SUMMARY

The PICU is a closed community in which the child is exposed to many stresses affecting his physical and psychological impact of illness and in turn he will react by different ways.

The most prominent ones are the nature of the disease, separation from family, pain and inability to communicate.

In PICU a patient's sensory balance becomes vulnerable to instability owing to many and varied external stimuli. Sensory over load and sensory deprivation may sound contradictory in terms but indifferentiating between them becomes clear how patients experience both.

The overt responses of children in PICU comparing to adult ICU are surprisingly mild.

Children admitted to PICU regardless the reason of admission have varying degrees of anxiety. Many patients have fluctuating degrees of delirium but seldom diagnosed as such because the effect are mild and not progressing, by definition delirium is a state in which the individual experiencing a change in amount, pattern or interpretation of incoming stimuli.

Children who have longer term PICU admissions, a typical Tripartite sequences have been described which are regression followed by depression and hostility.

The diagnostic criteria of depression are:- Sleep disturbance, loss of interest, guilt feeling, decreased energy, impaired concentration, disturbed appetite, psychomotor agitation or retardation, recurrent thoughts of death.

Parent's of children admitted to ICU experience more negative psychological consequences.

Greatest sources of distress are alterations in the parenting role, staff communications, painful procedures carried on their children, and sights and sounds associated with PICU environment, other sources are child behaviours, and child appearance.

As a response to ICU stress initially all parents go through a period of overwhelming shock and disbelief accompanied by a feeling of helplessness. Once the child be stabilized and survival seems likely, the phase of parental shock merges into anticipatory waiting. During this waiting time parents are more demanding of the staff, and anger may be expressed toward the staff when progress is slow.

After the anticipatory waiting, the next parental reaction is elation or mourning according to the progress of the child illness.

Another reactions occur when their child stays along or when PICU prophisized terrible prognosis are denial, hostility, ambivalence and fright .

Doctors may experience, depression, severe anxiety, extreme denial and psychosomatic symptoms. Sense of omnipotence experienced by some physicians is a double edged- sword.

Apathy, hyperactivity, over treatment, or be very authoritative with other staff members are common reactions of doctors as a protective mechanisms.

ICU Stresses may be environmental or into - individual. The effect of these stresses on nurses depends on what is called "Coping strategies" possessed by nurses, burn out may occur among nurses due to stress of ICU which defined as a state of physical and psychological exhaustion and is characterized by physical symptoms (GIT disturbances, headache...) or by psychological symptoms as (insomnia, depression, feeling of helplessness), cohesiveness between nurses is a solution to the multiple problems emerged from ICU, and it is provides emotional support.

The introduction of **liaison psychiatry** or consultation psychiatrist to the main stream of medicine was achieved after the development of the holistic conception of man as a body - mind complex.

The contribution of consultation psychiatrist should be considered under the heading of clinical work, teaching and research activities.

- Clinical work can usefully divided into primary which refer to direct involvement in patient care, secondary involves contribution to patient care indirectly by increasing the awareness and shills of other staff members regarding the psycho-social effect of the original disease on patient and family, tertiary is used to describe the psychiatrist's role in staff support and program development.
- Teaching about the psychosocial aspects of ICU shoud be part of curriculum for both undergraduate and postgraduate students and also may extend in simple manner to the community.
- Research: is so important because most of literature's is based largely on clinical onecdote and personal experience only, so the psychiatrist need to do more researches.

The psychiatrist's presence at weekly conferences with the patients and families have specific focus on the psychosocial problems of them, also the attendance at weekly group meetings with nurses and doctors provide vehicles for promoting psychological growth for staff.

In practical ₹50 children were admitted to PICU and another 50 children were admitted to hospital ward as a control .

They were subjected to the following psychometric tests:

- Intelligence test by Ahmed. S (1988)
- Child depression inventory test by Gharib.G (1989)
- Anxiety scale by Gharib. G (1991)
- Shaeffer's parent -child attitude question naire by Mahmoud.A (1980)

Mothers were subjected to:-

Eysenck personality questionnaire to asses personality by Eysenck.H (1989) Translated and prepared by salah EL Din.M

The results of research revealed that there were increase levels of both anxiety and depression in children admitted to ICU rather than children admitted to hospital ward, also there were increase levels of Introversion and Neuroticism among mothers of children in PICU than the other group.

As regard intelligence test and shaeffer's parent - child attitude questionnaire no statistical difference between the two groups.

By regression analysis we found many variables increase both levels of anxiety and depression among children as: Female more than male, increase mother anxiety, decrease parental attendance, prolonged hospital stay, previous admissions, and the severity of illness. Other variables didn't affect the levels of both anxiety and depression as: Mother's age, residence, intelligence level, hours of sleep per day, the child age related to a mild extent to depression but not related to anxiety.