Daily Hassles and Health Among Persons with Severe Mental Disabilities

Steven P. Segal  
Debra J. VanderVoort

Steven P. Segal, Ph.D., is a professor at the University of California, Berkeley, in the School of Social Welfare and is also the director of the Mental Health and Social Welfare Research Group and the Center for Self-Help Research. Debra J. VanderVoort, Ph.D., is an assistant professor at the University of Hawaii at Hilo. She was formerly a postdoctoral fellow at the University of California, Berkeley, in the School of Social Welfare. She has a doctorate in Educational Psychology from the Counseling Psychology program at the University of Utah.

Abstract: The present study investigated the impact of daily stress or hassles on the physical and psychological health of persons with severe mental disabilities. The results suggest that the most frequently reported hassles were financial concerns, loneliness, boredom, crime, concerns about accomplishments, problems with verbal and written expression, and declining health. High levels of stress were related to both increased somatic and psychiatric symptomology, indicating that the association found between hassles and adaptational outcomes in general population samples can be generalized to those with psychiatric disabilities. Implications of the results include a continued emphasis on rehabilitation programs focusing on strategies that help these individuals cope with the stresses of their daily lives.

The view that stress is involved in the etiology of mental and physical illness has been the impetus for much current theory and research in the behavioral sciences. Even for severe mental disorders, in which biological vulnerability tends to play a large causal role, social and environmental stressors are thought to affect the course of the disability. In these vulnerability/stress models of severe mental disorder, exposure to stressful situations is seen as capable of triggering psychotic episodes and hence perpetuating the disability (Anthony & Lieberman, 1986; Bowers & Wing, 1983; Nuechterlein & Dawson, 1984; Strauss & Carpenter, 1981). Persons with severe mental disabilities (PSMD) tend to be particularly vulnerable to the impact of stress, for they often lack the problem-solving and social skills needed to cope effectively with stressful situations (Cohen, 1978; Eisler, Hersen, Miller, & Blanchard, 1974; Hersen, Bellack, & Turner, 1978; Rochester, 1978; Spivak, Platt, & Shure, 1976).

One approach to assessing the impact of stress on mental and physical health has been to look at life events. Major life events (e.g., change in residence, death of a loved one, divorce) have been associated with the onset of
numerous medical disorders including cardiovascular disease, stroke, diabetes mellitus, rheumatoid arthritis, and hospitalization for any medical reason (Dohrenwend & Dohrenwend, 1984; Hinkle, 1974; Holmes & Masuda, 1974; Rahe & Arthur, 1978). A number of studies support the view that life events can precipitate psychotic episodes for those with severe mental disabilities (Brown & Birley, 1968; Harder, Strauss, Kokes, Ritzler, & Gift, 1980; Lukoff, Synder, Ventura, & Nuechterlein, 1984; Rabkin, 1980). However, the correlations between life events and health outcomes tend to be weak (Rabkin & Streuning, 1976), indicating that such events may not play a large causal role in the onset of illness (Paykel, 1978).

A more recent approach to assessing the impact of stress on physical and mental health, stemming in part from dissatisfaction with the life events approach, involves the investigation of relatively minor stresses that characterize everyday life or “hassles” (e.g., financial concerns, loneliness, family and work problems, too many responsibilities). In addition to evaluating stressors that people face on a regular basis, this approach includes an assessment of the subjective significance of events. That is, it focuses not only on environmental factors but on the interaction of personal and environmental factors, based on the view that how a person appraises and copes with a situation will determine whether or not it is experienced as stressful (Lazarus & Folkman, 1984).

As with life events, hassles have been associated with poor psychological and physiological health (Lazarus, 1984). Types of somatic illnesses associated with hassles range from minor problems (e.g. headaches, flu) to chronic conditions (e.g. hypertension, asthma), while depression and anxiety are among the psychological problems related to hassles (DeLongis, Coyne, Dakof, Folkman, & Lazarus, 1982; DeLongis, Folkman, & Lazarus, 1988; Gruen, Folkman, & Lazarus, 1988; Kanner, Coyne, Schaefer, & Lazarus, 1981). Although both life events and hassles have been associated with poor psychological and somatic health outcomes, research comparing the two indicates that hassles are more strongly related to poor health than life events (Burks & Martin, 1985; Delongis et al., 1982; Kanner et al., 1981; Monroe, 1983; Thoits, 1983; Wagner, Compas, & Howell, 1988; Zarski, 1984).

