

Tourette syndrome essay



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“ When I breathe, it breathes. When I speak, it speaks.

When I try to sleep, it won't let me. Whatever I attempt to do, it's there, waiting to spoil the moment. To a doctor, it's a disorder, a medical oddity. To an onlooker, it's a spectacle—perhaps humorous, perhaps grotesque. To me, it's a monster, a demon, a hellish beast who has no right to exist in my world or anyone else's—it's my unwelcome companion,” wrote Rick Fowler, a sufferer of Tourette syndrome. In a recent film, one of the characters suffered from TS.

This disease was portrayed as humorous and easily controlled. However, actual research of TS shows quite the opposite. Tourette's syndrome is mainly known as a tic disorder. Tics are involuntary, rapid, repetitive, and stereotyped movements of individual muscle groups (Bruun, 1984, p.

2). However, Tourette's is not the only tic disorder that one can have. A transient tic disorder begins during the early school years, occurring in up to 15 percent of all children. These tics are said to not persist for more than a year, but it is not uncommon for a child to have a series of transient tics over the course of several years. Chronic tic disorders are differentiated from those that are transient, not only by their duration, but by their relatively unchanging character (1984, p. 4).

These tics are said to persist unchanged for years. Chronic multiple tics suggest that an individual has several chronic motor tics, with a hard line between to determine the differences. The most debilitating tic disorder is Tourette syndrome (Fowler, 1996, p. 26).

TS is a complex behavioral disorder that is poised between the mind and body, governed by innate vulnerabilities and environmental circumstances. The interaction of these forces within the mediating influences of the individual's personality and interpersonal environment shapes the expression of this disorder and influences the individual's long-term adaptation (1996, p. 27). TS is so powerful that it can almost completely take control over the mind and body, in some cases forcing a person to withdraw from society. In the 1800s, Tourette's was once thought to be a demonic possession (Kushner, 1999, p.

15). However, a French neurologist, Georges Gilles de la Tourette, was fascinated by these supposed "demons" in the person. In 1885, he studied and described to medical doctors the symptoms of this disease, in which he discovered caused those afflicted to exhibit uncontrollable "tics" (Fowler, 1996, p. 33).

The disease later became known as Gilles de la Tourette syndrome. The symptoms of TS usually appear before the individual turns eighteen. When involuntary tics occur in a person for over a year, they are usually diagnosed with TS. However, this concept of "involuntary" tics may be hard to define operationally, since some patients experience their tics as having a volitional component—a capitulation to an internal urge for motor discharge accompanied by psychological tension and anxiety (Cohen, 1988, p. 19). Tourette syndrome is a complex disorder that can mimic other disturbances, sometimes making accurate diagnosis difficult.

TS is commonly misdiagnosed as schizophrenia, obsessive-compulsive disorder, epilepsy, or nervous habits (Bruun, 1984, p. 3).

Some doctors believe TS is related to multiple personality disorder, which it is not. It is a completely different disease because, unlike MPD, TS sufferers are aware of the mind being engaged in a “ never-ending struggle” (Fowler, 1996, p. 36).

Since more physicians are now aware of TS, there is a growing danger of over diagnosis and under treatment. Although TS involves a variety of symptoms, motor and vocal tics continue to be the essential element of this disorder (Kushner, 1999, p. 23). The very first symptoms of TS are usually motor tics—commonly eye blinking.

However, there are four kinds of motor tics: simple motor tics, complex motor tics, copropraxia, and echolpraxia. Simple motor tics can be explained as eye blinking, nose twitching, and rapid jerking of any part of the body.

Complex motor tics are hopping, clapping, throwing, and writing over-and-over the same letter or word. Copropraxia is “ giving the finger” or making other obscene gestures.

Echopraxia, imitating the gestures or movements of other people, varies from about 10 to 21 percent of all cases (1999, p. 27). In more severe cases of TS, unusual complex motor tics, such as copropraxia, echokenesis (repeating or mimicking of others’ movements), and coprographia (writing of obscene words or statements) tend to appear. Many different vocal tics are involved in the symptoms in TS. Simple vocal tics, which are the most

common, include coughing, spitting, barking, and sucking sounds. However, complex vocal tics involve linguistically meaningful words, phrases, or sentences, like “ wow,” or “ but, but....

” Rituals are the repeating of a phrase until it sounds “ just right” or saying something over-and-over three times. Speech atypicalities are unusual rhythms, tones, accents, loudness, and very rapid speech. Coprolalia, which is the shouting of vulgar, unacceptable words, exist in less than 30 percent of all TS cases (1996, p. 29).

