

What is Collaborative Problem Solving?

Collaborative Problem Solving (CPS) has been primarily presented in books, namely The Explosive Child by Ross W. Greene, Ph.D. and Treating Explosive Kids by Ross W. Greene, Ph.D. and J. Stuart Ablon, Ph.D. Ross Greene has been a frequent presenter at TSFC conferences.

Collaborative Problem Solving (CPS) was first articulated as a treatment model for children with social, emotional, and behavioral challenges. However, the model is equally applicable to a wide range of human interactions.

As applied to children with social, emotional, and behavioral challenges, the model sets forth two major tenets: first, that these challenges are best understood as the byproduct of lagging cognitive skills (rather than, for example, as attention-seeking, manipulative, limit-testing, or a sign of poor motivation); and second, that these challenges are best addressed by teaching children the skills they lack (rather than through reward and punishment programs and intensive imposition of adult will).

While challenging kids let us know they're struggling in some fairly common ways (screaming, swearing, defying, hitting, spitting, throwing things, breaking things, crying, withdrawing, and so forth), they are quite unique as individuals when it comes to the mix of lagging cognitive skills that set the stage for these behaviors. This means that prior to focusing on the teaching of cognitive skills one must first identify the

skills that are lagging in each individual challenging child. The precise skills that are involved and how to assess them are described in various publications and videos (see Books and Videos on page 3 and Articles on page 12), but the Pathways Inventory (see page 4) provides a comprehensive (but general) list of the skills that are usually involved.

The teaching of these skills may be accomplished in a variety of ways, but primarily through helping challenging children and their adult caretakers learn to resolve disagreements and disputes in a collaborative, mutually satisfactory manner. This, too, is described in various publications and videos, but involves three basic steps. The first step is to identify and understand the child's concern about a given issue (such as completion of homework or chores, sibling or peer interactions, and so forth) and reassure him or her that imposition of adult will is not how the problem will be resolved (this first step is called Empathy/Reassurance). The second step is to identify the adults' concerns on the same issue (this is called the Define the Problem step because, in the CPS model, a problem is defined simply as two concerns that have yet to be reconciled). The third step is the Invitation; this is where the child is invited to brainstorm solutions together with the adult, with the ultimate goal of agreeing on a plan of action that is both realistic and mutually satisfactory.

Sounds a bit complicated!

Collaboratively resolving problems with children isn't necessarily all that complicated, but it's something most folks haven't had a whole lot of practice at (probably because it hasn't been standard operating procedure with children), so it can take a while to get good at it. Figuring out what skills a child is lacking can be a bit more complicated, especially if one is unfamiliar with the skills

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Our Mission

The Tourette Syndrome Foundation of Canada is a national voluntary organization dedicated to improving the quality of life for those with or affected by Tourette Syndrome through programs of: education, advocacy, self-help and the promotion of research.

Our Vision

All People who have Tourette Syndrome will lead quality lives as accepted and valued members of an informed, tolerant society.

Regular Contributing Authors

Brigitte Heddle
Dr. Mary Jenkins
Gerard Johnson
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President's Message

In our August 2006 newsletter we included a story written by Marybeth Lambe, M.D. titled "Discipline Made Easy" which described a discipline technique devised by Thomas W. Phelan, Ph.D., a clinical psychologist in Glen Ellyn, Illinois.

After reading this article, the Brake Shop team at CPRI wrote a response which we published in our February 2007 newsletter. In this response the team cautioned readers about accepting any of a wide variety of approaches to dealing with kids with TS and ADHD without "a healthy dose of scrutiny."

The Brake Shop team pointed out that "an approach that assumes a child WILL stop themselves at the count of "2", assumes a child who is even CAPABLE of stopping him/herself in the moment" and

"This is not to say that some approaches are "right" and "effective", and others are "wrong" and "useless". What we ARE saying is that different children exhibit 'bad' behaviour for different reasons (e.g. poor behaviour versus a skill deficit), and different approaches are optimally suited for each of these reasons."

