CHAPTER I
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In this competitive world, professionals are facing lot of problems related to their work place. The problem got exaggerated when they are married because of one reason or the other. These unexplained reasons and poor coping strategies sometimes lead to genesis of suicidal ideation which may lead to deliberate self harm. The professionals in many areas such as corporate, health, education, military and other are at greater risks for these problems. There are several factors which may be responsible for suicidal ideation. These factors are personal, social and environmental. Some of the professional are very vulnerable to stressful situation, which may lead to the development of mental health problems. The link between married working life and mental health problems has been studied by the several researchers. Leading marital life along with employment put dual responsibility on married professionals that demands to be paid equally up to the expected level as determined by society. The professionals have to go out to earn money to meet their family expenses. Moreover, the married professionals have to take care of their children and whole family. As a result, a huge burden is put on married professionals that lead to psychological problems.

MENTAL HEALTH PROBLEMS AND SUICIDAL IDEATION

Mental health problems are important public health concern for all age groups, but especially for married professionals. The majority of mental disorders first emerge 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). Rastogi and Kashyap (2001) reported significant negative relationship between occupational stress and mental health among married employed in teaching, nursing and clerical jobs. The sources of stress for working professionals are heavy workload, lack of co-operation from colleagues or neighbours and negative community attitude.

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 person realizes his or her own abilities, can manage normal stresses of life, work productively and effectively, and is able to make a contribution to his or her community’. A mental disorder is any illness that affects people’s emotions, thoughts or behaviour, which is out of keeping with their cultural beliefs and personality, and is producing a negative effect on their lives or the lives of their families (World Health Organization, 2008). There are many different types of...
mental disorders ranging from common disorders such as depression and anxiety to more severe ones such as schizophrenia. Effective treatments are available for people with mental disorders, and many types of mental disorder can be managed at the primary health care level with complementary support from community-based workers and community members.

Empirical finding in literature revealed that mental health problems are closely related with suicidal ideation. In a study, Grant and Hasin (1999) found alcohol use disorder, unemployment and family history of alcoholism increased the risk of suicidal ideation. On the other hand researches revealed that Marriage played a protective role in suicidal ideation. Suicidal ideation were more prevalent among economically inactive people (e.g. unemployed) unmarried or divorced people (Kjoller & Larson, 2000; Mofidi, 2009). Mental disorders are most important factor associated with suicidal ideation among general population (Gili-Planas et al., 2001). Suicide ideation was associated with specific phobia (Dhossche, Ferdinand, Van-der Ende, Hofstra, & Verhulst, 2002). Poor physical health and poor mental health are the predicting factors of suicidal ideation among older adults (Yip et al., 2003). Somatic symptoms and common mental disorders are related to suicidal ideation (Sumathipala, Siribaddana, & Samarweera, 2004). PTSD and suicidal ideation has been significantly associated with each other (Sareen, Houllahan, Cox, & Asmyndron, 2005). Subjects with suicidal ideation had more problematic behaviour and poor functioning (Reinherz, Tanner, Berger, Beardslee, & Fitzmaurice, 2006). Poor sleep quality significantly predicted death by suicide among older adults (Bernert, Turvey, Conwell, & Joiner, 2007). Health and Impulsivity was found to be positive associated with suicidal ideation (Neufeld, 2008). Suicidal ideation was significantly associated with poor physical health and family history of suicidal behaviour (Zhang, Stewart, Philips, Shi, & Prince, 2009). Suicide ideation and suicide attempts are significant predictor of later mental health problems (MacDonald, Taylor, & Clarke, 2009). Skin disorders are related to suicide ideation among clinical population. The most common skin disorder among those who had suicidal ideation was acne, hair loss, and psoriasis (Golpour, Hosseini, Khademloo, & Mokhmi, 2010). Physical ill, higher level of hopelessness, and helplessness were the active suicidal ideation (Samaraweera, Sumathipala, Siribaddana, Sivayogan, & Bhugra, 2010). Psychological factors, includes negative family background environmental and task related problems and socio demographic problems were significantly associated with suicidal ideation (Anisi, Majdian, & Mirzamani, 2010). Common mental disorders are associated with suicidal ideation among working people (Takusari, Suzuki, Nakampura, & Otsuka, 2011). Single status, unemployment, ill health, physical disorders were strongly associated with suicidal
ideation among elderly people (Chan, Liu, Chau, & Chang, 2011). Borderline traits, dissociation, substance use, play an important role in suicidal ideation among boys and girls adolescent (Rodrse, Leeuwen, Nikki-van, Chabrol, & Leichsenring, 2011). Other population like, ADHD positive patient showed a marked increase in depression symptoms, suicidal ideation, and suicidal attempts (Bacskai, Czobor, & Gerevich, 2012). Other important factor such as, poor mental health, lower self efficacy, community support, dysfunctional coping strategies are related to suicidal ideation (Kavalidou, 2013; O’Dwyer, Moyle, Zimmer, & De-Leo, 2013).

There are some studies that revealed about the mental health of the professionals. In the context of private and public working sector study showed that women working in public sectors have far better mental health than the private sector (Soni, 2012). In another finding, Mankani and Yenagi (2012) revealed that working women had better mental health when 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. Family size had negative but significant relationship with mental health of the working women.

In the perspective of working and nonworking women one study finds out the significant difference between working and non-working women in mental health and depression. Mental health and depression found to be positively correlated with each other (Dudhatra & Jogsan, 2012). In the area of banking and medical professionals study revealed mental health factors was positively correlated with family adjustment among professionals. An important interactive affect of age and job, was revealed on marital adjustment, mental health of middle aged couples (Goel, Narang, & Koradia, 2013). In a cross-sectional study, Panigrahi, Padhy, and Panigrahi (2014) assessed the mental health status among married working women. Study revealed that 32.9% of respondents had poor mental health. They found 3 predictors of mental health status, such as favourable attitude of colleagues, sharing their own problems with husband, and spending time for yoga/meditation/exercise. These factors had significant positive impact on the mental health status of married working women. Some studies say the family context may be an important factor for influencing mental health among married couples. Mental health of married wives couples was poorer than their husbands. The influence of individual and family characteristics on mental health also differed between husbands and wives (Sanna, Grundy, & Emily, 2011). On the sample of teaching professionals, study reveals both the genders 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, Rios-Seidel, & Sevilla-Dedieu, 2007). In order to establish link between mental health status and associated demographic factors, study demonstrate sexuality, age, place of life and perceived socioeconomic class had an impact on the mental health among teachers (Davari & Bagheri, 2012). On similar sample, job pressure and personal factors was the predicator of mental ill health and Intention to leave was found to be positively related to mental ill-health among teachers (Travers & Cooper, 1993). In the military setup, those personnel who were married but not living with their spouses, and women reporting highest levels of occupational stress. Personnel with high levels of stress had significantly higher rates of mental health problems (Hourani, Williams, & Kress, 2006).

Mental health issues are more significant in the context of police officer; Psychological demands, low control and influence, and double exposure had significant inverse associations with mental health (Ghaddar, Mateo, & Sanche, 2008). Research has shown that engaged workers report well mental and psychosomatic health (Demerouti et al., 2001). There are number of factors that have been associated with mental health among professionals which are, hopelessness (Negron, Piacentini, Graae, Davies, & Shaffer, 1997), elevations in suicidal ideation (Prinstein et al., 2008), higher levels of affect deregulation, and greater numbers of self-injurious behaviours (Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). Housewives have better mental health in comparison to working women (Maqbool, Shrivastava, & Pandey, 2014).

Empirical data depicts that married working suffer from more stress (Hashmi, khurshid, & Hasan, 2007), anxiety (Mukkupadghah, 1997) and depression (Dudhatra & Jogsan, 2012) as compare to non-working. Job hassles and pressure contributed to anxiety in dual career among Indian women (Aleem & Danish, 2008). While managing work and family, the professionals tried to cope with the situation through reactive role behaviour (Ahmed, 1995). Working women encountered more problems at home and workplace (Manas & Mubeen, 2011). Married working women reported family responsibilities and day to day tension which play significant role to influence mental health issues. Moreover, majority of the women reported work-family conflict and mental tension at their workplace (Singh & Singh, 2005). Ojha and Rani (2004) observed significant negative correlations between life stress and positive mental health among working and non-working women.