To date, the literature reveals only one study investigating hassles among PSMD. In their comparison of the hassles experienced by community-dwelling PSMD (N=69) and a general population sample (N=35), Miller and Miller (1991) found that the main difference between the PSMD and the mainstream population was that the PSMD reported too few things to do and loneliness as problems whereas the mainstream population reported too many things to do and social obligations. Items of overlap among the 10 most frequently reported hassles between the two populations were
doing chores, planning meals, making decisions, losing things, and not getting enough rest.

There has been no published investigation of the relationship between hassles and physiological or mental health status among the PSMD. In light of the importance of hassles in personal outcomes in other populations, this study addressed the question of whether this relationship can be generalized to PSMD. It was expected that higher levels of daily stress or hassles would be associated with increased somatic and psychiatric symptomology. In addition, given that only one study investigated the nature of hassles experienced by PSMD and that the sample size was small (Miller & Miller, 1991), a description of the hassles characteristic of our PSMD sample was included. We anticipated that the hassles most frequently reported would reflect the lifestyle of a low income, socially isolated population.

**Methodology**

This project is part of a follow-up study of 393 PSMD residing in sheltered-care facilities (i.e., board and care, family care, and halfway houses) throughout California (Segal & Aviram, 1978). The first set of data was collected in 1973 while the follow-up data was collected from 1983–1985.

In 1973, the fire clearance records of the State Department of Mental Health were used to compile a list of all facilities offering supervised living arrangements that housed at least one person with a history of psychiatric hospitalization. From these records, the bed capacity of each facility was determined.

To obtain the sample, the state was divided into three areas (viz., Los Angeles County, the San Francisco Bay Area, and all other counties). The San Francisco Bay Area and Los Angeles areas were selected with certainty. For the rest of the state, a cluster sample was used where counties were the primary selection unit. Sacramento and Mendicino Counties were selected from the north and Ventura and San Diego Counties were selected from the south. From all six areas, a sample of facilities was drawn with probabilities proportionate to bed capacity. The final sample included 214 sheltered care facilities located in 157 census tracks in California. Individuals were selected within facilities with systematic random sampling, with an overall selection ratio of 1 to 36. Data was collected via structured personal interviews of the 393 residents. For further details on the sampling methodology, see Segal and Aviram (1977).

From 1983 to 1985, the residents were traced through both formal and informal sources. Of the 393 residents interviewed in 1973, 360 (91.6%) were located at follow-up (hereafter designated as 1983). Of these residents, 270 (75.0%) were alive and 90 (25.0%) were confirmed dead. Of the 270 residents located alive, 253 (93.7%) consented to be re-interviewed.
However, 19 of these interviews were deleted due to questionable validity as a function of the participants’ extreme psychological disability. Thus, the sample consisted of 234 subjects.

No significant differences in 1975 characteristics were observed between the sample members who were located versus those who were not, or the sample members who died versus those alive at follow-up. However, blacks were more likely to refuse to be interviewed ($\chi^2 = 10.3, p < .006$) at follow-up and were more likely to be too ill to complete an interview ($\chi^2 = 10.9, p < .01$).

**Instruments**

To investigate the relationship between stress and adaptational outcomes, the following instruments were employed.

