Indian Journal of Psychological Science, V-6, No.2 (095-106) ISSN-0976 9218

An investigation of Psychological Distress, Negative Affect, Daily Stress, Suicidal Ideation and Mental Health among Married Professionals: A Comparative Study

Sandeep Panchal* Hardeep Lal Joshi**

Abstract

The objective of the study was to explore the psychological distress, negative affect, daily stress, suicidal ideation and mental health among married professionals. The sample consisted of 300 married professionals in the age range of 25 to 40 years. Adult Suicide Ideation Questionnaire (ASIQ; Reynolds, 1991), General Health Questionnaire (GHQ-30; Goldberg & Williams, 1988), Symptom Check List-90 (SCL-90; Derogatis, et al., 1973), Negative Affect Scale-Expanded Version (PANAS-X; Watson et al., 1994) and Daily Stress Inventory (DSI; Brantley, 1989) were administered to the respondents. Results of the t test revealed that high and low mental health problems group do not differ on sadness, fear, and depression whereas both the groups differ significantly on psychological distress (anxiety, somatisation, & social dysfunction), negative affect (hostility & guilt), daily stress (interpersonal problems, personal competency, cognitive stressors, environment hassles & varied stressors) and suicidal ideation. Descriminant function analysis found four potent variables contribute significantly to the prediction of group membership of high and low mental health problems group among married professionals.

Key words- *Psychological Distress, Negative Affect, Daily Stress and Suicidal Ideation*

About Authors: **Sports Psychologist/Mental Trainer, Sports Authority of India, Delhi.*
***Assistant Professor, Dept. of Psychology, Kurukshetra University, Kurukshetra.*

INTRODUCTION

Mental health problems are an important public health concern for all age groups, but especially for married professionals. The majority of mental disorders first appear between the ages of 15-24 (Kessler et al., 2005). Mental health problems in young adulthood also are associated with substance use, and poorer academic, employment and other social outcomes later in life (Eisenberg, Golberstein, & Gollust, 2007). Mental health is very important for individuals, families and communities, and is more than simply the absence of a mental disorder. Mental health is defined by the World Health Organization (WHO, 2001) as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community'. There are many different types of mental disorders ranging from common disorders such as depression and anxiety to more severe ones such as schizophrenia.

Mental Health among Married Professionals

Literature shows the mental health's of the professionals are important factor for study. In the context of private and public working sector study showed that women working in public sectors have far better mental health. The marital status of women does not show significant difference in the areas of mental health (Soni, 2012). In the teaching professionals, Study showed teaching levels were found to be at a higher risk of mental health problems. The main occupational risk factors identified were lack of support from colleagues,

and to a lesser extent, depending on the mental health problem, the fear of physical or verbal abuse and the reasons the teaching profession was chosen (Kovess-Masfety, et al., 2007).

Some studies say the family context may be an important factor to influence on mental health, in married couples. Mental health of married wives couples had poorer than their husbands. The influence of individual and family characteristics on mental health also differed between husbands and wives (Sanna, Grundy, & Emily, 2011). To established the relationship between mental health status and associated demographic factors among teachers, some variables such as, sexuality, age, place of life and perceived socioeconomic class also had an impact on the mental health of teachers (Davari & Bagheri, 2012). One important study was conducted by Mankani and Yenagi (2012) to assess the status of mental health of the working and non-working women. The results revealed that there was no significant association between mental health dimensions among working and non-working women. The working women had better mental health as compared to non-working women. The demographic factors such as age, education, income and number of children had a positive and significant relationship with working women and family size had negative but significant relationship with mental health of the working women. In the context of working and nonworking women, recent study finds out the significant difference between working and non-working women in mental health and depression (Dudhatra & Jogsan, 2012).

In another study, Batth and Darolia (2014) investigated the effects of work-family interface on mental health of working women. The results indicated that family distress, job distress, work's interference with family and family's interference with work exert negative effect on mental health. These variables lead to somatic complaints, sleep disturbance, problems in social functioning, anxiety, and depression. They concluded that work facilitation as well as family facilitation has positive effect on mental health. In a recent study, Yadav (2015) examined the work-family conflict and mental health of women in teaching & bank employment belonging to two age groups, viz., early and mid adulthood were explored. On mental health areas, at early adulthood phase, teachers as compared to bank employees scored significantly higher on positive self evaluation, perception of reality and overall mental health. On the other hand, women belonging to the two professions were similar to each other on all areas of mental health at mid adulthood.

