DAILY HASSLES AND CHRONIC STRAINS: A HIERARCHY OF STRESSORS?

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Abstract—Among 105 poor, male heads of household in an urban center of India, common daily hassles were similar to those experienced by individuals from economically advantaged, western countries. However, we did not replicate the correlation between hassle frequency and mental health problems that has been previously found in a middle-class, western sample. In contrast to daily hassles, which include low-intensity, relatively discrete stressors (e.g. disagreement with spouse, missing a bus), chronic strains include ongoing social and environmental conditions that represent high-intensity stressors (e.g. substandard housing, inadequate access to water) that threaten survival. We found that chronic strains were associated with greater levels of psychosomatic symptomatology, as well as lower perceived social support. Furthermore, the correlation between chronic strains and psychosomatic symptoms increased when the effects of income were statistically controlled, suggesting that income attenuates the effects of chronic strains and that chronic strains affect symptoms independent of income. In sum, chronic strains may be a more valid and potent stressor than daily hassles in poor, urban populations in developing countries.

Key words—chronic strains, daily hassles, stress, psychosomatic symptoms, third world

The promise of a higher standard of living associated with increased industrialization and urbanization of cities has sparked the re-location of millions of people from the countryside into urban centers throughout the third world. There are many costs connected to the vast social, economic, and demographic changes resulting from these population shifts. Most urban centers have been unable to absorb the throngs of migrants, with burgeoning populations straining the urban infrastructure. People who are uneducated and unskilled tend to suffer the brunt of the social costs, as competition for menial labor (and wages), housing, and food becomes more acute. Many people are forced to reside in substandard housing, subsist on a minimal diet, and generally eke out an existence by whatever means available.

Rural migrants often aspire to elevate their social status by educating themselves or their children. For the present, however, the lower social classes must face considerable stressors just to survive. We are interested in describing the nature of the stressors accompanying extreme, urban poverty and the related coping resources and adaptive costs. This study is also a preliminary step toward understanding how well western models inform us about stressors and coping processes in a non-western, poverty-stricken sample. The sample more closely approximates urban dwellers in the third world, experiencing a range of stressors typically not found among the oft-studied, economically advantaged samples of North America and western Europe.† Moreover, the stressors observed in the current study sample appear to be more enduring and severe than those found in western stress research. We hypothesize that (1) chronic stressors that accompany urban poverty in the third world will be associated with negative health outcomes, specifically greater psychosomatic complaints, and (2) more mundane, daily hassles, which have been associated with disorder in western samples, will have little or no association with health in the population in this study.

A related goal of the present study is to describe the nature and distribution of two types of stressors, daily hassles and chronic strains, in a sample of poor, urbanites in a third world country. Daily hassles [7–13] are stressors that produce low-intensity threats [17]. Typical daily hassles include an argument with a friend, a lack of sleep, missing the bus, or a disagreement with a colleague. Daily hassles are annoyances that do not result in great adaptive challenges [18], although some western stress researchers have argued that the impact of daily hassles on health may be greater than that of major life events, such as death of a spouse [9].

In contrast, chronic strains [cf. 14–16] are stressors that produce high-intensity threats. Common chronic strains among third-world, urban dwellers include housing that offers little protection from the outside world and a lack of steady income. Chronic strains are social and environmental conditions that threaten and interfere with survival prospects for individuals and their families. In addition to differences in severity between these stressors, daily hassles and chronic stressors can be distinguished by a temporal dimension: daily hassles are time-limited, discrete events,
whereas chronic strains are continuous and long-term situations. Like daily hassles, chronic strains are believed to have a greater impact on health than major life events [16]. To our knowledge, however, no comparison has been made between the health impacts of daily hassles versus chronic strains.

