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Informant Report of Financial Capacity for Individuals with Chronic Acquired Brain Injury (CABI): An assessment of informant accuracy

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Abstract

Objective—Primarily, to investigate the association between informant report and objective performance on specific financial capacity (FC) tasks by adults with chronic, moderate to severe acquired brain injury (CABI), and to examine the nature of misestimates by the informants.

Design—Cross-sectional design.

Setting—A post-acute, community-based rehabilitation center.

Participants—Data were obtained from twenty-two CABI adults, mean age = 46.6 years ($SD = 8.67$), mean years of education = 13.45 ($SD = 2.15$), with moderate-to-severe CABI (86% had traumatic brain injury), with a mean post-injury period of 17.14 years ($SD = 9.5$). Whereas the CABI adults completed the Financial Competence Assessment Inventory (FCAI) interview—a combination of self-report and performance-based assessment, twenty-two informants completed a specifically designed parallel version of the interview.

Results—Pearson's correlations and one-sample t-tests based on the discrepancy scores between informant report and CABI group's performance were used. The CABI group's performance was not associated with their informant's perceptions. One sample t-tests revealed that informants both underestimated and overestimated CABI group's performance.

Conclusions—Results indicate lack of correspondence between self - and informant ratings. Further investigation revealed that misestimations by informants occurred in contrary directions with CABI adults' performance being inaccurately rated. These findings raise critical issues related to assuming that the informant report can be used as a “gold-standard” for collecting

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functional data related to financial management, and the idea that obtaining objective data on financial tasks may represent a more valid method of assessing financial competency in adults with brain injury.

INTRODUCTION

Financial capacity (FC), a multidimensional construct, can be conceptualized broadly as the ability to efficiently manage one's finances¹⁻⁴. Impairments in FC and its related cognitive abilities exist across a range of neurological conditions⁵⁻⁸, including acquired brain injury (ABI)⁹⁻¹¹, which can interfere with everyday functioning including financial management^{5,12}. It is estimated that approximately 30% of ABI patients have difficulty managing their finances independently^{13,14}. Crowe and colleagues also found that 83% and 33% of individuals with severe and moderate brain injury, respectively, were not able to independently perform automated teller machine tasks, such as inserting the card and entering the PIN¹⁵. Individuals with brain injury who have court appointed financial administrators generally perform worse on cognitive tests of attention, working memory and executive functioning, with these tests explaining about 63% of variance in performance¹⁶. Taken together, these studies suggest that many individuals with brain injury display inadequate financial management habits.

Accurately assessing and working to rehabilitate FC in chronic acquired brain injury (CABI) is critical because many individuals with this condition are young to middle aged adults, ready to join the work force or who were employed at the time of their injury^{5,10,12}. Such individuals may carry significant financial responsibilities, such as repaying mortgages. They may face activity restrictions leading them to take up jobs at a lower level than their premorbid functioning¹⁷⁻²⁰. They may get awarded large sums of money after winning a lawsuit or be supported by social security checks or retirement savings, for example. Under any of the aforementioned circumstances thoughtful planning and budgeting is critical.

Managing finances influences one's ability to integrate with the community and live autonomously^{20,21}. The adverse implications for individuals with CABI who have impairments in managing finances have long-term ramifications for the individual themselves and their family²². Therefore, it becomes critical to establish the most accurate means of assessing FC in such individuals. FC is rapidly gaining interest as a critical construct in clinical practice and research, and the availability of measures to assess this construct is increasing²³⁻²⁸. However, FC is still an evolving construct without a standard operational definition in research or clinical practice.

Caregivers or other types of knowledgeable informants, by nature of their proximity to the patient, can offer valuable information about a patient's FC. Indeed, informant report is often used as a proxy for real-life functioning when it is not practical to directly assess real-life function^{29,30}. Informant report is often considered preferable to self-report due to concern that patients with brain injury may underestimate their symptoms as a means of coping with emotional stress, or to receive a higher amount of compensation in legal cases^{31,32}, or as a function of cognitive deficits (i.e., memory impairment) or metacognitive deficits (i.e., lowered levels of self-awareness)^{30,33-35}. Studies often demonstrate

discrepancies in self and informant reports of FC as well as other aspects of functioning in TBI including physical, cognitive, and socio-emotional function^{30,31,37–39}. Patient-informant discrepancies are typically attributed to an inaccurate estimation by patients, who have been shown to either underestimate and overestimate their abilities in relation to both informant report^{29,30,40} or objective performance^{41,42}. As such, it has been proposed that obtaining reports from clinical staff or caregivers is more reliable than obtaining such reports from patients^{16,43}. Compared to self-reports, studies in patients with brain injuries have found strong evidence linking informant reports of patients' capacities to neuropsychological tests and to real-world functioning^{41,44–48}.

