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Marta Szymańska-Pytlińska, Maria Beisert

DIAGNOSIS OF PSYCHOSEXUAL IMMATURITY AS AN INDICATOR OF DESIGNING PSYCHOTHERAPY PROGRAMME FOR CHILD MOLESTERS

Department of Social and Clinical Sexology, Institute of Psychology,
Adam Mickiewicz University

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Summary: The aim of this article is to discuss the psychotherapy of psychosexually immature child molesters. The authors present their proposals of diagnostic criteria of psychosexual immaturity, which in the psychological and sexological practice is most commonly classified within the unspecified ICD-10 F66.8 category - Other psychosexual development disorders.

The diagnostic indicators were selected by defining the concept of sexual maturity and by establishing a contrario the characteristics of the state in which they are not fulfilled and which therefore is classified as psychosexual immaturity of an adult. For this purpose, biological, psychological and social approaches to psychosexual maturity were described and analysed by reference to Bancroft's [1] eclectic interactional model of sexual development.

The diagnostic criteria of psychosexual immaturity were defined on the basis of the three developmental strands proposed by Bancroft [1]: lack of a fully formed sexual identity, inability to formulate an adequate sexual response and inability to establish a dyadic relationship. Deficits in these areas characterize some child molesters.

Psychological work with sex offenders (with minors) should be preceded by a thorough functional diagnosis, which identifies the existing deficits and uses them to build a treatment plan. Developing a psychosexual maturity in the offenders could be used to create and strengthen new, more adaptive sexual behaviours and as a result may help to prevent relapse. The application of the proposed classification for the diagnosis of psychosexual immaturity requires: 1. adoption of a holistic perspective, integrating the various aspects of the sexual development, 2. reference to the individual's age, 3. taking into account the internal and external context in which the analysed sexual behaviour occurs, 4. cooperation of a psychologist-sexologist or a physician-sexologist with medical professionals of other specialties.

Introduction

Three forms of interventions are used (combined or separately) against child sexual offenders: 1. penitentiary interventions (isolation, supervision); 2. medical interventions (pharmacological, hormonal, surgical); and 3. individual and/or group psychotherapeutic

interventions. The effectiveness of these interventions is estimated by reference to the statistics of recidivism. Kowalczyk and Ciesielska [2] indicate that the return to crime occurs in 10–30% of treated offenders compared to 60–80% of untreated offenders. Offenders are rarely diagnosed with disorders of sexual preferences in the form of paedophilia (F65.4 according to ICD-10). So-called opportunistic paedophilia is observed more often. The distinction between them carries many implications for the offender as well as for the course and prognosis of the therapeutic process[1]. Considering the situation of people who do not meet the diagnostic criteria for F65.4 and constructing therapeutic programme, sexologists analyse their sexual development, searching for the factors leading to formation, development and maintenance of paedophilic behaviour. The resulting description of sexuality often leads to a diagnosis of psychosexual immaturity. Unfortunately, it is difficult to determine which intrapsychic, interpersonal and behavioural indicators the clinicians who use this term refer to, because it is not well defined in the existing diagnostic classifications and literature. According to the authors, diagnosing psychosexual immaturity[2] using ICD-10, one can use two categories: F66.8: Other psychosexual development disorders or F66.9 Psychosexual development disorder, unspecified. DSM-5 lacks a category which would directly correspond with these categories. Sexual development disorders are not mentioned in any of the sections related to human sexuality. The diagnostic manuals do not determine what is a normal state, which is the state of maturity, which would give a point of reference for the assessment of its lack. General guidelines included in manuals, however, lead to the conclusion that sexual maturity is a prescriptive category associated with age, gender and human development. Prescriptivism of maturity means that even the process of achieving it is a desired state, assessed positively, even recognised as an axiological category. The value, which is carried by maturity, would result not only from the developmental achievements, but also from the fact of acquiring the autonomous value. Sexual maturity is not unchangeable state or solid effect of developmental achievements. Besides that it has relatively permanent character and results from subjective conditions, it is a function of external influences. Mature sexual behaviour — manifestation and one of the indicators of maturity — is flexible and adapted to the current situation in human life. Hence the criteria for determining maturity and diagnosis of immaturity cannot be rigid and detached from the context, each case requires

[1] Differences in definition and consequences (legal, social, psychological and therapeutic) of a diagnosis of preferential paedophilia are discussed in, e.g. Marcinek and Kapała [3].

[2] The adjectives: *psychosexual and sexual* were used in the study to describe all aspects of human functioning concerning human sexuality. The authors treat them as synonyms because both refer to the sphere which includes three integrated elements of gender: biological, psychological and social one.

considering non-sexual spheres of functioning of the individual (cognitive, emotional, social, etc.).

