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VULNERABILITY TO EMOTIONAL DISTURBANCES IN FATHERS OF NEUROTIC AND PSYCHOTIC CHILDREN

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ABSTRACT

In the present research the level of anxiety among fathers of neurotic and psychotic children was studied. IPAT anxiety Scale was used followed by an interview to obtain information and history from them.

Three hundred fathers participated in the study. Hundred fathers had neurotic children, hundred had psychotic children and hundred had normal children.

A chi-square test was computed for the statistical analysis of the data and hypotheses were significant at . 05 level.

It was concluded that the fathers of neurotic children have high sten scores on anxiety scale than the fathers of psychotic children.

INTRODUCTION

When a loved one is mentally ill, every member of the family is affected in some way or the other. Whether the relative is son, daughter, sister, brother, parent, grandparent, or a grand child, they all share the suffering. They are stunned and bewildered. They hope that the odd behavior of the patient and his scary talk will end. They are also hopeful that soon things will be back to normal.

In Pakistan, it is very difficult to detect mental illness because of lack of awareness and understanding of emotional disorders. Even if the parents are aware that their children are suffering from mental disorder they are restrained to admit it due to the social and cultural stigma. In Pakistan the culture is basically male oriented, hence men are responsible for provision of all the needs, especially those of health and education of their children. Since families are generally the responsibilities of fathers, therefore they are more concerned about the health problems of their families where as the other needs are looked after by the mothers.

It may be noted that parents specially fathers wait for a few days and then take their ill children to the hospital or physician for treatment. Parents with psychotic children do not admit that their child is suffering from psychosis. In the beginning of emotional disorder the fathers normally take their children to Spiritual leaders (Pirs) or to the Shrines and Graves of the holy man (Mazars) as generally advised by the older people, friends, neighbors etc.

After exhausting all the possibilities they come to the hospitals and get advice from the psychiatrists and psychologists. Hence the children are already in the category of chronic patients. The parents have lot of questions and queries and their feelings of

despair are quite normal. Many relatives and friends share their sorrows and concerns but do not actually share the financial and emotional burden of the fathers.

The feelings of the father are very unique as he feels tense because it is his child who has fallen mentally ill. A promising young person, on the threshold of becoming an adult, suddenly becomes very changed. He begins to feel as though he has a stranger in his midst. His once happy and competent son/daughter becomes withdrawn, unkempt, and unable to function. His affectionate, dependable daughter/son argues, destroys useful house hold items and utters sentences that make no sense. He, like other fathers, wants to protect and nurture his child. When his desire is thwarted, he feels that he has failed in his duties. He may blame himself for the failure.

It is a well known fact that other family members may escape the immediate responsibilities that fall upon the fathers of the mentally ill children, although, they do share equally the painful feelings. The brothers and sisters are bewildered, frightened, and some time ashamed and angry.

Pakistani culture has very close-knit families and the mentally and physically ill people are accepted by the entire family. In spite of that, the burden is bore by the father more than others as they are financially responsible for the child. According to Coleman (1976) the general appearance and clinical picture of the individual suffering from emotional disturbance is one of dejection, discouragement and sadness.

Typically there is a high level of anxiety and apprehensiveness, together with mixed activity, lowered self-confidence, constricted interests and a general loss of initiative. The person usually

complains of difficulty in concentrating, although his actual thought processes are not slowed down. Often he has difficulty in going to sleep, and after waking up during the night cannot go back to sleep easily. In severe cases, the person is unable to work and prefer to sit, hopelessly staring into space, and able to see only the dark side of life. The person having anxiety lives in a relatively constant state of tension, worry and diffused uneasiness. He is oversensitive to interpersonal relationship and frequently feels inadequate and depressed. Symptoms vary from person to person, but typically they include palpitations, shortness of breath, profuse sweating, faintness and dizziness, coldness and pallor of the face and extremities, gastric sensations and an ineffable feeling of unhealthiness, Lader & Mathews (1970).

In this study, the emotional disturbance is operationally defined as the symptoms of anxiety.

Anxiety: An emotional attitude involving a feeling of anticipated future danger accompanied by a symptom of apprehension and tension. The focus of anticipated danger may be internal or external.