However, it is not clear that informants' reports are entirely accurate as informants may not be fully aware of patients' difficulties or style of coping, and may consequently underestimate or overestimate the patients' abilities. For example, one study found that as compared to caregivers, patients endorsed more problems with memory and emotional regulation³¹. A separate study examining disability rates in people with TBI found that financial management was a key area in which informant ratings substantially diverged from the patients' ratings, with about 72% of informants rating patients as having no difficulties in managing finances as opposed to only 59% of patients endorsing no difficulties³⁶.

The accuracy of informant perception and report regarding FC has not been examined. In order to do this, it is critical to have a standard, objective method of evaluating the ability upon which the patient is being evaluated, and against which informant report can be compared. Questions about FC often arise in a clinical context, and practitioners may often automatically rely on informants to gather information about the individual's financial habits and behavior. By investigating the question of whether informant reports are accurate when pitted against an objective standard, practitioners will be able to estimate how heavily to weigh the informant report when making FC determinations. The current study is the first to our knowledge to implement such an approach in an effort to examine the association between informant report and objective patient performance on specific FC tasks, and to characterize the nature of any misestimates by the informants. We hypothesized that there would be discrepancies across the CABI group's performance and their informants' report, likely characterized by informant underestimation in some domains and overestimation in others. Results from this study will provide information regarding the extent to which informant report can be reliably used to gather information on specific FC abilities in CABI individuals, and whether certain aspects of FC are more readily and accurately reported by informants than other aspects of FC. The findings will be used to provide practitioners strategies to assess FC in individuals with brain injury.

A variety of instruments are available for assessing FC and it is important to consider the psychometric properties of the instrument including the sample in which the instrument has been validated^{24,49,50}. Another important consideration is the ease of accessing the instrument for clinical work and research. The FCAI was selected for examining FC in the current study because of its ability to comprehensively examine FC across multiple dimensions (see Table 1) and more broadly across two frameworks (clinical and legal) and thus can be useful for both clinical and research work³. More importantly the FCAI provides a conceptual framework for FC determination in individuals with brain injury, and has

applied relatively rigorous methodology to validate the instrument as compared to some of the other instruments²⁴.

METHODS

Participants

The study enrolled 29 individuals with moderate to severe ABI from Bancroft Brain Injury Services, a post-acute, community-based comprehensive rehabilitation center based in central and southern New Jersey. Inclusion criteria for CABI individuals included, the presence of an ABI; age at the time of injury was 18 years or more; aged between 18 to 60 years, ability to read English at the 5th grade level. Participants with depression were excluded because of the presence of high prevalence rates of depression even a year after the brain injury⁵¹. Exclusion criteria included presence of psychiatric disturbances, those currently undergoing pharmacological treatment for substance abuse or dependence; estimated pre-morbid intellectual ability below 70; compromised ability to understand instructions and inability to give informed consent; current or active involvement in a lawsuit; severe motor and/or sensory deficits, and for informants, no neurological condition.

To ensure that participants met the inclusion/exclusion criteria, a two-tiered screening process was adopted – for the first-tier, a brief telephone screening was conducted with control participants. For those with CABI, given the chronicity of the injury, several participants' medical records did not have all the information pertaining to their initial Glasgow Coma Scale rating, the presence and length of posttraumatic amnesia, and their neuroimaging records. Therefore, to determine eligibility, in addition to the medical records, a formal meeting with the day-treatment program's neuropsychologist was conducted. Twenty nine out of 70 individuals were deemed eligible. All the CABI participants that were recruited were characterized as having moderate to severe brain injury, and were confirmed by the neuropsychologist as living in a residential community requiring at least some level of supervision. For the second-tier, these potential participants were invited to participate in the study. If they indicated interest, a testing session was scheduled wherein after obtaining informed consent, participants underwent a formal screening process to ensure they met criteria for participating in the study. Four out of the 29 participants did not meet the exclusion criteria—three individuals did not understand the instructions to provide informed consent, and 1 individual had severe visual difficulty. The remaining sample consisted of 25 CABI participants. Informants were available for 22 participants, and therefore after considering informant-CABI dyad pairings, the total sample for this study consisted of 22 participants.

