Tourette Syndrome

Fast facts

- Tourette syndrome was first identified in the 1880s, and is known as Tourette’s disorder in the DSM-5.
- It is much more common in boys than girls, and emerges in early childhood.
- Behavioural treatments (such as Habit Reversal training) are effective interventions, and medication may also be helpful.

Interventions that work – at a glance

This table represents a compilation of information from several different sources (including Fonagy et al. (2015) and Dunnachie (2007) and is designed to provide an overview only. Directly consulting these sources will provide considerable additional information.

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<td>Habit reversal</td>
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The fine print

- **Habit reversal** involves pairing a competing behaviour with the sensation of a tic, with the competing response preventing the tic from being carried out. The core components are awareness training and competing response training, with other important elements being self-monitoring, relaxation training, contingency management, motivational aspects and training in generalisation (McGuire et al., 2014).

- Several **medications** may be effective treatments for children and adolescents with Tourette syndrome and persistent motor tics, but more research with larger sample sizes is needed (Fonagy et al., 2015). Medications that may be effective include haloperidol, risperidone, ziprasidone, pimozide, metoclopramide, pergolide, atomoxetine, transdermal nicotine, and Tri Cyclic Anti-depressants (TCAs) (Fonagy et al., 2015). Combined medication treatment does not appear to lead to better outcomes than single drug treatment (Fonagy et al., 2015).

- **Parent training** alone appears to be ineffective in managing tics in children and adolescents with Tourette syndrome, and in situations where pervasive motor tics occur with ADHD (Fonagy et al., 2015). Parent training may help in reducing disruptive behaviour in children and adolescents with Tourette syndrome alongside ADHD, but more research is needed to confirm this.

Description and demographics

Tourette syndrome was first described by Georges Gilles de la Tourette, a student of the French physician Charcot in the 1880s (Fonagy et al., 2015). In the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013), it is known as “Tourette’s Disorder”, and is one of three tic disorders described, with the others being Persistent (Chronic) Motor or Vocal Tic Disorder, and Provisional Tic Disorder.

**DSM-5 defines a tic as a sudden, rapid, recurring, non-rhythmic vocalisation or motor movement** (American Psychiatric Association, 2013). Tourette’s Disorder is diagnosed when both motor and vocal tics have been present at some time during the illness (American Psychiatric Association, 2013). Tics may occur many times each day (often in episodes) or intermittently. Vocal tics may include grunts, throat clearing, squealing or obscene language (coprolalia) (Fonagy et al., 2015). Motor tics may include simple movements such as blinking or shrugging, or complex movements such as gestures or facial expressions (Fonagy et al., 2015).
Tourette syndrome is usually first apparent in early childhood, and prevalence rates have been reported to be between 0.4% and 3.8% for children between 5-18 years, and 0.05% in adults (Knight et al., 2012, and Robertson & Eapen, 2014, both cited in Eapen et al., 2016). It is much more common in boys than girls, and symptoms usually become apparent around 5-7 years of age (Fonagy et al., 2015). Tourette syndrome commonly occurs alongside other conditions such as Obsessive Compulsive Disorder (OCD) and other anxiety disorders, depression, ADHD and conduct and/or learning difficulties (Fonagy et al., 2015).

There is little, if any, information available about the prevalence of Tourette syndrome within Māori and Pacific communities, and no interventions specifically designed for Māori were able to be identified.

References