Empirical data showed that married working suffer from more stress (Hashmi, khurshid, & Hasan, 2007), anxiety (Mukkupadhah, 1997) and depression (Dudhatra & Jogsan, 2012) as compare to non-working sample. Job hassles and pressure contributed to anxiety in dual career women in India (Aleem & Danish, 2008). Working person, while managing work and family, tried to cope with the situation via reactive role behavior (Ahmed, 1995). Working women encountered more problems at home and workplace (Manas & Mubeen, 2011). A study investigating the family and psychosocial health status reveals that about 36% married working women, out of total sample, reported family responsibilities and day to day tension affecting their mental health. Moreover, about 56% women, in the same study, reported work-family conflict and mental tension at their workplace (Singh & Singh, 2005). Azar, Vasudeva, and Abdollahi (2006) explored the significant positive relation between quality of life, hardiness, self-efficacy, and self-esteem among professional and non-professional employed and unemployed women. Mental health issues are more

significant in the context of police officer one cross-sectional study was conducted by Ghaddar, Mateo, and Sanchez (2008) to explore the association between workplace psychosocial risks and the mental health of correctional officers in a Spanish penitentiary center. They found Psychological demands (highest impact), low control and influence, and double exposure had significant inverse associations with mental health. The association between low social support, low self-esteem, and insecurity at work with mental health was insignificant. Psychosocial work conditions are a potential target for mental health promotion programs at work. Research has shown that engaged workers report well mental and psychosomatic health (Demerouti et al., 2001). Factors that have been associated with mental health in married professionals include hopelessness (Negron, Piacentini, Graae, Davies, & Shaffer, 1997), elevations in suicidal ideation (Prinstein et al., 2008), higher levels of affect dysregulation, and greater numbers of self-injurious behaviours (Zlotnick, Donaldson, Spirito, & Pearlstein, 1997).

Rational of the Study:

Recent reviews (Batth & Darolia, 2014; Yadav, 2015) show the family distress, job distress and positive self evaluation play an important role in mental health of the working population. Some of the studies found there was a significant difference between working and non working samples (Dudhatra & Jogsan, 2012; Mankani & Yenagi, 2012). After the extensive review, it is found that there are number of factors which lead to mental health problems among working professionals. The present study was planned for the sample of married professionals to examine the difference between low mental health problems and high mental health problems on psychological distress, negative affect, daily stress and suicidal ideation. There is large number of studies on mental health in the area of youth, adult and old age but there is paucity of research in the area of married professional especially in India with these variables together. The present study is an attempt in this line. The problem can be stated as **"An investigation of Psychological Distress, Negative Affect, Daily Stress, Suicidal Ideation and Mental Health among Married Professionals: a Comparative Study"**

OBJECTIVES:

1. To examine the differences of high and low mental health problem groups on psychological distress among married professionals.
2. To examine the differences of high and low mental health problem groups on daily stress among married professionals.
3. To examine the differences of high and low mental health problem groups on negative affect among married professionals.
4. To examine the differences of high and low mental health problem groups on suicidal ideation among married professionals.

HYPOTHESES:

1. High mental health problems group is likely to show high level of daily stress as compared to low mental health problems group.
2. High mental health problems group is likely to show high level of psychological distress as compared to low mental health problems group.
3. High mental health problems group is likely to show high level of negative affect as compared to low mental health problems group.
4. High mental health problems group is likely to show high level of suicidal ideation as compared to low mental health problems group.

METHOD

Sample:

The present study conducted on a sample of 300 regularly employed married professionals drawn from different organisations using random sampling method. The age range of the sample was from 25 to 40 years. The length of marriage was more than of two years. The job experience of individuals in the profession was on regular basis for at least five years. The sample excluded those professionals who are suffering from any critical disease such as cancer, AIDS etc.