Study revealed women have shown poor mental health at their organisation environment because they are not sharing their problem with other (Kaushik and Behmani
In recent study, Dhanalakshmi (2015) found general health problems negatively correlated with work satisfaction and positive correlated with work family conflict and both are the predictor of general health problems. Among police personnel study investigated by Sharan and Shyam (2015) in which they have found stress turned out to be a negative predictor of self-rated health as well as general health whereas optimism was found to contribute positively to the domain of health. Self-awareness and spiritual belief are predictors of mental health among working professionals (Nagar & Sadhu, 2015). Hasnain, Ansari, and Sethi (2011) reported the difference between married and unmarried on mental health dimension i.e. life satisfaction and self esteem, no significant difference was observed between working and non-working woman on mental health. In recent research, Yadav (2015) has shown male teachers score significantly high on mental health as compared to male bank employees. On the other hand, women belonging to the two professions were similar to each other on dimension of mental health. Batth and Darolia (2014) revealed family distress and job distress 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.

NEGATIVE AFFECT AND SUICIDAL IDEATION

Emotional behaviour can be understood in terms of feeling state which refers to individual’s response to a particular stimulus. In the past, the term emotion and affect uses interchangeable but later on these terms are differentiated. Affect may be the product of drives (innate compulsions to gratify basic needs). It generates both conscious and unconscious feelings (those of which we are not aware but which influence our behaviour). In contrast, emotion is always consciously experienced. Further, we need to know about the emotion and mood for comprehensive understanding. The emotion and mood are not same rather they are differ; mood refers to feeling disposition that is more constant than emotion, it is less intense, and less tied to a particular condition.

Affect is a word that catches attention of the scholar throughout the world, because it is a very broad area for researcher to explore the gap in knowledge. Dated back when the German writers used affect as “a general seizure of excitement” (William James, 1920, p. 358). Freud explains affect in terms of psychoanalytic approach. Furthermore, people consider affect as an inward state (according to field of Medicine). In the early 1990s, in general psychology, "most often, the terms affect, mood, and emotion are used interchangeably, without any attempt at conceptual differentiation" (Batson, Shaw, & Oleson,
1992, p. 295). Nowadays progress is being made by different researcher to draw a line of demarcation between these terms (Alpert & Rosen, 1990; Batson et al., 1992; Beedie, Terry, & Lane, 2005; Russell, 2003; Russell & Feldman Barrett, 1999). In the recent time, affect described by Panksepp (2003) the feelings associated with emotional processes.

Affect, more general terms, it refers to consciously accessible feelings. Though, affect shows its presence with the emotions (it is a component of subjective experience), its presence is also observed with several other emotional phenomena, including physical sensations, attitudes, moods, and even affective traits. Thus, emotions and affect differ in several ways. First, emotions are usually about some personally significant event (i.e., they have an object), whereas affect is often free-floating or objectless (Oatley & Jenkins, 1996; Russell & Feldman Barrett, 1999). Furthermore, emotions are usually short and associate the multiple-component systems described above, whereas affect is often more long-lasting and may be salient only at the level of subjective experience (Ekman, 1994; Rosenberg, 1998; Russell & Feldman Barrett, 1999). Finally, emotions are often conceptualized as fitting into discrete categories of emotion families, like fear, anger, joy, and interest. Affect, by contrast, is often conceptualized as varying along two dimensions, either pleasantness and activation (Russell & Feldman Barrett, 1999) or positive and negative emotional activation (Tellegen, Watson, & Clark, 1999). Although affect, emotions, and moods are independent in theory, in practice the difference isn’t always so clear. In fact, in psychology field, researchers have studied mostly moods, and in other areas, mainly emotions. But this is a state of research that is confusing in nature.

Negative Affect comes under the emotional aspect of subjective well being. It is characterized by the frequency and intensity as a result of which subjects are prone to feel negative emotions such as, anger, and sadness. Negative Affect (NA) is a common factor of subjective distress, and it consist of broad range of negative mood states, including fear, anxiety, hostility, scorn, and disgust. Mood states associated with depression such as sadness and loneliness, which also have considerable loadings on this factor. In terms of trait view, it is a broad and persistent tendency to experience negative emotions that has further influences on cognition, self-concept, and world view (Watson & Clark, 1984). Most of studies regarding the affects have been revealed that personality is an important predictor of affects (Hayes & Joseph, 2003; DeNeve & Cooper, 1998; Steel, Schmidt, & Shultz, 2008). Negative affect is positively correlated with dimension of neuroticism (e.g., Eysenck, 1967) and trait anxiety (Gray 1982; Speilberger, 1985). Eysenck’s (1967; 1983) viewed about this construct reflects a stable personality trait of emotional instability and elevated baseline sympathetic
activity. According to Eysenck view such types of persons tends to respond to events with strong emotions, and are highly condition able. The high levels of Negative Affect are positively correlated with depression, and anxiety (Nolen-Hoeksema, 1991; Nolen-Hoeksema, 2000; Trapnell & Campbell, 1999).

**Dimensions of Negative Affect**

It is very important to describe affect in terms of its dimensions there are three dimensions which are very relevant. Valence explains the value (positive or negative) of the feelings involved. Activation refers to the strength of the individual’s disposition to act. And third is Potency which describes the individual’s sense that he/she has the power to deal with relevant events. Most of the researcher agreed upon views regarding one-dimensional model of a valence (e.g., pleasant–unpleasant) dimension is not sufficient to understand the full realm of emotions. Implicit in such a one-dimensional account is the notion that NA reduction and positive affect enhancement are actually the same phenomenon. A more complete model of emotional response is a two-factor model which, in addition to valence, includes an arousal dimension as well (e.g., Lang, Bradley, & Cuthbert, 1990; Russell, 1989; Schachter & Singer, 1962). According to this conceptualization, the emotion “fear” would be high on the arousal dimension and low (unpleasant) on the valence dimension. “Relaxed” would be represented low on the arousal and high on the valence dimension. Other two-dimensional models of affect (e.g., negative and positive affect) have also proven influential in shaping the field’s thinking about emotion and how it is best conceptualized and measured (e.g., Watson & Tellegen, 1985; Watson, Wiese, Vaidya, & Tellegen, 1999).

Literature suggests that there are very less number of study on the variable of negative affect and suicidal ideation with altogether. Some of the studies are trying to find out the relationship between negative affect and suicidal ideation. These studies revealed that negative affect is found to be positively associated with suicidal ideation whereas positive affect is negatively correlated (Hirsch, Dubersten, Chapman, & Lyness, 2007; Green, Chorpita, & Austin, 2009; Yamokoski, 2006; Yamokorski, Scheel, & Rogers, 2011). It is well established that higher trait NA reflected more negative attitude during job in a organizational setup. High NA employees likely to remain expressively dissatisfied in working setup despite improvements (Watson, Pennebaker, & Folger, 1987). Other study by Brief, Butcher, & Roberson (1995) purposed how high negative affect create situation which leads to dissatisfaction among employees. High NA individual are more sensitive to negative stimuli, and produce more extreme emotion when they experience negative event. In a recent study, Yilmaz and Arslan (2013) examined the relationship between subjective wellbeing and
negative affect among university students. They revealed a significant negative relationship between subjective well-being and negative affect. Further, it was found that negative affects significantly describe the subjective well-being.

**DEPRESSION AND SUICIDAL IDEATION**

The oxford dictionary (2000) defines depression as a medical condition in which a person feels very sad and anxious and often has physical symptoms such as being unable to sleep etc. The rapid development in the world in every sphere of life puts a lot of pressure on people to adjust to the situation. Inability to do so leads to stress and this begins to wear out people and the result is most often depression. In major depression individuals’ daily routine life is disturbed because of experiencing severe mood changes. Although we all may suffer depression from one time to another in our lives, this is only transitory. The person reports loss of interest and pleasure in the activities which used to be enjoyed previously as well as having a disturbed appetite, sleep and motor functioning, loss of energy, feelings of worthlessness and guilt, impairment in thinking and concentration with the report of suicidal ideation and suicidal attempts (American Psychological Association, 2000).

**Symptoms and Types of Depression**

Symptoms of depression include a constant sad mood; loss of interest or enjoyment in daily activities that were once enjoyed; important change in appetite or body weight; sleep disturbance or oversleeping; physical slowing or agitation; loss of energy; feelings of worthlessness or inappropriate guilt; difficulty in concentrating or thinking; and recurrent thoughts of death or suicide. A diagnosis of major depressive disorder (or unipolar major depression) is made if a person has five or more of these symptoms for the period of the two-week. Major depressive disorder usually present in distinct episodes that persist during an individual’s life span.

