OBSTACLES, DIFFICULTIES AND PRACTICAL PRINCIPLES OF OPTIMAL PSYCHOACTIVE THERAPY IN CHILDREN AND ADOLESCENTS

ABSTRACT:

1. The optimal use of psychoactive substances in children and adolescents is facing obstacles. They bear the stamp of: biological, psychological and social peculiarities of the suffering individuals, of their age, of the respective disorder, and of the psychoactive preparation.
2. Instead of decreasing, the obstacles in front of new optimal medicament solutions for the psychic disorders in children and adolescents become more diverse.
3. The diversification process of obstacles in front of optimal medicament solutions for psychic disorders in children and adolescents is caused by:
   - a vertiginous rise in number of psychoactive substances;
   - a development of knowledge in psychopharmacology;
   - the need to harmonize the therapeutic options with the ones of the multidisciplinary team, including the ones of the patients and of their carers;
   - the requirements of modern medicine to ensure not only the disappearance of the symptoms but also the patients' amelioration of their life quality and their optimal inclusion in the community.
4. The optimal solution in the chemotherapy of psychic disorder implies the deliberate assumption of a risk.
5. In order to diminish this risk, the paedopsychiatrist is bound to obey a series of rules, and in order to eliminate his responsibility he must assume this risk together with the patients and their carers.

Key words: psychoactive substances, paediatric psychopharmacology

Today psychiatry treats neither affections nor syndromes and even less diagnoses covered by codes but neurobiological dysfunctions.

1. GENERAL CONSIDERATIONS

a. First of all, it must be pointed out that only in exceptional situations do we have an aetiological treatment; for more that 50 years, we have been witnessing a very active change from a symptomatic perspective on the psychic disorders to a more and more pathogenically documented one, and this means significant progress. Of course this fact requires:

- identification of primary psychic disorders,
- knowledge of their neuro-biological[1)] basis and
- existence and access to the means capable to correct them.

b. Secondly, it must be mentioned that most of the aspects of chemotherapy used in psychic disorders in children and adolescents do not differ from the same therapy in adults. The former is more particular due to a number of reasons as follows:

— a more active metabolism in child and adolescent, a shorter halving time and thus, generally speaking, a better tolerance on kg/organism/day, at least for the short term;

— existence of a growing and biologic, psychological and social development process which, at least theoretically and on the long term, raises the problem of the impact of medication on this process; this is an obstacle that requires our attention because it is well known the fact that, in psychiatry, the medication is administered over long periods of time;

— doubts, with which, from ethical considerations, we look upon testing the tolerance and efficiency of the new psychoactive molecules in children and adolescents and thus, the compulsion to use these molecules, when needed, only based on the data obtained from adults.

— particular aspects connected with compliance;

— the reduced capacity of the child in general and especially of the child with psychic disorders to recognise, express and accuse explicitly the secondary undesirable phenomena induced by medication;

— the fact that the child and the adolescent are

[1] By a neuro-biological basis of the psychic disorders we understand the substrate of morphofunctional dysfunctions at molecule, cerebral mediator and receptor levels which generates them, respectively at the level of their pathogene mechanisms.

totally dependent on their social-familial system.

c. Thirdly, the Hippocratic imperative "primum non nocere" has today a more rigorous content, on the one hand there is the compulsion of not doing any harm, on the other hand it is important to improve the patients' life quality. But, it is well known the fact that the administration of the majority of the psychoactive substances is accompanied by undesired side-effects too, that are not only accidental but also predictable, which, if we do not want to shrug our shoulders in front of sufferance, we have to accept.

d. Fourthly, today, the psychiatrist has got an ever wider range of preparations, some of them being hypothetically similar, of minute studies and of ever richer knowledge offered by the current neuro-psycho-pharmacology. We would be tempted to believe that we are closer to the moment when it would be enough to identify and aim at the neurobiological basis of a symptom with "intelligent" chemical molecules and everything will solve by itself. Unfortunately, the clinical practice demonstrates that we are far from the implementation of standardised programmes or even of certain therapeutic guides meant to secure a risk-free choice for the patient. In fact, if the psychiatrist is responsible, it is not easy for her to decide over a conduit, even if she is more informed than before. Actually, although more profound and precise, the present data prove to be more and more complex, interdependent and often contradictory. As a consequence, when choosing the optimal medication, the psychiatrist has to face many difficulties and dilemmas imposed by: the complexity of the problem, the polymorphism of the neurobiological basis of the psychic disorders, the still limited knowledge of numerous aspects, the contradictory character of some of the accessible data and the more and more rigorous conditions the psychotherapist is expected to obey.