Although cursing is not present in every case of TS, this symptom, more than any other, periodically has brought TS to medical and popular notice. What is most interesting about coprolalia in TS sufferers is that they invoke the most unacceptable curses of these particular times and cultures (Fowler, 1996, p. 48). Early adolescence is the time when coprolalia first manifests itself. Another vocal tic is palilalia, which is repeating one’s words or parts of words.

Echolalia is the repeating of sounds, words, or parts of word of others. These vocal tics are a major contribution to Tourette syndrome.

Related disorders of TS are attention deficit disorder, attention deficit hyperactivity disorder, and obsessive-compulsive disorder (Bruun, 1984, p. 7). Up to 50 percent of all children with TS who come to the attention of a physician also have ADHD, which is manifested by problems with attention span, concentration, distractibility, impulsivity, and motor hyperactivity (Fowler, 1996, p.

58). Attention deficits may also persist unto adulthood and together, with obsessions and compulsions, can seriously impair any performance.

Obsessive-compulsive disorder may actually be another expression of the TS gene, and therefore, an integral part of the disorder (Kushner, 1999, p. 48).

These obsessions are defined as thoughts, images, or impulses that intrude on consciousness, are involuntary and distressful, and while perceived as silly or excessive, cannot be abolished (Fowler, 1996, p. 60).

Some TS patients also have significant aggression directed toward others, including temper fits.

One important factor in TS influence on behavior is its ability to cause a “disinhibiting” effect, in which an individual performs, acts, or makes statements, which would otherwise be censored by the conscious mind. Antisocial and inappropriate sexual behavior is considered to be frequently associated with TS by Comings and Comings (1985), who find that 44 percent of their patients have discipline problems, 42 percent with anger and violence problems, and 14 percent exhibit some form of exhibitionism (Marsden, 1986, p. 791). Excitement, anxiety, and impatient anticipation will cause an increase in tics, which concentration on an absorbing activity will produce a decrease in tics.

Rather than trying to make a distinction, it is perhaps more helpful to think of TS sufferers as having a “thin-barrier” (Fowler, 1996, p. 72).

Family genetic studies strongly support an etiologic relationship with TS. Because Tourette results from imbalances of neurotransmitters and other chemicals in the brain, the primary approach to controlling symptoms

continues to be the administration of drugs, which affect these neurochemicals (Bruun, 1984, p.

9). There are over seventy different chemicals in the brain, which may influence human behavior, but the number contributing to TS is still unclear. Serotonin is the neurotransmitter believed to be primarily responsible for censorship, or inhibition. Dopamine, another neurotransmitter, affects muscle movements, as well as behavior.

An increase in dopamine levels can cause exaggerated behaviors, including aggression and increased sexual activity. A particularly important risk factor in tics and TS is the use of stimulant medication (1984, p. 9). Stimulants will increase the severity of tics in 25 to 50 percent of all TS patients (Kushner, 1999, p. 42).

However, over the past several years, studies have shown that the use of stimulants has been correlated to the onset of motor and phonic tics (Bruun, 1984, p.

10). TS is now seen as a relatively common disorder affecting up to one person in every 2, 500 in its complete form, and three times that number in its partial expressions that include chronic motor tics and some forms of OCD (Fowler, 1996, p. 74). TS is a genetic disorder; the vulnerability of TS is transmitted from one generation to another. The gene, called Gts (Gilles de la Tourette syndrome) gene, primarily affects the functioning of neurotransmitters, the brain's chemical messengers, which carry signals from one neuron to another across a gap called a synapse (Goldman, 1995, p. 69).

Most people who inherit the gene(s) will not develop symptoms severe enough to warrant medical attention. A person with TS has a 50-50 chance of passing the gene(s) on to one of his/her offspring (Bruun, 1984, p. 11).

This pattern of inheritance is called autosomal dominant. For female carriers, there is a 70 percent chance that they will express some kind of symptoms of TS (1984, p. 11).

There is a 99 percent chance that male carriers will show some clinical expression of the gene (1984, p. 11) The degree of expression in gene carriers is described as penetrance. In males, penetrance is higher than in females; thus, males are more likely to have some form of expression of the genetic vulnerability. A 30 percent chance of female gene carriers will show no symptoms at all, while one percent of males will have no symptoms (Kushner, 1999, p.

63). Males are more likely to have TS or tics; females are more likely to have OCD; however, both may have any combination or severity. TS involves a clinical diagnosis, but no blood tests or other laboratory tests that definitely diagnosis this disorder are available.

There is no genetic or biochemical test to determine if a person with TS or an unaffected person carries the gene. Also, there is no prenatal test for the vulnerability to TS. Non-genetic factors are also responsible both as causes and as modifiers of TS.