An approach to managing a child who is not "CAPABLE" of stopping him/herself used by the Brake Shop team is similar to the treatment model advocated by Dr. Ross Greene.

There isn't a great amount of information available about Collaborative Problem Solving other than in the 2 books by Dr. Greene (and Dr. Ablon.) We were able to find the information we have included in this newsletter on the website www.cpsinstitute.org and there is a book-review of The Explosive Child on our web site at www.tourette-london.ca. Click on lending library, find The Explosive Child and click on review.

We have given 4 pages of this newsletter to Collaborative Problem Solving and I hope you find this information helpful and informative.

"Book Review" and "Putting the Brakes On" will return next time and we have an article on counting that may be of interest.

Ray

Collaborative Problem Solving -continued

involved. But that's why we've made available lots of materials and resources to help: we know it's not so easy to do the right thing for challenging kids.

As you might imagine, because CPS represents a bit of a departure from the conventional wisdom, many people have misconceptions about the model. For example, some folks believe that implementing CPS means that adults must eliminate all of their expectations (it doesn't mean that at all), or that we're simply making excuses for the child (understanding a child's challenges and helping him or her overcome these challenges is a far cry from making excuses...it's hard work), or that adults no longer have the authority to set limits (not to worry...CPS does involve setting limits, but in a way that's a little different and probably a lot more effective than what people might be used to).

Where has the CPS model been applied?

In countless families, classrooms, and schools, and in selected inpatient psychiatry units, residential facilities,

and juvenile detention facilities, the CPS model has been shown to be an effective way to reduce conflict and teach the skills kids need to function adaptively in the real world.

Besides challenging kids, who else can benefit from Collaborative Problem SolvingSM?

We find that the model is applicable to diverse human interactions, but especially those that can result in conflict. So CPS can be applied to interactions between classmates, siblings, couples, parents and teachers, employees and supervisors, and nations. All people benefit from learning how to identify and articulate their concerns, hear the concerns of others, and take each others' concerns into account in working toward mutually satisfactory solutions.

Besides books and videos, in what other ways is the word being spread?

We've established the non-profit Collaborative Problem SolvingSM Institute to help us get the word out. To learn more, visit www.cpsinstitute.org.

Collaborative Problem Solving Books and Video

The Explosive Child - Understanding and Helping Easily Frustrated, "Chronically Inflexible" Children by Ross W. Greene, Ph.D.

Now available in a completely revised and updated third edition, **The Explosive Child** is the internationally acclaimed book in which the Collaborative Problem Solving approach was first described. As in prior editions, the third edition describes a more contemporary approach to understanding and helping inflexible, easily frustrated, explosive children at home and school, but also includes the various updates to the CPS model that have occurred since the first edition was published in 1998.

Treating Explosive Kids: The Collaborative Problem Solving Approach by Ross W. Greene, Ph.D. and J. Stuart Ablon, Ph.D.

The first comprehensive presentation for clinicians of the groundbreaking approach popularized in Ross Greene's acclaimed parenting guide, *The Explosive Child*, this

book provides a detailed framework for effective, individualized intervention with highly oppositional children and their families. Many vivid examples and Q&A sections show how to identify the specific cognitive factors that contribute to explosive and noncompliant behavior, remediate these factors, and teach children and their adult caregivers how to solve problems collaboratively. The book also describes challenges that may arise in implementing the model and provides clear and practical solutions. Two special chapters focus on intervention in schools and in therapeutic/restrictive facilities.

Parenting the Explosive Child (DVD or VHS)

Explosive and noncompliant children and adolescents present significant challenges to parents and cause distress to all family members. Such children tend to be quite misunderstood and their behavioral challenges are often poorly addressed by traditional discipline strategies which conceive such challenges as attention-seeking, willful, and manipulative.

Research suggests that such children may actually lack cognitive skills essential to handling frustration, solving problems, and mastering situations requiring flexibility and adaptability. In other words, the difficulties of these children may be best understood as a learning disability. Naturally, if a child is lacking crucial cognitive skills, the goal for parents and other adults is to teach those skills.