More than that, there is ever growing access to information, which is often fragmented or, as Werry and Aman (1999) state, subjective or lacking a scientific basis. This information is offered through a multitude of channels, including the internet, and, on the one side, it makes the beneficiaries become more doubtful or even inclined to incriminate the therapists in case of any inconvenience, on the other side it makes the latter prefer to protect themselves taking refuge in standard solutions lacking the positive valences of individualisations.

e. Fifthly, the psychiatrist must also take into considerations the fact that the experimental data cannot be extrapolated automatically from adult to child and even less from animal to human.

f. Finally, a sixth consideration refers to the fact that the psychiatrist today is more and more facing both pressures which force him to decide for the best solutions from an ethical and economic point of view, and with the fact pointed out by Werry Scott and Aman (1999 p. 13) according to which the interests of the therapist and those of the medicine companies are not necessarily convergent, and here we refer not only to the ratio price/quality.

2. OBSTACLES AND DIFFICULTIES FACING OPTIMAL THERAPEUTIC CONDUIT

In order to adopt an optimal therapeutic conduit, the psychiatrist has to face, first of all, the problems raised by the interaction among three essential components, namely:

— the patients with their biological, psychological and social peculiarities,

— the particular psychic disorder,

— the potentially efficient pharmacological preparation.

Secondly, the psychiatrist must not forget that the medicaments validated only for adults, even if they are proved to be very efficient, can be used with children and adolescents only on his own responsibility.

Thirdly, today, the psychiatrist is confronted, on one side with the atheoretical and aetiological systematization of the psychic disorders, and on the other, with the duty to obey therapeutic guides structured on such a nosography.

Fourthly, the present day psychiatrist is part of a multidisciplinary team and he must harmonize his options with the ones of the other team members, in a relationship with interdisciplinary character. A special place within this team is occupied by the patient's parents or carers and their role as advised partners.

All these issues have the potential to generate obstacles, some of them difficult to remove because they are marked by unknown elements, contradictions, incertitude and subjectivity.

2.1. Obstacles and difficulties pertaining to the patient and his biological, psychological and social peculiarities

These are numerous and difficult because they are also generated by still unknown and even unpredict-

able factors. The well known geneticist F. Jacob used to declare in 1970 (1972) that an individual's neurobiological pattern is as unique as his fingerprints. In this way, every sick person's tolerance and reactions to treatment are only probable because each particular patient hides numerous psychological and biological enigmas.

For example, it is known that the intolerance to medicaments is genetically determined and that, in certain subjects, they may have paradoxical effects. But, most of the times, the physician has got only anamnesis data, and even these are approximate, to be allowed to anticipate with certitude both the patient's tolerance and the patient's response to treatment, while, in case of emergencies, he lacks them altogether.

The age of the child, too implies a series of conditions, each psychoactive substance having its limits and surpassing them can be done only at one's own responsibility. More than that, to all the above issues, one must add the difficulties implied by compliance. They are sometimes amplified because of the profile of the psychic disorders – the absence of the critique of the disease, delirious convictions of prejudice, the unacceptable character of the secondary effects, the incapacity to understand the reason of a long duration of the treatment, etc. These are aspects that, in children and adolescents, acquire a distinctive character linked not only to age but also to the need to involve the parents or carers and transform them into advised partners.

If, in connection to their age, children and adolescents have supplementary resistance to the treatment, which makes them refuse it or accept it formally, then throwing it out of the mouth in secret, the present day patient's parents or carers have more and more often preconceived opinions based on anterior information and supported by the medication guides. These guides, out of the natural need of the drug manufacturing firms to protect themselves, offer an exhaustive presentation of the possible risks and thus induce resistances which are not easy to surpass. More than that and more difficult, too, is the situation where the patient's carers apply their own initiatives concerning dosage and administration of the drugs, without informing the physician and even denying them.