To summarize, in anxiety following are the common symptoms: Anxiety is part and parcel of human existence. All people feel it in moderate degrees, and in moderate degrees it is an adaptive response. According to Stephen M. Paul, quoted in Scheneck (1990), "Without anxiety, we would probably all be asleep at our desk", we would also expose our selves to danger. It is anxiety that compels us to go for medical checkup, to slow down on a slippery road, to study for exam, and thus to lead longer and productive lives. But while most people feel anxiety some of the time, some people feel anxiety most of the time. For these people it is not an adaptive response. It is a source

of extreme distress, relievable only by strategies that limit freedom and flexibility. Anxiety may range from highly adaptive to highly maladaptive reactions. Adaptive anxiety is appropriate to the situation and can even enhance efficiency and achievement. In contrast, maladaptive anxiety is self-defeating, it tends to interfere with efficiency and achievement. For example, excessive anxiety can increase errors on various tasks. It can also result in overly cautious behavior, such as delaying appropriate responses and decision (Eisdorfer, 1977).

One can experience moderate level of anxiety and still perform effectively. Indeed, under certain circumstances moderate anxiety can be motivating and constructive. A study of anticipatory anxiety prior to major surgery illustrates this point. (Janis, 1971). Patients who expressed a moderate degree of anxiety prior to the operation faired better in their postoperative adjustment than those who had shown either a very low or a very high level of preoperative anxiety. This particular investigation was carried out by means of intensive interviews and inspection of observational notes made by doctors and nurses. In a follow-up study, college students who had under gone major surgery completed questionnaires concerning their preoperative and postoperative feelings about their ordeal (Janis, 1971, pp, 96, 97).

These results not only illustrate the disruptive effects of excessive anticipatory anxiety but also contradict the popular notion that people who remain extremely calm about an impending ordeal will be much less disturbed when they handle the subsequent stress than people who show some anxiety. Indeed, the finding suggest that when people are exposed to severe stress, those who are not confident about their invulnerability at the beginning may well be the most likely to be highly disturbed when they actually under go the stressful

events. Furthermore, a moderate degree of anxiety and fear about realistic danger can be constructively motivating, helping the individual develop effective inner defenses for coping with the danger (Janis, 1971, p, 71).

The term neurosis is still widely used in psychodynamic writings and mental health professionals of many other theoretical persuasions continue to use it as an indication of the severity of a psychological disorder, "neurotic" indicating the milder disturbances and "psychotic" indicating the more debilitating ones.

In that sense of severity, the anxiety disorders are "neurotic" conditions. They do not destroy reality contact. People with anxiety disorders may misinterpret or overreact to certain stimuli related to their psychological problems, but in general they see the same world as the rest of the people and in most cases they still go about their daily rounds, studying or working, carrying on fairly reasonable conversation, engaging in relationships with other people and so on. They may cope poorly, but they cope. Though the anxiety disorders as a group may not be crippling, they still represent the single largest mental health problem in the United States (Kessler, McGonagle, Zhao, et al 1944). They are more common than any other psychological disorder, and they can lead to more severe disorders, such as depression and alcoholism. They may also lead to physical disorders such as heart disease (Barlow, 1988, Wells, Golding & Burname, 1989).

Psychodynamic Perspective of Anxiety:-

Freud S., (1924) argued that anxiety stemmed not just from external threats but also from internal ones, in the form of id impulses attempting to break through into consciousness. It is this latter type of anxiety that Psychodynamic theory sees as the root of neurosis. In the mind of the neurotic, the id is pushing in one direction , toward the enactment of its sexual or aggressive impulse. Meanwhile, the ego, knowing that the id impulse is unacceptable in terms of both reality and the superego's ideals, is working in the opposite direction, pushing the impulse back into the unconscious through repression and other defense mechanisms. This push and counter push goes on all time in normal lives and usually works well enough so that anxiety over the id impulse is never experienced consciously. In some cases, however, the anxiety is so intense that it is experienced consciously, with debilitating results. Or it is kept away only through the employment of extremely rigid defense mechanisms. It is these situations that, according to Psychodynamic theory, constitute neurotic behavior.

In cases where anxiety is experienced chronically and directly, with out elaborate defense, what we see is generalized anxiety disorder. The cause is repressed, but the anxiety leaks through. In the panic attack, the cause that is, the id impulse move closer to the boundaries of the conscious mind, resulting in the rapid buildup of anxiety. The ego responds with desperate efforts at repression, and a state of maximum conflict ensues. Once the ego regains the upper hand and the impulse is once again safely repressed, the attack passes.