We believe that the association between chronic strains and disorder will be greater than that between daily hassles and disorder. That is, the effects of chronic strains on health are hypothesized to overshadow the presumed negative health consequences of daily hassles. Chronic strains also are expected to be more potent than daily hassles because they are probably coupled with a lack of coping resources. The economically impoverished context within which chronic strains are likely to occur will probably have a negative impact on coping resources [19–21]. For example, not bringing home a regular paycheck is a potent stressor because people attach considerable importance to such role activities [14]. Evidence both from people who have recently lost their jobs [22] and from those undergoing economic hardship [23] suggests that financial problems are a major source of stress associated with negative health outcomes. However, for the destitute in the third world this "role strain" may become a devastating, chronic strain because of the usual corresponding lack of other economic and social resources to cope with the problem. That is, the severity and duration of the stressor experienced by a poor person missing a paycheck may be exacerbated by the fact that his or her social network is likely to be poor also, and consequently unable to help mitigate the financial crisis. One strain often leads to another and subsequently to a chain of strains. Lack of food or medical help may prolong ill health or even result in the death of a child or other family member. High infant mortality rates and shorter lifespan are well-known phenomena in communities such as the one we studied.

Within our sample, common chronic strains include inadequate access to water, to steady employment, or to decent shelter. The effect of stressors operationalized at this level has received little empirical attention. Contending with non-affordable housing and inadequate access to public services redefines the phrase "adaptive challenge". As noted above, the health consequences of daily hassles may be negligible in the context of chronic strains. A person besieged daily by a lack of health and material resources for himself and his family may suffer little or no distress from exposure to minor daily hassles, such as missing a bus or having a spat with his wife.

Western researchers have observed that exposure to stressors does not necessarily result in or exacerbate physical and psychological pathology. Individual differences in vulnerability to illness from stressors depend upon a number of factors. Thus, in addition to describing the stressful conditions of the urban poor in India, and the respective role of daily hassles and chronic strains in psychosomatic health, a third objective is to examine the role of social support in the stress process. In western research, at least, social support appears to play an important role in the stress process [for reviews see 24–27]. Social support is often an important moderator of the stressor–pathology link, acting to buffer or partially ameliorate the negative impacts of stressors on health [28–31].

Social support is intriguing to consider in the sociocultural context of a third world country like India [32], particularly because family life and close friendships, often dating from childhood, play a central role in Indian life. The centrality of social relationships in Indian life stands in contrast to the peculiarly western pre-occupation with work and professional advancement. Social, geographic, and economic mobility are very limited in India, as in most of the world. One result of this immobility is that people remain highly interconnected with family and the same circle of friends throughout their lives. However, the extent to which friends and family are viewed as support resources by a sample such as ours is unknown. Perhaps individuals facing life-threatening chronic strains, who are embedded in a network that has few resources to alleviate those strains, may not perceive their network as supportive.

In summary, most studies on stressors and coping consist of affluent samples from North American and western Europe, which comprise a small and unrepresentative portion of the world's population. This study examines stressors and social coping resources in a poor, third world sample. We have three objectives: (1) We provide a description of common sources of stress, including seldom studied stressors called chronic strains. (2) The association between chronic strains and psychosomatic symptoms is compared with the association between daily hassles and psychosomatic symptoms. These associations are examined with and without statistical controls for income to rule out potential spurious relations between the stressors and symptoms that might be driven by income. (3) The role of social support as a coping resource is examined. Through largely descriptive analyses we hope to begin to understand whether western psychological models of stress and coping derived mainly from research with North American and western European middle- and upper-class samples are valid for a larger share of the world's population.

**METHOD**

**Participants**

Participants were 105 males heads of household from Pune, India. The median age of the sample was 24 years. The households sampled appear to be representative of the urban poor and lower classes in India [33]. * Table 1 presents the distributions of major

*According to a publication by the Task Force of the Planning Commission in India, and subsequent National Sample Surveys, 40% of India's population has been living below the poverty line continuously over a long period [41]. In the city of Pune, where our study was conducted, the population exceeds 2 million. About 33% of the population of Pune lives in slums and 10% belong to the scheduled castes (which are a disadvantaged social class, qualified for affirmative action programs, have low-level jobs and education achievement). Clearly our sample is from this lower tier of the social class in Pune, with 51% living in the slums and 73% in scheduled castes.
Table I. Demographic characteristics of study participants