**Stress.** The daily stress of our population in 1983 was assessed via the use of a shortened version of the Hassles Scale (Kanner et al., 1981). The scale was reduced to 46 of the original 117 scale items, given that some of the original items had little relevance to this population (e.g., items dealing with work and home maintenance). The internal consistency of the shortened version was $\text{Alpha} = .91$. The validity of using a shorter version of this scale is supported by other research in which a shortened version was employed and found to be related to somatic and psychological health problems (DeLongis et al., 1988; Gruen et al., 1988; Holahan, Holahan, & Belk, 1984; Sternbach, 1986). With the exception of items dealing with work and home care responsibilities, there was considerable item overlap between our scale and the 53 item scale used by Delongis et al. (1989) and Gruen et al. (1988), the 35 item scale used by Holahan et al. (1984) and the 22 item scale used by Sternback (1986). Given our interest was in what tends to be a source of chronic daily stress for this population, a trait version of the revised Hassles Scale was used (Kanner et al., 1981). That is, we investigated the hassles that were typical for the person rather than those experienced in the last month (the state version of the scale). Each hassle was rated on a four-point scale with zero indicating none and three indicating an extremely severe hassle. For the regression analyses, total hassles scores were obtained by summing across ratings given to all items with the exception of health-related items (see Table 1 for deleted items). This allowed for the avoidance of overlap between items on the Hassles Scale and our measures of health status.

**Physical Health Status.** Two self-report measures of physical health status were employed, one measuring relatively major health problems (the Health Problems Scale), and the other assessing relatively minor physical symptoms (the Physical Symptoms Scale). The Health Problems Scale (HPS) was based on questions from the National Health Interview Survey.
<table>
<thead>
<tr>
<th>Hassle</th>
<th>% Hassled</th>
<th>Health-related Items Deleted for Regression Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rising prices of common goods</td>
<td>48.3</td>
<td></td>
</tr>
<tr>
<td>2. Being lonely</td>
<td>44.7</td>
<td></td>
</tr>
<tr>
<td>3. Troubling thoughts about the future</td>
<td>42.3</td>
<td></td>
</tr>
<tr>
<td>4. Too much time on hands</td>
<td>42.3</td>
<td></td>
</tr>
<tr>
<td>5. Crime</td>
<td>39.5</td>
<td></td>
</tr>
<tr>
<td>6. Filling out forms</td>
<td>39.2</td>
<td></td>
</tr>
<tr>
<td>7. Not enough money for entertainment</td>
<td>39.0</td>
<td></td>
</tr>
<tr>
<td>8. Regrets over past decisions</td>
<td>35.3</td>
<td></td>
</tr>
<tr>
<td>9. Inability to express myself</td>
<td>35.0</td>
<td></td>
</tr>
<tr>
<td>10. Concerns about getting ahead</td>
<td>33.5</td>
<td></td>
</tr>
<tr>
<td>11. Declining physical abilities</td>
<td>33.5</td>
<td>Deleted</td>
</tr>
<tr>
<td>12. Smoking too much</td>
