unfortunately, Brown (2008) has questioned whether clinicians are adequately prepared to recognize and respond with cultural competence to the risks of trauma during financial crises. She warns that we clinicians can be victims of "internalized classism" based on our own naïveté, especially about the unique plights of those in the middle- to upper-middle-class socioeconomic ranges.

> Middle- and upper-middle-class people, whose class status is largely dependent on continued participation in the paid workforce, are vulnerable to economic disruptions catalyzed by the aftermath of trauma exposure in ways that very wealthy people, whose financial well-being is not related to their ability to appear at work regularly, are not. Disruption in earning capacity can lead to a fall in class status, which can be experienced by and of itself as traumatic depending on what that class status represents emotionally to individuals and their culture. (Brown, 2008, p. 200)

These research findings underscore two key points. First, clinicians can gain enhanced cultural competence by expanding their knowledge and understanding about the unique interplay of financial stressors with social identity and socioemotional health. A systems perspective can help to focus on the reciprocal processes between the individual's characteristics (e.g., gender, age), social roles, and the socioeconomic and interpersonal (e.g., spouse, children, others in family, community) networks in which the individual functions. Second, in practice, clinicians can proactively and sensitively gather information from their clients about their socioeconomic social identities, as well as their histories of socioeconomic statuses and financial stressors: "Because of this complexity of the meanings of social class, culturally competent practitioners engage the topic best by asking their clients about the economic and educational realities of their lives, both in childhood and adulthood in a descriptive way that will invite information and decrease associated shame" (Brown, 2008, p. 202). This kind of history-taking supports comparable exploration of current financial stressors and stages of change across time. The clinician's cultural competence can support those clients who may be reluctant to share or may underestimate the impact that these kinds of life events may have on their socioemotional health.

Results of this study also support arguments for community partnerships that take a multidisciplinary approach to economic crises (Zolezzi-Wyndham, 2012). Community response should advocate for those with the *unique challenge of change in financial and social status,* which has been found elsewhere to predict a higher risk for suicidal ideation and depression than chronic poverty (Turvey et al., 2002). Public health professionals should consider ways to provide support services that are sensitive and attractive to individuals in Moderate and High income groups who are faced with the complex combinations of financial loss, social alienation or stigmatization, and risks to mental health.

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