In this two-hour program, Dr. Ross Greene (author of *The Explosive Child*) and his colleague, Dr. Stuart Ablon, help parents understand the specific cognitive skill deficits that can impair a child's capacities for flexibility and frustration tolerance and provide step-by-step guidance on their approach -- known as Collaborative Problem Solving (CPS) -- for teaching these skills. This video features live interviews with parents of behaviorally challenging children and provides answers to many of the common questions parents have about the CPS approach.

Center for Collaborative Problem Solving

PATHWAYS INVENTORY (Rev. 4/21/07)

Child's Name _____ Date _____

- | | |
|--|---|
| _____ Difficulty handling transitions, shifting from one mindset or task to another (shifting cognitive set) | _____ Doesn't take into account situational factors that would suggest the need to adjust a plan of action |
| _____ Poor sense of time/difficulty doing things in a logic sequence or prescribed order | _____ Inflexible, inaccurate interpretations/cognitive distortions or biases (e.g., "Everyone's out to get me," "Nobody likes me," "You always blame me," "It's not fair," "I'm stupid," "Things will never work out for me") |
| _____ Disorganized/difficulty sorting through thoughts | _____ Difficulty attending to or misreading of social cues/poor perception of social nuances/difficulty recognizing nonverbal social cues |
| _____ Difficulty considering the likely outcomes or consequences of actions (impulsive) | _____ Lacks basic social skills (how to start a conversation, how to enter a group, how to connect with people) |
| _____ Difficulty considering a range of solutions to a problem | _____ Seeks the attention of others in inappropriate ways; seems to lack the skills to seek attention in an adaptive fashion |
| _____ Difficulty expressing concerns, needs, or thoughts in words | _____ Seems unaware of how behavior is affecting other people; is surprised by others' responses to his/her behavior |
| _____ Often appears not to have understood what was said | _____ Lacks empathy; appears not to care about how behavior is affecting others or their reactions |
| _____ Difficulty thinking rationally when frustrated or anxious (separation of affect) | _____ Poor sense of how s/he is coming across or being perceived by others |
| _____ Frequently cranky, grouchy, grumpy, irritable (outside the context of frustration) | |
| _____ Sad, fatigued, tired, low energy | |
| _____ Anxious, nervous, worried, fearful | |
| _____ Concrete, black-and-white, thinking; often takes things literally | |
| _____ Insistence on sticking with rules, routine, original plan | |
| _____ Does poorly in circumstances of unpredictability, ambiguity, uncertainty, novelty | |
| _____ Difficulty shifting from original idea or solution; possibly perseverative or obsessive | |
| _____ Difficulty shifting from original idea or solution; difficulty adapting to changes in plan or new rules; possibly perseverative or obsessive | |
| _____ Difficulty appreciating another person's perspective or point-of-view | |

TRIGGERS (list)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Adult Onset Tic Disorders

By Dr. Mary Jenkins

Can adults develop tics or Tourette syndrome? What is the cause of this?

Tourette syndrome is defined by the presence of both vocal and motor tics, persisting for one year, and beginning before 18 years of age. When a child has only motor or vocal tics that persist for greater than one year, this is termed Chronic Tic Disorder. When the tics last less than this year, this is termed Transient Tic Disorder. In all cases, there is no underlying disease process that caused the tics. By definition, these disorders must all begin in childhood. It is known, however, that rarely tics may start in adulthood as well; these are termed Adult Onset Tic Disorders. Many adults have Tourette syndrome or Chronic Tic Disorder that began in childhood and persisted, but the focus of this article is newly developed tic disorders that begin in adulthood.

Adult onset tic disorders are very rare and consequently, much less are known about them. There are few published reports that deal with adult onset tic disorders. This article will review some of these features and discuss the implications.