*Bipolar disorder (or manic-depressive illness)* is considered as episodes of major depression as well as episodes of mania -- periods of abnormally and persistently elevated mood or irritability accompanied by at least three of the following symptoms: over-inflated self-esteem; decreased need for sleep; increased talkativeness; racing thoughts; distractibility; increased goal-directed activity or physical agitation; and excessive involvement in pleasurable activities that have a high potential for painful consequences.

Other type of depression is major depression. It is characterized by the inability to enjoy life and experience cheerfully. The symptoms are continuous, range from moderate to severe. Left untreated, major depression usually lasts for about six months. A few individuals experience just a single depressive episode in their life span, but more usually, major
Depression is a frequent disorder. However, there are many things you can do to support your mood and reduce the risk of recurrence.

*Dysthymic disorder* (or *dysthymia*), a less severe yet typically more chronic form of depression, is diagnosed when depressed mood persists for at least two years in adults (one year in children or adolescents) and is accompanied by at least two other depressive symptoms. Many people with dysthymic disorder also experience major depressive episodes. While unipolar major depression and dysthymia are the primary forms of depression, a variety of other subtypes exist. In comparison to the distinctive emotional experiences of sadness, loss, or passing mood states, depression is intense and persistent and can interfere considerably with a person’s ability to function.

**Demographic and Psychosocial Risk Factors for Depression**

In terms of socio-demographic variables studies have shown that depression is more common in women (Nandi, Banerjee, Mukherjee, Nandi, & Nandi, 1997; Poongothai, Pradeepa, Ganesan, & Mohan, 2009; Ramachandran, Menon, & Arunagiri, 1982), younger subjects (Ponnudurai, Somasundaram, Balakrishnan, & Srinivasan, 1981), in subjects from poor economic background (Mohandas, 2009; Poongothai et al., 2009) and subjects with poor nutritional status (Mohandas, 2009), those who are divorced or widowed (Poongothai et al., 2009), those residing in nuclear families (Sethi & Sharma, 1980) and urban areas (Reddy & Chandrashekhar, 1998). Studies which have evaluated the subjects with late onset or old age depression (first episode of depression at or after the age of 50) have also shown that depression is more common in low social class, and in widowed state (Nandi et al., 1997; Ramachandran et al., 1982; Sharma, Satija, & Nathawat, 1985), unemployed condition, low educational level, in subjects living in nuclear family or in those living alone (Jain, & Aras, 2007; Ramachandran et al., 1982; Sharma et al., 1985; Tiwari, 2000). With regard to gender, most of the studies have reported that it is more common in elderly females (Nandi et al., 1997; Sharma et al., 1985). However, some clinic-based studies suggest that it is more common in elderly males (Venkoba & Madhavan, 1983). It is also seen that prevalence of depression increases with increasing age in elderly (Barua, Acharya, Nagaraj, Vinod, & Nair, 2007). Studies have shown that compared to healthy controls and subjects with schizophrenia, depressed patients have significantly greater number of life events prior (6–12 months) to the onset of their illness (Chatterjee, Mukherjee, & Nandi, 1981; Raju, Kumaraswamy, & Mani, 1980).
In terms of type of life events, it is seen that depressed patients experience significantly higher proportion of life events (death of a family member, personal health related events, bereavement), interpersonal and social events (Bhugra, Gupta, & Wright, 1997; Chandran, Tharyan, Muliyil, & Abraham, 2002; Chatterjee et al., 1981), and lower number of life events in the form of illness of family members compared to patients with schizophrenia (Prakash, Trivedi, & Sethi, 1980). It is also seen that compared to patients with mild depression patients with moderate and severe depression tend to use avoidance as a coping strategies more frequently for the stressful life events, suggesting that it may be a maladaptive way to cope with the situation, which is responsible for development of depression (Satija, Advani, & Nathawat, 1998). Studies have also reported that parental loss before the age of 18 years; parental disharmony and eldest birth order tend to be more common in subjects with depression (Bagadia, Jeste, Dave, Doshi, & Shah, 1973).

Studies in elderly also suggest that life events, especially financial problems and death in the family are important as a precipitating event for depression as they are in young adult (Barua et al., 2007; Chakrabarti, Nehra, Sharma, Mankotia, & Jhirwal, 2005). It is also seen that stressful life events were specifically more in the elderly females and those with lower per capita income (Agrawal & Jhingan, 2002). With respect to life events in children and adolescents, Patel, Shah, Patel, Tilwani, and Vankar (1998) found that depressed adolescent girls report life events in the form of death of a family member, change in residence, failure in examination, end of a relationship and serious illness. Other risk factors identified to be associated with depression in children including stress at school and family as well as family history of mental illness (Krishnakumar & Geeta, 2006).

However, one of the older studies failed to find a link between childhood bereavement and depression (Venkoba, 1970). Women as a group have also received considerable attention with regard to risk factors for development of depressive disorders. In an incidence study of common mental disorders, Patel, Kirkwood, Pednekar, Weiss, and Mabey (2006) reported that poverty (low income and having difficulty in making ends meet), being married as compared with being single, use of tobacco, experiencing abnormal vaginal discharge and reporting a chronic physical illness were associated with risk of developing a common mental disorder. Studies have also reported that economic and interpersonal relationship difficulties, partner violence, sexual coercion by the partner are the common causal factors related to development of depression in general and depression during antenatal and postnatal period (Chandran, Tharyan, Muliyil, & Abraham, 2002; Pereira, Andrew, & Pednekar, 2007; Verma, Chandra, Thomas, & Carey, 2007). It has been shown that gender of the newborn
child is an important determinant of postnatal depression (Chandran et al., 2002; Patel, Rodrigues, & DeSouza, 2002; Rodrigues, Patel, Jaswal, & De Souza, 2003). Among the psychological factors, attribution style was proposed to predispose individuals to depression and maintain depressive symptoms once they develop. A study using the Attribution Style Questionnaire (Seligman, Abramson, Semmel, & Von, Baeyer, 1979) showed that depressed patients have a specific attribution style for their failures and successes in comparison to patients with schizophrenia and medical disorders. According to this study, patients with depression made more internal, stable and global attributions for bad events when compared to other disorders (Bhojak, Vyas, Nathawat, & Vijayvergia, 1989). A study evaluating the cognitive model of depression as given by Beck failed to find support for the causal role of cognitive errors in relapse of depressed subjects as a significant proportion of patients were free from cognitive distortions following remission. However, it was also observed that those who had persistent cognitive distortions during remission ran the risk of early relapse (Rao et al., 1989). It has also been seen that patients with neurosis, including depression, have poor social interactions and reports more interactions of unpleasant and less interactions of pleasant social interactions as compared with healthy controls (Srivastava, 2006). With regard to personality factors, a study showed that higher scores on the hardiness, a personality trait, correlates with lower scores on the depression scale suggesting that presence of hardiness doesn’t allow depressive feelings to become more severe (Sinha & Singh, 2009).

Impact of Depression

Researchers have shown that depressive disorders lead to significant dysfunction (Chadda, 1995) disability (Chaudhary, Deka, & Chetia, 2006) and poor quality of life in sufferers (Tharoor, Chauhan, & Sharma, 2008) and pose a significant burden on the caregivers (Chakrabarti, Kulhara, & Verma, 1992). The pattern of burden experienced by relatives of patients suffering from affective disorders and schizophrenia, have been shown to be similar, being principally felt in the areas of family routine, leisure, interaction and finances. However, the caregivers of subjects with depression experience lesser degree of burden compared to caregivers of schizophrenia and bipolar disorders (Chakrabarti et al., 1992; Chakrabarti, Raj, Kulhara, Avasthi, & Verma, 1995). Another study showed that the burden of dysthymia is similar to neurotic disorders like obsessive compulsive disorder and generalized anxiety disorder (Chakrabarti, Kulhara, & Verma, 1996). It has also been seen that patients with dysthymia have significant impairment on measures of quality of life, disability, social support and marital adjustment compared to normal/medically ill controls. The study also showed that duration of illness and severity of depression are the most
important correlates of impaired quality of life and disability (Subodh, Avasthi, & Chakrabarti, 2008). A study assessing the relationship of stigma to both depression and somatization in psychiatric patients of south India showed that although both depressive and somatic symptoms were distressing, perceived stigma was more for depressive symptoms. Depressive symptoms were perceived as socially disadvantageous as compared to somatization symptoms (Raguram, Weiss, Channabasavanna, & Devms, 1996).