Tools:

Adult Suicide Ideation Questionnaire (ASIQ; Reynolds, 1991): The ASIQ is a 25-item self-report measure of suicide ideation and behaviour in adults. Participants rate the frequency of suicidal thoughts or behaviour during the past month, using a 7-point scale for each item (0 = Never had this thought; 1 = I had this thought before, but not in the last month; 2 = About once a month; 3 = Couple of times a month; 4 = About once a week; 5 = Couple of times a week; 6 = Almost every day). The ASIQ yields a total score, ranging from 0 to 150 with higher scores indicating greater suicide ideation. The ASIQ exhibits good reliability and validity (Reynolds, 1991a; 1991b). The ASIQ has high internal consistency reliabilities for the adult community sample, college student sample, and psychiatric sample with Cronbach's alpha coefficients of .96, .96, and .97, respectively (Reynolds, 1991a; 1991b).

General Health Questionnaire (GHQ-30; Goldberg, et al., 1988): We used the 30-item version of the General Health Questionnaire, which consists of 15 negatively worded questions concerning symptoms of psychological distress (e.g., 'Have you recently felt that life is entirely hopeless?') and 15 positively worded questions about normal everyday functioning (e.g., 'Have you recently been managing to keep yourself busy and occupied?'). GHQ-30 measures the four dimension of general distress which includes-anxiety, somatisation, social dysfunction and depression. A four-point Likert-type scoring system is used, with responses from strong 'symptom absence' to strong 'symptom presence' (Whittington & Huppert, 1998). The wording of the items means that they can all be scored in the same direction. The scale is summative, with a minimum total scale score of 0 and a maximum total scale score of 90. Higher scores indicate that conditions are more severe.

Symptom Check List-90 (SCL-90; Derogatis, et al., 1973): Symptom Check List 90 self report tools to measure the mental health of the participants. SCL- 90 measure the nine dimension of the mental health, which includes-Somatisation, Obsessive Compulsive, Interpersonal Sensitivity, Depression, Anxiety, Hostility, Phobic Anxiety, Paranoid Ideation, and Psychoticism. For the purpose of present study we have taken composite score of all the dimensions of SCL-90 as a mental health problems score. SCL-90 has good psychometric properties. *Good internal consistency coefficients* have been reported for the SCL-90 subscales. For example, coefficient α in a study with 209 symptomatic volunteers ranged from 0.77 to 0.90 (Derogatis et al., 1976). Stability coefficients (test-retest reliability) for the SCL-90 have generally been adequate across a range of patient groups and test-retest intervals with a 10-week interval between tests had correlation coefficients ranging from 0.68 to 0.80 (Derogatis, 2000). Some studies have claimed good convergent validity for the SCL-90 (Derogatis et al., 1976; Dinning & Evans 1977).

Daily Stress Inventory (DSI; Brantley, & Jones, 1989): The DSI is a 58 item self-report measure that allows a person to indicate events that they have experienced in the past 24 hr. After indicating which events occurred, individuals

rate the stressfulness of those events, on a Likert-type scale from 1 ("occurred but was not stressful") to 7 ("caused me to panic"). DSI has adequate reliability, and validity as reported by (Brantley, Waggoner, Jones, & Rappaport, 1987).

Negative Affect Scale-Expanded Version (PANAS-X; Watson et al., 1994): The PANAS-X is a 60-item adjective checklist that respondents rate on a scale from 1 (very slightly/not at all) to 5 (extremely), with two higher order scales (Positive and Negative Affect). For the purposes of the present study we use only Negative affect scale which includes 23 items. In prior research on university, community, and clinical samples, internal consistencies for the positive and negative affect scales ranges from .83 to .90 and from .79 to .91 for the two scales, respectively. Strong divergent validity has been demonstrated, as well as strong convergent validity between self and peer ratings and between scores on the PANAS-X and other measures that assess multiple levels of affect (e.g. Profile of Mood States (POMS)) (Watson & Clark, 1994).

PROCEDURE

After establishing rapport and providing proper instructions, above mentioned psychometric tools were administered on target sample for obtaining the data. The responses of sample in questionnaires were collected and scored as per the manual. The obtained score were statistically analysed using SPSS, and applied descriptives, t test and discriminant function analysis.