In 25 percent of all cases, there are no apparent genetic inheritances (1999, p. 68). These non-genetic factors include stressful processes or events

during the prenatal, perinatal, or early life periods as fatal compromise and exposure to drugs or other toxins (1999, p. 72). In most cases of TS, careful repeated observation and questioning are the only diagnostic procedure. Assessment of a case of TS involves far more than a simple diagnosis.

With diagnosis, a thorough understanding of the patient may take a considerable amount of time for the doctor (Fowler, 1996, p. 86). As the patient becomes more comfortable with the doctor, there will be a less likely chance of symptom suppression or inhibition. These symptoms are generally pronounced when patients relax their self-vigilance.

However, some patients seem to gain mastery over their tics almost unconsciously, while others can gain control with only greater inner effort, making diagnosis difficult (1996, p. 89).

The nature, severity, frequency, and degree of disruption produced by the motor and vocal tics need to be carefully assessed from the time of emergence until the present (Bruun, 1984, p. 13) Parents of children with TS report their long and difficult journey through a medical maze in search of a diagnosis for their child's behavior. During the evaluation of a child, family issues, including parental guilt, need to be resolved (Cohen, 1988, p. 45).

TS children with school performance difficulties often do not clearly have delineated learning disorders, and the average IQ of a TS patient is normal. Careful assessment of cognitive functioning and school achievement is indicated for children who do have school problems (Bruun, 1984, p. 14).

If a child has received stimulant medications, it is important to determine what the indications for medication were, whether there were any pre-existing tics or compulsions, and the temporal relation between the stimulants and the new symptoms. Patients and families may be excellent at identifying and reporting side effects, but they may also not appreciate that symptoms such as depression or school phobia are related to neuroleptic treatment rather than to psychological issues (Fowler, 1996, p. 94).

A behavioral pedigree of the extended family, including tics, compulsions, attention problems, and the like, is useful. Once determining the use of medication, other medications must be discontinued. Rapid discontinuation from drugs may lead to severe withdrawal effects, including two or three months of any increased symptoms (Kushner, 1999, p. 104). For proper withdrawal, the doctor must plan carefully so that the patient's life is disrupted as little as possible.

Correct withdrawal is an important factor in determining the proper medication. Tourette syndrome is considered incurable; however, it is treatable with medicine and other techniques (Bruun, 1984, p. 18). Yet, mild cases do not require treatment as long as the patient can function properly without no medication or therapy. If not properly treated, more severe cases of TS can destroy a person's quality of life.

With or without any kind of treatment, this complex disorder tends to change in both severity and nature (Kushner, 1999, p. 118). The decision about whether to treat, and if so, what form the treatment should take will depend on the degree which the tic or TS is interfering with the child's normal

development or the adult's ability to function normally (1999, p. 132). In monitoring, the clinician can usually follow a patient for several months before a specific treatment plan is organized.

The goals of monitoring are to establish a baseline of symptoms; define associated difficulties in school, family, and peer relationships; obtain necessary medical tests; and monitor through check lists and interview the range of fluctuation of symptoms of greatest difficulties; and establish a relationship (Bruun, 1984, p.

19). Another treatment is reassurance, which is just telling the parents or patients what is going on and how to help deal with TS. Pharmacologic treatment is the only proven effective treatment for simple and complex motor and vocal tics. Medication is usually given in very small doses that are slowly increased until the best possible balance between symptoms and side effects are achieved (1984, p.

21) However, late 20th century medicine has accepted Gilles de la Tourette's as a description of symptoms as a designation for a clinical syndrome (Fowler, 1996, p. 96). In some cases, especially in children, TS sufferers seem to be medicated primarily for the benefit for those around them.

Since 1961, the choice drug for treatment of TS has been Haldol (halperidol); it works by blocking dopamine receptors in the brain and is successful in 80 percent of all cases in relieving tics (Kushner, 1999, p.

143). However, the drug Haldol causes restlessness, fatigue, and ruins concentration. Another drug used to treat TS patients is Catapres (clonidine),

which has proven to be effective in reducing TS symptoms in over half the patients that have tried it, particularly those with mild to moderate cases (1999, p. 156). Like all medications, Catapres is not perfect, but it is one of the best tolerated and effective drugs used in the treatment of TS.

Prozac also helps many TS patients with depressive and obsessive-compulsion as well as tics. The most effective treatment of TS can be psychotherapy along with the proper medication.

Although psychotherapy will not eliminate tics, it will still be beneficial to some TS patients who require treatment of the psychological sequel of this difficult illness (Bruun, 1984, p. 22). TS causes a great strain on the family as well as on the individual.

As will all disorders, much care, understanding, and compassion is needed for those who do suffer from Tourette's. If more people understood TS, they would realize it has no entertainment value. As drug therapy progresses, they might be able to find a way to truly help TS sufferers. Many, including patients' family members, can only hope so.

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