According to Beck (2006) depression is because of faulty or maladaptive cognitive processes. The physical and emotional symptoms are a consequence of the thinking patterns that Beck assumes to be the contributor of the disorder. Beck suggests that depressed people have unrealistically negative ways of thinking about themselves, their future and their experiences. He suggests that the inner life of depressed people is dominated by a set of assumptions that shape conscious cognitions. These predictions lead ultimately from the messages we receive from parents, teachers, friends, and other significant people (intentional or not; we infer them from the way these people behave and talk to us).

By the year 2020, depression will be the second major predictive causal factor of disability all over the world among other different causes like back pain, diabetes, arthritis, heart disease, cancer etc. (WHO, 2000). Among the working population, the rate of depression in both male and female employees was found to be higher with 36% reported having high and 42% having moderate levels of depressed mood according to a Canadian survey (Duxbury & Higgins, 2003). In another study, the prevalence of both psychological distress and depression were higher in a younger age group of 20-29 years old (Umi et al., 2011).

There are numbers of past studies which revealed about the relationship between depression and suicidal ideation. Researcher revealed the increase prevalence of depression and severe suicidal ideation among those who were bullied and those who were bullies (Kaltilala-Heino, Rimpela, Marttinen, Rimpela, & Rantanen, 1999). Depression was a significant risk factor for suicidal ideation (Goldney, Wilson, Dal-Grande, Fisher, & McFarlane, 2000). Psychological autopsy study showed recurrent major depression was most strongly positively associated with suicide among elderly individuals (Waern et al., 2002). In another study, Sokero et al. (2003) revealed high severity of depression and present alcohol dependence and low level of social and occupational functioning were predictor of suicide attempt. One of the important study found suicidal ideation was higher among widowed people then married people (Stroebe, Stroebe, & Abakoumkin, 2005). Casey et al. (2006) investigated the suicide risk factor in general population. Severity of depression and concern
by other were independently associated with serious suicidal ideation. On the sample of police officer, study by Violanti and colleagues (2008) showed prevalence of suicide ideation significantly increased with higher depression symptoms and increasing day shift hours. Chan, Liu, Chau, and Chang (2011) reported depressive symptoms, physical disorder and pain symptom were strongly associated with suicidal ideation. Mousavi, Keramation, Maracy and, Fouladi (2012) revealed depression and suicidal ideation significantly differ in married and unmarried students. Depressive patient had greater level of fatigue and anxiety, more common suicidal ideation, poor quality of life then non depressive patient (Patel, Sachan, Nischal, & Surendra, 2012). In another study, Nyer et al. (2013) showed student with suicidal ideation were more symptomatic, having significantly higher levels of depressive symptom, helplessness and anxiety. One of contradicted study by Cato and Hammer (2012) revealed that there was non-significant relationship between depression and suicide among college students. In the cross sectional studies, researcher found depression is strongly positive associated with suicidal ideation (Pfaff & Almeida, 2004). The effect of self forgiveness on suicidal behaviour was fully mediated by depression (Hirsch, Webb, & Jeglic, 2011). In another study, age, previous history of depression and current depression were significantly associated with suicidal ideation among women. The study concluded that rate of suicidal ideation among pregnant women testing for HIV are high (Rochat, Bland, Tomlinson, & Stein, 2013).

Depression and life satisfaction was significant predictors of suicidal ideation among adolescents (Park, Koo, & Schepp, 2005). On the similar line, the coping mechanism found a predictor of suicidal ideation in women who experience symptom of post partum depression (Doucet & Letourneau, 2009). Arria et al. (2009) showed in the low level of depression symptom group, low social support and affective dysregulation were important predictor of suicidal ideation. Fong, Shah, and Maniam (2012) has yielded suicide attempt and social readjustment are predictors of suicidal ideation among depressed inpatients. Wang, Lightsy, Tran, and Bonaparte (2013) showed depression and life satisfaction were strong predictors of suicidal behaviour among Black men. Further, more frequent reason for living moderated the relationship between depression and suicidal thought among black women. Takeuchi and Nakao (2013) examined the major depressive disorder was related to suicidal ideation among Japanese Workers. Worthless had higher area under the curve in predicting suicidal ideation. Worthless, concentration loss and depressive mood were the predictors of suicidal ideation.

Married professionals may be prone to depression because they bear the double burden of housework and a job outside the home. Because they have to work in two
environments, one is the office environment and the other is home environment. Both are vastly different from one another. Study revealed about the depression among married professionals. The working married women have to face more problems in their married life as compared to non-working married women. The highly educated working and non-working married women can perform well in their married life and they are free from depression as compared to educated working and non-working married women (Hashmi, Khurshid, & Hassan, 2007). The professionals among the managers and lawyer were more depressed than teachers, lecturers (self-employed) and doctors. Factors like family system, education, monthly income, number of children, and age appeared to be associated with depression of these professionals (Akram & Khuwaja, 2014).

One study revealed about the depression in IT professionals, 84% of the respondents experience medium level of depression and they also suggest that age and experience significantly influence the overall stress and depression experienced by the employees (Vimala & Mdhavi, 2009). Among nursing professionals, study investigated by Schmidt, Dantas, and Marziale (2011), they found that depression was high on the nursing professionals. They also revealed a statistically significant difference between for the occurrence of anxiety and depression for holding two types of jobs. Doing dual duty at home and workplace is very problematic which cause psychological problems among married working women. The married working women significantly reported more somatic complaints, social dysfunction, anger and hostility than non-working married women. There was no significant difference between depressions among working and nonworking married women (Sadiq & Ali, 2014). In order to predict depression in married working women, the sex role orientation and fear of success was examined by Sharma, Prabha, and Malhotra (2009), Fear of success is positively and significantly related to depression, the femininity, masculinity and androgyny are negatively related to depression and vice versa, and the stepwise regression analysis reveals that masculinity explains 15% of variance in depression i.e. low masculinity in women could contribute to depression due to lack of strength of mind. In another study, examine the difference between working and non working women on anxiety and depression. The results revealed significant differences on level of anxiety and depression with respect to both working and non working women (Bhadoria, 2013). Empirical data depicts that the married working women suffer from lots of problems. For instances, Depression is the only significant contribution in marital satisfaction among couples (Bano, Ahmad, Khan, Iqbal, & Aleem, 2013), in IT professionals, stress and alcohol use are highly risk factor for depression (Darshan, Raman, Rao, Ram, & Annigeri, 2013), a
significant relationship between working hours and depression among factory worker. The social support and gender difference were found to have significant influence in depressive symptom among factory workers (Anthony, 2009).

There might be a strong relationship between stress and depression among professionals. In a study, Mohan and Ashok (2011) investigated the stress and depression among information technology professionals. Results showed that 85 percent of the respondents experience medium level of depression and they also suggested that age and experience significantly influence the overall stress and depression experienced by the employees. Similarly, in another research revealed that working married women are high on depression than working unmarried women. Findings also suggest that non-working unmarried women are high on depression than non-working married women (Kumar, 2014). In another investigation, Bhattacharjee (2011) compared the self concept, anxiety and depression in married and unmarried women. Research revealed that married and unmarried women differed significantly in regard to their self concept, state anxiety and depression in comparison to unmarried women. However they did not differ significantly in regard to their trait anxiety. Depression among the working women examined by Prianka and Thenmozhi (2014) revealed women in low socio economic status show mild level of depressive symptoms than the high socio economic status women.

**STRESS AND SUICIDAL IDEATION**

The term stress is derived from the Latin word strictus, which means hardship, or adversity. Stress is borrowed from the physics discipline which actually means pressure. Dates back in 17th century when the prominent physicist-biologist, Robert Hooke was concerned about the stress which were used in terms of man-made structures, such as bridges, that must be designed to carry heavy loads and resist buffeting by winds, earthquakes, and other natural forces that could destroy them. Hooke’s analysis significantly influenced the early 20th century models of stress in physiology, psychology, and sociology. The idea that survives in recent times is, stress as an external load or demand on a biological, social, or psychological system.