<td>33.3</td>
<td>Deleted</td>
</tr>
<tr>
<td>13. Physical illness</td>
<td>31.6</td>
<td>Deleted</td>
</tr>
<tr>
<td>14. Fear of rejection</td>
<td>31.4</td>
<td></td>
</tr>
<tr>
<td>15. Concerns about owing money</td>
<td>31.1</td>
<td></td>
</tr>
<tr>
<td>16. Trouble with reading, writing, spelling</td>
<td>31.1</td>
<td></td>
</tr>
<tr>
<td>17. Too many interruptions</td>
<td>30.6</td>
<td></td>
</tr>
<tr>
<td>18. Not enough money for transportation</td>
<td>30.2</td>
<td></td>
</tr>
<tr>
<td>19. Fear of confrontation</td>
<td>29.9</td>
<td></td>
</tr>
<tr>
<td>20. Being exploited</td>
<td>29.9</td>
<td></td>
</tr>
<tr>
<td>21. Troublesome neighbors</td>
<td>29.2</td>
<td></td>
</tr>
<tr>
<td>22. Difficulties seeing or hearing</td>
<td>29.1</td>
<td>Deleted</td>
</tr>
<tr>
<td>23. Concerns about new events</td>
<td>27.3</td>
<td></td>
</tr>
<tr>
<td>24. Gossip</td>
<td>26.8</td>
<td></td>
</tr>
<tr>
<td>25. Concerns with meeting high standards</td>
<td>26.6</td>
<td></td>
</tr>
<tr>
<td>26. Inconsiderate smokers</td>
<td>24.9</td>
<td></td>
</tr>
<tr>
<td>27. Concerns about bodily functions</td>
<td>24.2</td>
<td>Deleted</td>
</tr>
<tr>
<td>28. Concerns about inner conflicts</td>
<td>24.0</td>
<td></td>
</tr>
<tr>
<td>29. Prejudice and discrimination</td>
<td>23.8</td>
<td></td>
</tr>
<tr>
<td>30. Too many responsibilities</td>
<td>23.3</td>
<td></td>
</tr>
<tr>
<td>31. Trouble with arithmetic skills</td>
<td>23.2</td>
<td></td>
</tr>
<tr>
<td>32. Concern over the meaning of life</td>
<td>22.5</td>
<td></td>
</tr>
<tr>
<td>33. Social obligations</td>
<td>22.4</td>
<td></td>
</tr>
<tr>
<td>34. The weather</td>
<td>21.8</td>
<td></td>
</tr>
<tr>
<td>35. Concerns about medical treatment</td>
<td>21.2</td>
<td>Deleted</td>
</tr>
<tr>
<td>36. Not getting enough rest</td>
<td>20.5</td>
<td>Deleted</td>
</tr>
<tr>
<td>37. Side effects of medication</td>
<td>20.0</td>
<td>Deleted</td>
</tr>
<tr>
<td>38. Nightmares</td>
<td>19.2</td>
<td></td>
</tr>
<tr>
<td>39. Not enough time to do necessary things</td>
<td>18.9</td>
<td></td>
</tr>
<tr>
<td>40. Financial dealings with friends</td>
<td>18.5</td>
<td></td>
</tr>
<tr>
<td>41. Television</td>
<td>15.5</td>
<td></td>
</tr>
<tr>
<td>42. Too many things to do</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>43. Problems with children</td>
<td>12.1</td>
<td></td>
</tr>
<tr>
<td>44. Sexual problems—physical</td>
<td>10.7</td>
<td>Deleted</td>
</tr>
<tr>
<td>45. Legal problems</td>
<td>9.3</td>
<td></td>
</tr>
<tr>
<td>46. Menstrual problems</td>
<td>4.7</td>
<td>Deleted</td>
</tr>
</tbody>
</table>
(National Center for Health Statistics, 1985). It determines the number of problems, out of a possible 10, experienced in the last 6 months. The problems are 1) hardening of the arteries; 2) high blood pressure; 3) heart trouble; 4) a stroke or general neurological problems; 5) Parkinson's disease; 6) epilepsy, fits, or seizures; 7) fainting or loss of consciousness; 8) trouble controlling bowel movement or urination; 9) trouble with the teeth or gums; and 10) other injury or chronic condition.