RESULTS

Independent t test has been used to analyse the difference in the mean scores of these two groups. The whole data are arranged in ascending order on the variable of Mental Health Problems (SCL-90 Composite score). Then lower 27 percent group is named as low Mental Health Problems group and upper 27 percent population is taken as High Mental Health Problems group. The results of t test are shown in table -1

Table -1 Mean and SD of High and Low Mental Health Problems Group of Married\ Professionals on Different Variables

Variables	Low Mental Health Problems Group (N =81)		High Mental Health Problems Group (N = 81)		t value	P
	Mean	SD	Mean	SD		
Anxiety	8.77	9.09	14.26	10.34	3.59	**.001**
Somatisation	6.51	5.78	10.53	5.59	4.51	**.001**
Social Dysfunction	2.11	2.10	2.93	2.39	2.32	**.001**
Depression	1.56	1.90	2.10	2.12	1.72	**N.S.**
Fear	8.25	3.33	8.44	3.03	.38	**N.S.**
Hostility	8.93	3.28	9.23	3.26	.60	**.05**
Guilt	8.06	2.94	8.50	3.20	.91	**.05**
Sadness	7.17	2.83	7.40	2.86	.51	**N.S.**
Interpersonal PROB	16.61	5.93	22.52	7.41	5.62	**.001**
Personal COMP	15.12	6.23	20.43	7.14	5.06	**.001**
Cognitive Stressors	7.83	3.63	9.86	3.46	3.66	**.001**
Environment Hassles	21.73	7.87	27.74	9.61	4.37	**.001**
Varied Stressors	26.32	10.47	32.77	12.37	3.59	**.001**
Suicidal Ideation	4.05	9.54	11.62	26.64	2.41	**.001**

Note = N.S., Non Significant

A perusal of the results of t-test reveals that out of fourteen variable eleven variables of the study differ significantly on the group of High and Low Mental Health Problems Married Professionals. On anxiety, mean and SD of the high mental health problems married professionals is 14.26 and 10.34 whereas for low mental health problems married professionals group, mean and SD are 8.77 and 9.09, respectively. The obtained value is 3.59 which is significant at .001 levels. It may be interpreted that high mental health problems married professionals group has high anxiety level as compared to low mental health problems married professionals group.

On somatisation, mean and SD of the high mental health problems married professionals is 10.53 and 5.59 whereas for low mental health problems married professionals group, mean and SD are 6.51 and 5.78,

respectively. The obtained value is 4.51 which is significant at .001 levels. It may be interpreted that high and low mental health problems married professionals group differ significantly on somatisation variable.

On social dysfunction, mean and SD of the high mental health problems married professionals is 2.93 and 2.39 whereas for low mental health problems married professionals group, mean and SD are 2.11 and 2.10, respectively. The obtained value is 2.32 which is significant at .05 levels. The result revealed that high and low mental health problems married professionals group differ significantly on the variable of social dysfunction.

There was no difference between low and high mental health problems married professionals group on the variable of depression, Fear and Sadness.

Hostility and Guilt found to be significantly differ on the low and high mental health problems group of married professional at .05 levels of significant.

On the measure of daily stress, the finding of the study revealed that the all the variables of daily stress found to be significant differ at .001 levels of significant. The variables are interpersonal problems, personal competency, cognitive stressors, environmental hassles and varied stressors. It can be interpreted that high and low mental health problems married professional group differ significantly on daily stress variables.

On Suicidal Ideation, mean and SD of the low mental health problems married professionals is 4.05 and 9.54 whereas for high mental health problems married professionals group, mean and SD are 11.62 and 26.64, respectively. The obtained value is equals to 2.41 which is significant at .001 levels of significant. It may be interpreted that high and low mental health problems married professionals group differ significantly on the measure of the suicidal ideation.

Discriminant Functions:

In order to examine whether daily stress, psychological distress, negative affect and suicidal ideation, can differentiate between high and low mental health problems groups, the data were subjected to discriminant function analysis. To find the most potent predictors of group membership, the stepwise (forward) method of discriminate function analysis was employed (Tabachnick & Fiddle, 1989).

Table 2 and 3 present the results of stepwise discriminant analyses. A perusal of these results suggests that four out of the fourteen variables contribute significantly to the prediction of group membership of high and low mental health problems among married professionals.