Informants

Interviews with 22 informants were conducted. Although 25 informants were contacted, FCAI interviews with 3 informants could not be conducted due to scheduling conflicts. Informants consisted of 19 professional staff members working with CABI participants, and 3 family members. Specifically, they consisted of cognitive therapists ($n=16$, 73%), clinical case managers ($n=2$, 9%), speech therapists ($n=1$, 4.5%), and family members (sister, $n=2$, 9%; father, $n=1$, 4.5%). A common approach employed by studies to gather informant data,

is to request participants to name an informant who they thought was familiar with their habits and personality. In the current study this approach was considered inadequate because the CABI participants could have named an informant who was not specifically familiar with their financial skills and/or had limited knowledge about how they were behaving financially (e.g. budgeting and borrowing money). Therefore, after consulting the center's neuropsychologist, informants were chosen based on those who had the most knowledge and familiarity with the CABI individual's past and present financial habits. Informants had known the participants on average for about at least 1 year or more.

Procedure

All participants were given a battery of neuropsychological tests along with a FC interview that lasted for a mean time of 60 minutes. At the end of the session, participants were paid \$5. Paying a larger sum was deemed by the center's Institutional Review Board (IRB) as being potentially coercive. Five out of 22 CABI participants took two sessions to complete the study. For the interview, informants of CABI participants were interviewed either face-to-face or over the telephone with each interview lasting for about 45 to 60 minutes. All procedures were approved by Drexel University's and Bancroft Brain Injury Services' IRBs.

Measures

Financial Capacity—The Financial Competence Assessment Inventory (FCAI) is a 38 item structured interview that uses a combination of self-report and performance-based tasks^{3,24,49}. Using factor analysis, the FCAI was found to have six underlying factors (represented as the six clinical dimensions) that accounted for 54% of the variance in performance. Two indices – scores on the six clinical dimensions and the overall score—were considered as the outcome variables for the current study.

For the self-report items, individuals respond to questions such as, do you budget regularly and do you owe debts. For the performance-based items, individuals perform tasks such as filling out an insurance form and performing calculations based on a hypothetical situation. Financial capacity is measured on six clinical dimensions: *Everyday Financial Abilities*, *Financial Judgment*, *Estate Management*, *Cognitive Functioning related to Financial Tasks* (henceforth called *Financial Cognition*), *Debt Management*, and *seeking Support Resources*. Table 1 provides a description of the tasks included in each of the six dimensions and how it relates to everyday functioning. The majority of the items are scored on an ordinal scale ranging from 0 (no understanding or knowledge) to 4 (complete understanding and knowledge), while the remaining other items are scored dichotomously (Yes/No). The FCAI produces several outcome indices based on – (1) each of the six clinical dimensions, and (2) the overall FCAI score.

For the purposes of the current study, in an effort to maximize the objectivity of the FCAI, a subset of 20 out of 38 items were selected. This modified version of the FCAI will be henceforth referred to as the FCAI-objective. Specifically, in the current study for the FCAI-objective, objective items referred to those items which: (i) were purely performance-based and observable (e.g., writing a check), and (ii) responding to questions which examine conceptual knowledge that can be scored objectively with an external criterion (e.g., what is

the meaning of assets?). Responses for which verifiable information would have to be obtained through other sources (e.g., do you have debts? do you budget?) were considered as non-objective or subjective, and thus not included in the current analyses.

For the subset of 20 items, as compared to the FCAI-original, the number of items subsumed under each clinical dimension varied. Specifically, the FCAI-objective included 2/9 items (possible score range 0-8) in the Everyday Financial Abilities domain, 7/8 items (possible score range 0-28) in Financial Judgment, 4/7 items (possible score range 0-16) in Estate Management, 6/6 items (possible score range 0-24) in Financial Cognition, 0/4 items in Debt Management, and 1/4 items (possible score range 0-4) in Support Resources. An overall maximum score of 80 could be obtained for the 20 items, with higher scores reflecting better financial management.