The most common areas of worry are family, money, work, and health (Rapee & Barlow, 1993). Many normal people worry about such things, but it is the excessiveness and uncontrollability of the worrying that makes it a disorder. People with generalized

anxiety disorder are continually waiting for some thing dreadful to happen, either to themselves or to those they care about, and this subjective conditions spills over into their cognitive and physiological functioning. They feel restless and irritable, they have difficulty in concentrating, they tire easily. Typically, they also suffer form chronic muscle tension and insomnia in response to symptoms, many of them develop secondary anxiety that is, anxiety about their anxiety fearing that their condition will cause, them to develop ulcers, lose their jobs, alienate their spouses, and so forth. Most people with generalized anxiety disorder develop the condition fairly early in life, many report that they have always felt anxious. It is a common disorder, affecting as much as four to five percent of the U.S population, and it is twice as common in women as in mem (Kessler, McGonagle, Zhao, 1994; Rapee, 1991). The rates are similar across a variety of cultures (Anderson, 1994).

Generalized anxiety disorder sounds as though it might be the "resting state" of panic disorder, and some researchers believe that this is the case that these syndromes are two phases of a single disorder (Barlow, 1988). At the same time, there are strong grounds for separating them. In a recent comparison, Noyes and his colleagues found three major differences between the two, syndromes. First, their symptom profiles differ. The symptoms of generalized anxiety disorder suggest hyper arousal of the central nervous system (Insomnia, restlessness, inability to concentrate). Where as the symptoms of panic disorder seem connected to hyper arousal of the autonomic nervous system (pounding hearts, rapid breathing , dizziness, nausea). Second, generalized anxiety disorders usually has a more gradual onset and a more chronic course than panic disorder. Finally, when these disorders run in families, they tend to run separately. First-degree relatives of people with generalized anxiety disorder are more likely to have generalized

anxiety disorder than panic disorder, first-degree relatives of panic disorder patients are more likely to have panic disorder than generalized anxiety disorders (Noyes, Woodman, Garvey, et al., 1992).

Generalized anxiety disorder is relatively common in U.S society. Surveys suggest that up to 3.8 percent of the United Sates population have the symptoms of it in any given year (APA, 1994, Kessler et al., 1994; Blazer et al., 1991). Although the disorder may emerge at any age, it most commonly first appears in childhood or adolescence. Women diagnosed with it out number men 2 to 1.

People with generalized anxiety disorder typically feel restless, keyed up or on edge, are easily fatigued, have difficulty concentrating, are irritable, experience muscle tension, and have sleep problems. The symptoms last at least six months (APA, 1994). The majority of people with this disorder also develop another anxiety disorder, such as a phobia, at some point in their lives (Roy-Byrne & Katon, W. et al., 1997; Blazer et al., 1991). Many experience depression as well (Sherbourne et al., 1996; Kendler et al., 1995, 1992). Nevertheless, most individuals with this disorder are able, with some difficulty, to maintain adequate social relationships and occupational activities.

Many studies have shown that generally anxious people tend to have their attention drawn towards threat cues when there is a mixture of threat and non threat cues in the environment. Non anxious people show, if anything the opposite bias, tending to have their attention drawn away form threat cues. (MacLeod & Mathews, 1991; Mathews, 1993; Mineka, 1993).

Creer and Wing (1974) nearly half of the relatives thought their health was severely or very severely affected by having a

mentally ill member of the family living at home.

SOME FEATURES OF ANXIETY
PHYSICAL FEATURES OF ANXIETY

Jumpiness, jitteriness
Trembling or shaking of the hands or limbs
Sensations of a tight band around the forehead
Tightness in the pit of the stomach or chest
Heavy perspiration
Sweaty palms
Light-headedness or faintness
Dryness in the mouth or throat
Difficulty talking
Difficulty catching one's breath
Shortness of breath or shallow breathing
Heart pounding or racing
Tremulousness in one's voice
Cold fingers or limbs,
Dizziness
Weakness or numbness
Difficulty swallowing
A "lump in the throat"
Stiffness of the neck or back
Choking or smothering sensations
Cold, clammy hands
Upset stomach or nausea
Hot or cold spells
Frequent urination
Feeling flushed
Diarrhoea
Feeling irritable or "on edge"