Table –2 : Summary of Discriminant Functional Analysis

Step	Variable	Wilk's Lambda	F value	Df	p
1	Interpersonal Problems	.83	31.69	1/161	.001
2	Anxiety	.74	27.91	2/160	.001
3	Somatisation	.67	25.71	3/159	.001
4	Suicidal Ideation	.64	22.53	4/158	.001

It may be noted that overall Wilk's Lambda equals to .64, F value equals to 22.53 (df = 4/158) which is significant at .001 probability level. These results clearly indicate that all the four variables entered in discriminant function equation differentiate between high and low mental health problems group among married professionals.

The Wilk's Lambda coefficient appears to be decreasing with entry of a new variable at each step. It is pertinent to mention here that higher Lambda value is an indication of lack of discrimination by the variables in equation. If the value of Lambda is exactly 1.00 the variable does not make any differentiation between the groups. The Lambda coefficient at step one to step four are .83, .74, .67, and .64, respectively for the variables interpersonal problems, anxiety, somatisation and suicidal ideation.

The variable Interpersonal Problem being the major contributor to the group discrimination, entered the equation at step one. The F value of its discriminant functions equals to 31.69 (df 1/161), which is significant at .001 probability. Therefore Interpersonal Problem may be regarded as most potent discriminant of low and high mental health problems group. The second important variable with regard to discrimination is anxiety, which entered the equation at step 2. The F value of its contribution is 27.91 (df 2/160), which is significant at .001 probability. It is clear from the result that high and low mental health problem groups differ significantly on anxiety. Somatisation took entry at step 3 with F value of 25.71 (df 3/159, $p < .001$). It may be interpreted that high and low Mental Health problem groups differ significantly on somatisation.

The Fourth important variable with regard to discrimination is suicidal ideation, which entered the equation at step 4. The F value of its contribution is 22.53 (df 4/158), which is significant at .001 probability. It is clear from the result that high and low mental health problem groups differ significantly on suicidal ideation.

Values of Tolerance statistic range between .83 and .64 for all the four variables in the equation. These values are highly satisfactory. High Tolerance values indicate that Lambda coefficients and other discriminant functions are relatively free from inaccuracy due to co-linearity among the variables. It further adds to the stability and reliability of the data for differentiating between high and low married professionals on mental health problems.

Table- 3
Predicted classification of High and Low Mental Health Problems group

Observed	**Predicted**		
	Low Mental Health Problems	**High Mental Health Problems**	**Total**
	66	15	81
Low Mental Health Problems %	81.5%	18.5%	100
	14	68	82
High Mental Health Problems %	17.1 %	82.9%	100

The efficiency of the four variables entered into the equation is clearly evident from the predicted grouping of the high and low mental health problems groups (Table-3). It is clear from the predicted frequencies given in the table that out of 81 cases of low mental health problems group, 66 were correctly identified as low mental health problems in the discriminant analysis. Only 15 of the cases were not identified correctly. Therefore 81.5% of the cases are differentiated correctly whereas out of 82 cases in high mental health problems group, 68 were identified correctly and 14 were misdiagnosed. The percentage of correct identification comes to 82.9 % in total 100 % of the cases could be identified correctly by the equation loaded with four variables. The structural combination of these variables is clearly distinguishable at two extreme levels of mental health problems.

DISCUSSION

The current study examined the difference between high mental health and low mental health problems group married professionals on the measures of psychological distress, negative affect, daily stress and suicidal ideation. It has been revealed in a study that there is a significant difference in mental health level of working women and housewives. This study indicated the housewives have better Mental Health as compared to working women (Maqbool, Shrivastava, & Pandey, 2014). The results explored adjustment is related to life satisfaction and life satisfaction is linked to better mental health. Therefore Adjustment and life satisfaction is very important factor which affect the mental health of the professionals (Rani & Sunita, 2013).

The present study also found the significant difference between high and low mental health problems married professionals group on the stress measures. Therefore, Hypothesis 1 stating that the High mental health problems group is likely to show high level of daily stress as compared to low mental health problems group is true and accepted here. It was found that job pressure and personal factors was the major contributor of mental ill health. High job pressures affect the internal harmony of the person which influences the mental health of the person (Travers & Cooper; 1993).