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Religion:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hindu</td>
<td>80</td>
<td>76</td>
</tr>
<tr>
<td>Baudha</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td>Jain</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Caste:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scheduled</td>
<td>77</td>
<td>73</td>
</tr>
<tr>
<td>Nonscheduled</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Education:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Middle school</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>Higher secondary school</td>
<td>52</td>
<td>50</td>
</tr>
<tr>
<td>Earnings per month (Rs = rupees):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 500 Rs</td>
<td>17</td>
<td>16</td>
</tr>
<tr>
<td>500-1000 Rs</td>
<td>39</td>
<td>37</td>
</tr>
<tr>
<td>1001-2000 Rs</td>
<td>41</td>
<td>39</td>
</tr>
<tr>
<td>Greater than 2000 Rs</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Marital status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>90</td>
<td>86</td>
</tr>
<tr>
<td>Single</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

demographic characteristics of the sample. The median income was 750 rupees per month (16 rupees equals one U.S. dollar), none of the participants graduated from high school, 76% were Hindu, 86% were married, and 73% were in a scheduled caste (i.e. socially and culturally disadvantaged groups eligible for affirmative action programs in India). The majority (75%) of the respondents were renters and had lived in their homes for an average of 8 years.

Basic services and housing infrastructure were lacking by western standards (see Figs 1–3). Residential density ranged from 11 persons per room to 2 rooms per person, with a mean of 3.5 persons per room; 92% of the sample had no refrigerator or telephone; 85% had no scooter or car for transportation; 47% had no running water in the home; 31% had no indoor bath facilities. A majority of the sample was financially insecure: 54% had no savings or government bonds, and 67% had no insurance of any kind.

**Procedure**

Approximately one quarter of India’s 750 million people live in cities, making it the fourth largest urban population in the world. With a population exceeding 2 million people, Pune is the seventh largest city in India. Pune is located in Maharashtra state, one of the more heavily industrialized areas of India. A total of 480 male heads of household in Pune were initially interviewed (the refusal rate was less than 10%).

The interview included approximately 75 sociodemographic questions focusing on the decision to migrate to Pune, about 75 questions on stressors and social support. All of the scales were translated into Marathi, the local language, and then back translated. In addition, the scales were pilot tested with a poor urban sample using interview probes to check the interpretability and comprehensibility of the scales. A random subset of 105 respondents completed an additional checklist of psychosomatic symptoms. This smaller random sample was used in the present study.

All respondents were interviewed at home in the local language, Marathi, by a pair of trained graduate students. The interviewers were blind to hypotheses of this study. Each interview lasted approximately 1.5 hr. Each participant was informed that the research was being conducted by the University of Poona to examine migration to Pune and what impacts this had on him and his family. Respondents were assured that their responses would remain anonymous and confidential.

Among the sociodemographic questions were items on housing and daily living conditions that were used
to develop the chronic strains measure. These items included information about respondents' monthly salary (regular or not?), cost of housing (affordable, reasonable, high, or very high?), adequacy of housing size (too small for family?), and access to basic services (running water in house?). In addition, respondents were classified by researchers as living in a slum or non-slum section of Pune. Respondents received one point each on their chronic strain score if they did not have a regular monthly salary, couldn't afford their rent, had crowded housing, had no running water in house, and lived in a slum (range 0–5). This scale had adequate internal consistency (alpha = 0.81). The chronic strains scale also appears to be a valid stressor measure: the scale was positively correlated with subjects appraisals of whether they
thought life was stressful \( (r = 0.40, P < 0.001) \), which was measured on a scale ranging from 0 (never) to 4 (always).

The daily hassles scale was derived from the daily hassles checklist developed by Lazarus and colleagues [7]. The hassles scale was also internally consistent (alpha = 0.98). Participants were asked to check the hassles they had experienced in the past 2 months and to indicate the perceived severity of the hassles on a 3 point scale (1 “slight” to 3 “severe”). Three daily hassles scores were computed [9]: (a) frequency, or number, of hassles experienced; (b) cumulated severity, the sum of the 3-point severity ratings; and (c) intensity, the cumulated severity divided by the frequency. Consistent with Kanner and colleagues’ [9] findings, frequency and cumulated severity scores were highly intercorrelated \( (r = 0.87, P < 0.001) \), as were cumulated severity scores and intensity \( (r = 0.54, P < 0.001) \). Because of the high redundancy between severity and the other indicators of stress by hassles, the cumulated severity scores were dropped from further analyses. Hassle frequency and intensity were not intercorrelated and will be examined separately. Unlike the chronic strains measure, the hassles measure was not correlated with the degree to which respondents thought life was stressful \( (P > 0.05) \).

