



Family Therapy and Tourette's Syndrome

Johnny's Problem ~ Tourette's Syndrome Revisited

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As a small child brought up in a market town in the South West of England during the 1950s anything unusual came as a shock. Imagine then when one market day when accompanying my mother a giant bronzed porter, dressed in workman's garb, similar to that worn today by villagers from Eastern Turkey, suddenly raised his fist in the air and exclaimed: Shit, Fuck, Piss, and after a short pause added: Fuck the Pope.

At once other market men appeared around the strange man who pointed at him more in assertion and compassion than hostility telling 'John' to stop, that he must not behave in that way, and that he was being very bad.

This seemed to make the poor mans problem worse and as he ran in embarrassment he shouted more obscenities through the market place before disappearing into the churchyard.

My mother told me to take no notice of the man. He was ill and couldnt help himself. Her words made his actions seem O.K. I wondered what sort of illness this could be and on subsequent visits to the market hoped that I might see the strange man again. More importantly if he would do something 'naughty'.

Some vears later Iohnnv was still helping the market stallholders move and manage their

wares and I was much older. My friends echoed my devilish hope that the man might behave badly and when John would erupt into one of his favourite obscenities we would encourage him.

You tell 'em Johnny, we would yell, Tell him to F off.

Frequently this would interrupt John's process and he would stop shouting obscenities and instead laugh and sing us a song or perhaps dance a little jig in the street for us.

Whenever someone confronted him, the obscenities would worsen and John would make fists, but he never hit out at others, the battle was within him.

In that small town where we all knew each other at least by sight, Johnny was one of us. He was not a bad man, nor did he deliberately set out to shock or offend. He simply could not control these spasms or tics as they are properly called. Even as children we knew this.

The compassionate authority of other adults and the threat of unemployment were impotent in the face of his symptoms. But us boys with our recognition and encouragement of his problem could ameliorate the symptom transforming it into a harmless entertainment for us. Mad John was one of us, and he knew it.

Gilles de la Tourettes Syndrome

It is likely that John suffered from Gilles de la Tourettes Syndrome (Gilles de la Tourette 1885). This condition is generally life-long although long periods of remission are possible. It was once thought that Tourette's Syndrome indicated a predisposition to Schizophrenia in later life (Bochner 1959), but this has been disproven by subsequent research (Shapiro et al 1978, Lucas 1979).

Tic Disorders are common in childhood, and the chronic tic disorders are no longer

considered rare and unusual diseases. (Hanna 1995). They pose challenges in understanding the neurobiology of complex behaviour.

Distractibility, impulsiveness, lack of inhibition, restlessness and obsessive-compulsive symptoms may indicate the presence of a tic disorder.

Tics are generally thought of as involuntary, as opposed to compulsions which are intentional, (Hanna op cit). Involuntary vocalisations are common to vocal tic disorder and Tourettes syndrome, but are rarely to be found elsewhere.

Symptoms that frequently impair psychosocial development, interpersonal relationships, and educational or occupational performance when chronic may lead to a diagnosis of Tourettes Syndrome especially when vocal tics form part of the picture.

Symptoms of Tourettes Syndrome may include involuntary swearing, barking, coughing and spitting. Because such symptoms are perverse and anti-social teachers, therapists, doctors and parents sometimes think of them as deliberate and potentially controllable by will-power leading to misinterpretations of their causes and meanings. Unfortunately this is not the case in Tourettes Syndrome. Such interpretations add to patients distress which sometimes makes symptoms worse, in turn leading to a further blaming of them.

Tic disorders sometimes develop into Tourettes Syndrome, but most disappear, or occur mainly during periods of stress (Hanna op cit).

TREATMENT:

In encountering tics and Tourettes Syndrome it is essential therefore to accept that the symptoms are not deliberate. Requiring patients to control themselves is asking something that they have tried countless times and simply cannot achieve by voluntary means.

DSM-IV warns us that severe tics can interfere with daily activities such as eating.

reading and writing.

Complications from Tourette's Disorder include physical injury such as blindness as a result of retinal detachment during head-banging, orthopaedic problems due to violent involuntary jerking, and skin problems due to picking.

A need to treat acute symptoms with pharmacology may therefore become necessary, and indeed studies indicate that the most effective treatment of Gilles de La Tourettes Syndrome is with haloperidol, (Shapiro 1982).

Wide ranges of other treatments have been applied to this dramatic condition over time. These include behavioural therapy (Clark, 1966), in-patient therapy with psychoanalysis (Faux 1966), and Family Therapy (Tiller 1978, Prata and Masson 1985). I will now summarize these studies in Family Therapy.