As the number of items within any clinical dimension varied, conducting a factor analysis to determine whether the original factor structure can be retained would be ideal. However, given the sample size and pilot nature of the study, another approach was adopted wherein each item was individually examined to understand whether it was correlated with the overall score. Content analysis further revealed that 10/20 items were based on performance tasks, and 10/20 on conceptual understanding or knowledge of financial terms and procedures.

Financial Capacity Assessment - Third-Party Perspective (Informant Report)—

The FCAI Third-party Perspective response form was designed to be administered to someone who knows the person well (such as a family member, caregiver)⁵². This form comprises 38 items, analogous to the self-report FCAI form, with the aim of measuring the same six FC dimensions. Research has found that informants' reports on four of the six FCAI subscales (Everyday Financial Abilities, Financial Judgment, Estate Management, Financial Cognition) were positively associated with those of the participants with cognitive impairment⁵². In the current study, only responses to the 20 items representing the FCAI-objective were considered.

Sixteen informants were interviewed in person, and six informants were interviewed over the phone. Interviews lasted on average for about 40 minutes. Similar to the original FCAI, the interviewer asked the questions that were worded from a third-person perspective. Informants commented on both the self-report items and were asked to estimate the CABI participant's ability to perform the objective items.

Statistical Analysis

All analyses were performed using PASW 22.0. Preliminary analysis was conducted to examine the data for the presence of outliers, and the appropriateness of assumptions of linearity and normality. Analyses in the current study included descriptive analyses, deriving Cronbach's alpha to measure internal consistency of the FCAI-objective, Pearson's correlations and one-sample t-tests using patient-informant discrepancy scores.

First, a Pearson correlation was used to examine the association between patient performance and informant perceptions of FC on the overall score of the FCAI-objective.

Next, to investigate discrepancies between the informants' report of CABI group's financial skills and knowledge versus objective patient performance, a difference score was calculated for the overall FCAI-objective score and for each of the 20 items. Positive scores indicated that informants overestimated the patient's ability to perform the activity, whereas negative scores indicated underestimations of patient performance by the informant. Following a commonly used analytic approach in metacognitive research⁵³, we conducted one-sample t-tests on the difference scores (overall and item level FCAI scores) to determine whether these scores could be considered under or over estimations (i.e., whether they were significantly different from zero, absolute agreement between patient and informant).

RESULTS

The demographic details of the CABI group with respect to age, education, and current and premorbid intelligence, and injury characteristics are presented in Table 1.

Reliability of FCAI-objective

Cronbach's alpha for the 20 items was in the acceptable range for both the CABI group ($\alpha=.67$), and for the informant group ($\alpha=.88$).

Association of CABI group's performance with informant report

Although on average, overall performance in the CABI group ($\bar{x} = 49.41$, $SD = 7.84$) was similar to the level of performance reported by the informant ($\bar{x} = 50.12$, $SD = 12.18$), there was no association between objective performance and informant report ($r = 0.159$, $p = 0.48$) within patient-informant pairs.

Accuracy of Informant Report

Analyses were conducted within informant-patient pairs to investigate the reasons for the lack of an overall association between patient performance and informant report. With regard to the total FCAI-objective score, when calculating discrepancy scores within patient-informant pairs, the average discrepancy score was not significantly different from zero ($\bar{x} = 0.77$, $SD = 13.39$, $t(21) = 0.27$, $p = 0.79$). However, the discrepancy scores for six out of twenty items (30%) were found to be significantly different from zero, with three items being underestimated and the other three being overestimated by the informants. Table 2 shows the results of only the significantly discrepant items. Further information about the frequency of scores across the 22 informant-CABI dyad pairings on the 6 items and results of the part-whole correlations for each item with its corresponding subscale can be found in the Supplemental Digital Content (Supplementary Tables 1 and 2, respectively).

To estimate whether variability in ratings existed between informants who were professionally trained staff versus family members, we repeated the one-sample t test using only staff ratings ($n=19$, 86%). Results were identical compared to the prior one in terms of both the direction and significance level for 5 out of 6 items. One item (winning large amount of money) was not significant, although the directionality was the same. Detailed results for this analysis can be found in the Supplemental Digital Content (Supplementary Table 3).

