Test Your Tardive Dyskinesia (TD) Knowledge

Myth: TD movements only occur in the face and are always rapid and jerky in appearance.

Fact: Specific TD movements may include the following and could affect the face, torso, and/or other body parts.^{1,2} Movements may appear rapid and jerky and/or slow and writhing.^{1,2}











Myth: There are no known specific risk factors for why people develop TD.

Fact: TD symptoms can start after taking antipsychotics for a few months.^{3,4} In addition to taking mental health medicine, the following factors may also play a role in your risk for TD:

- Having a mood disorder, such as depression or bipolar disorder⁵
- Older age (55+)⁶

- Substance use disorder⁷
- Being postmenopausal⁸

Myth: It takes a couple of years, at least, for TD to develop.

Fact: TD may develop after a few months of taking certain types of mental health medicine (antipsychotics) to treat bipolar disorder, depression, schizoaffective disorder, or schizophrenia.^{3,5,9}

Myth: Once you stop taking your mental health medicines your TD symptoms will stop.

Fact: TD is a chronic condition that is often persistent and generally does not go away without treatment. Do not stop taking your medicines without talking to your healthcare provider.

Myth: There are no FDA-approved treatment options for adults who live with TD.

Fact: There are FDA-approved treatments for TD. If you or someone you know is experiencing symptoms, it's important to talk to a healthcare professional about potential treatment options.

Learn more about TD, living with TD, and how to treat TD by visiting TalkAboutTD.com

This material was developed by Neurocrine Biosciences.

Sources

1. Task Force on Tardive Dyskinesia. Tardive Dyskinesia: A Task Force Report of the American Psychiatric Association. American Psychiatric Association; 1992. 2. Guy W. ECDEU Assessment Manual for Psychopharmacolagy. National Institute of Mental Health; 1976. 3. Kenney C, Hunter C, Davidson A. Metaclopramide, an increasingly recognized cause of tardive dyskinesia. J Clin Pharmacol. 2008;48[3]:379-384. 4. Glazer WM, Morgenstern H, Doucette JT. Predicting the long-term risk of tardive dyskinesia in outpatients maintained on neuroleptic medications. J Clin Psychiatry. 1993;54[4]:133-139. 5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th ed. Arlington, Va. American Psychiatric Association; 2013:712. 6. Woerner MG, Alvir JM, Saltz BL, Lieberman JA, Kane JM. Prospective study of tardive dyskinesia in the elderly: rates and risk factors. Am J Psychiatry. 1998;155[11]:1521-1528. 7. Miller DD, McEvoy JP, Davis SM, et al. Clinical correlates of tardive dyskinesia in schizophrenia: baseline data from the CATIE schizophrenia trial. Schiza Res. 2005;80[1]:33-44. 8. Seeman MV. Interaction of sex, age, and neuroleptic dose. Compr Psychiatry. 1983;24[2]:125-128. 9. Cloud LJ, Zutshi D, Factor SA. Tardive dyskinesia: therapeutic options for an increasingly common disorder. Neurotherapeutics. 2014;11[1]:166-176. 10. Caroff SN, Hurfort I, Lybrand J, Campbell EC. Movement disorders induced by antipsychotic drugs: implications of the CATIE schizophrenia trial. Neurologic clinics. 2011;29[1]:127-viii.