

***Introduction
and
Aim of Work***

The pediatric intensive care unit (PICU) is a busy place. The child is exposed to constant visual, auditory and tactile stimuli that are not part of his or her normal routine and are often emotionally and physically painful.

It is a place where the child's autonomy and sense of self are often lost and the traditional roles of the family severely disrupted (Riggs and Lister, 1987).

They often experience extreme stress, anxiety, and fear of impending death. This can cause serious mental disturbance which may adversely affect the progress of the underlying physical condition (Charles and Hinds, 1987).

In adults, previous empirical studies have observed a considerable overlap between psychiatric and physical factors in clinical practice emphasizing that physically ill patients in hospitals have a greater prevalence of psychiatric morbidity than that found in general population. (Cavanguh, 1983).

It is a reasonable assumption that acute life threatening illnesses have the most dramatic psychological impact (Lloyd and Cawely, 1988).

Illness is a family affair. A family member sickness affect homeostasis of the entire family system. More over when an acute life threatening illness affect child more family distress occur (John, et al., 1980).

In some areas of medicine and critical care, the risks and adverse occurrences have been clearly described and often quantified (Ravin et al., 1976).

In contrast and despite the evolution of pediatric critical care as subspeciality, there is very little information in addressing adverse occurrences in the realm of pediatric critical care (Riggs and Lister, 1987).