DISCUSSION

Numerous studies have documented that individuals with brain injury have difficulties with managing their everyday activities, especially problems with their finances^{1,3,23,30,54,55}. However, studies often rely on informant reports without ascertaining the accuracy of their reports in an objective manner, with the implicit assumption that individuals with brain injury lack awareness of their abilities, are cognitively impaired, and are therefore unreliable reporters. The current study primarily sought to estimate the accuracy or reliability of informants' report by examining the concordance between informant report and CABI group's performance on the objective financial tasks. No significant associations were found between informants' perception of CABI participants performance on objective financial tasks, indicating a disconnect between what the patient knows, or is able to do, versus what the informant's perception of the patient's ability or knowledge is. To further understand the reason for this disconnection, we characterized the nature of FC misestimates by the informants. Informants significantly misestimated the CABI group's performance on 30% (6/20) of the measured items in both upward (i.e., overestimations) and downward (i.e., underestimations) directions.

The lack of correspondence between informant report and CABI individual's performance on financial tasks was surprising, especially because the majority of the informants were cognitive therapists working closely with these individuals. This finding raises the question of the extent to which informant reports can be singularly used as the 'gold standard' while assessing critical functional abilities such as financial management in cognitively impaired patients. Similar findings have been reported by previous studies even in other clinical populations including dementia^{56,57}. Such a lack of concordance can lead to an unnecessary curtailment, or lack of curtailment, of patients' access to finances. In addition, such discrepancies can result in interpersonal disputes between the two individuals, and consequently result in affective disturbances in the CABI individual⁵⁸.

A reason for the lack of association could be because of a combination of measurement issues and individual differences in response styles^{31,57}. A common problem while assessing functional activities is the use and interpretation of non-specific questions while collecting informant reports^{56,59}. For example, in the current study, CABI individuals were observed while performing specific tasks (e.g. writing a check, or identifying and calculating currency) and asked conceptual questions (e.g. describe the meaning of assets). Scoring was based on actual performance (e.g., correctly filled out all the elements of a check) and the extent to which they answered the question adequately (e.g., displayed full versus partial knowledge of what assets are). Informants, on the other hand, estimated how the individual would perform on a task (e.g., whether they could fill out a check, or calculate currency) and state whether the individual would be able to answer the question (e.g., whether they would know the meaning of assets).

Although the questions are seemingly identical for the CABI individual and the informant, in the current study several factors related to response styles might have influenced the informants responses, such as – (1) The informant may have only sporadically observed the performance of a task or may not have had a chance to observe the task at all. In such

instances, informants tend to make an educated guess based on past behaviors that they may or may not have frequently observed. (2) Memory biases could contribute to their misestimates. The informant may have observed errors while performing the task on one occasion, and despite the individual having improved on that task or not making errors in the following instances, informants may predominantly remember the negative event and report it. This phenomenon of negativity bias is well documented in learning and memory studies wherein individuals show a tendency to recall and recognize more instances of negative words and behaviors than the positive instances due to their affective potency^{60–62}. (3) CABI individuals may have been unable to answer a question adequately or show compromised task performance due to heterogeneous reasons. For instance, an individual may have difficulty adequately explaining concepts due to language difficulties or due to lack of knowledge. An individual may have been unable to perform a task due to cognitive impairments (attention, memory) or behavioral issues (impulsivity). Thus, certain deficits may truly reflect a deficit in financial capacity, whereas others such as impulsivity may not reflect an exclusive financial capacity impairment, but rather a broader behavioral disturbance. As informants are not asked about fine-grained mechanistic issues surrounding a deficit, some informants may carefully parse out the behavioral disturbances affecting FC and may not report a FC deficit per se, whereas others may not distinguish between behavioral (e.g., impulsivity) versus functional deficit (e.g., not knowing how to perform a task) and report FC to be impaired. Inter-individual differences in response styles of the informants may result in variable FC estimates for any given item. (4) Informant level of burden and negative affect may impact the ratings⁶³. Although this was not explicitly measured by the study, the majority of the informants interviewed were full-time professionals working at the day-care center, and thus may not have had significant burden of care. (5) Lastly, informants may have been aware of specific financial task performance and responses, but may have had no knowledge of CABI individual's skills and knowledge on other tasks and items. Thus, given the multidimensional nature of FC, informants may display varying levels of knowledge about individual items. As such, the *overall* score may not be an ideal method to assess informant accuracy. On the other hand, the overall score was not significantly different between the patient-informant pairs. Therefore, it can be argued that the overall score as opposed to the item-level individual score can be a useful measure because it serves to give a quick synopsis of the individual's functioning.

