18th International Conference on Tourette Syndrome & Tic Disorders

TS-school

Training course on Tourette syndrome

Tuesday, 16 June 2026

13:00-18:00

Grand Hotel Union Eurostars

hybrid

- Diagnosis and definition of tic disorders
- Nature of tics, Course of TS
- Comorbidities - Focus on OCD
- Differential diagnoses
- Assessments
- Pathophysiology including genetics
- Treatment

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Focus on OCD

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DSM 5 Criteria for OCD (1)

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1) Recurrent and persistent thoughts, urges, or impulses that are experienced as intrusive and unwanted, and that in most individuals cause marked anxiety or distress

2) The individual attempts to ignore or suppress such thoughts, urges, or images, or to neutralize them with some other thought or action (i.e., by performing a compulsion).

Compulsions are defined by (1) and (2):

1) Repetitive behaviors or mental acts that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.

2) The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive

DSM 5 Criteria for OCD (2)

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or **cause clinically significant distress or impairment** in social, occupational, or other important areas of functioning.

C. The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

D. The disturbance is not better explained by the symptoms of another mental disorder

Specify if: tic-related, the individual has a current or past history of a tic disorder

OCD in Tourette syndrome

- Onset: 4-10 years [1]
- Women++ [2,3]
- Prevalence: 30-50%[3] (sometimes lower in community- based studies)[4,5]
- Associated with increased tic severity
- Compulsions are different from tics [6] (respond to urges)

[1]Bloch et Leckman, 2009, [2]Lewin et al., 2012, [3]Hirschtritt et al., 2015, [4]Kurlan et al., 2002, [5]Khalifa and Von Knorring, 2006, [6]Martino et al., 2017

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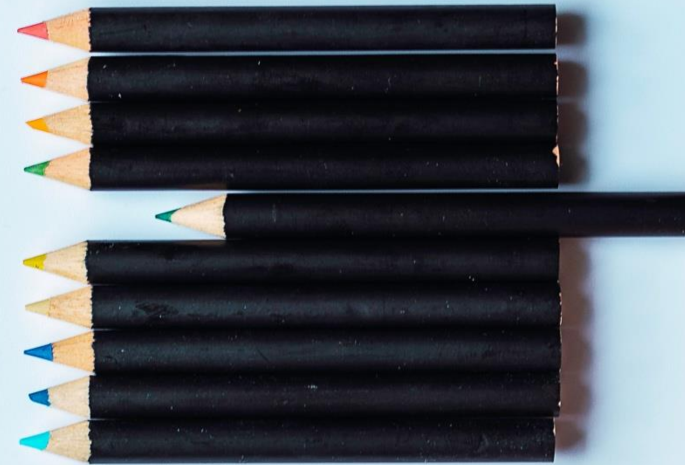
OCD in TS

- Tic-related OCD may differ from pure OCD; inconsistencies reported across studies
- Tic-related OCD has an **earlier age of onset** and is more common in **males**
- Patients with tic-related OCD have higher rates of ADHD, autistic traits, other disruptive behaviour disorders, trichotillomania, and body dysmorphic disorder than patients with OCD without tics
- May have different types of OCD symptoms
- May have more aggressive, sexual, religious and symmetry related obsessions
- **More counting, ordering, touching, blinking, hoarding and self-damaging compulsions, just-right phenomena**



Tourettic OCD

Intermediate phenotype

Symptoms are influenced by features of both OCD and TS and differ from either disorder alone

Patients present with thoughts, sensations, and behavioural urges at the interface of compulsions and tics

Rather than describing obsessional thoughts, patients describe a feeling of intense physical discomfort that drives compulsive behaviours

The sensation can become intolerable and anxiety provoking if not mitigated by engaging in the desired behaviour

Compulsions consist of complex motor acts such as touching or tapping in a specific way, vocalizing phrases, or a multistep progression of movements and vocalizations

Compulsions often need to be repeated multiple times until they feel “just right”

