

## **Behavioral Problems and Social Competence in Girls With True Precocious Puberty (TPP)**

The authors evaluated 33 girls between 6 and 11 years of age with true precocious puberty (TPP) of various etiologies. At the time of presentation, 55% were above the 95th percentile for height-for-age; bone age was advanced by two to five years in all subjects. Before treatment, the parent(s) completed a 120-item child behavior checklist, from which a child behavior profile was generated. It consisted of three social competence scales, nine behavior problem scales, and two second-order factors (internalizing or externalizing scales). The personality profiles were compared with those of matched controls, and appropriate statistical data were extracted.

Many, but not all, of the girls were reported to have behavior problems. For example, 27% had a total behavior problem score at or above the 98th percentile for normals and many scored significantly higher than controls in all of the internalizing factors—eg, depression, social withdrawal (45% >97th percentile), somatic complaints (30%), and schizoid/obsessive traits. The incidence of hyperactivity and aggressiveness was significantly higher in TPP patients than in controls. The authors considered whether all these increases could be related to the expected changes of behavior that occur in adolescence and determined that such was not the case.

Other behavioral traits that were frequently observed in these girls included clinging to adults, feelings of worthlessness, sulking, fatigue, strange or unpredictable behavior, inability to sit still, daydreaming, crying, teasing, temper tantrums, and whining. They also tended to sleep less than most children.

Overall, the girls with TPP could be described as troubled, depressed, aggressive, socially withdrawn, and moody. The authors emphasize, however, that to view these children as psychiatrically disturbed and/or in need of psychiatric treatment is to misinterpret the findings. The behavioral "breakdown" reported may reflect the

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mechanisms for maintaining homeostasis in an abnormal environment. These children need to cope with an age-appearance disparity that modifies the response of their social milieu. Adults expect children to perform tasks that are commensurate with height age. Consequently, these children may have an abnormal body image, lack self-confidence, or prefer to be by themselves. Their social withdrawal may well be related to the disparity of age and appearance and expected social behavior.

Sonis WA, Comite F, Blue J, et al: *J Peds* 1985;106:156.

**Editor's comment**—*In their summary, the authors emphasize that a majority of the girls in their series did not have behavioral problems, although a significant and large minority did have a dysphoric and stressful adjustment.*

*Relevant to this report is one by Ehrhardt et al (J Am Acad Child Psychiatry 1984;23:1), entitled "Idiopathic Precocious Puberty in Girls: Psychiatric Follow-Up in Adolescence." This was a systematic, controlled study of psychopathology in 16 adolescent girls between 12 and 13 years of age, signif-*

*icantly older than the patients studied by Sonis et al. The average height (160.7 cm) was below the average height (166.4 cm) of the controls, as would be expected in females with a history of sexual precocity. Patients and controls were similar regarding various aspects of self-image, except for marginal differences in morals and sexual attitudes. The patients had a somewhat less positive attitude toward sexuality, rating having a boyfriend as far less important than did the controls. There were also marginal differences in intellectual and school status, with decreased popularity and less anxiety being associated with the patients. Conduct problems, antisocial behavior, inadequacy or immaturity, and socialized delinquency were marginally increased in the patients.*

*It is important to note that both sets of authors stressed that an increased incidence of definitive psychiatric disorders was not found. Both sets also emphasized the probability that the psychosocial concomitants of TPP, especially the reactions of families and peers, contribute to the behavioral outcome.*

*Both of these articles prompt the editor to recommend that psychologists, psychiatrists, or others with special expertise in TPP closely monitor and counsel patients with sexual precocity.*