After the World War II it has come to the notice that many circumstances of everyday life, like marriage, growing up, facing school exams, and being ill, all were producing effects of combat. This leads to a growing interest in the areas of stress as a cause of human distress and dysfunction. Further, the American psychological schools like behaviourism and positivism explained scientific way of understanding stress. During worlds war II military
wanted to select the person who are stress resistant and there should be some training of stress management for military personnel’s. During that time, the effects of stress and how they could be explained and predicted are major research question for them. Experimental research was widely accepted method for study at that time.

In the year 1952, Lazarus and Eriksen discovered that stressful situation did not produce dependable effects, stress was great for some person in a particular situation, while for other it was small. Under the stress situation, depending upon the task, the performance of some person was markedly impaired, for other it was improved, and for still other there was no verifiable effects. They concluded that to understand stress we should understand the individual differences in motivational and cognitive variable which intervened between stressor and the stress reaction (Lazarus et al., 1952). Brown and Farber (1951) by the viewing analysis of frustration and a treatment of emotion as an intervening variable and they emphasised on stimulus organism response (S-O-R) models rather than stimulus response (S-R) models to understand the concept of stress.

Robert hook was also interested to understand the individual’s difference in the resilience of people that are under stress. This is evident today that personality trait and coping process play an important role to resist the adverse effects of stress in a better way in some people than others. There was inconsistent and potentially confusing meaning of stress variable to denote the variable as a stress process. In medical word, stress refers to a set of physiological and psychological response to noxious stimulus. Hans Selye denoted stress agent as a stressor, and stress to denote reaction; and by sociological point of view stress as the disturbing agent and strain as a collective reaction (Smelser, 1963).

Despite these different usages of the terms stress process we must always consider four concepts to understand the stress process (Lazarus, 1993). One is a causal factor (external or internal agent), which Hook called a load and others call stress or a stressor. Second, an evaluation (by a mind or body) that distinguishes what is threatening or noxious from what is benign. Third, coping processes used by the mind (or body) to deal with stressful demands. Fourth, a complex pattern of effects on mind and body often referred to as the stress reaction. Earlier, stress concept was unified under two concepts: homeostatic and activation. As we all know, the principle of homeostasis was first explained by Claude Bernard, and later explored by Walter Cannon in 1939.

In 1950, Hans Selye seeks attention of the people to emphasise on the overlaps between physiological and psychological stress. Selye (1956/1976) described that any agent that is noxious to the stressor would produce more or less the same physiological stress
reaction. He gave the thought of General Adaptation Syndrome (GAS) to understand the stress process in terms of physiological analogue of the psychological concept of coping. Mason et al. (1976) reported that corticosteroid secretion may be more or less specific to psychological stress and not particularly responsive to physiological stresses such as heat, exercise, and hunger. On the other hand there are important overlaps between them; physiological stress and psychological stress require entirely diverse levels of examination (Lazarus, 1966; Lazarus & Folkman, 1984). Stress that is noxious to tissues is called physiological stress which is different from the psychological stress. The difference between physiological and psychological stress was more difficult issue for psychologist for dealing with stress. The major question was how to define the stressor in terms of psychology.

Lazarus tried to answer this question and focused on some of the factor which played a role in psychological stressors that are harm, threat, challenge, or benefit. This view was opposite to the idea of stress is a form of activation (an early idea). There have been two influential meaningful exploration of the concept of stress. First, selye (1956/1976), non-specific physiological response to any stressor, later he viewed a health centred distinction between eustress and distress. Second, the distinctions among three kinds of stress, harm, threat, and challenge (Lazarus, 1966; Lazarus Launier 1978; Lazarus & Folkman, 1984). Regrettably, Selye did not tell us clearly about the difference, whether it was psychological or physiological. It is our guess, of course, that, consistent with his views about the GAS, the differences would involve adrenal corticosteroids, some of which are protective (anabolic) while others are destructive (catabolic). The modern development of technology for measuring, immune response variables and processes offer additional means of distinguishing the two kinds of stress. For instance, eustress may improve immune system ability whereas distress may harm it.

The 21st century is called “century of the stress” because there are no single person without stress on this worlds. From children to old person, everyone has some kind of stress. Stress can be understood in terms of nonspecific response of the body to any demand. Stress considered a physiological effect on a person and it can be psychological as well as emotional too. It can be any circumstances or factor that can cause stress. Personality is the one of the major factor which played a significant role in stress. It depends on a person how much stress he/she can sustain. It is also related to individual capacity of adjustment also. The same situation can be differently tackled in different way by the same person. Stress, according to physicists, can simply be defined as ‘the pressure or force that is exerted to a body’. On the other hand, according to psychological point of view, stress refers to more complicated
factor, which is looked upon in terms of ‘the demands it possesses on an individual and how the individual attempts to acclimatize or cope with the specific demands’. There are numerous meaning of stress for the convenience of our understanding we are giving some of the popular definition of stress here.

Different researcher has different opinion regarding meaning of stress. According to Lazarus and Folkman (1984), stress refers to ‘a pattern of negative physiological states and psychological responses occurring in situations where individuals perceive threats to their well-being, which they may be unable to meet.’ Other defines it as “the non-specific response of the body to any demand made on it” (Hans Selye, 1976). These different kinds of psychological stress indicate that these are presumably brought about by different precursor situation, both in the environment and within the person, and have different consequences. For example, threat is an unpleasant state of mind that may seriously block mental operations and impair functioning, while challenge is exhilarating and associated with expansive and often with outstanding performance. To some extent we can take these variations critically. Stress cannot be considered in terms of a single dimension such as activation. It involves considering different emotional states, which are negative and positive.

**SYMPTOMS OF STRESS**

There is individual difference in behaviour, so keeping this view in mind that every individual reacts to stress in different manners. But there are common symptoms of stress. People may shake uncontrollably, breathe faster, deeper than normal or even vomit. Stress can trigger an asthma attack. There are four common types of symptoms of stress.

**Intellectual symptoms of stress include**, Memory Problem, Difficulty in taking decision, Confusion, Poor judgment, Lack of concentration. **Physical symptoms includes**, Digestive problem, Sleep disturbance, Fatigue, High Blood pressure, Weight gain or loss, Skin problems, Asthma or shortness of breath, Decreased sex drive, Heart palpitations. **Emotional Symptoms include**, Moody and hypersensitive, Restlessness and anxiety, Depression, Anger and resentment, Irritation, Lack of confidence, Apathy, Urge to laugh or cry at inappropriate times. **Behavioural symptoms include**, Sleeplessness, Eating more or less, loneliness, Neglecting everyday jobs, Increased alcohol and drug use, Nervous habits, Teeth grinding or jaw, Clenching, Overdoing activities such as exercising or shopping, Losing temper, Overreacting to unexpected problem.
TYPES OF STRESS

Stress can be understood in many forms depending upon its intensity or context. Basically stress has four types namely, Eustress, Distress, and Acute and Chronic stress. These are four basic type of stress which affects the human behaviour in a different manner.

1. The word **Eustress** comes from the Latin word “eu”, which means the positive or “good” stress that happens during pleasant situations. Some time it may surprise the individuals and it can lead to positive outcomes also. An example of eustress is planning for holidays, other example of getting married, or buying new things etc. These pleasant situation demands on the body and body will respond to those changes of positive experiences. Eustress is helpful in boosting confidence, learning new skills and increase motivation. Although this type of stress is often overlooked when thinking about stress management and understanding positive coping techniques for a person’s to deal with stress more effectively.

2. The **Distress** word originated form Latin “dis” which means negative or “bad” stress that occurs when individuals perceive stress as dangerous, difficult, or painful. Examples include the loss of a job, death of a loved one, long-term illness, serious injury, divorce, failing in an exam and depression etc.

3. **Acute stress** is short-term stress. It can be eustress or distress. An example of acute stress is presentation of individuals in front of a group of people. During this situation person sweat, heart races and persons breathing is quicken. These feelings last only for a short time for an individual and body recovers quickly.

4. **Chronic stress** lasts for longer periods of time. This type of stress is due to significant events, yet also occurs when little stressors accumulate and persons become unable to bounce back from them. Examples of chronic stress include long-term illness, downsizing or reorganizing at workplace, and long-term marital troubles. Chronic stress is probably the most dangerous for people’s health, as individuals become more prone to the negative effects of the stress.