To address the issue related to the nature of information yielded from the individual scores versus the overall score, discrepancies for individual items were calculated to measure the extent and direction of the misestimation. Out of 20 items, informants overestimated CABI individual's skills and knowledge on 3 items, and underestimated on 3 other items. Interestingly, 5 out of 6 items were based on conceptual understanding of the CABI individual's knowledge, whereas only 1 was based on performance of an actual task (see Table 2; interpreting insurance brochure). Stated differently, out of 10 items that were based on conceptual level responses, 5 or 50% were misestimated, whereas 1/10 or 10% of concrete performance based tasks was misestimated. It has been previously proposed that individuals with brain injury may have difficulty estimating their skills for complex and abstract tasks³⁰. The current study findings extends this notion to informants as well – generally speaking, it appears that conceptually-based, abstract items are more prone to

misestimations than those based on concrete performance. It appears more difficult for informants to know “what patients know” than to know “what patients can do”. Therefore, both the overall score and the individual scores, in conjunction, serve a symbiotic function and provide unique perspectives to aid the individual.

When questions about FC arise in a clinical context, the practitioner is confronted with the dilemma of whether and to what extent s/he should rely on informant. Based on the current findings, we can suggest some strategies to approach this question, (1) Practitioners should preferably rely on collecting objective data whenever possible. This can be accomplished by using available instruments such as the FCAI, the financial domain in the Texas Functional Living Scale (TFLS)/Test of Everyday Functional Abilities (TEFA), among others (for a full review see ^{24,49,50}), (2) For data which cannot be objectively collected (such as for understanding whether the individual budgets), the practitioner can gather such information through carefully worded questions. Instead of asking abstract and open-ended questions, practitioners can ask concrete questions with forced choice answers. For example, instead of asking whether the individual budgets, practitioners can ask whether the individual has run out of money in the past 6 months, and whether this reflects a change in behavior. However, it must be acknowledged that under some circumstances solely collecting and relying on objective data may not be feasible and/or this may represent an oversimplification of the skill in question. For example, an individual may be able to adequately review an imitation of bank statements when shown in the clinic, but may have difficulty performing the task in real-time (e.g., when doing it online at home), or be unable to understand how debts (e.g., home mortgages) can affect the bank statement on a monthly basis, for example. Under such circumstance, informants become an essential part of the FC determination process.

The accurate perception of one’s ability to manage finances is critical. For example, an individual may forget to pay monthly bills, but because of lowered awareness, believe that s/he does not have such a difficulty. In fact, a recent study found that in individuals with moderate to severe brain injury, awareness was domain-specific (general vs. fatigue-related awareness) and that each type of awareness was proposed to rely on distinct processes⁵⁸. Therefore, awareness may not be a unitary construct and studying financial awareness and perhaps its diverse aspects may be more useful.

Some limitations of the study are, 1) We recruited a relatively small number of CABI individuals who were primarily living in a supported community setting, and who were demographically homogenous (older, white males). Before generalizing the findings to other populations, more research needs to be undertaken. (2) The FCAI is still being validated for its psychometric properties. And although not perfect, this tool holds promise to capture both the clinical and legal aspects of financial capability. Objective items (FCAI-objective) extracted for the current study belong to a standardized, longer instrument. Psychometric properties of the FCAI-objective needs to be established before it can confidently be used by future studies. (3) Informants in the current study consisted of both professional staff and family members. The selection of the informant was based on the degree of familiarity they had regarding the CABI individual’s financial abilities. Although concerns related to the disparate ratings by staff versus family members may arise, an analysis of the data with only the staff ratings revealed identical results. Thus, in the current study, variability across

informants was not problematic. (4) Lastly, we propose that financial awareness (awareness about one's own financial capacity) needs to be studied in an objective context. This will help clinicians assess financial capacity empirically without evoking subjective biases and errors.