Review: Katz 2022 Frontiers in Psychiatry

“Pure O” OCD

- “Purely obsessional” OCD
- 2% of people with OCD
- Describes OCD phenotype in which visually obvious compulsions are absent
- Taboo or unacceptable thoughts
- Patients with Pure O engage in mental rituals that are unseen
  - Mentally reviewing memories or information
  - Mentally repeating words
  - Mentally undoing and redoing actions
  - Compulsive reassurance seeking

Treatment of OCD in TS

- First line treatment of OCD in individuals with (or without) tics should be **cognitive behavioural therapy**
- One RCT (POTS1) suggested that individuals with tics **may not respond as well as those without tics to SSRIs** for OCD symptoms

October 27, 2004

Cognitive-Behavior Therapy, Sertraline, and Their Combination for Children and Adolescents With Obsessive-Compulsive Disorder

The Pediatric OCD Treatment Study (POTS) Randomized Controlled Trial

The Pediatric OCD Treatment Study (POTS) Team

Author Affiliations

JAMA. 2004;292(16):1969-1976. doi:10.1001/jama.292.16.1969

- Meta-analysis of 20 RCTs of CBT and SSRIs for pediatric OCD found that tic-related OCD moderates CBT efficacy, **suggesting that youth with TS may be more responsive to CBT**

Treatment of OCD

- Effect size greater for CBT than SSRIs for treatment of OCD in children
- Systematic review and meta-analysis (McGuire 2015)
- **CBT**

  Hedge's g = 1.21, 95% CI 0.83-1.59, NNT = 3
- **SSRI monotherapy**

  Hedge's g = 0.50, 95% CI 0.37-0.63, NNT = 5

POTS-I

- Pediatric OCD Treatment Study
- RCT of 112 youth ages 7-17 years with OCD
- Randomized to sertraline, CBT, combined sertraline plus CBT, or placebo
- **All 3 active treatments were superior to placebo**
- **Combined treatment superior to either treatment alone**
- CBT and sertraline alone did not differ for reducing symptom severity
- For remission, combined treatment and CBT alone did not differ and both outperformed sertraline alone

POTS-II

- RCT of 124 youth 7-17 years with OCD
- Examined efficacy of CBT augmentation strategies in those with a partial response to optimal SSRI treatment
- Participants randomized to (1) medication management, (2) medication management plus CBT augmentation, or (3) medication management plus instruction in CBT skills

POTS-II

- **Participants who received medication management plus CBT augmentation had significantly greater symptoms reduction than the other two groups**
- 66 of 124 (53%) had tic-related OCD, suggesting a partial response to optimal SSRI treatment may be more common in this subgroup

SSRIs for OCD

Trials of fluoxetine, fluvoxamine, paroxetine and sertraline suggest similar efficacy

Effect size for clomipramine appears larger than SSRIs

Not used first line because of adverse effects and possible cardiac arrhythmias

Antipsychotic augmentation in OCD

- Augmentation of SSRIs with antipsychotics is used in people with treatment resistant OCD
- Randomized controlled trials of several antipsychotics vs placebo, added to SSRI treatment
- All trials in adults
- Hedges' g

  Risperidone -0.59 (-1.06, -0.11)

  Aripiprazole -1.35 (-1.95, -0.75)

  Haloperidol -0.82 (-1.51, -0.14)

Dold et al, International Journal of Neuropsychopharmacology 2015

Antipsychotic augmentation of SSRIs in resistant tic-related OCD in children & youth

Naturalistic study of 120 patients (7-18 years) with tic-related OCD

Treated with SSRI monotherapy for 12 weeks; non-responders (n=69) received augmentation with risperidone or aripiprazole for 12 weeks

39/69 had clinically important improvement in OCD symptoms with antipsychotic augmentation

47/69 experienced improvement in tics

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Treatment of tic-related OCD

- Based on available evidence
- **Give high priority to CBT as initial treatment**
- Patients who do not demonstrate adequate improvement with CBT alone should go on to pharmacotherapy with an **SSRI,** using doses at the higher end of the recommended range and waiting at least **12 weeks** for a treatment response
- In treatment refractory patients, **antipsychotic augmentation can be considered**

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