Empirical studies have investigated the association between stress and suicidal ideation and have consistently specified stress as a risk factor for such behaviour (Grover et al., 2009; Thompson et al., 2012; Zhang, Wang, Xia, Liu, & Jung, 2012). For instance, studies have demonstrated that adolescents with lack of reason for living and higher level of life stress were more likely to have suicidal ideation. Among adolescents, level of stress is higher who are thinking to suicide as compare to those who do not have suicidal thought (Zhang et al., 2012). Stress perception is significant positively related to thought of committing suicide.
(VilhJalmsson, Kristjandottir, & Sveinbjarnardottir, 1998). Acculturative stress, perceived discrimination, Post-traumatic stress disorder, mental distress job stress, stress and self esteem significant predictors of suicidal ideation (Hovey, 2000; Gomez, Miranda, & Polanco, 2011; Sareen, Houlahan, Cox, & Asmundson, 2005; Tyssen, Vaglam, Gronvold, & Ekeber, 2011; Wilburn & Smith, 2005). To investigate the relationship among coping, stress and suicidal ideation of police official study showed suicidal ideation is significantly correlated with passive coping, job demands and lack of job resources (Swanepoel, 2003). Suicidal ideation was significantly associated with service stress exposure; results also indicated that service stress exposure and suicidal ideation was mediated by posttraumatic stress symptoms and general mental health problems (Thoresen & Mehlum, 2008). One of the findings of the study showed that daily stress had a positive relationship with suicidal ideation. Depression, anxiety, mental health, resilience and daily stresses were the contributor factors in predicting suicidal ideation (Izandinia, Amiri, Jahromi, & Hamidi, 2010). In 2012, Linda, Marroquin and Miranda, reported that life stress may be especially important for individual who is vulnerable to suicidal ideation due to an attempt history. Other important factors like, perfectionism trait, stress, depression, hopelessness was also observed by the researchers in connection with suicidal ideation variable (Chen, 2012). Organizational stress, critical incident trauma, shift work, relationship problems and alcohol use and abuse are important factor associated with risk factor for suicidal ideation (Chae & Boyle, 2013). Finding of a study revealed a significant positive relationship between suicidal ideation and perceived stress. Further, perceived stress, coping strategies were the predictors of suicidal ideation (Asghari, Sadeghi, Aslani, Saadat, & Khodayari, 2013).

**Stress among Married Professionals**

Daily stress is defined as routine hassles, strains, or annoyances associated with everyday daily activities and transactions of everyday life. Daily stress is relatively minor, but has the potential to disrupt the flow of routine life and add to overall levels of stress. Daily stress can be both anticipated and unanticipated. Observed daily stressors include, for example, driving in rush traffic on the way home from work, paying bills, working long hours, job performance evaluations, or taking children to other activities. Unanticipated stressors may include arguments with spouse, car trouble, getting stuck in long lines at the grocery store, getting sick, losing one’s keys, or inconveniences due to weather. Professionals stress is important concern for study in psychology. It refers to a pattern of emotional, cognitive, physiological and behavioural reactions to adverse and harmful aspects of work
content, work organisation and the working environment. Studies revealed about the stress among professionals, In a study Bhuvaneshwari (2013) revealed that stress in married working women is caused due to long working hours, various family and official commitments, harassments and improper work life balance. Such form of stress can leads to a variety of problems, such as prolonged headaches, obesity and hypertension. In the IT industry, study showed employees with high and medium self-esteem experience high level of stress. Long working hours, work pressures, erratic food intervals, anxiety were found to be the reasons of affecting personal health (Mohan, Balaji, & Kumar, 2012). Stress among the married working women’s has been found to be high then the unmarried working women. The high level of occupational stress on the sample of married women can be explained in terms of traditional trends, demands of society and more roles and responsibilities assigned to them as a mother, wife and homemaker, as compared to unmarried women (Parveen, 2009). In the police officer, one study conducted by, Husain, Waqar; Sajjad, and Rahat (2012), found significant differences between married and unmarried police officers on the variables of depression, anxiety and stress.

Professionals in the service sector suffer more stress and anxiety compared to those in the manufacturing sector. Study revealed unmarried and a younger age group of professionals perceived to have a higher level of anxiety and stress than married and the senior age group (Srivastava, 2012). In the teaching professionals, the teacher educators experienced moderate level of occupational stress. The variable Gender and marital status has been found to be significantly different on the stress among the teacher educator (Nagra & Arora, 2013), Occupation stress among the working female teachers indicates the impact and occurrence of justification of job duties. There has been significant difference in stress level between female teacher working in the public and private schools (Vyas, 2014). Stress is very significant factor that contributes in suicide ideation in working professional’s life. A study of married working women in India revealed that high role stress promotes suicide ideation in general, but neurotics and introverts are more susceptible to the effects of high role stress in relation to suicide ideation (Khokhar & Chatterjee, 2010). Occupational stress played a significant role in executives of public sector in steel plants. Research found that occupational stress does affect job involvement in a significant manner that means the high work stress was high when they expressed high job involvement (Mukherjee & Singh, 2011).

In a sample of medical professionals Singh and Kumar (2015) revealed that alexithymia and its various dimension in general, are associated with higher level of occupational stress and burnout. They also suggest that a doctor having more difficulty in
identifying feeling is likely to experiences higher level of occupational stress particularly related with incompatible working ambiance, work overload and difficulty in caring the problematic patient, the tendency for externally oriented thinking is responsible for higher level of occupational stress related with external interferences in the practice of medical profession. Govil and Singh (2014) revealed that job stress was associated positively with poor wellbeing. Lack of organization support was associated with greater psychological distress and poor wellbeing. Emotion- focused coping was positively related with problem-focused coping and negatively related with wellbeing. In teaching professionals, the role of effectiveness of education is very important aspect of study, Rana (2014) reported less effective teachers were having high occupational stress and female teachers were under more occupational stress. In another study, Chaurasia and Upadhyay (2013) investigated the subjective well-being and stress of working and non-working women. Results indicated statistically significant difference between working and non-working women on subjective well-being but there was no significant difference between working and non-working women on stress.

Police professional are considered as a more challenging group which are exposed to different stressors day by day which influence the life of a police man. The study indicated that the two groups differed significantly on the parameters of occupational stress and a linear relationship was found between occupational stress and life satisfaction among police professionals (Gupta & Suman, 2012). Similarly, in another research a majority of the police officers suffer from high job stress. The study also revealed the socio demographic variables have a significant difference between the job stress in police professional (Nathawat & Dadarwal, 2014). In another study, Bandhu (2012) revealed that male teachers experienced significantly higher organizational stress in terms of role erosion and resource inadequacy than their comparable female counterparts. Occupational stress and burn out play a significant role among the male and female professional managers in private hospitals (Janet & Velayudhan, 2014). In IT professional, investigation by Mukherjee, Dogra, and Banerjee (2014) shows that there was a significant difference between male and female with regard to four dimensions of organizational role stress, but there was no significant difference in terms of stressful life events.

To examine stress and interpersonal behaviour among IT professionals finding reported significant differences on stress, gender, age, marital status and work experience (Sreecharan & Reddy, 2013). On the other hand, Deshmukh (2009) found there was no significant difference in physical and family stress among working and non working women.
Role stress was significantly higher among working than non-working women. Further, life satisfaction was better in working women than non-working women. On similar line, Raghavan, Sakaguchi, and Mahaney (2008) reported the perceived workload, role ambiguity, work facilitation, and decision latitude are potential stressors. Remove role ambiguity and getting better work facilitation decrease work-related stress and allowing employees to have flexible work schedules relieve their perceptions of workload. In another research, Chaudhry (1995) reported significant negative correlation between life stress and general well-being among professional, non-professional and unemployed women.

SUICIDAL IDEATION

Suicidal behaviour has become a major public health problem throughout the world. It is estimated that every suicide has serious impact on at least six other people and the psychological, social and financial impact of suicide on the family and community is immeasurable. Approximately one million people worldwide commit suicide annually. Every 40 seconds a person commits suicide somewhere in the world. Suicidal behaviour includes, suicidal ideation, suicide attempt and completed suicide, it may be on the continuum of self-harming behaviours. Suicidal behaviour includes the tendency, thoughts or acts of self-harming behaviour or life-threatening risks. Suicidal behaviour can be direct (suicidal ideation, suicide attempt or completed suicide) or indirect (such as risky driving, high-risk hobbies, hazardous alcohol drinking, and drug misuse). Our focus of attention is to study the suicidal ideation among married professional (direct behaviour of suicide). During the past decade, suicide in India has been recognized as a great public health concern. It is considered to be part of a continuum that culminates in suicide attempts and completed suicides. These behaviours are linked to the same risk factors, with variations more likely to occur in the degree rather than in the type of risk factor. Previous studies have shown that suicidal ideation is a powerful predictor of completed suicide.