BEHAVIORAL FEATURES OF ANXIETY

Avoidance behavior
Clinging, dependent behavior
Agitated behavior

COGNITIVE FEATURES OF ANXIETY

Worrying about something
A nagging sense of dread or apprehension about the future
Belief that something dreadful is going to happen, with no clear cause
Preoccupation with bodily sensations
Keen awareness of bodily sensations
Feeling threatened by people or events that are normally of little or-no concern
Fear of losing control
Fear of inability to cope with one's problems
Thinking the world is caving in
Thinking things are getting out of hand
Worrying about every little thing
Thinking about the same disturbing thought over an over
Thinking that one must flee crowded places or else pass out
Finding one's thoughts jumbled or confused
Not being able to shake off nagging thoughts
Thinking that one is going to die, even when one's doctor finds nothing medically wrong
Worrying that one is going to be left alone
Difficulty concentrating or focusing one's thoughts

SUMMARY OF SYMPTOMS UNIQUE AND COMMON TO ANXIETY

Type of Symptoms	Unique to Anxiety	Overlap both Symptoms
Affective	Sever fear and tension	Negative affect Crying Irritability
Behavioral	Increased activity Behavioral agitation	Decreased activity Lowered initiation of responses Decreased energy Behavioral disorganization and performance deficits Increased dependency Poor social skills
Somatic	Increased sympathetic arousal	Restless sleep Initial insomnia Panic attack
Cognitive	Perceived danger and threat Uncertainty Hyper vigilance (watchfulness)	Helplessness Rumination and obsessions Worry Low self confidence Negative self evaluation Self-criticism Self-preoccupation Indecisiveness Poor Concentration

SOURCE: Adapted form Alloy, Kelly, Mineka & Clements (1990), P.507.

Common Automatic Thoughts Associated With Anxiety:-

1. What if I get sick and become an invalid?
2. I am going to be injured.
3. What if no one reaches me in time to help?
4. I might be trapped.
5. I am not a healthy person.
6. I'm going to have an accident.
7. Something will happen what will ruin my appearance.
8. I am going to have a heart attack.
9. Something awful is going to happen.
10. Something will happen to some one I care about .
11. I'm losing my mind.

Hypotheses

1. Fathers of neurotic children will have high anxiety sten scores than the fathers of normal children.
2. Fathers of psychotic children will have low anxiety sten scores than the fathers of neurotic children.
3. Fathers of normal children will have less anxiety sten scores than the fathers of psychotic children.

METHOD

Participants

Fathers of neurotic and psychotic children were selected from the various psychiatric hospitals and the Institute of Professional Psychology, Bahria University, Karachi. Fathers of normal children were selected from the various educational institutions of Karachi. The age of children selected ranged from 10 years to 30 years.

A total number of three hundred subjects were selected for the present study. Out of which hundred fathers from the group of psychotic children, hundred fathers from the group of neurotic children and hundred fathers from the group of normal children were administered the tests.

At this stage it is imperative to give the definition of neuroses and psychoses. DSM-II has given a very comprehensive classification and definition of both psychoses an neuroses. It has also differentiated the two disorders very effectively.

Anxiety Reaction

Anxiety is diffused and not restricted to definite situations or objects, as in the case of phobic reactions. It is not controlled by any specific psychological defense mechanism as in other neurotic reactions. This reaction is characterized by anxious expectation and frequently associated with somatic symptomotology.

Dissociative Reaction

It represents a type of gross personality disorganization, the basis of which is a neurotic disturbance, although the diffuse dissociation seen in some cases may occasionally appear psychotic. The personality disorganization may result in aimless running or "freezing". The repressed impulse giving rise to the anxiety may be discharged by, or deflected into, various symptomatic expression, such as depersonalization, dissociated personality, stupor fugue, amnesia, dream state, somnambulism etc. These reactions must be differentiated from schizoid personality, from schizophrenic reaction, and from analogous symptoms in some other types of neurotic reactions.

Conversion Reaction

The impulse causing te anxiety is "Converted" into functional symptoms in organs or parts of the body, usually those that are mainly under voluntary control. The symptoms serve to lessen conscious anxiety and ordinarily are symbolic of the underlying mental conflict. Such reactions usually meet immediate needs of the patient and are, therefore, associated with more or less obvious "Secondary gain". Symptomatic manifestations will be specified as Anesthesia (Anosmia, Blindness, Deafness), Paralysis (Paresis, Aphonia, Monoplegia, or Hemiplegia), Dyskinesis (Tic, Tremor, Posturing, Catalepsy).