Family Therapy

In the first case study (Tiller 1978) Ruth (8 years) was referred with a six-day history of repetitive jerking movements of her arms and head associated with a cough like sound.

Ruth is the third of four girls. At two and four years she had been hospitalised because of chronic bronchitis. Except when under the influence of the tics she was well coordinated and generally healthy.

Ruth appeared quite happy when on the ward, but her family seemed over involved with her to the point of stifling any independent activity on Ruths part.

Despite the family's assurances that they were a normal family the parents presented as distant toward each other, the eldest child seemed to force enthusiasm and hilarity, whilst the next child seemed depressed and the youngest attention-seeking.

Although treatment with drugs was considered the paediatricians decided on treatment

through Family Therapy alone. The whole family met for one hour a week with two co-therapists. It was agreed that Ruth would be treated with medication if no improvement to the symptoms were achieved within two months.

During a course of seven weeks Ruth slowly disengaged from her mother and father becoming a member of the sibling sub-system. The father changed his transactional pattern to being more accommodating of the mother. The amelioration of the tics occurred concomitantly with the changes in the family dynamics and interactional patterns.

Nine months after the first presentation Ruth remained asymptomatic.

In the second case study (Prata and Masson) Eric (4 years) had gradually developed tics affecting his face and head, later including his limbs and subsequently including screams, snorts and barks. He had become enuretic and encopretic continuously, except during holidays when it disappeared. At a nursery Eric tended to be a loner and staff observed him to have a love of order.

The family comprised father 35 years, mother 28 years, Jean 6 and Eric. The family was reported as functioning normally until Eric developed his symptoms.

Since marriage the mother had given up her career as a musician in order to devote herself to the family.

The father had continued in his profession.

The therapists following the Milan School made a systemic hypothesis about the family's functioning, (Selvini, Boscolo, Cecchin and Prata 1980). They concluded that the symptoms served the function of monopolising the mother's attention when father was at work. During holidays the symptoms were not needed because the mother's attention was monopolised by the husband. Eric's symptoms then provided a means through which the mother is prevented from resuming her career and becoming more

independent. The symptoms mask the husband's jealousy about the wife's talent and his fear of her becoming independent. The wife in turn is able to believe that she stays at home, not to appease her jealous and insecure husband, but to look after their 'sick' child.

The hypothesis is further confirmed in the team members minds. Eric's symptoms started just when the wife had decided not to have a third child, which would have kept her from resuming her career.

The husband who finds making social relationships difficult does his best to isolate the more sociable wife. Neither discusses this directly and so the problem is denied in awareness but surfaces instead as an uncontrollable symptom in another family member.

The therapists offered the following advice to the family:

We have been working in Milan for many years and we have found that Family Therapy helps us to achieve very rapid results. Now it is precisely the rapidity of the results that poses the risk to your family. If you were some other family I would say that Family Therapy is just what Eric needed. But in your case although Family Therapy is clearly indicated I must advise you to wait for at least three months. Right now everything is still hidden away behind Eric's problems and tics, and it is impossible to foresee any changes while he is like that!

At this advice the father was able to acknowledge that doubts that he and his wife had concerning their compatibility and the stability of the marriage might surface, were it not for Eric's symptoms. Two months after the conclusion of the session the parents remained afraid of the upheaval that might occur in their married life were the family to come for therapy.

Eric's tics had however ceased. Eric remained symptom free five years after this single consultation.

It can be seen that in the first case example (Tiller 1978), the description of the process underlying the resolution of Ruths tics is described in the language of structure and hierarchy. The second example (Prata and Masson 1985) the language is that of circularity and circular hypotheses.

Since these papers were written there is recognition that therapy is itself a social construction and that the language that therapists use in building models influences the conclusions reached and methods used, (Hoffman 1990, Cecchin 1992).

Caution Family Therapists!

At the 1st Balkan Family Therapy Congress, May 11th ~ 13th Geofffranco Cecchin now a grandparent of the Family Therapy community emphasised that Family Therapy is revolutionary and disturbing. It does not care for medication and frequently offends the medical establishment. Cecchin has shifted his thinking from the therapist knows best approach suggested in his early collaboration in the development of systemic therapy, (Selvini et al, op cit). Tom Andersen the Norwegian family therapist who has done so much to deconstruct working with families and find new ways to empower family members to find their own solutions through his concept of the reflecting team (Andersen 1987), underlined this view.