Adult onset tics disorders are usually secondary to some other event, exposure or illness. However, in some cases, adults can develop tics spontaneously without a known secondary cause. Sometimes the individual has a history of a childhood tic disorder that resolved or a family history of tics. Because tics are often very mild and fluctuate in severity, it is not always clear if the childhood tics completely resolved or if they were simply less obvious for a while. On the other hand, there are some cases that are clearly new onset tics in adulthood that occur spontaneously, very similar to Tourette syndrome.

As stated above, usually adult onset tic disorders are caused by an underlying event, exposure or illness. Tics occurring due to an underlying cause are termed Secondary Tic Disorders. Tics have been reported to occur secondary to drug exposures, injury to the brain, or underlying degenerative diseases. In the cases of drug exposures causing tics, this has occurred with both prescription “legal” and non-prescription “street” drugs. It is very rare for prescription drugs to cause tics, but there are a few isolated cases with medications used to treat psychosis. In terms of “street” drugs, tics have been linked with cocaine and alcoholism. In cases of brain injury, tics have developed following strokes and head injuries. Tics have also occurred following brain infections (encephalitis). In cases of degenerative diseases, the individual usually develops many other motor and intellectual problems in addition to the tics. For example, in Huntington’s disease, a rare inherited disease, people may develop tics as one of the symptoms.

There is some debate about whether adult onset tic disorders are more severe than childhood onset tics. Because these are so rare, it is difficult to know. One study reported that the people with adult onset tics had mild tic severity, whereas another article reported that the people with adult onset tics had moderate to severe tic severity. Regardless of the severity, most people reported that they were socially disabled by their tic disorders. Many people sought treatment, but not unlike treatment of childhood tics, the medications were not always effective and had undesirable side effects. In many cases, people chose not to continue taking medication.

In summary, adult onset tic disorders are rare but do occur. Some cases may be a recurrence of a childhood tic disorder that resolved. In other cases, the tics may begin without cause or previous history of tics. In these first two groups, the tics disorder is very similar to the childhood onset tic disorders. In most cases of adult onset tics disorders, it is felt that there is an underlying cause, which may include medications, injury, or an underlying disease process. Although this is a rare occurrence, the symptoms are reported to be very socially disabling.

Parent Self-help Meetings

The London Chapter of the TSFC hosts monthly parent Self-help meetings from 7pm to 9pm on the second Thursday of each month, except July and August. Meetings are held at:

Madame Vanier
Children's Services,
871 Trafalgar Street,
London, Ontario

Directions: Go south on Rectory Street to the end of Rectory. Turn left. You are now on Trafalgar Street. Madame Vanier is approximately 100-200 meters on the right.

Our Resource Library is available during meetings and books can be taken out on loan.

The Kids Klub meets at the same time as the Parents Meeting. *(Please see our website www.tourette-london.ca for a list of rules for Kids Klub)*

Our next 4 meetings dates are:
September 13, 2007
October 11, 2007
November 8, 2007
December 13, 2007

All parents of children with TS are welcome to attend. Members and non-members are equally welcome.

If the moon were to develop
"involuntary, rapid sudden
movements or vocalizations that
occur repeatedly in the same way"
would they be lunartics?

What's New in Research

By Brigitte Heddle

In this issue I am going to share with you the findings of a study designed to find out if patients with Tourette Syndrome who are open about their illness fare better socially than patients who are not.

The article is called: "Impact of Tourette Syndrome: A Preliminary Investigation of the Effects of Disclosure on Peer Perceptions and Social Functioning" by Brook A. Marcks, Kristoffer S. Berlin, Douglas W. Woods, and W. Hobart Davies published in the journal *Psychiatry* by the Guilford press, spring 2007 edition.

The authors knew that people who have TS (Tourette Syndrome) often have a hard time finding social acceptance and that their social difficulties are made worse by others' lack of knowledge about TS and about the individuals they encounter, who have TS. The authors had the theory that if a person with TS informs others about TS and how it affects them personally the person with TS would find that he/she would have less social difficulties. This concept is called attitude change strategy by preventative disclosure. The authors also knew that up until they started their own study on this subject there was no known research in this area.