2.2. Obstacles and difficulties pertaining to the targeted psychic suffering

The targeted psychic suffering, the comorbid and associated affections, be they psychic or somatic, each with its specificity and subtleties, bring with them their own set of obstacles and difficulties. In what follows, we shall limit our consideration only to those aspects which pertain to the basic psychic disorder. Indisputably, for an optimal therapeutic conduit, the psychiatrist needs a diagnosis as precise, complete, correct, detailed, and fast to establish as possible. In reality, these challenges are not always easy to reach, thus, most of the time, at the moment of the therapeutic decision, be it an emergency or not, the diagnosis is, and for a long time remains uncertain and even unknown. The difficulties in front of a certain diagnosis are often so great that modern psychiatry, with its component which we have called "administrative" (2009), almost gave up the idea of an authentic diagnosis. Out of administrative considerations, the modern diagnosis and classification systems of the psychic disorders (DSM-III -1980, DSM-III-R-1987, DSM IV-1994) have become too schematic too formal and too general, a fact that alienates them from the therapist's needs. Their atheoretical, aetiological and standardised character has transformed the diagnosis into descriptive formulas and codes which synthetically nominate the association of a number of symptoms considered representative. More than that, the diagnosis represents only a minimum number of representative symptoms considered as being sufficient, and these symptoms are mentioned only in combinations varying from one case to another.

Let us give the example of the diagnosis of conduit disorder which might be certified based on the presence of three symptoms in a suite of 15, which means that apart from the possibility of the presence of other symptoms considered as representative and even more by the presence of the representative ones, the same diagnosis covers 455 different clinical variants, a number that corresponds to the value of the combination of 15 objects taken in threes. If we add the fact that there are no exceptions in the situations in which it is recommended that the diagnosis of certainty should be stated only after a certain time interval has passed (for example 6 months for schizophrenia, 2 years for somatisation disorder, and so on), then we shall understand that there are not few situations in which, at the moment of the therapeutic decision, the diagnosis is unsure and even unknown.

In this way, the modern diagnosis does not take into consideration:

— the symptomatic complex existing in reality which defines and individualises the patient;

— which of the symptoms considered as representative are included in the combination and which are not;

— the fact that they are not equal among themselves either as diagnostic value or as therapeutic target;

— their intensity or severity;

— the fact that, in psychiatry, there is almost no pathognomonic symptom or groups of symptoms;

— any causal arguments;

— in case of psychic disorders, the Hippocratic requirement "there is no disease but only sick people", cannot be ignored.

This fact deprives the psychiatrist's thinking from landmarks indispensable for his choice of an optimal conduit and confers the therapeutic guides, focused on diagnosis and not on the individual, an orientation role with only an administrative value.

It is true that, from the therapeutic point of view, the psychoactive medication is not aimed at clearly defined clinical entities but especially the neurobiological substrate of certain target psychopathologic manifestations. However, not even at this level, does the modern psychiatric diagnosis offer any information. This fact means that, before establishing the treatment, often in a very limited time interval and with insufficient investigation means, the psychiatrist is forced to:

— take into consideration all the present symptomatology;

— make a clear difference between the psychic disorders proper and those that are an expression of certain somatic affections as well as those somatic affections that are a consequence of psychic dysfunctions;

— delimitate primary psychic manifestations from secondary ones;

— identify simulated and over simulated manifestations as well as manifestations over invested by the patients' carers.;

— make pertinent assumptions about the neurobiological substrate of the psychic manifestations identified as primary because only their targeting assures the success of the therapy. He must identify all the comorbid or associated psychic or somatic affections as well as the potential negative consequences of the medication on them, in a word, all the elements that particularize the patient and not only the minimal ones which allow the framing in a diagnostic code which is aimed only at grouping the patients and not at individualizing them.

More than that, when he must choose a treatment, in spite of being freed from the burden of aetiological and theoretic controversies peculiar to the modern diagnostic systems, the psychiatrist is still obliged to identify the causes, the biologic and psychological mechanisms and the neurobiological substrate of the disorders because only thus he may act efficaciously.