Given the important role of suicidal ideation and attempt in leading to completed suicide (Reynolds, 1991), researchers have called for a greater effort to further understand the risk factors associated with suicidal ideation and attempt (Borges, Walters, & Kessler, 2000). Literature from Western societies suggests multiple risk factors for suicidal ideation and suicidal attempt, including biological, cognitive, psychological, social, and family factors. Psychopathology (e.g., depression and substance abuse) has been recognized to be the strongest predictor of suicidal behaviours (Brockington, 2001; Chaudron & Caine, 2004).
Suicide has been defined by Comer (2002) “Self inflicted death in which one makes an intentional, direct and conscious effort to end one’s own life”. Suicide is the term used for the deliberate self destruction of a human being, by causing their body to cease life function. Such actions are typically characterized as being made out of despair, or attributed to some underlying causes (Hawton & Van Heeringen, 2009). In a study which was conducted in Finland, 22% of the suicides examined had discussed suicidal intent with a health care professional in their last office visit (Halgin & Susan, 2006) that means before committing suicide individuals have thoughts or ideations about suicide which they may express in various ways. Many people experience suicidal thoughts at some time in their lives. A recent cross-sectional study by Arun and Chahan (2009) has reported 6% of suicidal ideation and 39% suicidal attempt among school children. Suicidal ideation is a common medical term for thoughts about suicide, which may be as detailed as a formulated plan, without the suicidal act itself. Research evidence suggests that a significant minority of young people may have suicidal thoughts and ideas, with the majority not acting upon these ideas (Coggan et al. 1995; Horwood & Fergusson, 1998). Although most people who experience suicidal ideation do not commit suicide, only some of them go on to make suicide attempts (Gliatto & Rai, 1999). The diversity of suicidal ideation differ extremely from brief to comprehensive planning, role playing and unsuccessful attempts, which may be deliberately constructed to fail or be discovered, or may be fully deliberate to succeed.

A number of factors are linked with suicide ideation: mental illness, substance abuse, drug addiction, and socioeconomic factors such as unemployment, poverty, homelessness, and discrimination that may trigger suicidal thoughts (Qin, Agerbo, & Mortensen, 2003). Some external circumstances, such as a traumatic event, may trigger suicide ideation but it does not seem to be an independent cause. Financial difficulties, interpersonal relationships and other undesirable situations also play a significant role. Thus suicidal ideations are more likely to occur during periods of socioeconomic, familial and individual crisis. Psychological theories of suicide suggest that individuals engage in suicidal behaviours because of an inability to tolerate or change the experience of negative affect (Lynch, Cheavens, Morse, & Rosenthal, 2004; Zlotnick, Donaldson, Spirito, & Pearlstein, 1997). The suicide rate is rising in India. It is estimated that half million people die of suicide every year worldwide, among which 20% are Indian. The National Crime Records Bureau (NCRB, 2012) has revealed the causes of suicides in India, are family problems, illness, drug abuse, love affairs, sudden
change in economic status, dowry dispute, professionals or career problem, and unemployment.

Predictors of Suicide Ideation

A large numbers of researches have focused on investigating the risk factors that predict suicide ideation. However, the suicide process, particularly suicide ideation, is complex (Wu & Bond, 2006). A large number of college students who experienced suicide ideation before committing suicide (Gould & Kramer, 2001). There are numerous risk and protective factors believed to be associated with suicide ideation, attempts, and completion: depression, ethnicity, family socioeconomic status, prior suicidal behaviour, anxiety, hopelessness, substance use, family and relationships issues, aggressive/impulsive behaviours, physical and sexual abuse, stressful life events, impaired coping abilities, exposure to suicide, low self-esteem, homosexual or bisexual orientation, poor communication with family members, family discord, financial problems, personality, aggression, poor academic achievement and performance, and poor peer relationships (Brener, Hassan, & Barrios, 1999; Cukrowicz, Wingate, Driscoll, & Joiner, 2004; De Man, Labreche, & Leduc, 1993; Dogra, Basu, & Das, 2008; Evans, Hawton, & Rodham, 2004; Fergusson & Lynskey, 1995; Furr, Westefeld, McConnell, & Jenkins, 2001; Gutierrez, Osman, Kopper, Barrios, & Bagge, 2000; Hintikka et al., 2009; Konick & Gutierrez, 2005; Meilman, Patis, & Krause-Zeilman, 1994; Rey, Narring, Ferron, & Michaud, 1998; Roberts, Roberts, & Chen, 1998; Smith, Alloy, & Abramson, 2006; Stephenson, Pena-Shaff, & Quirk, 2006; Wilburn & Smith, 2005). Knowing that these predictive factors are associated with suicide ideation allows clinicians in both mental and physical health settings to identify people who are at a greater risk for suicide ideation, and thus, efforts can be made to prevent the suicide process from beginning or progressing beyond suicide ideation.

One significant predictor of suicide ideation in young adults is depression. Depression in young adults is frequently reported by those who have engaged in suicide attempts (Bae, Ye, Chen, Rivers, & Singh, 2005; Evans et al., 2004; Garlow et al., 2008; Konick & Gutierrez, 2005; Westefeld et al., 2006). In addition, research has found that affective disorders, specifically a depressive episode, are common psychiatric diagnoses among people who have completed the act of suicide (Houston, Hawton, & Shepperd, 2001). Kisch, Leino, and Silverman (2005) have showed that a depressed mood is a possible risk factor for suicidal behaviour in college students. In addition, various studies have reported a significant relationship between depression and suicide ideation among college students, where high
levels of depression are associated with high levels of suicide ideation (Garlow et al., 2008; Singh & Joshi, 2008; Weber, Metha, & Nelsen, 1997). Furthermore, various researches have revealed that depression is a strong predictor of suicide ideation among college students (Gibb, Andover, & Beach, 2006; Singh & Joshi, 2008; Stephenson, Pena-Shaff, & Quirk, 2006). It is evident from past research that high levels of depression is associated with increased suicide ideation, suggesting that depression is a significant predictor of suicide ideation (Furr et al., 2001; Gibb et al., 2006; Hirsch, Conner, & Duberstein, 2007; Kumar & Pradhan, 2003; Lipschitz, 1995; Singh & Joshi, 2008; Stephenson et al., 2006; Thompson, Moody, & Eggert, 1994). Thus, depression is a risk factor predictive of suicide ideation.

Hopelessness is another risk factor that predicts suicide ideation in young adults. Many studies have found a relation between suicide ideation and feelings of hopelessness, attempts, and completions (Abramson et al., 1998; Beck, Steer, & Brown, 1993; Chioqueta & Stiles, 2005; Evans et al., 2004; Konick & Gutierrez, 2005; Pinto & Whisman, 1996; Kuo, Gallo, & Eaton, 2004; Simons & Murphy, 1985; Smith et al., 2006). Hirsch et al. (2007) and Weber et al. (1997) have reported in their study that there is a significant positive relationship between hopelessness and suicide ideation among college students. In other words, high levels of hopelessness are linked to high levels of suicide ideation. For years, research has supported the notion that hopelessness is a significant predictor of suicide ideation among college students (Beck, Steer, Kovacs, & Garrison, 1985; Dixon, Heppner, & Rudd, 1994; Gibb et al., 2006; Heisel, Flett, & Hewitt, 2003; Lipschitz, 1995; Stephenson et al., 2006). Clearly, hopelessness is also a risk factor predictive of suicidal ideation. In addition, perceived stress is a risk factor for young adult suicide ideation, particularly for the college population, because college students are believed to have high levels of perceived life stress (Hirsch & Ellis, 1996). An association has been recognized between suicide ideation and stress. Joiner and Rudd (1995), Lipschitz (1995), and Chang (2002) findings put forward that life stress is positively related with suicide ideation.

Particularly, Hirsch and Ellis (1996) have shown in their study that students who experience suicide ideation have greater levels of life stress. In addition, Weber et al. (1997) and Singh and Joshi (2008) have revealed significant relations between stress and suicide ideation among college students, which means that people with a high level of life stress may have a greater tendency to experience suicide ideation. Moreover, Singh and Joshi (2008) have concluded that stress is a strong predictor of suicide ideation among college students. One study, conducted by Vilhjalmsson, Kristjansdottir, & Sveinbjarnardottir (1998) specifically examines the relationships between life stress and perceived stress and suicide.
These researchers have found that life stress and stress perceptions are significantly associated with thoughts of suicide; their research suggests that perceived stress is a risk factor for suicide ideation (Vilhjalmsson et al., 1998). Consequently, it reveals that an individual’s perceived level of stress is a significant predictor of suicide ideation.