In the first part of the article the authors mention several studies on how TS affects a person's social functioning. In one of those studies it was found "that children with TS are viewed as more withdrawn and less popular than their peers" (Stokes, Bawden, Camfield, Backman, & Doley, 1991). Another study by Jagger and colleagues from 1982 "found that 75% of children with TS were teased by peers because of their tics." The same study also found that "Children and adolescents with TS may also experience difficulties with teachers." The authors of this article go on to quote (and I find the numbers alarming!): "Furthermore, nearly half of children with TS have difficulty getting along with their teachers (Jagger et al., 1982); Shady et al., 1988) and one-quarter report being teased about their tics by their teachers (Jagger et al., 1982)." Further studies suggest that the problems continue in the adult years. They mention studies that found adults with TS had difficulties making and keeping friendships. The authors also

state that research had found 50% had difficulties with dating and romantic relationships. The authors also mention employment problems such as being ridiculed by coworkers and/or employers because of their tics.

The authors then list a couple of possible explanations for why TS sufferers have social difficulties. One being the symptoms from the often accompanying OCD, ADHD etc. There are studies both supporting and failing to support the first possible explanation. Another possible explanation is that other people's negative view on the person's tics is the cause of the TS patient's social problems. A study is quoted as showing "that children with tics have been found to be viewed as less socially acceptable than tic-free peers" (Boudjouk, Woods, Miltenberger, & Long, 2000). Other studies in 1999 and in 2000 got the same results for both adolescents and adults.

In research published by Woods, 2002 and Woods, Marcks, 2005 it is suggested that there may be benefits to providing educational material about TS to other people, but cautions that in certain contexts (which unfortunately are not explained by the authors) the advantage of doing so may be limited. The authors mention that some people do not disclose their illness and information about it to just anybody and at all times, but rather pick and choose the people, places, circumstances, and timing at their own discretion; i.e. only disclose information when and for whom they feel it is needed. The authors mention several researchers who had theorized that this would be beneficial for people with TS to do, but also go on to write that until the authors decided to conduct a study to find out if disclosing one's illness is a good idea in any or all circumstances to others, outside home and family, there had been no known research on this topic. They point out that when people with TS decide to disclose their illness the decision is often made together with family and/or their health care provider.

The last part of the article is devoted to the actual study that the authors did, whereas the first part was to show the reader the research that led the authors to conduct their study.

The authors explain that the purpose of their study was to determine what happens when a person, who exhibits motor and vocal tics, tell their peers that they have TS. They predicted that if a person discloses he/she has TS that person would:

1. Experience less social rejection.
2. Be accused less of having drug/alcohol problems.
3. Experience less concern about their behaviour.
4. Decreased perceptions of psychological and medical problems (I would have liked to see the last prediction explained in more detail).

369 people in the age bracket of 18-26 participated and filled out a questionnaire with 32 questions.

The results from the study supported the predictions by the authors that:

Re. 1. The person would experience less social rejection

Re. 2. Be accused less of abusing alcohol and drugs

Re. 3 Experience less concern about their behaviour.

However, the results of the study failed to support the prediction that

Re. 4. There should be a decreased perception of psychological and medical problems.

The authors focus on their positive findings and state, based on their findings, that if a person discloses that he/she has TS there is less risk of tics being attributed to another condition esp. alcohol and drug abuse, although they admit that to date (2007) there is no research done to show that tics can be attributed to other conditions by people who do not know the person has TS. However, their own study clearly showed that tics could be perceived as symptoms of an alcohol and drug problem, which could cause numerous problems for the person who has TS.

The authors would like to see their study repeated hoping to find the same results to back up their own study. One aspect that the authors admit was not considered in their study was prior knowledge of or

education about TS. The authors believe that if a person has prior knowledge of TS they would respond differently to a person who has TS as opposed to a person, who has no prior knowledge. To me that is really common sense, but in research it has to be proven by studies.