The Physical Symptoms Scale (PSS) consists of six items, namely 1) clogging or fullness in the head or nose; 2) shortness of breath; 3) trembling hands; 4) sour stomach; 5) headaches; and 6) feeling weak all over. Participants were asked whether they experienced these symptoms often, sometimes, or never. There was a strong correlation between the HPS and PSS ($r=.43, p<.0001$). The use of self-report measures of somatic symptomology is common in research on daily stress (DeLongis et al., 1982; Gruen et al., 1988) and have been found to be highly correlated with objective measures of health such as medical records (Andrews, Schonell, & Tennant, 1977; Brook et al., 1979; Meltzer & Hochstam, 1970).

**Mental Health Status/Psychopathology.** Psychological functioning at follow-up was measured via the use of the 16-item Brief Psychiatric Rating Scale (BPRS) (Overall & Gorham, 1962). The BPRS is a 16-item scale where each item ranges from one to seven, with one indicating "not present" and seven indicating "extremely severe." Trained social workers, with at least a year’s experience in working with PSMD, were used as interviewers. Definitional anchors for each BPRS symptom item as well as films of interviews with patients conducted at the time of admission and discharge from the psychiatric hospital were used to train the interviewers. The internal consistency of the BPRS was Alpha=.86.

**Dual Diagnosis/Substance Abuse.** In light of evidence indicating that PSMDs are at high risk for substance abuse (Drake & Wallach, 1989; Richard, Lislow, & Perry, 1985), coupled with the fact that this may clearly impact health status, we controlled for the effect of substance abuse in our regression models predicting health outcomes. The assessment of a dual diagnosis (i.e., a diagnosis of a psychiatric disorder as well as alcohol and/or other substance abuse) was undertaken in the following way. Primary and secondary discharge diagnoses were obtained for 201 sample members from 1,038 (89.6%) of their 1,159 episodes of psychiatric hospitalization during the time between the initial interview and follow-up. These episodes were derived from hospital records provided by 119 facilities, 90 of which were located in California, and 29 out of state. Of these 119 facilities, 34 were state mental hospitals, 11 were Veteran’s Administration hospitals, 70 were local acute psychiatric facilities, and four
were L-facilities or convalescent hospitals. The primary and secondary diagnoses consisted of their most recent primary and secondary diagnoses. Of the 201 individuals, 58 (28.9%) had a dual diagnosis.

*Social and Instrumental Support.* Given that previous research has demonstrated the importance of supportive relationships in health outcomes for both the general population as well as those with psychiatric disabilities (Berkman & Syme, 1979; House, Landis, & Umberson, 1988; Strauss & Carpenter, 1977), measures of social and instrumental support were also included as control variables in our regression models. Both social and instrumental support were assessed using dichotomous variables (i.e., having or not having at least one relationship in which social or instrumental support was received) in light of the fact that this appears to be more crucial for this population than the number of supportive relationships (Gottlieb, 1981; Miller & Ingham, 1976).

**Results**

Sample demographic characteristics in 1983 are summarized as follows: 1) 53% were male, 47% were female; 2) age ranged from 28–75 (X=53.4, s.d.=12.4); 3) 53.6% were never married, 5.6% were married, and 40.8% were divorced widowed, or separated; 4) 7.7% were employed; and 5) 55.6% resided in sheltered care facilities, 31.2% resided in the community (i.e., lived in their own or a rented house or apartment, with family, or in a hotel), and 13.2% resided in institutions, primarily nursing homes. None of the participants was homeless.

A rank-ordered list of the most frequently reported hassles is reported in Table 1. Financial concerns (1, 7), loneliness (2), boredom (4), crime (5), concerns about accomplishments and goals (3, 8, 10), problems with verbal and written expression (6, 9), and declining health (11) were among their most frequent sources of daily stress. When considering the severity of hassles, little difference in rank order was found. The eight most frequent stressors were also reported to be most severe, with additional physical health concerns (12, 13) being included in the 10 most severe hassles.

In the multivariate analyses used to assess the relationship between stress and health outcomes, the following control variables were included in the regression models: age, sex, substance abuse, emotional support, and instrumental support. The results of the regression analyses regarding the relationship between stress and health status are reported in Table 2. In the regression model involving the HPS, stress and age were significant. That is, high scores on the Hassles Scale were related to higher numbers of reported health problems. As one might expect, the elderly also reported more major health problems.
### Table 2
**Daily Hassles and Health Status**