Phobic Reaction

Anxiety of these patients becomes detached from a specific idea, object, or situation in daily life and is displaced to some symbolic idea or situation in the form of a specific neurotic fear. Commonly observed forms of phobic reaction include fear of syphilis, dirt, closed place, high places, open places, animals, etc. The patient attempts to control his anxiety by avoiding the phobic object or situation.

Obsessive Compulsive Reaction

In this reaction, anxiety is associated with the persistence of unwanted ideas and of repetitive impulse to perform acts, which may be considered morbid by the patient. The diagnosis will specify the symptomatic expression of such reactions, as touching, counting, ceremonials, hand washing or recurring thoughts (accompanied often by a compulsion to repetitive action).

COMPARISON OF PSYCHOSES AND NEUROSES

Psychoses	Neuroses
• Gross impairment in reality testing.	• Reality testing is grossly intact.
• Grossly disorganized behavior.	• Behavior does not violate gross social norms.
• Markedly incoherent speech	• The disturbance is relatively enduring with treatment.
• Presence of hallucinations delusions, illusions.	• Absence of hallucinations, delusions, illusions.
• Fails to relate with other people	• Can relate with other people.
• Inability to cope with life situations	• Can cope with life situations.
• Impairment of perceptions.	• No demonstrable organic etiology.
• Disoriented behavior.	• Oriented behavior.
• Inattentive.	• Attentive.

MEASURES

IPAT Anxiety Scale was administered separately in order to find out the level of anxiety. It is well known that this Scale is standardized and widely used for research due to the following reasons.

IPAT Anxiety Scale:

Anxiety is very common factor in the personality of the individual. In order to detect the abnormal level of anxiety most of the psychologists and experts depend on the technique of depth interview. This technique although very helpful and necessary is full of subjective biases hence the diagnosis cannot be based only on this technique .Many people evolve standard interview technique but that is also not so effective.

In order to make it more scientific the standardized, reliable and valid questionnaires and scales were constructed for the measurement of various factors of personality. IPAT anxiety scale was evolved in 1957 by the Institute for Personality and Ability Testing.

The scale is brief and applicable to the lowest educational levels. It can be given to people who belong to age 15 years and above. It gives accurate estimate of anxiety level an supplement clinical diagnosis. Moreover the scale facilitates all kind of screening operations and research. The central features of scale are worry, tension, low self control, suspiciousness and emotionality. These features are known as the trait components of anxiety.

The scores derived from the scale are reliable enough for research purposes and group comparison. Each question in the scale has three possible answers, YES, NO & UNCERTAIN. A further division of pattern is made as covert and overt anxiety which can be easily obtained from the scores.

Procedure

IPAT anxiety scale was administered with simple instructions to 100 fathers of Neurotic children, 100 fathers of Psychotic children and 100 fathers of Normal children who were diagnosed and labeled by the experts in the hospitals and the Institute of Professional Psychology.

The fathers of normal children were selected only on the basis that none of their children suffered from any mental illness. The fathers were also interviewed in order to obtain information and history from them.

A chi square test was conducted to determine the statistical significance of the results.

RESULTS

The aim of this study is to assess the vulnerability of the fathers of psychotic and neurotic children to anxiety.

The IPAT anxiety scale was administered to find out the level of anxiety in 100 fathers of neurotic children and 100 fathers of psychotic children. On the other hand 100 fathers of normal children were assessed as a control group.

The results obtained prove that the hypotheses are statistically significant. In one of the categories there is a tendency towards the positive results.

Fathers of neurotic children will have high anxiety sten scores than the fathers of the normal children.
The results of the Statistical analysis are shown in Table No 1 and Graph 'A'.

The chi square $X^2 = 63.8$, df = 1, P< .001. This indicates that there is a significant difference in the two groups. The fathers of neurotic children have high anxiety scores than the fathers of the normal children.

Fathers of psychotic children will have low anxiety sten scores than the fathers of the neurotic children.
The results of the Statistical analysis are shown in Table No 2 and Graph 'B'.