On a personal note, I can only support the findings by the authors. My son, who has TS and OCD has been teased for years by his peers and encountered both very understanding teachers and also very ignorant teachers who outright harassed him because of his TS and OCD. My son used to be embarrassed by his illness and tried to hide his tics etc., but that changed when he saw a documentary about Dr. Duncan McKinlay, whom I cannot praise enough for his candid and humourous approach to his own TS, which makes him an excellent role model and spokesperson for anybody with TS and TS+! After my own son, whose first name happens to be MacKinley, had seen this documentary, he decided that he would no longer be embarrassed about his TS and OCD and that he would like to speak to his class about it. So we consulted with his learning support teacher, who helped make it happen and it also happened right around the time that Dr. McKinlay came to my son's school to talk to the students about what it is like to have TS. It was a great success. My MacKinley felt much relieved to get the opportunity to tell why he often acted "strange" and made "strange sounds" and even better, a handful of his worst tormentors came up to him and apologized and have been very good to him since. Of course this didn't stop all the teasing by far, but for my son it was a huge boost to his self esteem; he didn't feel embarrassed by his illness anymore. That being said, we have had plenty of problems with teaching staff, who in spite of our best efforts to educate them and help them by giving them ideas and tools to bolster MacKinley's learning while at school, continued to act inappropriately towards my son. It is surprising and rather disappointing that it is by far the teachers we have had our biggest struggles with.

The bottom line is that though no matter how uphill the struggle seems living with TS or having a loved one with TS, it is very important to be open and honest about having TS, but at the same time use one's judgement in when, where and how much one discloses. It doesn't make all problems go away, but it really does help a lot and most of all it gives the person with TS a sense of pride of being just who they are. That is what really matters!

The CPRI Brake Shop service for Tourette Syndrome & Associated Disorders presents

"Leaky Brakes" 101

For the family member (including secondary school-aged children), educator, mental health professional, spouse, friend, neighbour, bus driver, babysitter...or anyone else invested in learning more about Tourette Syndrome and its associated conditions (Obsessive-Compulsive Disorder, Sensory Processing Dysfunction, Attention-Deficit/Hyperactivity Disorder, oppositional-defiance, and "rage").

Each week is devoted to a different topic:

"leaky brake" disorders and their misperceptions
pharmaceutical management
sensory issues/cognitive-behavioural management
school interventions
home support
review, and panel of experts (professional, parent, child, supports)

Various "CPRI Brake Shop" team members will present these topics. Time for questions and networking is allotted. Each spot is reserved for a particular attendee, and successive sessions assume past information. Hence, you are encouraged to attend all sessions.

Annual fall and spring courses offered.

Enrolment is without charge.

To reserve a spot for the next available 6-week programme beginning September 19, 2007, call

(519) 858-2774 ext. 2025.

Growing Up With Undiagnosed Tourette Syndrome

– Part 3

By Gerard Johnson

This is the ongoing story of one man's life growing up with undiagnosed TS+...

I had started to drink when I was 13 and thought this was a way to feel “normal” in the distorted world of my crazy thoughts and actions. Believe me when I tell you a drunken teenager with TS+ is anything but normal! By 1970 I was a mixed up, frightened 15 year old. I had many problems that I had not been able to deal with in a healthy way. How do you tell people that you have obsessions and compulsions that drive you up the wall, but can do nothing about? How do you tell friends or family that you become paralyzed with an overwhelming terror when you want to ask someone out on a date? I actually used to call girls I was interested in for a date and start moving my mouth, but no sound would come out! I would then just hang up. Thank goodness there was no call display back then. How do you deal with many puzzling body movements that you are so self-conscious about that you stay in your room for fear of having people see them and open yourself up to ridicule? I was emotionally immature, like a lot of 15 year olds, but I didn't see that anyone else was messed up. I didn't talk to other people about what I thought or felt because I was afraid I'd get thrown into an institution for the insane. My way of dealing with social situations was to drink so I could get rid of the fear that constantly gnawed at my gut.

