Comorbidities & Complex Cases in TS

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INTRODUCTION

• Co-occurring conditions are the rule rather than the exception in tic disorders
  • 85% meet criteria for at least one comorbidity
  • >50% have multiple comorbidities

• Q. What are the most common?
  • ADHD
  • OCD
  • Other Anxiety Disorders
  • Disruptive Behaviour (Episodic ‘Rage’)
  • Autism/ASD
  • Specific Learning Difficulties
  • Mood Difficulties/Depression

  *Hirschtritt et al., 2015*

• Often associated with greater functional impairment and distress than tics themselves
  (Bernard et al., 2009)
A Complex Genetic Relationship

- Hirschritt et al (2018) examined symptom patterns and heritability of OCD and ADHD in TS families ($N = 3494$)

**Exploratory Factor Analysis**
- **Strong associations between TS and ADHD factors** (inattentiveness & hyperactivity/impulsivity).
- **Some OCD symptoms were associated with TS**: symmetry/exactness, fear-of-harm, aggressive urges. Others were not (e.g. contamination & hoarding)

= Complex and highly overlapping symptom profiles in TS, OCD, and ADHD
= Underlying vulnerability (e.g. failure of top-down cognitive control) common to all three disorders?

Addressing Comorbidity & Complexity in Treatment

• Evidence that psychoeducation & behavioural therapies (HRT/CBIT & ERP) are effective, first line treatments for tic disorders (Andren et al., 2021).

• However...

  • 😞 Few studies looking at the impact of comorbidity or complexity on treatment, despite comorbid conditions being the norm
    • ASD an exclusion criteria in most large-scale trials to date

  • 😞 Co-occurring conditions may moderate treatment effects, particularly ADHD (McGuire et al., 2014) and anxiety (Sukhodolsky et al., 2017)
Until then, learning from:

- Available evidence
- Experience from clinical practice
- Behavioral theory

Inclusion of BT for tics in transdiagnostic & Modular Treatment Approaches

What we need....

- Trials of existing treatments including ‘complex’ & representative cases (e.g. ORBIT)
- Research into adapted treatments for specific disorders and groups (cf. CBIT-JR)

Addressing Comorbidity & Complexity in Treatment
Some General Principles

- **Thorough assessment**
  - Semi-structured diagnostic clinical interview (e.g. K-SADS-PL DSM V)
  - Disorder specific screenings (e.g. Conors 3; Y-BOCS II/CY-BOCS)
  - Consider cognitive/neuropsychological assessment for specific impairments

- **Address most impairing symptoms first**
  - NB. Tics may be referring problem, but ADHD/Anxiety may interfere with BT if not addressed

- **Person-centred psychoeducation**, including impact of comorbidities and interaction with tics
  - Clear dialogue with patients/families about treatment ordering & rational (e.g. treating anxiety first)
  - Manage expectations: BT will not eliminate tics completely, or be a universal solution to wider difficulties
Some General Principles

• Engage family and wider network (parents, teachers, carers as coaches)

• Effective and personalized reward systems may be particularly important for YP with neurodevelopmental difficulties

• Measure therapeutic gains not just in terms of tic severity (e.g. YGTSS), but also functional gains, goal-based outcomes and quality of life (GTS-QOL)

• Give BT a go!
  • Tics can be a burden to those with more complex needs and BT for tics can really help
  • Clinicians may be inclined to see tics as “just” a feature of ASD or other neurodevelopmental conditions, or have limited knowledge of BTs for tics
  • Review progress early in treatment & regularly, and adjustment for specific needs