For example, the present diagnostic criteria for mental anorexia may hide disorders such as the delirious disorders (dysmorphophobia delirium or poisoning delirium), phobias and phobic obsessions, both of them linked to the physical appearance, a simple loss of weight after a diet or a somatic or endocrinal affection, the latter being invoked too often by those who see in amenorrhea the primary disorder. Also, in patients who refuse to communicate, whatever the reason, the refusal to eat, as a consequence of certain delirious convictions that there is poison in their food, may easily be assimilated with eating negativism from the catatonic disorder, while the psychomotor inhibition in the major depression or the neuroleptic impregnation syndrome may also be taken for the same catatonic disorder. Movement stereotypes in autism may falsely suggest an ADHD comorbidity and the enumeration may continue.

Unfortunately, today, the individualisation of the treatment, especially in children and adolescents, is also obstructed by the therapeutic guides which, in order to eliminate the risk of certain indictments of malpraxis, suggest the limitation to template schemes, which, in children, from ethical reasons, exclude most of the new therapeutic solutions, even if these proved to be very efficient in adults. This fact determines the paedopsychiatrist to assume on own responsibility the decision to turn to them. Thus, first of all, he risks that his prescription might not be honoured by the too rigorous health care services and then that he may be held liable for the eventual negative consequences even if in adults these consequences are considered natural.

We must mention that today, it is known that various psychic disorders have are generated by certain dysfunctions of some molecular neurobiological structures, of neuromediators and/or of cerebral receptors. It is these dysfunctions and not the symptoms, syndromes, diagnoses or the codes that represent them that are targeted by the psychoactive substances. Apparently, these data simplify and consolidate the therapeutic option based on them. Only apparently, since it is still the actual data which reveal the fact that

there is not a doubtless correlation between a particular clinic manifestation and the location or the type of dysfunction identified on the basis of experimental or clinical studies. This so because there is no psychic disorder with an elementary character and neither is it the expression of a single cerebral morpho-functional structure.

Every time, the psychic functions and dysfunctions are the expression of the interaction of many morpho-functional mechanisms, of certain chained complex processes, so that the same symptom might be the consequence of different types of dysfunctions or of their associations. This fact depends on which of the numerous links in the particular process chain that lies at the basis is affected. Let us not forget the fact that, in the entire biology, following the existence of certain interactive relationships, the functional excess or deficiency might be achieved by stimulating, respectively diminishing, the function of the structure which generates it, but also by the inhibiting or stimulating the system that controls it using feed-back mechanisms.

Maybe the most convincing example for the statements above is offered by depression, a case in which, it has been spoken for a long time (Marinescu 1997 and many others) about forms with a neurobiological, serotoninergic, domaninergic, adrenergic, cholinergic, endorphinic or norepinephrinic substrate. The fact has generated and stimulated the emergence of antidepressants with selective action on each of these domains. However, sure clinical markers are absent which could allow the clinician to differentiate among them. It is the reason that deprives us both here and in front of almost all the psychopathological manifestations of the certitude concerning the type of neurobiological dysfunction which must be corrected by means of medicamental treatment.

2.3. Difficulties and obstacles that pertain to the potentially efficient preparation

During the last 30 years the knowledge in the field of psychopharmacology has accumulated in an alert rhythm. Among other things we refer to:

— emergence of new classes of substances and of numerous psychoactive molecules and preparations with reduced side-effects, that act mono- of bifocally or in the long run, are more selective and are considered more or less similar;

— vertiginous development of knowledge in the field of pharmacokinetics and pharmacodynamics. It allowed the doctors to know: the halving times; the data concerning biodisponibility; metabolism and excretion mechanisms; medicament interactions; role of the cytochrome P_{450} enzymes, of the numerous cerebral receptors; tropism of the psychoactive substances for certain structures of the brain, molecular sites, pre or post-synaptic and for different cerebral mediators and receptors and, very important, the action and their specific effect at these levels;

— The emergence, besides the classic systematization of the psychoactive substances according to the target symptoms (antidepressant, anxiolytic, antihallucinatory, anti delirium, antimanic, hypnotic, antiepileptic, etc.) of a new one based on mechanisms of action. The first classification became less valid (Kaplan şi Sadock -2001), with the evidence of the fact that, on the one side, the psychoactive substances in one class have much more favourable effects (for example, the use of antiepileptic drugs in the affective pathology, of antidepressant drugs in psychoses and anxious disorders, etc.) and on the other side, that some of the medicaments used in somatic pathology are also efficient in the treatment of different psychic affections. As such, the first classification system promoting a mainly symptomatic therapy (Werry and Aman -1999) is double today by another, more rigorous one, with pathogenic potential because it is based on knowledge in the field of the pharmacokinetics of psychoactive substances. Thus, the systematization of psychoactive substances based on affinities and to their specific action on different cerebral mediators or receptors is more and more taken into consideration (**Table 1**).