The social support scale was developed from Gottlieb’s [34] classification scheme for semi-structured interviews, in which people were asked to describe how others had been helpful to them in dealing with an important, personal problem. House’s [25] taxonomy of supportive acts was also used to derive scale items. The 40 dichotomous (yes or no) items were designed to measure the functional content of relationships with family and friends. Individuals were asked whether specific types of support had been available during the past 2 months. The scale incorporated multiple-item measures of emotional support (e.g. tried to understand you), tangible support (e.g. gave you financial support), and informational/appraisal support (e.g. I learned new things from). These three subscales were highly intercorrelated and proved more reliable (alpha = 0.91) in combination than as separate scales. Additional data on support network, or structural support were modest (M = 17.9, SD = 8.0).

**RESULTS**

Results are presented in the following order: (a) descriptive data on stressors, (b) comparison of the association between hassles versus chronic strains and psychosomatic symptoms; and (c) examination of the role of social support in the stressor-symptom relationship.

The mean number of hassles was 32.6, with a wide range of scores (SD = 16.4, range = 3-52). Most respondents reported that the hassles had only affected them slightly in the past two months \( (M \) intensity = 1.4, SD = 0.3). Table 2 presents the 10 most frequent hassles reported by respondents. More than 90% of the sample reported economic concerns (rising prices of common goods, income reduction, not enough money for daily needs, home maintenance). Other common hassles emerged from work (obstacles at work, disagreements with colleagues, strenuous job) and social relationships (comparison with others, disagreements with colleagues).

The average respondent experienced 2 chronic strains \( (M = 1.9, SD = 1.1, range = 0-5) \). The most common chronic strain was being in a slump (51%), followed by unaffordable housing (50%), no running water in the home (47%), and crowded housing conditions (43%). Only a small percentage (11%) reported no regular monthly salary.

Table 3 presents the zero-order correlations, as well as the means and standard deviations, for all of the variables. Chronic strains and hassle frequency were not correlated. Moreover, chronic strains were positively associated with psychosomatic symptoms \( (r = 0.28, P < 0.01) \), but hassle frequency was not. By partialling out the effects of income, the correlation between chronic strains and symptoms was increased considerably (partial \( r = 0.38, P < 0.001) \); although the correlation between hassle frequency and symptoms was not affected by partialling out income. Parallel correlation and partial correlation analyses between symptoms, chronic strains, and hassle intensity revealed a similar pattern, except that chronic strains were positively correlated with hassle intensity \( (r = 0.37, P < 0.001) \). After partialling out the effects of income, the correlation between chronic strain and hassle intensity disappeared \( (r = 0.06, NS) \), suggesting a spurious correlation. These findings suggest that psychosomatic symptoms are not influenced by frequency or intensity of daily hassles. For these respondents, only chronic strains were significantly correlated with symptoms, even after adjusting for the effects of income.

Table 3 shows that the reported levels of functional social support were modest \( (M = 17.9, SD = 8.0) \). This translates to a positive response to 45% of the social support items. However, the number of family

<table>
<thead>
<tr>
<th>Rank</th>
<th>Hassle Description</th>
<th>Percentage of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Rising prices of common goods</td>
<td>93</td>
</tr>
<tr>
<td>2.</td>
<td>Salary reduction</td>
<td>92</td>
</tr>
<tr>
<td>3.</td>
<td>Not enough money for daily needs</td>
<td>92</td>
</tr>
<tr>
<td>4.</td>
<td>Obstacles at work</td>
<td>90</td>
</tr>
<tr>
<td>5.</td>
<td>Not enough rest</td>
<td>88</td>
</tr>
<tr>
<td>6.</td>
<td>Home maintenance</td>
<td>80</td>
</tr>
<tr>
<td>7.</td>
<td>Strenuous job</td>
<td>80</td>
</tr>
<tr>
<td>8.</td>
<td>Comparison with others</td>
<td>80</td>
</tr>
<tr>
<td>9.</td>
<td>Disagreement with friends</td>
<td>78</td>
</tr>
<tr>
<td>10.</td>
<td>Disagreement with colleagues</td>
<td>78</td>
</tr>
</tbody>
</table>

*Items are those most frequently checked as occurring in the past two months.
and friends available for support was high (M = 10.2, SD = 5.9). None of the respondents reported having no friends or family members to turn to in times of need; half the sample had more than 8 support network members. The two support measures were highly intercorrelated (r = 0.65, P < 0.001). Remaining analyses will use the functional measure of support because it overlaps with the structural measure and is probably more reliable.