In conclusion, the current study found that informants' perceptions diverge from CABI individuals' actual performance on financial tasks. The direction of misestimation was in both the upward and downward directions, and it was primarily for conceptually-based items rather than for those relying on actual performance. Various informant-related and task-related factors such as negative biases and non-specific nature of the questions, may have contributed to the discrepancy between informant report and CABI individual's performance. A set of practical strategies such as asking specific, close-ended questions to the informants are suggested to help clinicians obtain more reliable information. Although not specifically examined, it is apparent that informants may serve as a critical link between clinicians and CABI individuals for understanding the latter's capacity for executing complex tasks which cannot be assessed simplistically. Future work can shed light on the circumstances under which informant data will be crucial.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Table 1

The six FCAI dimensions along with a detailed descriptive of the activities it subsumes.

FC Dimension	Overview
Everyday Financial Abilities	Activities done on a routine basis such as paying bills and knowing how to pay bills; also includes daily financial problem-solving and knowing how to budget
Financial Judgment	Ability to use reasoning skills to make financial decisions, such as selecting the right kind of insurance, or setting financial goals and having a plan to achieve them
Estate Management	Conceptual understanding of assets and banking protocols
Financial Cognition	Requires basic financial literacy and numeracy skills, including functionally memory to remember four digits
Debt Management	Ability to manage finances efficiently without incurring debts.
Support Resources	Ability to seek assistance when faced with financial problems

Table 2

Demographic and Injury characteristics of the CABI group.

	Mean (<i>SD</i>), Range
Age (in years)	45.60 (8.67), 30–59
Education (in years)	13.45 (2.15), 9–19
Race %	Cau (90%) Black (4.5%) Asian (4.5%)
Sex (% Females)	6 (27%)
Relation Status	<i>n</i>
Never Married	13 (59%)
Divorced	5 (23%)
Married	2 (9%)
In a relationship	2 (9%)
Employment Status	<i>n</i>
Working, part-time (paid)	8 (36%)
Working, part-time (volunteer)	4 (18%)
Retired	3 (14%)
Disabled	2 (9%)
Unemployed	5 (23%)
Legally appointed Guardian of Finances *	Yes 1 (5%)
No. of years since injury	17.14 (9.5)
No. of years living in Supported Community Setting	9.24 (7.84)
Injury Type/TBI	<i>n</i>
Motor Vehicular Accident	13 (59%)
Other	6 (27%)
Fall	2 (9%)
Snowboarding accident	2 (9%)
Hit by vehicle	1 (4.5%)
Hit by object	1 (4.5%)
Unknown	3 (14%)
	Mean (<i>SD</i>), Range
BDI-II	14.59 (11.35), 1–42
BAI	6.27 (6.54), 0–23
WTAR T	47.41 (7.10), 35–63

	Mean (SD), Range
WASI-II Abv IQ	90.73 (8.51), 77–102

Note: MVA = Motor Vehicle Accident, BDI II = Beck's Depression Inventory – 2nd version, BAI = Beck's Anxiety Inventory, TBI = Traumatic Brain Injury, WTAR = Wechsler's Test of Adult Reading, WASI-II Abv IQ = Wechsler Abbreviated Scale of Intelligence.

* See Supplemental Digital Section for more information about the procedures for appointing a legal guardian of finances. In the FC determination process, the implications of having (or not having) a legal financial guardian is discussed.

Table 3

Summary of items which were significantly misestimated by the informants when compared to CABI group's objective performance.

Item	Description	Clinical Dimension	Mean (SD)		t	df	Sig. (2-tailed)	Direction of informant estimation
			Patient Performance	Informant Rating				
1	Importance of paying bill	Everyday Financial Abilities	3.64 (0.49)	2.64 (1.33)	3.40	21	.003	Under estimation
2	Where to seek financial assistance	Support Resources	1.91 (1.19)	1.23 (0.61)	2.64	21	.015	
3	Getting a large amount of money	Financial Judgement	1.59 (0.73)	1.00 (1.07)	2.27	21	.034	
4	Understanding overdraft facility	Estate Management	1.50 (1.37)	2.45 (1.34)	-2.31	21	.031	Over estimation
5	Long term financial goal	Financial Judgement	1.18 (1.18)	2.18 (1.01)	-3.58	21	.002	
6	Interpreting insurance brochure	Financial Judgement	0.45 (1.06)	1.41 (1.01)	-2.77	21	.012	