Today it is known the fact that all the psychoactive substances act concomitantly and in various degrees over more cerebral sites mediators and receptors so that for every one of them there are descriptions of both scales of the intensity of their actions and the multiple effects, some of them necessary sometimes, others always or sometimes unwanted. That is why we state that, in spite of the knowledge in the field of psychopharmacology that accumulates in a rhythm too difficult to keep pace with, the obstacles in front of an optimal therapeutic option instead of being reduced are amplified in this direction, too.

Table 1. Classes of psychoactive substances according to affinities and to their specific action on different cerebral mediators or receptors

Class name	Mono-Amino-Oxidase Inhibitors (MAOI)
	Antagonists of domapinergic receptors represented by the classic narcoleptics
	Antagonists of serotonin – domapinergic receptors or atypical antipsychotic
	selective serotonin reuptake inhibitors (SSRIs)
	Antagonists of beta adrenergic receptors
	Antagonists of H1 histaminic receptors
	Calcium channels inhibitors
	Agonists of opioid receptors
	Agonists and precursors of dopaminergic receptors
	Cholinesterasis inhibitors
	Antagonists of beta adrenergic receptors
	Antagonist of norepinephrine reuptake
	Agonists of alfa 2 adrenergic receptors
	Diazepine, anticholinergic, antihistaminic drugs

3. PRACTICAL PRINCIPLES OF OPTIMAL PSYCHOACTIVE THERAPY

The above mentioned statements underline the fact that today, in front of any therapeutic option, the paedopsychiatrist is confronted with and is forced to accept a smaller or bigger risk coefficient. Of this situation, the following instances must be made conscious: The Health Insurance Company, the instances implied in the assessment of malpraxis and the whole community. This is more important because in children and adolescents there are frequent the situations when the paedopsychiatrist is obliged to decide over therapeutic solutions that are not included in guides or in ruling documents of the qualified institutions. In fact, while the therapeutic guides do not allow a series of new psychoactive preparations to be administered to children, although they are better in many aspects than the former ones but they have been validated only for adults, their use is often required from paedopsychiatrist by his professional conscience in case of failure of the already tried or existing solutions, and even by the fact that the data offered by the practice in adults offer the chance of a better therapeutic solution. However, this solution requires the psychiatrist to engage his accountability.

What can be done in order to reduce the risks and that the possible undesired consequences should not be imputed to the psychiatrist:

3.1. First of all, the patient will be examined thoroughly with the aim of obtaining as precise answers as possible to the problems mentioned at point 2.2 above.

3.2. Secondly, as a general rule, especially in emergencies, that preparation will be preferred which:

a) statistically speaking is the most efficient for the individualised primary disorders and which, in order to avoid polypragmasia, covers by itself better, and most of the peculiarities of the case. We take into consideration the availability of, for example, preparations with multifocal action in which, according to the case, the basic antipsychotic, anti-depressive or anxiolitic action is, on the one hand larger, covering more psycho-pathogenic mechanisms, and on the other hand, it is doubled by other effects: sedative, dynamogenous, anti-depressive, anxiolitic, hypnotic, mio-relaxant, etc. – necessary according to the case.