As I sank into despair and confusion, my drinking escalated and I became a full blown alcoholic. I quit school when I was 16, but fortunately I returned the following year and somehow managed to graduate. I continued on my self destructive path after high school, going from one job to another. I was never satisfied with my job and kept looking for something I wanted to do. I had many jobs over the 5 year period after I graduated from high school. On the weekends I partied and got drunk. My fears increased and turned into self-loathing and anger. I started thinking about suicide. I started to isolate myself from friends and family, sometimes just sitting in my room staring at the wall for hours on end.

I sought help for my drinking when I was 23 and haven't had a drink now in over 28 years. I still had all kinds of trouble dealing with anger, fear and other things, but as time passed I managed to slowly come to terms with a lot of my past, without the benefit of knowing I had TS. It wasn't till I was 44 years old that I discovered I have TS and it has helped to

explain so much of my life. Knowing I have TS has helped me to reconcile much of my troubled years and has given me a greater appreciation for dealing with other people. As I continue in this adventure called life, I will endeavour to sustain my optimism for the future and for the goals and aims of educating people about Tourette syndrome and its' associated disorders. TS can be a source of great confusion to the newly diagnosed trying to come to terms with this disorder but if left undiagnosed or ignored it can destroy an individual that struggles with the unknown and frightening aspects of living with a disorder that is not understood or acknowledged. I am one of the lucky ones. I stopped destroying my life without knowing all the root causes of my trouble. If my TS had been more severe, I fear for what my life may have turned out like, given the road I started down as a teenager.

I am fortunate to have a son that doesn't have to go through the bewildering dilemma of trying to find an explanation for his tics and other “quirks” because of the knowledge we now have for his TS+ and the early diagnoses he received at 7. He is the brightest light of my life and I am so thankful I am around to enjoy and help him grow into a fine young man. I'm not just an adult that grew up with undiagnosed TS+, I'm also a doting father! Life is good.

Centre for Addiction & Mental Health
Lunch and Learn

Wednesday, September 5, 2007

12 noon – 1pm

**Regional Mental Health Care London
850 Highbury Avenue North
Wickware Auditorium**

(across from the main entrance. Two visitor parking lots at front of building; if full, there are two visitor lots at the rear of the building, proceed through the Loading Dock entrance.)

“Give these Kids a Brake!

**An Overview of CPRI's Brake Shop Service for
Tourette Syndrome and Associated Disorders”**

Presented by: Dr. B. Duncan McKinlay

For further information, please contact Beth Muia at (519) 455-5110, ext. 47323 or beth.muia@sjhc.london.on.ca or visit “What's New” at www.sjhc.london.on.ca

No Registration Necessary – Bring you own lunch

**Tourette Syndrome Foundation of Canada
Conference 2007**

September 27-29, 2007

Brock Plaza Hotel, 5685 Falls Ave.
Niagara Falls, Ontario

Keynote Speaker

Roger Kurlan, MD

What's new in TS? How common is it? Can strep cause it? Surgical and other new treatments - what are they and are they safe?

And

Ryan Clarke LL.B: Can we change how our children are perceived within the education system?

B. Duncan McKinlay Ph.D., C. Psych: What is Habit Reversal Training (HRT)?

Sheryl K. Pruitt, M.Ed. and Daniel G. Pruitt, CPCC, PC: So you expect them to leave home?

Aureen Pinto Wagner, Ph.D.: Is anxiety helpful or harmful?

Also

TSFC Annual General Meeting

Educators Program for teachers and teaching assistants

**Workshop for Mom and Dads
Program for Youth**

Program for children

Wrap-up banquet on Saturday evening

For more information or to register
www.tourette.ca
or
1-800-361-3120

**Tourette Syndrome Foundation of
Canada**

Launches a New Website

The TSFC has recently unveiled a new website and if you haven't already, we invite you to drop by and take a look. You will find a fresh look to the usual content and a few surprises.