One of the finding of the present study showed significant difference between high and low mental health problems married professionals group on the variable of suicidal ideation. Therefore, hypothesis 2 stating the high mental health problems group is likely to show high level of suicidal ideation as compared to low mental health problems group is true and accepted here. On a similar line, Srivastava and Kumar (2005) found risk factors for suicide behaviour were being below 30 years of age, having higher education, a married woman. Suicide attempters also had more suicidal ideation, agitation and paranoid symptoms.

Finding of the study revealed significant difference between high and low mental health problems married professionals group on the measure of negative affect. Therefore, hypothesis 3 regarding the high mental health problems group is likely to show high level of negative affect as compared to low mental health problems group is true and accepted here. Similar finding have also been revealed that higher levels of affect dysregulation important factor in mental health among married professionals (Zlotnick, Donaldson, Spirito, & Pearlstein, 1997).

The present study also showed a significant difference between high and low mental health problems married professionals group on the variables of psychological distress. Therefore, hypothesis 4 stating that the High mental health problems group is likely to show high level of psychological distress as compared to low mental health problems group is true and

accepted here. The present results are consistent with the finding that showed working professionals differ significantly on the variable of mental health (Dudhatra & Jogsan, 2012).

One of the finding of the present study has revealed that four out of the fourteen variables contribute significantly to the prediction of group membership of high and low mental health problems. The interpersonal problems, anxiety, somatisation and suicidal ideation were the major contributed factors. The study has an important implication towards enhancing the mental health of married professionals so that their working life and married life become healthy and fruitful.

REFERENCES

Ahmed, A. (1995). Role of conflict and coping behaviour of married working women. *Pertanika Journal of Social Sciences and Humanities, 3*(2), 97-104.

Aleem, S., & Danish, L. (2008). Marital satisfaction and anxiety among single and dual career women. *Journal of Indian Academy of Applied Psychology, 34*, 141-144.

Azar, I. A. S., Vasudeva, P., & Abdollahi, A. (2006). Relationship between quality of life, hardiness, self-efficacy and self-esteem amongst employed and unemployed married women in Zabol. *Iranian Journal of Psychiatry, 1*(3), 104-111.

Batth, N., & Darolia, C. R. (2014). Impact of psychological distress, work family interface and social support on mental health of working women. *Indian Journal of Health and Wellbeing, 5*(7), 852-857.

Brantley, P. J., & Jones, G. N. (1989). *Daily Stress Inventory: Professional manual.* Florida: Psychological Assessment Resources, Inc.

Brantley, P. J., Waggoner, C. D., Jones, G. N., & Rappaport, N. B.(1987). A Daily Stress Inventory: Development, Reliability and Validity. *Journal of Behavioural Medicine, 10*(1), 61-74.

Davari, S., & Bagheri, M. (2012). Mental health status and demographic factors associated with it in Teachers. *Middle-East Journal of Scientific Research, 12*(3), 340-346.

Demerouti, E., Bakker, A. B., De Jonge, J., Janssen, P. P. M., & Schaufeli, W. B. (2001). Burnout and engagement at work as a function of demands and control. *Scandinavian Journal of Work, Environment & Health, 27*(4), 279-286.

Derogatis, L. R. (2000). Symptom checklist 90-Revised. In *Handbook of psychiatric measures* (pp. 81-84). American Psychiatric Association.

Derogatis, L. R., Lipman, R. S., & Covi, L. (1973). SCL-90: An outpatient psychiatric rating scale—Preliminary Report. *Psychopharmacology Bull. 9*, 13–28.

Derogatis, L. R., Rickels, K., & Rock, A. (1976). The SCL-90 and the MMPI: A step in the validation of a new self report scale. *British Journal of Psychiatry, 128*, 280-289.

Dinning, W. D., & Evans, R. G. (1977). Discriminant and Convergent Validity of SCL-90 in Psychiatric Inpatients. *Journal of Personality Assessment, 41*, 304-310.

Dudhatra, R. R., & Jogsan, Y. A. (2012). Mental health and depression among working and non working women. *International Journal of Scientific and Research Publications, 2*(8), 1-4.

Eisenberg, D., Golberstein, E., & Gollust, S. (2007). Help-seeking and access to

mental health care in a university student population. *Medical Care, 45*(7), 594- 601.

Ghaddar, A., Mateo, L., & Sanchez, P. (2008). Occupational stress and mental health among correctional officers: a cross-sectional study. *Journal of Occupation Health, 50*(1), 92-98.