<table>
<thead>
<tr>
<th>Measures of Health Status</th>
<th>HPS(^1) (Beta)</th>
<th>PSS(^2) (Beta)</th>
<th>BPRS(^3) (Beta)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily Hassles</td>
<td>.26**</td>
<td>.33***</td>
<td>.19*</td>
</tr>
<tr>
<td>Controls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional Support</td>
<td>n.s.</td>
<td>n.s.</td>
<td>-.26**</td>
</tr>
<tr>
<td>Instrumental Support</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>n.s.</td>
<td>.17*</td>
<td>n.s.</td>
</tr>
<tr>
<td>Age</td>
<td>.19*</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Sex</td>
<td>n.s.</td>
<td>n.s.</td>
<td>n.s.</td>
</tr>
<tr>
<td>Adjusted</td>
<td>Adjusted</td>
<td>Adjusted</td>
<td>Adjusted</td>
</tr>
<tr>
<td>(R^2 = .08)</td>
<td>(R^2 = .08)</td>
<td>(R^2 = .07)</td>
<td></td>
</tr>
<tr>
<td>(P = .003)</td>
<td>(P = .002)</td>
<td>(P = .008)</td>
<td></td>
</tr>
<tr>
<td>(F = 3.4)</td>
<td>(F = 3.7)</td>
<td>(F = 3.0)</td>
<td></td>
</tr>
<tr>
<td>(df(6, 154))</td>
<td>(df(6, 154))</td>
<td>(df(6, 153))</td>
<td></td>
</tr>
</tbody>
</table>

*Note: All \(p\) values are two-tailed. Betas are partial standardized regression coefficients.

***\(p<.001\); **\(p<.01\); *\(p<.05\)

1. **HPS** = Health Problems Scale (major physical health problems)
2. **PSS** = Physical Symptoms Scale (minor physical symptoms)
3. **BPRS** = Brief Psychiatric Rating Scale (psychopathology)
4. **n.s.** = not significant

In the regression analysis involving the PSS (more minor physical symptoms than the HPS), stress and substance abuse were important contributors to the model. Once again, high scores on the Hassles Scale were associated with increased physical health symptoms, as was substance abuse.

In the final analysis, psychopathology was the dependent variable. Here, stress and emotional support were significant. That is, higher stress and a lack of emotional support were related to poor psychological functioning. Although the results reported in Table 2 involved deleting the physical health items (and the item “concern over inner conflicts”) from the stress measure, the relationship between stress and psychopathology was also significant when the problem of item overlap was dealt with by deleting the somatic concern item from the measure of psychopathology (BPRS). Thus,
even when the measure of psychopathology included only psychological symptoms, stress was found to play a role in poor psychological health.

In sum, the results suggest that high stress is associated with somatic and psychological health problems. That is, high scores on the Hassles Scale were significantly related to major and minor physical health problems as well as increased psychiatric symptomology. This relationship was maintained when the effects of age, gender, substance abuse, emotional support, and instrumental support were taken into consideration. Although the results indicate that stress plays a role in both, the relationship between stress and somatic health was somewhat stronger than the relationship between stress and psychological health (as noted by the beta weights in the regression models). This was substantiated in a test for the significance of the difference between the correlations of the PSS and Daily Hassles Scale ($r=.37$) and the BPRS and Daily Hassles Scale ($r=.20$). The observed difference was significant at $p<.05$. The difference between the correlation of HPS and Daily Hassles and BPRS and Daily Hassles was not significant.

**Discussion**

The results suggest that the relationships found between hassles and adaptational outcomes in general population samples can be generalized to PSMD. That is, high daily stress was associated with both increased psychological and somatic symptomology amongst those with psychiatric disabilities. The finding that the strongest relationship was between hassles and somatic health suggests that daily stress may play a particularly prominent role in the physical health status of this population. The fact that health-related items were deleted from the stress measure lends additional support to this conclusion. That is, the lack of item overlap between the stress and physical health measures weakens the circularity argument.

The finding that the relationship between hassles and somatic health was stronger than the relationship between hassles and psychological health contrasts with the results of other research where the reverse was found (Gruen et al., 1988). These differential results may be explained on the basis of methodological differences. In the study by Gruen and his colleagues (1988), a state version of the Hassles Scale was employed to investigate the relationship between stress and somatic and psychological outcomes over a relatively short period of time, whereas in the present study, as mentioned, a trait version of the scale was used to assess chronic sources of daily stress. Hence, the relationship between hassles and psychological functioning may be stronger in this population, as with mainstream populations, during particularly problematic times.