Look for us at

www.tourette.ca

Membership

To carry out our mission of helping those affected by TS the #1 service we provide is free information.

As part of this duty we strive to always have current, up-to-date information. We make this information available to newly diagnosed families and to families that have been dealing with TS for years. We provide free information to doctors, teachers, support workers, grandparents, aunts, uncles and siblings, the media, the government and the legal system.

The information goes out by mail and e-mail, by phone, on our web site, as handouts at information sessions such as "CPRI's 101" series, through our support meetings and our lending library.

After giving away this free information to anyone in need, whether members or not, we don't have a lot left to offer our members - discounts on our booklets and conference registration, a vote at our annual general meeting and our local and national newsletters.

Why then should you be a member?

That's easy to answer:

**Help us provide free information to families
who need help.**

Bingo

Fundraising to help others

The face of Bingo in Ontario has changed. The provincial government recently revised the rules that dictate how bingos are run.

Previously, as the charity holding the event license, we were required to have between 12 and 16 people present to sell tickets, hand out prizes and do the administrative work. Under the new rules a big part of that work has been made the responsibility of the bingo hall owners and we are required to have only 5 people present.

These new procedures make it easier for us in that we no longer have to find 12 volunteers to run each event. However, the five people who do attend are going to be scrutinized more closely.

To all the people who have helped over the past 2 years – thank you. If you would like to continue to help and be part of the smaller team, let us know.

The number of events per year and the money we raise will not change and we will continue to use the proceeds to help families with TS.

TS in the News

An article that recently appeared on the internet tells about a nine year old boy, Rick, who could “hardly cross a room. With nearly every step, he felt compelled to do a deep knee bend - a strange dance that left him frustrated and exhausted at the end of each day. “Every time I went anywhere it was like, squat, squat, squat,” said Rick, “I could never get anywhere.”

Over a period of 8 months, Rick has learned Habit-reversal training in a program at a Duke University Medical Center clinic. The story tells about his success in reducing unwanted sounds and motions and stopping the medications he had been using.

“He hasn’t squatted since September,” said Clare Shocket, who says she would have tried behavioral therapy before drugs if she had known it was an option. “I’ve tried to figure out why more people don’t rush out and do this.”

The story is typical of a family learning that a child has TS with phrases like “for years, the Shockets tried to overlook Rick’s odd behaviors,” “at 4, he coughed all the time, even though he wasn’t sick,” and “he couldn’t even put a sock on if the seam didn’t lay just right.”

When a family told Rick’s mother that she should get him tested for Tourettes Syndrome she was offended. “To me, Tourette’s was this wacky thing where people yelled and cursed,” she said. “To me

(Tourette’s) was an ugly thing and an ugly word.”

The story hi-lighted the words “CHANGE THOUGHTS, CHANGE BEHAVIOR” and provided a look at the process Rick went through at the centre while talking about cognitive behavioral therapy. The story concludes with a look at some recent studies:

2004: A national study led by Duke University child psychiatrist Dr. John March reports that behavioral therapy, or a combination of therapy and medication, is more effective than drugs alone at reducing symptoms in children with obsessive-compulsive disorder.

2005: Researchers in California, Maryland and Wisconsin launch the first large clinical trial to test behavioral therapy in children with tic disorders, including Tourette’s syndrome. It is still under way.

MARCH 2007: The Duke psychiatrist publishes data from his earlier study that suggest children with tic disorders in addition to obsessive-compulsive disorder also responded best to behavioral therapy or a mix of medicine and therapy.

This is a big change from the early ‘90s when we were told there were alternatives to medication but no-one seemed to be able to tell us what those alternatives were.

Collaborative Problem Solving Articles

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This newsletter was produced for the London Chapter of the Tourette Syndrome Foundation of Canada by Ray Robertson and Gerard Johnson. Anyone wishing to make suggestions or comments about the content or if you would like to contribute an article for inclusion in the newsletter, please contact Gerard Johnson via email at:

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