As school counselors we deal with a wide variety of personal issues of children and adolescents. Though school counselors may only encounter a few students with Tourette’s disorder in their career, our knowledge of the disorder can not only have an impact on the student with Tourette’s but on the entire classroom learning environment.

Tourette’s disorder is typically characterized by rapid eye blinking, which later may turn into facial grimaces, barking sounds, mouth movements and motor tics. The average age of onset is 7 years old, though symptoms may appear up to the age of 18. Boys are affected 3 to 4 times more than girls. Also, for the disorder to be classified as Tourette’s, the symptoms have to last more than a year and the individual can never be free from symptoms for more than 3 months.

The exact cause of Tourette’s disorder is unknown. It would appear that genetic factors do play a role in the transmission and expression of TD as well as neurochemical abnormalities. Other medical factors that may influence this disorder include low birth weight, intrauterine crowding and poor prenatal circulation. Attention Deficit Hyperactivity Disorder and Obsessive Compulsive Disorder are often associated with TD. Stress can also exacerbate the symptoms.

There is no cure for Tourette’s. Medications are available, but because of the side affects of some of these medications, it is recommended that parents and doctors delay their use until the social, emotional, and academic impact is significant enough to warrant their use.

What is the role of the school counselor?
One of the most important roles the counselor may play is to inform teachers of the facts of TD. If the counselor is informed and recognizes TD symptoms, the identification, intervention and prognosis for the child becomes more favorable. Coordinating parent and teacher knowledge is imperative for designing intervention plans and selecting teaching methods. The following recommendations may be beneficial:

- Allow for oral or untimed tests and in a private place so the student does not have to worry about suppressing tics.
- Allow for preferential seating near teacher as well as away from windows and doors. Give the child a quiet workplace and change tasks frequently. A reward system for desired behaviors often works well.
- Avoid acting with anger at expression of tics. Consider privacy and safety of TD student as well as other classroom students when planning activities that involve tools or chemical. Allow for tape recording of oral reports.
- Provide a structured environment with minimal distraction to reduce mental tics. (the need to silently repeat words, numbers or phrases.)
- Allow presentation of taped reports and modify as well as minimize written work.
- Work together with parents and teachers to plan a realistic, consistent behavioral plan for both school and home.
- Provide classroom guidance to assist peers in understanding and accepting the TD condition.
- Ensure the safety of the student and the classmates. Limits and a structured environment must be established and maintained.
- Encourage parents and TD children to be involved in counseling.

In spite of the fact that there is no cure for TD, the prognosis is positive. There is often a significant reduction in tics by the late 20’s and, in some cases, the individuals may even experience a complete remission after puberty.

It is imperative that the parents and school work together collaboratively to ensure a quality educational experience. School counselors can provide the leadership in helping school professionals and parents deal with TD children.