b) has the smallest expected and unwanted secondary effects in general and especially for a particular patient, both immediate and in the long run. This is because it is no longer allowed to ignore the patient's life quality, and not only during the remission has period, but also in that of state, even if this means higher immediate costs. It is not only the recognition of the patient's right to a better quality existence. Reduced unwanted side effects equally means more rapid and better social, familial, school, professional reintegration, and these are reflected by more reduced collateral costs so that, finally, in the long run, the overall costs are smaller. For example, it is known that, as a rule, a psychotic episode treated with classic (cheaper) medication means, because of the modest quality of the remissions affected by the neuroleptic impregnation syndrome (trembling, psychic slowness, somnolence, ocular accommodation disorders, etc) a failed school year, while today, with the modern medication, going back to school is possible after approximately 2-3 months. WE do not speak here only about the avoidance of an individual drama limited to a patient who suffers, loses his skills is obliged to repeat the school year and to reconsider his self image. The community as a whole bears the supplementary costs required by prolonged and repeated hospitalization, by repeating the school year or when one of its members becomes an outsider. On the other hand, it is known that often, the treatment of the psychic disorders lasts a long and sometimes a very long period of time, implying the risk of certain tardy disorders. This is the reason why we should temper our haste in using too new and insufficiently validated preparations.

Knowing the profile as well as the prompt and attentive assessment of the peculiarities of the secondary disorders that appear after the administration of the psychoactive drugs give other advantages, too:

— the anticipated profile of the secondary effects may incline the balance of choice towards a certain preparation if some of them are useful, as it has been pointed out above, according to case and period.

— the absence or reduced spread of predictable unwanted secondary side-effects, may constitute the proof of a good choice;

— in their turn, as it has been pointed out before, their prompt or too intense occurrence testify the administration of too big doses or an inadequate choice. According to the specific case, this fact imposes either the diminution of the doses or the change of the preparation with another one with a different profile concerning the cerebral receptors and mediators on which it acts.

c) proved efficient before, too, either in that particular patient or in the blood relatives if the doctor considers the suffering has a genetic origin.

d) has the most prompt and stable answer. It is known that, not infrequently, the therapeutic effect manifests itself after anticipated periods of time varying between days and weeks. We have the conviction that a shorter than expected latency period is proof of a good choice and vice versa, a motive for which, where there are many possible solutions to choose from, we do not plead for patience carried on until the maximum accepted time limit. Of course, impatience is a bad adviser, but it is preferred to choose the preparation whose effect is felt not only faster, but also nearer and especially under the low limit of admitted latency period instead of the one whose effect is waited for too much. This is so even if, out of professional pride, the doctor is slow in denying his previous option.

e) does not have a habit –inducing risk, especially if a long treatment is anticipated.

f) has the longest halving time. One should prefer a preparation that due to the long halving time allows its administration in rarer doses, because in school children especially, the lunch dose is difficult to control by the parents while the compensatory supplement of the morning dose affects the school performance. Nevertheless, if it is possible, we plead for the avoidance of unique doses. In this way, we obtain a diminution of the daily doses, a uniform plasmatic concentration and reduced unwanted predictable effects.

g) do not interact negatively with other medicaments which, out of various reasons the patient is obliged to take.

h) do not influence negatively the contingent affections which the patient suffers from.

i) do not have the toxic dose too near the therapeutic one and which have a specific antidote, accessible in order to avoid the risks of an accidental overdose or of accidental or voluntary ingestion in suicidal scope. For example, it is known that where lithium salts are concerned, although they are advantageous due to their low costs, the toxic dose is relatively close to the therapeutically active one and there is no specific antidote.

j) is registered and consequently attested not only internationally, but also by the legislation of the country. Not only that, in the opposite situation, the health insurance companies cannot be obliged to compensate the costs, but also it is the risk that in case of unpredictable intolerance phenomena, the doctors could be accused of malpraxis. We remind the fact that, some years before, the natural substitution of the diagnosis of child psychosis with the one of child autism blocked the covering of the costs of prescriptions with neuroleptic preparations based on the reason that, in conformity with the laws in force, the latter are compensated only if prescribed in psychoses.

k) have the most convenient form of presentation. We consider injections for emergencies or uncomplicated cases, those in form of solution which allow the easy adjustment of doses and, if we refer to children, the pills or capsules should have a pleasant dimension, aspect and even taste, in order to be accepted by them.

l) the most fit for the evolution stage of the disease: in the beginning, in the acute phase, the maintenance or the prevention of relapses. If in the acute period of the disease, the unwanted secondary effects can be more easily accepted, they are unacceptable during the other periods in the evolution of the disease because they affect the quality of life and the family, school and socio-professional integration of the patient thus working against the aim of the modern treatment which cannot be limited only to the control over the psychopathologic disorders.