The chi square $X^2 = 7.40$, df = 1, P < .001. This indicates that there is a significant difference in the two groups. The fathers of psychotic children have low anxiety scores than the fathers of the neurotic children.

Fathers of normal children will have less anxiety sten scores than the fathers of the psychotic children.
The results of the statistical analysis are shown in Table No 3 and Graph C.

The chi square $X^2 = 30.64$, df = 1 P <.001. This indicates that there is a significant difference in the two groups. The fathers of normal children have less anxiety scores than the fathers of the psychotic children.

TABLE NO 1

LEVEL OF ANXIETY AMONG FATHERS OF NORMAL AND NEUROTIC CHILDREN

Levels	Normal	Neurotic	Total
High	26 (54.50 Fe)	82 (54.50 Fe)	108
Low	74 (46.50 Fe)	18 (46.50 Fe)	92
Total	100	100	200

$$X^2 = \frac{(Fo-Fe)^2}{Fe}$$

$$X^2 = 63.12$$

df = 1

Highly significant at .001 level

TABLE NO 2

LEVEL OF ANXIETY AMONG FATHERS OF NEUROTIC AND PSYCHOTIC CHILDREN

Levels	Neurotic	Psychotic	Total
High	82 (73.5 Fe)	65 (73.5 Fe)	147
Low	18 (26.5 Fe)	35 (26.5 Fe)	53
Total	100	100	200

$$\chi^2 = \frac{(Fo-Fe)^2}{Fe}$$

$$\chi^2 = 7.40$$

df = 1

Highly significant at .001 level

TABLE NO 3

LEVEL OF ANXIETY AMONG FATHERS OF PSYCHOTIC AND NORMAL CHILDREN

Levels	Normal	Psychotic	Total
High	26 (45.5 Fe)	65 (45.5 Fe)	91
Low	74 (54.5 Fe)	35 (54.5 Fe)	109
Total	100	100	200

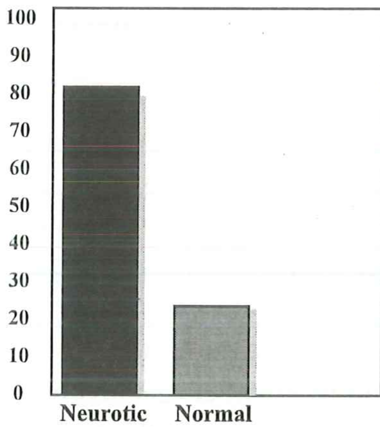
$$\chi^2 = \frac{(Fo-Fe)^2}{Fe}$$

$$\chi^2 = 30.64$$

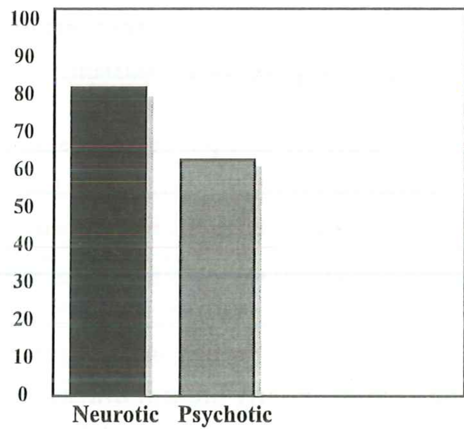
df = 1

Highly significant at .001 level

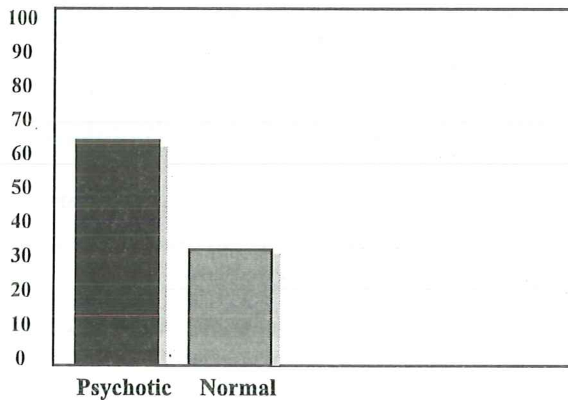
(GRAPH A)
LEVEL OF ANXIETY AMONG
FATHERS OF
NORMAL AND NEUROTIC CHILDREN



(GRAPH B)
LEVEL OF ANXIETY AMONG
FATHERS OF
NEUROTIC AND PSYCHOTIC CHILDREN



(GRAPH C)
LEVEL OF ANXIETY AMONG
FATHERS OF
PSYCHOTIC AND NORMAL CHILDREN



DISCUSSION

The purpose of the present study is to find out the emotional disturbance i.e. anxiety among fathers of neurotic and psychotic children. The recent awareness about the mental illnesses has made it imperative to study the most important risk factor in the fathers of neurotic and psychotic children.