In any case, the relationship found between reported daily hassles and psychopathology supports the vulnerability/stress model of psychiatric dis-
abilities, which suggests that stress plays a role in severe mental disability (Anthony & Lieberman, 1986; Bowers & Wing, 1983; Nuechterlein & Dawson, 1984; Strauss & Carpenter, 1981). Once again, there was no item overlap between the stress and psychological health measures. Although future longitudinal research is needed to determine the importance of daily stress in the long-term course of psychiatric disabilities, the finding in this study that stress is associated with the severity of psychological symptoms yields support for the pursuit of such investigations.

The association between stress and psychopathology suggests that an emphasis on coping skills is an important aspect of rehabilitation programs for the SMI. Increased availability of psychosocial rehabilitation centers and skills training programs would be particularly beneficial for PSMD, for the focus in these programs is on strategies to help people cope with the stresses of their everyday lives (Beard, Propst, & Malamud, 1982). Based on the results of this study, one would expect that better coping skills would facilitate improvement in both their psychological and physical well-being.

As one might expect, the stressors that were of greatest concern to this population reflected the life-style of a low-income, socially isolated, and predominantly unemployed population whose disability renders upward mobility and negotiation of complex organizational systems difficult. Although some of the most frequently reported stressors differ from those found by Miller and Miller (1991), the scales used in the two studies were not identical. Nonetheless, problems with loneliness and boredom (or having too much time on one’s hands) were common across the two studies.

While it may not be possible to address all the most frequently reported stressors of PSMD, it may be possible to address some of them (e.g., loneliness, boredom, crime, declining health, and problems with verbal and written skills). For example, concerns regarding physical health could be addressed by placing more emphasis on the delivery of preventive medical services and adequate interface between primary care and mental health care services. This may help alleviate their concerns by reducing the high rate of unrecognized medical disorders, which contributes to the high morbidity and mortality risk among psychiatric populations (Eastwood, 1975; Hall, Gardner, Popkin, LeCann, & Stickney, 1981; Karus, Walzman, Lindenmeyer, & Buckley, 1980; Koranyi, 1977, 1979; Marticle, Hoffman, Bloom, Faulkner, & Kepers, 1987).

Increased participation in psychosocial rehabilitation programs may not only enhance their coping skills, as indicated previously, but aid in the reduction of social isolation and boredom via the formation of broader social networks. Involvement in self-help programs would be another means of increasing social ties. This, in turn, may enable them to improve their skills of self-expression, thus reducing another major source of stress.
for these individuals. Skills training programs that include a focus on the paperwork involved in negotiating the receipt of federal and state services (e.g., Social Security, state health care) would also benefit these individuals.

Finally, the likelihood that sheltered care facilities located in central city high crime neighborhoods are more likely to remain open than those located in more desirable neighborhoods (Segal & Silverman, 1991) validates the concern of the population of people with mental illness with crime. While it has become increasingly problematic to locate such facilities in diverse neighborhoods (Dear & Wolch, 1987), programmatic efforts to do so should be reinforced. This may involve education of neighborhood residents (e.g. through brochures, personal contacts) in locations of proposed facilities in order to help minimize misconceptions about PSMD and hence foster more benevolent attitudes. For community dwelling PSMD who live on their own, assistance from mental health care professionals in locating housing may increase their chances of finding suitable housing in reasonably safe neighborhoods.

Although longitudinal replication of the results is needed before causal inferences can be drawn, the findings of this study suggest that daily stress plays an important role in the psychological and physical health status of PSMD. Incorporation of additional information on individual health habits would strengthen the claim that daily stress is related to the more severe types of somatic illness. Finally, future research might focus on the nature of coping styles characteristic of this population, the effectiveness of rehabilitation programs designed to improve coping skills, and the impact of improvement on adaptational outcomes.

The research has been supported by grants from the Robert Wood Johnson Foundation and the National Institute of Mental Health.

REFERENCES


Behavioral Medicine, 4, 1–39.
hood contributions. Manuscript submitted for publication.
tion and synthesis of the literature. In H. B. Kaplan (Ed.), *Psychosocial stress: Trends in the-
an integrative model of psychosocial stress. *American Journal of Community Psychology, 16*,
189–205.