Lastly, religiosity is a significant predictive factor of suicide ideation and it is frequently acting as a protective factor against it. Studies related with the protective effects of religion against suicide ideation are wide-ranging. In general, research supports that suicide risk is lower in people who are religious compared to those who are nonreligious (Maris, 1982; Sorri, Henriksson, & Lonnqvist, 1996). There are many studies which exposed that people who report being more religious also report lower levels of suicide ideation, and people who report being less religious also report greater suicide ideation (Bagley & Ramsay, 1989; Simonson, 2008; Walker & Bishop, 2005; Zhang & Jin, 1996). Diverse aspects of religion are thought to protect against suicide ideation: the integrative benefits of religion, such as social support; the culture of hope represented by religion; and/or the moral constraints of religious beliefs that coincide with religious affiliation and practicing religion, given that many religions maintain beliefs prohibiting suicidal behaviour (Dervic et al., 2004; Koenig, McCullough, & Larson, 2001; Neeleman, Wessely, & Lewis, 1998; Pescosolido & Georgianna, 1989; Stack, 1983; Stack, 1992; Stack & Lester, 1991; Stillion & Stillion, 1998). Nevertheless, it is clear in research findings that religiosity is believed to predict suicide ideation.

In an another study on the psychosocial and clinical factors associated with adolescent suicidal attempts Kumar and Chandrasekharan (2000) compared potential risk factors between adolescent and adult suicide attempters and revealed that the adolescents had significantly higher levels of hopelessness, lethality of event, depression, and stressful life events. In a study on 100 female burns cases admitted at the Madurai Medical college, Rao et al. (1989) reported the most common reasons for suicidal attempts were marital and interpersonal problems followed by psychiatric and physical illnesses respectively. One of the study reported that the isolation and inability to form relationships were identified as important factors in the suicidal attempts (Chakraborty, 2002). In general, females are more likely to report suicidal ideation than males (Beautrais, 2002; Yoshimasu et al., 2006). However, the inverse findings have also been reported with regard to gender differences in completed suicide versus suicidal ideation (Stein, Brom, Elizur, & Witztum, 1998; Weissman et al., 1999). In addition, previous study showed that depersonalization was found to be risk factor for suicidal ideation in males with depression, whereas de-realization and depressive
moods posed the major risk in females (Yoshimasu et al., 2006). This discrepancy may be related to behavioural differences between males and females, and investigations focusing on gender differences could contribute to measures of mental health problems. More than 90% of suicide victims were diagnosed as having psychiatric problems at the time of their death, and approximately two-thirds were diagnosed as having depression (Isometsa et al., 1995). Depression has been identified as the major risk factor for suicidal ideation, suicide attempts, and successful suicide (Groholt, Ekeberg, Wichstrom, & Haldorsen, 2000; Turvey et al., 2002). Because of the strong relationship between suicidal behaviour and depression, screening and treatment for depressive disorder has been proposed for the prevention of suicide (Oyama, Koida, Sakashita, & Kudo, 2004).

Existing literature on suicide and the factors associated with suicide in India revealed suicide rates are highest in persons that are 20 to 29 years old. Female suicide rates are higher than male in persons under 30 years of age but the opposite is true for those who are 30 years of age or older. Hanging and ingestion of organophosphate pesticides are the most common methods of suicide. Among women, self-immolation is also a relatively common method of suicide. Low socioeconomic status, mental illness (especially alcohol misuse) and interpersonal difficulties are the factors that are most closely associated with suicide (Rane & Nadkarni, 2014). It was noted that cultural and religious factors play an important role in suicidal behaviour in India. The rate was higher for males as compared with females and was greater in joint family than in nuclear family. Similarly, married persons of both gender had a higher frequency of suicide. Ethnically the rate among Hindus was higher than among Christians. Mental illness constituted a major cause of suicide, followed by domestic conflicts. An interesting feature observed in the study was that more persons commit suicide in their own birth place and near their locality (Sharma & Gopalakrishna, 1978).

Nock et al. (2008), in a survey of almost 85,000 individuals across 17 countries, found that one-third of suicide ideators make a suicide plan, and over half of those with a plan make an attempt at some point in their lives, with the majority of these transitions taking place within one year of ideation onset. In a recent study, Srivastava (2013) investigated the demographic characteristics, psycho-social factors, psychiatric co-morbidity in hundred completed suicide victims. Males committed suicide significantly more often than females. The most common age group was 30-44 years, followed by 15-29 years. Most of them were married (68%) and majority (78%) had education less than 10th standard. Psychiatric morbidity is observed in 94%, depression being the most common diagnosis (54%), followed
by alcohol use disorders (42%). And 40% of the victims had contact with mental health services and 50% with general health services in the 3 months preceding suicide.

INDIAN STUDIES

Among the Indian studies researcher are more interested to find out relationship among these variables very precisely. In a important study, Srivastava and Kulshreshta (2000) found a positive correlation between severity of depression, being married, being male, being employed, being ex mental hospital patient and age below 35 years. Marital status and psychiatric illness are playing important role in suicide attempt (Narang, Mishra, & Mohan, 2000). Another study by Srivastava and Kumar (2005) found single men; married women and students were more likely to attempt suicide. They concluded that young patient with depression, especially unmarried men, married women and students, having severe suicidal ideation with agitation or paranoid symptoms are more likely to attempt suicide. A significant study by Singh and Joshi (2008) revealed suicidal ideation was a positively associated with depression, stressful life event and personality dimension. Depression was a predictor of suicidal ideation. In an important study, it has been found that unmarried scored significantly higher than married on depression, and married scored higher than unmarried on suicidal ideation (Iqbal et al., 2012). Suicidal ideation was found to be positively correlated with depression (Sharma & Agarwal, 2010). Another researcher like, Sharma, Chahal, and Upmanu (2012) presented the view that depression, hopelessness, and psychoticism play a significant role in suicidal ideation among adolescents. Reasons for living has been found to have negative correlation with suicidal thought (Chatterjee & Basu, 2010). In a recent study, Suicidal ideation was positively associated with aggression, hopelessness and conflict measure of family environment (Singh, 2013).

RATIONALE OF THE STUDY:

Recent reviews (Greene, Chorpita, & Austin, 2009; Yamokoski, Scheel, & Rogers, 2011) show that there is increase in the suicidal ideations among general population specially in youth, adult and old age due to many factors. A large number of studies focus on the role of depression, hopelessness, some of the personality dimensions like psychoticism. Now recent studies try to find out the role of other factors like affect mainly negative affect and health problem. Negative affect is associated with suicidal ideation (Hirsch, Duberstein, Chapman, & Lyness, 2007; Yamokoski et al., 2011). Recent reviews (Bacsakai, Czobor, & Gerevich, 2012; Takusari, Suzuki, Nakamura, & Otsuka, 2011) suggest role of health problems in suicide ideation. Studies show the relationship between stress and suicidal ideation (Ang & Huan, 2006; Griffith, 2012; Zhang et al., 2012). After the extensive review,
it is found that there are number of factors which lead to suicidal ideation. Earlier studies are mainly focussed on adolescents, old age persons, and clinical sample of depression and other mental disorder. Other sections of the population are not taken which may face different problems which may contribute in suicidal ideation. The present study was planned for the sample of married professionals to find out role of health, negative affect, depression and stress in suicidal ideation among. There is large number of studies on suicidal ideation 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

“Role of Health, Negative Affect, Depression and Stress in Suicidal Ideation among Married Professionals”

OBJECTIVES

1. To examine differences between married male and female professionals on mental health problems, general health problems and negative affect.
2. To study gender differences on depression, daily stress and suicidal ideation among married professionals.
3. To study relationship between mental health problems, general health problems and suicidal ideation among male and female professionals.
4. To find relationship between negative affect and suicidal ideation.
5. To investigate relationship between depression and suicidal ideation among male and female professionals.
6. To examine relationship between daily stress and suicidal ideation among professionals.
7. To examine predictive strength of suicidal ideation among married professionals.