Nunn (1985), cautions us against the charismatic reductionism that characterised the early development of Family Therapy. Whilst acknowledging the effectiveness of the treatment by Selvini, Prata and Masson in the paper Short Therapy of a child with Gilles de La Tourettes Syndrome, he takes the authors to task for implying that the familys role is not simply contributory, but the main cause of the childs symptoms. He might have made the same criticism of the earlier paper by Tiller.

Nunn argues that the biomedical model needs to expand to include a psychosocial perspective. Cohen et al. (1982) have developed an intrapsychic, biological and family interactional model of Tourettes Syndrome. This work confirms with others (e.g. Lucas et al., 1967) that there is no convincing evidence of a specific constellation of family dynamics in cases of Tourettes Syndrome.

Nunn compares the systemic hypothesis of Masson and Prata to the naive interpretations of early psychoanalysis where the drooling of patients suffering with Parkinsons disease might be interpreted as sublimated seminal emissions. Ferenczi (1921), for example regarded Tourettes Syndrome as a form of autoeroticism.

Nunn believes that a bio psychosocial model is required in order to ethically hypothesise about conditions such as Tourettes Syndrome, which have a biological component. In his view a system might then be tracked into biological and neurological arcs, as well as understandings about families. This is in the authors view rather an impractical and pretentious assertion, as it would seem to preclude the application of a talking cure for the majority of conditions despite advances in the understanding of neurology.

During his long career, Milton H. Erickson a pioneer of Family Therapy treated four adult patients who suffered with Tourette's Syndrome using hypnotherapy. The treatment consisted of offering carefully constructed behavioural prescriptions whilst the patient was in trance. The symptoms were ameliorated in two of the four patients, (Erickson 1965).

Hypnosis is recognised as an effective means of modulating the autonomic nervous system (Crasilneck & Hall, 1959, 1985; Gorton, 1957, 1958). The vital processes of all the organs regulated by the autonomic nervous system are subject to the influences of learning via their association with the hypothalamic-limbic system. During times of stress state-bound patterns of information may be generated in the regulation of any individual organ or combination of them, (Rossi 1986). Although not previously considered as part of the limbic system, neuropeptide receptors may filter and prioritise incoming sensory information so that the whole organisms perception is most compatible with survival, (Pert et al 1985).

This learning may not occur in awareness and in the case of Tourettes Syndrome tics are unlikely to have any symbolic or unconscious meaning (Hanna op cit).

Their timing may however indicate an automatic response to perceived stress within a family system (Tiller, op cit., Masson and Prata op cit).

This section is not a critique of Family Therapy as science, or as a discipline. It is to be read as a caution against raising false expectations either for reasons of enthusiasm, or commercialism.

PROGNOSIS

Despite the successes of Family Therapy in the two studies cited, and indeed some success in my own experience, Family Therapy is not generally considered as the treatment of choice for Gilles de La Tourettes Syndrome. It may however be indicated in the lesser condition of childhood tic syndrome.

The childhood tic syndrome has a good prognosis when:

There are no other signs of brain disease

There are no severe learning difficulties

Good I.Q. and academic performance

The child is socially integrated

The child can maintain her/his attention

There is no history of copralalia ~ (Lucas op cit)

Indications for Family Therapy may be:

Brief duration of illness

Responsiveness of tics to family change

Vulnerability factors in the child

Interfamilial emotional problems

Changing dynamic responses in family and child ~ (Tiller op cit)

Exceptions where the tic does not occur ~ (Masson and Prata op cit)

A Responsible Approach

Family Therapy may usefully be used to elicit meanings ascribed to symptoms by other family members. These may then be deconstructed, and the family guided toward the conclusion that tics are involuntary.

During this phase of treatment a history of the illness may be obtained, and family's attempted solutions recorded. Giving a name to a disorder, especially to teachers may help the child to be accepted both at home and at school. The more cautious diagnosis of childhood tic syndrome provides more hope for parents, teachers and therapists. Indeed a premature diagnosis of Gilles de La Tourette's Syndrome with its life long implications may lead to a child's exclusion from school.

Family Therapy should initially focus on helping the family to support a child suffering from tics both emotionally and in terms of his/her social relationships.

Care needs to be taken in framing explanations about the involuntary nature of tics, so as to match models held as true by family members. Belief systems can then be changed toward non-blaming understanding of the involuntary nature of tics. This is not to say that we prescribe the problem, but rather that we are prepared to befriend and reframe it (Minuchin and Fishman 1981, Sinclair and Bray 1997).