Regression analyses were used to test the direct and stress-buffering effects of social support on symptoms. Separate analyses were performed for the two hassle variables (frequency and intensity). Neither the support nor the hassle variables were significant predictors of symptoms. Moreover, the addition of either block of interaction terms (Support x Frequency and Support x Intensity of hassles) did not account for a significant gain in variance.

The Support x Chronic Strains interaction term was not significant and support was negatively correlated with chronic strains (r = -0.42, P < 0.001). Statistically adjusting for the effects of income diminished the correlation between chronic strains and support, but it was still statistically significant (r = -0.29, P < 0.01).

**DISCUSSION**

In our sample of poor, urban males in India, neither frequency nor intensity of daily hassles was associated with psychosomatic symptoms. The types of frequent hassles observed in our sample were similar to those observed in Kanner and colleagues' [9] sample. The most common hassles in our sample were related to money (e.g., inflation, salary reduction). This is not a surprising finding given the economic condition of our sample. Interestingly, Kanner et al. [9] found similar economic concerns topped the list of most frequent hassles among a predominantly white, middle-class sample in America. The work hassles (e.g., frequent obstacles, strenuous job) reported by our sample seem to reflect the menial and labor intensive nature of jobs typically held by the poor. Compared with our sample, Kanner et al. [9] found that professionals experienced very different types of hassles related to work (e.g., too many responsibilities, not enough time to do the things you need to do). The large proportion of our respondents reporting social hassles (e.g., comparison with others, disagreement with friends) probably reflects the importance of social life in the Indian culture and the emphasis on social status (i.e., castes and other indicators of social position).

The similarity between common hassles in this study and in the sample studied by Kanner et al. [9], makes for a compelling comparison of the effect of hassles in different world contexts. In the Kanner et al. [9] study, hassle frequency explained up to 30% of the variance in mental health (Hopkins Symptom Checklist) in a sample of white, middle-class men. Hassles also had greater predictive power than major stressful life events in their study. In the present study, there was no association between hassle frequency and psychosomatic symptoms, which reflect mental health. Moreover, hassle frequency was not associated with respondents' ratings of the stressfulness of their lives. These findings suggest that daily hassles is not a valid indicator of stress in populations such as ours.

Chronic strains, however, were positively correlated with symptoms. Although the correlation was modest, it is possible that the narrow range of chronic strains (5 strains), attenuated the correlation. Partial correlation analyses further demonstrated that the chronic strains index is not simply a proxy for income. After adjusting for the effects of income, the correlation between chronic strains and symptoms increased relative to the zero-order correlation. That is, chronic strains had health impacts independent of income. These results also suggest that income may mitigate the impact of chronic strains on health, but does not create a spurious correlation. Furthermore, the variability in chronic strains occurs within a narrow range of income and education—a range that in most studies would have all been classified as one class, the underclass.

Chronic strains also were negatively correlated with social support resources. The lack of association between social support and symptoms ruled out the possibility that support mediated the relationship between chronic strains and support. However, the negative association between chronic strains and support suggests that social support is not a highly viable coping option for individuals facing chronic strains, and raises the intriguing possibility that support is diminished or nullified as chronic strains increase. The demands of chronic strains may distract one from maintaining and developing some social relationships that might otherwise be desirable and beneficial. Alternatively, individuals may not be able to mobilize social support to cope with chronic strains because potential support providers may be facing similar problems of their own, and feel too burdened to help a friend or neighbor to overcome their strain. Support providers also may not have the material resources needed to cope with chronic strains.

### Table 3. Zero-order correlation matrix with means and standard deviations

<table>
<thead>
<tr>
<th></th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Psychosomatic symptoms (GSI)</td>
<td>26*</td>
<td>-02</td>
<td>-02</td>
<td>-12</td>
<td>09</td>
<td>7.5</td>
<td>4.6</td>
</tr>
<tr>
<td>2. Severe chronic strains</td>
<td>-09</td>
<td>37*</td>
<td>-42*</td>
<td>-57*</td>
<td>-57*</td>
<td>1.9</td>
<td>1.1</td>
</tr>
<tr>
<td>3. Frequency of hassles</td>
<td>08</td>
<td>-10</td>
<td>05</td>
<td>32.6</td>
<td>16.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Intensity of hassles</td>
<td>-31*</td>
<td>-61*</td>
<td>1.4</td>
<td>0.3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Social support</td>
<td>-42*</td>
<td>18.0</td>
<td>8.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Income</td>
<td>800.0</td>
<td>287.7</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Decimals are omitted from correlation coefficients.