m) is the most adequate to the age, sex or weight index. This means that, for example, we must take into consideration: the enzymatic immaturity of the small child, the necessity to avoid the preparations that induce weight gain in adolescent girls preoccupied with

their appearance or in over weight individuals, or, on the contrary, accepting them in case of low appetite or underweight individuals.

n) has a different chemical formula or has a profile of action over the receptors, different from the one which at a certain moment proved to lack efficiency or it is marked by secondary effects which influence the quality of life negatively.

o) one knows better inclusively from the point of view of thebiological mechanisms of action since it is only so that one could make the correct choice and avoid the risk of attributing one's failures to the patient or to the disease.

p) last, but not least, is produced by a prestigious company which confers the guarantee of the respect for quality.

3.3. Thirdly, it is necessary that the psychiatrist should be conscious of the fact that no matter how judiciously he might make his choice, he must remain prudent because his option might be contradicted, some times dramatically, by the clinical reality. This means that in every patient apart, the answer to any new psychoactive preparation must be carefully assessed and supervised at first. As a consequence, both in hospital and ambulatory, the administration starts obligatorily with a single preparation and in small, rapidly increasing doses, with warning those in the entourage on the eventual negative consequences and the attentive appreciation of the tolerance and of the expected effect.

3.4. Fourthly, it is absolutely necessary that the patient's carers, the members of the therapeutic team, and, according to the case, the patient should be informed and receive the acceptance for the possible negative consequences and for the measures of fighting against them. Depending on the situation, but especially in case the psychiatrist is forced to adopt solutions outside the accepted standards, he is indebted to obtain a consensus from the patient's carers, eventually in writing. In this case, we must point out that such an obligation comes only to the psychiatrist because we consider that it is not recommendable that doctors of other specialties should prescribe such preparations.

Of course, there are situations where we find ourselves in front of a patient whom we have known before, or for whom we have got credible sources of information concerning the anterior treatment in the acute and remission period, the quality of its response, tolerance and compliance, and thus the issues are much simplified. In these cases, only further laboratory tests are needed and the identification of the new aspects of the clinical picture because it is known that there are not rare the situations when the symptomatology changes in time and this is not only the case with the bipolar disease. According to the context, one may decide to recommence the treatment, to increase the doses, to associate new medication and even to reconsider the therapeutic conduit.

However, there are also special situations where, out of various reasons, we lack data on the history of the case or the required medicaments are not at hand; the urgency of the intervention does not allow sufficient time to take a decision; or the somatic affections narrow the palette of the therapeutic options. In such cases, the temporisation of the intervention is necessary, and the following measures may be taken: the isolation of the patients in adequate spaces and, if needed, their immobilisation by means that do not imply any risks; the minute examination both psychic and, we must underline, somatic with the identification of the primary psychic disorders; choice of a preparation that had been tested administratively, with multifocal action profile and recognised for its tolerance; administration with prudence; permanent surveillance and instruction of the people in the entourage about the assumed risks and their profile.

CONCLUSIONS

a) The optimal use of psychoactive substances with children and adolescents is confronted by obstacles. They bear the stamp of: biological, psychological and social peculiarities of the suffering individuals; of their age; of the respective disorder; of the psychoactive preparation.

b) Instead of decreasing, the obstacles in front of new optimal medicament solutions for the psychic disorders in children and adolescents become more diverse.

c) The diversification process of obstacles in front of optimal medicament solutions for psychic disorders in children and adolescents is caused by:

— a vertiginous rise in number of psychoactive substances;

— more profound knowledge in psychopharmacology;

— the need to harmonize the therapeutic options with the ones of the multidisciplinary team, including the ones of the patients and of their carers;

— the requirements of modern medicine to ensure not only the disappearance of the symptoms but

also the patients' amelioration of their life quality and their optimal inclusion in the community.

d) The optimal solution in the chemotherapy of psychic disorder implies the deliberate assumption of a risk.

e) In order to diminish this risk, the paedopsychiatrist is bound to obey a series of rules, and in order to eliminate his responsibility he must assume this risk together with the patients and their carers.

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