If the condition worsens during therapy the team must critically examine the content and form of the therapeutic sessions. It may be necessary to review videotapes for clues of anything that might have provoked such a change. Similarly, improvements must be examined in order to determine if interactional explanations are appropriate.

These explanations are not necessarily causal in the direct way, but occur through structural coupling as in the case of biological organizations, (Maturana and Varela 1987). In other words, different holons, (Koestler 1979) simply fit with one another and attempting to explain their interaction in a causal way is only a story constructed by an observer.

Minuchin and Fishman (1981) advise that the concept of the holon is very important to therapists. They write: The individual, the nuclear family, the extended family, and the community is both a whole and a part, not more one than the other, not one rejecting or conflicting with the other. A holon exerts competitive energy for autonomy and self-preservation as a whole. It also carries integrative energy as a part. Each whole contains the part, and each part also contains the program that the whole imposes.

To quote a friend: Life is like a dot picture. The events that happen are like the dots. The lines that join them are like the stories we construct to provide meaning. The dots and the picture however are not the same.

I might add to this that whilst the dots and lines are not the same, they are co-dependent. If the dots were placed in different configurations they would be joined up to form different pictures. Events then determine the content of stories told and the stories in turn determine how past, present and future events are experienced.

In cases of illness where there is known to be a biological component such as Tourettes Syndrome, any intervention aimed at altering behaviour is best offered to the family within the framework of being an experiment. In this way improvements, should they occur may be correctly ascribed to the intervention rather than a non-specific response to hopeful therapists, (Frank 1975).

Belief in ones method of treatment has been established to be a consistent component in the amelioration of suffering via counselling and psychotherapy, (Frank op cit).

This quality I refer to as *Beginners Mind* in appreciation of the insight of the late Shunryu Suzuki, (Suzuki 1979). It demands that we approach each situation with a naive not-knowing optimism aiming to make the best that we can from each situation that we encounter. It is entirely consistent with being curious. Curiosity about oneself in relation to the family is an attitude espoused by the post Milan school of Family Therapy. Curiosity leads to an exploration and invention of alternative views, and alternative moves breed curiosity (Cecchin, 1987). Another way of thinking about curiosity might be as a form of playfulness, which is not the same as making light of people or their problems.

Returning to the Market Place

For a long time family therapists presented their art as a solution to all ills. Initial successes were emphasised and hosts of professionals eager for a magic bullet to kill their patients miseries trained in its approaches. In turn they propogated the myth of Family Therapy as a cure all. This does not appear to me to be a responsible stance.

In this paper I have attempted to highlight that therapists working with families where a member suffers from conditions that have a biological component must find means to acknowledge, and engage with that component. We must understand that the component impacts on different holons including the therapeutic system. We can use all means at our disposal in our aim, including neuro-linguistic communication, (Sinclair and Bray op cit).

Capra (1982) suggests that a bootstrap model of society might help us to develop a new paridgm for medical intervention. Bootstrapping is a term used to denote the linking of mutually consistent models, giving one no more priority than another (Chew 1968).

This means gradually formulating a network of interlocking concepts and models and at the same time developing corresponding social organisation. Such theories and models and organisations will have to be trans-disciplinary, using whatever language becomes appropriate to describe different aspects of the multi-levelled, inter-related fabric of life.

According to Chew, it is essential that one ask as soon as a certain model or theory is found to work: why does it work? What are its limits? In what ways exactly is it an approximation?

Similarly we do best when probing the limits of our theories about families. Acting with curiosity enables us to create positively charged empathy, which is wholly authentic and compassionate as a communication style. It enriches family members and us alike with a sense of life-enhancing purpose.

To quote Checchin: When we are curious about the patterns or relationships of ideas, people, events, and behaviours, we perturb the system in ways that are different from perturbations based upon our attempts to discover a correct description/explanation. (Checchin 1987 op cit).

Our attitude then as therapists must not be to be self assured in knowing the truth, but curious about the lives of those with whom we work, and how these tend to organise us when sitting in the consulting room.

Although the market town in England is still there it has changed. The men now wear jeans and Johnny is nowhere to be found. I am truly grateful to him for teaching me that madness is not something to be feared and that difference can be accepted and integrated within communities.

Should he have been cured of his disease through the administration of Haliperdol or Family Therapy?

Should he have been discouraged in dancing jigs and singing songs to entertain us youths? Were we wrong to befriend him in this way, or did we contribute to his life?

We may ask such questions but the answers can only ever be opinions based upon our respective stories.

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