*P < 0.01 two-tailed test.

*P < 0.001 two-tailed test.
strains—which tend to result from a lack of material resources.

Interestingly, the apparent lower levels of social support associated with high chronic strains did not appear to potentiate the association between chronic strains and psychosomatic symptoms. This is partially due to the lack of association between social support and symptoms—which may be an artifact of the extensiveness of the support networks. The average size of support networks was eight people. None of the respondents in this study had no one they could turn to in times of need, which is probably the social situation that has the most negative health consequences [27].

The negative associations between chronic strains and social support and psychosomatic functioning can be understood within Maslow's [38] theory of human motivation. According to Maslow:

Human needs arrange themselves in hierarchies of pre-potency...the appearance of one need usually rests on the prior satisfaction of another more pre-potent need... Also no need or drive can be treated as if it were isolated or discrete; every drive is related to the state of satisfaction or dissatisfaction of other drives [38, p. 370].

If we accept that certain needs have priority over others, and that particular needs (e.g., hunger, thirst) must be satisfied before others (e.g., engaging in satisfying social relationships), then it seems reasonable to accept that threats to gratifying some needs will be greater than threats to gratifying other needs. In addition, the greater the threat, the greater the probability that the stress induced by the threat will have negative effects on individuals' physical and psychological functioning. Chronic strains, which threaten basic needs (e.g., access to water and adequate housing), are likely to have a greater impact on health than stressors which threaten higher, social needs (e.g., arguments with spouse). Our comparison of the effects of chronic strains and daily hassles supports this view. Very poor individuals in an underdeveloped country experienced many of the same hassles as middle-class Americans, yet in the context of more pressing chronic strains those hassles had no association with psychosomatic symptoms.

Although scholars have extolled research on the role of cultural factors in stress processes [39-40], the applicability of the psychological stress concept to populations in developing countries has hardly been tested. Nor has the stress process been examined in great detail among extremely poor groups—i.e., homeless—in developed countries. The present study at least begins to operationalize the types of stressors confronting disadvantaged social groups.

Characteristics of our sample and the study design raise some caveats in interpreting the results. The sample is restricted to male heads of household who live primarily in urban slums in India. We have suggested that the present sample faces conditions similar to those faced by other poor, urban dwellers throughout the world. This assertion has yet to be tested, as does the assumption that the results would be similar in other settings with similar conditions. Caution also is warranted in generalizing our conclusions to women or people living in rural impoverished conditions. Finally, the cross-sectional design of this study raises ambiguity about the direction of effects. For example, it is possible that people with prior, greater psychosomatic symptoms, are less able to hold down a job that would provide for more bearable living conditions for themselves and their family. Although this alternative hypothesis can only be tested with longitudinal or experimental data, it does not seem highly plausible given the fact that economic conditions prevailing in India provide very few of the urban poor with an opportunity to maintain a steady income or choose a dwelling unit.

In summary, among poor, male heads of household in an urban center of India, the most common daily hassles were similar to those experienced by individuals from economically advantaged, western countries. However, the average intensity of the hassles was low and the associations between hassles and mental health were not comparable. The correlation between hassle frequency and mental health problems found previously in a middle class, western sample, was not replicated in our sample. In addition, daily hassles did not overlap with chronic strains. Although there was a positive correlation between strains and hassle intensity, this was a spurious effect caused by income. Chronic strains were associated with higher psychosomatic symptoms and lower perceived social support. The correlation between strains and symptoms increased when the effects of income were statistically controlled, suggesting that income attenuates the effects of strains and that strains have effects on symptoms independent of income. The negative correlation between strains and perceived support did not affect symptoms. Additional research on psychosocial factors in mental and physical health is desperately needed in the third world. Western psychological concepts such as coping, social support, and stress need to be investigated and possibly modified in other social and cultural contexts.

REFERENCES