Goldberg, D. P., & Williams, P. (1988). *A user's guide to the General Health Questionnaire*. Basingstoke: NFER–Nelson.

Hashmi, H. A., Khurshid, M., & Hassan, I. (2007). Marital adjustment, stress and depression among working and non-working married women. *Internet Journal of Medical Update, 2*(1), 19-26.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age of onset distribution of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry, 62*, 593-602.

Kovess-Masfety, V., Rios-Seidel, C., & Sevilla-Dedieu, C. (2007). Teachers mental health and teaching levels. *Teaching and Teacher Education, 23*(7), 1177-1192.

Manas, G. M., & Mubeen (2011). Dual responsibility of Degree College lectures in Gulbarga City. *International Referred Research Journal, 2*(4), 24-29.

Mankani, R. V., & Yenagi, G. V. (2012). Comparative study of mental health of working and non-working women. *Karnataka Journal of Agriculture Science, 25(4), 510-513.*

Maqbool, M., Shrivastava, N., & Pandey, M. (2014). A Comparative study of mental health of working women and housewives. *Indian Journal of Health and Well Being, 5*(11), 1398-1400.

Mukkupadhah, S. (1997). Working status and Health: A study of Calcutta women. *The Indian Journal of Social Work, 57*(2), 327-336.

Negron, R., Piacentins, J., Graae, F., Davies, M., & Shaffer, D. (1997). Microanalysis of adolescent's suicide attempts and ideators during the acute suicide episode. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(1), 1512-1519.

Prinstein, M. J., Nock, M. K., Simon, V., Aikins, J. W., Cheah, C. S., Spirito, A. (2008). Longitudinal Trajectories and predictors of adolescent suicidal ideation and attempts following inpatient Hospitalization. *Journal of Consulting and Clinical Psychology, 76*(1), 92-103.

Rani, S., & Sunita (2013). A comparative study of adjustment and life satisfaction in working and non-working women. *Indian Journal of Psychology and Education, 3*(2), 56-58.

Reynolds, W. M. (1991a). *Suicide Ideation Questionnaire. Professional Manual*, Odessa, FL: Psychological Assessment Resources.

Reynolds, W. M. (1991b). Psychometric characteristics of the adult suicide ideation questionnaire with college students. *Journal of Personality Assessment, 56*(2), 289-307.

Sanna, Grundy, & Emily (2011). *Mental health among older married couples: the role of gender and family life. Social Psychiatry and Psychiatric Epidemiology, 46*(4), 331-341.

Singh, M., & Singh, G. (2005). A study on family and psychological health status of middle aged working women of

Varanasi city. *The Internet Journal of Third World Medicine, 3*(2), 8426.

Soni, B. J. (2012). A study of mental health in relation to public sector working women. *International Indexed & Referred Research Journal, 4*(40), 3-4.

Srivastava, A. S., & Kumar, R. (2005). Suicidal ideation and attempts in patients with major depression: Socio demographic and clinical variables. *Indian Journal of Psychiatry, 47*(4), 225-228.

Tabachnick, B. G., & Fidell, L.S. (1989). *Using Multivariate Statistics* (2nd ed.). New York: Harper Collins.

Travers, C. J., & Cooper, C. L. (1993). Mental health, job satisfaction and occupational stress among UK teachers. *Work & Stress: an International Journal of Work, Health & Organisations, 7*(3), 203-219.

Watson, D., & Clark, L. A. (1994). *The PANAS-X: Manual for the Positive and Negative Affect Schedule-Expanded Form*. Ames: The University of Iowa.

Whittington, J., & Huppert, F. A. (1998). Creating invariant subscales of the GHQ-30. *Social Science and Medicine, 46*(11), 1429–1440.

World Health Organisation (2001). *The World Health Report 2001*. Mental health: new understanding, new hope. Geneva: World Health Organisation.

Yadav, S. (2015). Work-family conflict and mental health of women in banking and teaching profession. *Indian Journal of Health and Wellbeing, 6*(3), 277-281.

Zlotnick, C., Donaldson, D., Spirito, A., & Pearlstein, T. (1997). Affect regulation and suicide attempts in adolescent inpatients. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(6), 793-798.