Fathers are perceived as strict and authoritative as men are considered more powerful than the women in Pakistan. The reason is that the father being the head of the family is responsible to run all the affairs of children i.e education, health etc within his own resources. More over in our culture fathers are supposed to take care and settle all the matters of young ones. Therefore, if a child in the family suffers specially from any mental illness all the family members get involved but financial and emotional burden is mostly borne by the fathers even when the joint family system is prevalent.

Results obtained indicate that the fathers of neurotic children have high anxiety sten scores than the fathers of psychotic children on IPAT anxiety scale. It may be noted that in overall comparison of the results, anxiety sten scores are higher in fathers of neurotic children.

Unfortunately in our country generally people are not well conversant about the mental illness. Even if they are aware of the illness they are restrained to admit due to the social and cultural stigma. These difficulties are multiplied slowly and gradually.

Results obtained in the present study are corroborated further by the studies carried out earlier by Gupta (1973), Samuele, Krug (1976) and Stroebe and Storebe (1983).

Fathers of neurotic children will have high anxiety sten scores than the fathers of normal children.

This hypothesis is supported by the data and was highly significant at P<.0001 level.

The results are shown in Table No. 1 and Graph ‘A”.It is obvious that the fathers of neurotic children have high anxiety sten scores than the fathers of normal children. Similar results have been obtained when compared with the fathers of psychotic children. Table No 2 and Graph ‘B’ also confirm the significance of the hypothesis.

It may be noted that the neurotic children are most frequently found to be troublesome for the entire family because they are aggressive in behavior and remain in conflict with the environment. The father being the head of the family always faces criticism by the family members, neighbours and the society. This ultimately becomes a source of tension and worry for him.

It is interesting to note here that the fathers of neurotic children do feel that home atmosphere is not conducive. Whenever a son or daughter misbehaves or creates problems for the rest of the family, fathers will be held responsible for it. All the family members especially wife and children put blame on fathers because of their strict behavior. He is even blamed for the lack of finances which are required to sustain the family and provide the basic need to the wife and the children. He is also held responsible for spoiling the future of the children.

Literature review suggests that the most common areas of worry are, family, money, work and health. Many normal people worry about such things excessively and develop mental problems. They also suffer from chronic muscular tensions and insomnia.

The constant state of worry makes the parents upsets and discouraged. Parents of the mentally ill children generally feel threatened and anticipate future danger accompanied by insecurity feelings.

Fathers of psychotic children will have low anxiety sten scores than the fathers of neurotic children.

The hypothesis is supported by the data and was highly significant at $P<.001$ level.

Table No 2 an Graph 'B' clearly indicates that the fathers of psychotic children have low anxiety scores than the fathers of neurotic children.

The psychotic children are no doubt seriously ill and their personality is more disorganized than the neurotic children. Their reality contact is obviously impaired but they are not trouble creators and remain withdrawn from the family members and the society. Fathers of psychotic children are mentally ready to accept their illness, in most of the cases they admit their children in the hospital and get a bit relief from worry and tension. Generally the fathers of psychotic children do rationalize that it is God's will which helps them to lessen their anxiety since the illness is obvious and pronounced.

Fathers of normal children will have less anxiety sten scores than the fathers of psychotic children.

The hypothesis is supported by the data and was highly significant at P<.001 level.

According to Table No 3 and Graph 'C', It is quite clear that the fathers of normal children have less anxiety scores than the fathers of psychotic children.

Fathers of the normal children have less anxiety scores as compared to the fathers of neurotic and psychotic children. There is no doubt that the fathers of normal children do suffer from anxiety. The literature review also suggests that the normal people have adaptive anxiety pattern. Adaptive anxiety is appropriate to the situation and can even enhance efficiency and achievement. Whereas in contrast maladaptive anxiety is self-defeating as it tends to interfere with efficiency and achievement.

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