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Social deficits in children with chronic tic disorders: Phenomenology, clinical correlates and quality of life

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Abstract

Youth with chronic tic disorders (CTD) experience social problems that have been associated with functional impairment and a diminished quality of life. Previous examinations have attributed social difficulties to either tic severity or the symptom severity of coexisting conditions, but have not directly explored performance deficits in social functioning. This report examined the presence and characteristics of social deficits in youth with CTD and explored the relationship between social deficits, social problems, and quality of life. Ninety-nine youth (8–17 years) and their parents completed a battery of assessments to determine diagnoses, tic severity, severity of coexisting conditions, social responsiveness, and quality of life. Parents reported that youth with CTD had increased social deficits, with 19% reported to have severe social deficits. The magnitude of social deficits was more strongly associated with inattention, hyperactivity, and oppositionality than with tic severity. Social deficits predicted internalizing and social problems, and quality of life above and beyond tic severity. Social deficits partially mediated the relationship between tic severity and social problems, as well as tic severity and quality of life. Findings suggest that youth with CTD have social deficits, which are greater in the presence of attention-deficit hyperactivity disorder and obsessive compulsive disorder. These social deficits play an influential role in social problems and quality of life. Future research is needed to develop interventions to address social performance deficits among youth with CTD.
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1. Introduction

Chronic tic disorders and Tourette disorder (afterward collectively referred to as CTD) are neuropsychiatric conditions defined by the childhood onset of chronic motor and/or phonic tics. Epidemiological studies in several countries suggest that between 3 to 8 children per 1000 have CTDs [1]. Although tic severity ranges from mild to severe, most cases exhibit a fluctuating course with symptom severity waxing and waning over a period of weeks [2]. Following the onset of tics in early school-aged years, tic symptoms often increase in number, type and frequency into early adolescence only to subside in early adulthood [3]. Tic disorders frequently co-occur with other childhood psychiatric conditions that can be viewed as more problematic than tics themselves [4,5]. Many studies report the co-occurrence of CTDs with obsessive compulsive disorder (OCD), non-OCD anxiety disorders (e.g., separation anxiety, generalized anxiety), attention-deficit/hyperactivity disorder (ADHD), and learning disorders [6–8]. Additionally, youth with CTD frequently exhibit disruptive behavior [9] and interpersonal difficulties [10] and are subjected to teasing and bullying by peers [11,12]. Collectively, tics, co-occurring conditions, and associated difficulties contribute to functional impairment [5], and a diminished quality of life among youth with CTD [13,14]. Although there has been much investigation on the role of coexisting conditions (e.g., ADHD, OCD) and psychological/emotional difficulties (see Robertson [15] for

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a review), there has been limited examination of social deficits in tic disorder phenomenology. Social deficits can be broadly characterized as the impairment of social abilities that can include difficulty picking up on social cues, inaccurate interpretation of identified social cues, limited reciprocal social behavior, difficulty with social engagement/ motivation, and perseverative interests [16]. Performance deficits in social abilities can influence youth's abilities to function and interact across multiple domains, and thereby impact their overall quality of life. An improved understanding of the nature and characteristics of social deficits in youth with CTD is an important step toward developing customized interventions to address these social deficiencies.

Although the nature and characteristics of social deficits have not been directly evaluated within tic disorder phenomenology, mild to moderate social interference among youth with CTD has been regularly reported by both children and parents [5,17,18]. At least six studies have indirectly assessed aspects of social deficits by examining social problems encountered by youth with CTD. First, Carter et al. [10] compared youth with CTD, CTD + ADHD, and healthy control participants using the Child Behavior Checklist (CBCL). Children with CTD had more social problems, lower social interaction/competency scores, and an increased risk for difficulties on the internalizing scale compared to healthy controls. Additionally, the combination of ADHD and CTD was associated with worse social functioning relative to CTD alone. Second, Sukhodolsky et al. [9] investigated the association between disruptive behaviors and social functioning in youth with CTD, ADHD, CTD + ADHD, and healthy control participants. The CTD, ADHD, and CTD + ADHD groups scored significantly below healthy controls on the CBCL Social Competency Scale, but did not differ from each other. Children with CTD were more impaired than unaffected controls on measures of social competency and daily living skills, but less impaired than youth with CTD + ADHD. Third, Storch et al. [5] found that children with CTD regularly reported difficulty in at least one functional domain (school, home, and social activities), with over a third of children reported to have problems in two or more domains due to their tic symptoms. Comparatively, 70% of parents reported that these youth experienced non-tic-related impairments in at least one of the three domains. Additionally, many children were reported to have at least one significant problem with social activities (42%), with parents reporting that children had difficulties either making new friends (21%), and/or being with a group of strangers (15%). Fourth, Storch et al. [12] identified that youth with CTD frequently experience peer victimization, with peer victimization ratings being associated with tic severity, loneliness, anxiety severity, and parent-reported child internalizing symptoms on the CBCL. Fifth, Conelea et al. [17] used an Internet survey of children and parents to examine impairment associated with tics. Positive associations reported between social interference and tic severity. Youth and parents reported some interference and avoidance of social activities due to tics, with the presence of coexisting conditions associated with greater social difficulties. Lastly, Zinner et al. [11] used the same Internet survey sample to examine peer victimization among children with CTD. Twenty-six percent of the sample reported experiencing peer victimization, which was associated with increased tic severity, stronger premonitory urges, worse quality of life, and elevated parental ratings of internalizing symptoms (e.g., anxiety, depression).

Collectively, these studies suggest that children with CTD experience greater social problems than healthy controls, with co-occurring ADHD increasing the extent of social difficulties. Furthermore, many youth with CTD experience victimization from peers—which has been associated with tic severity. Although some reports have found a direct association between tic severity and social difficulties [11,12,17], others have not [10,19]. These previous examinations of social problems among youth with CTD have used responses to individual survey items [5,11,17], CBCL subscales [9,10], and/or ratings that specifically address peer victimization [12]. Unfortunately, these ratings do not directly examine the presence or phenomenology of social deficits among youth with CTD. As social performance deficits may vary across previous samples, the differing levels of social deficits may account for the differential findings reported about the relationship between social problems and tic severity. Indeed, there is evidence that some youth with CTD exhibit severe social deficits characteristic of autism spectrum disorders [20,21], with prevalence rates reported to range between 1% and 9% for pervasive developmental disorders (PDD) [7]. As ASDs (which encompasses PDD) represent the severe end of a continuous distribution of social deficits found in the general population [22], many youth with CTD may also experience social deficiencies to a lesser degree.

The Social Responsiveness Scale (SRS) is a measure of social impairment that is characteristic of autistic traits [23]. The SRS has been widely used to examine social deficits in children with anxiety and mood disorders [24,25], ADHD [26], and PDD [27]. Although the SRS total score has been suggested to correspond with diagnoses along the autism spectrum [28,29], questions remain as to the degree to which it measures distinct features of ASD or overlaps with symptoms of other psychiatric conditions [30]. Appreciating that a high rating on the SRS total score is not equivalent of an ASD diagnosis, we report on the endorsement of social deficits on the SRS in a cohort of youth with CTD to better understand the phenomenology of social impairment among youth with CTDs. First, we examined the presence and clinical correlates of social deficits in youth with CTD. Second, we examined whether the magnitude of social deficits differed across common coexisting conditions (CTD, ADHD, and OCD). Third, we investigated whether the magnitude of social deficits accounted for tic-related impairment, quality of life, social problems and internalizing

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