Sexual maturity is defined in relation to the biological age of a person. In the literature, the term *sexually mature* person [4] includes an individual whose age falls to adulthood, beginning about 20 years of age [5] and continuing to death, and so about 5–6[3] decades. During those 50–60 years there are biological changes in sexual development of an individual. These changes can be generally described as growth (early adulthood), stability (the end of early adulthood and middle adulthood), ending with menopause in women and andropause in men, and involution (old age) [4]. Therefore, the formulation of criteria for sexual immaturity relates primarily to people in early and middle adulthood[4]. An expression of this position is — in modern sexology — separate formulation of sexological standards for people in various stages of sexual development.

Gender is not a precondition of sexual maturity. However, due to a clear differentiation and distinct description of the female and male line of sexual development [7], different reproductive roles of women and men and data concerning the relationship between the epidemiology of sexual dysfunction and gender, included in diagnostic manuals, there is a question whether the criteria of sexual immaturity should also be differentiated at the detailed level.

Aim

The aims of this work are as follows: 1. conceptualization of sexual immaturity and identification of indicators useful for diagnosis of Other psychosexual development disorders (F66.8 according to ICD-10) in adults in an early and middle adulthood, i.e. women and men aged 20–50 years and 2. indication of methods of sexual maturity development in the psychosexual therapy for non-preferential child sexual offenders.

Category of sexual maturity was used as a reference for the search of criteria for the diagnosis of psychosexual immaturity. A review of biological, psychological and social concepts that define maturity, originating from different traditions, has been done. To integrate these concepts the authors used Bancroft's [1] eclectic interactional model of sexual development and on the basis of its assumptions selected indicators for diagnosing sexual immaturity.

[3] According to data provided by the Central Statistical Office, in 2013 Polish men lived, on average, 73.1 years and women 81.1 years [6].

[4] The specificity of childhood with its biological characteristics, instability and turbulence of phase of maturation and involution changes of the old age period result in completely different character of maturity of an individual than maturity of the early and middle adulthood. What is an indicator of sexual immaturity in adulthood, may serve as an indicator of mature behavior of a child or an old man [4].

Then, based on the results of empirical research and clinical experience, the authors indicated which of the indicators identified in the proposed classification are observed in the child sexual offenders and recommended the method of therapeutic work.

Categories useful in the assessment of sexual maturity

Biological approach to sexual maturity

A prerequisite of sexual behaviour (first autoeroticism and later dyadic behaviour) is a possession of anatomically and functionally efficient genitals. Sexual maturity in terms of biological aspect is manifested, among others, by: (1) a uniform system of criteria for gender, developed in the course of the anatomical sex differentiation (in prenatal life); (2) primary, secondary and tertiary sex characteristics, formed as a result of sexual maturity (at the end of puberty); (3) achieving hormonal balance; (4) ability to formulate sexual response — occurrence of changes in organs and changes not related to organs in various stages of sexual response cycle [see 1, 4, 8].

Having intersexuality characteristics, i.e. ambiguous development of male or female sex, must not prevent one from sexual contact. However, it can significantly hinder and block the possibility of natural sexual reproduction. Bancroft [1] indicates that the appropriate course of sexual differentiation include: chromosomes, gonads, hormones, internal and external genitalia and secondary sex characteristics, sex assigned at birth, gender identity and gender of the brain [see 8].

Reaching sexual maturity allows us to perform sexual intercourse, expanding the repertoire of sexual behaviour available to the individual, and enables the procreative function of sexuality. In adulthood genital behaviour begin to dominate over pregenital behaviours and autoeroticism that are more characteristic of earlier stages of sexual development [4]. Boys reach biological sexual maturity around the age of 18, girls at the age of 16–17 years, after the normalisation of ovulatory cycles, although the reproductive ability in both sexes appears earlier [see 1, 4].

Sexual experiences involve the whole body, and involved psychological and somatic processes interact with each other. Psychological processes involve cognitive, emotional, and interpersonal (social) processes, personality etc, while somatic processes involve changes in sexual organs, brain, endocrine, muscular, cardiovascular, and respiratory system. The stimulus, to which the individual will assign sexual meaning and in the presence of which the individual will not activate mechanisms that inhibit the occurrence of sexual arousal (excitement), may initiate a sexual response cycle. There is a number of proposals of its

course — universal models and models created separately for men and women, circular and linear models. In short, one can assume that arousal, plateau, orgasm and relaxation are the elements of this cycle.

Reaching biological maturity is the starting point for the formation of gender and gender identity of an individual and for his/her effective functioning in the dyadic relationship. Biological sexual maturity includes having male or female sex and conditions for genital intercourse and procreation, including formed primary, secondary and tertiary sex characteristics, levels of sex hormones within the range of medical standard and functional genitals.

Psychological approach to sexual maturity

Classical psychoanalysis identifies psychosexual maturity with the primacy of genitality over non-genital forms in sexual life and the ability to achieve orgasm during an intercourse. In modern psychodynamic concepts, for example in Kernberg's concept [7], the determinant of maturity is to integrate elements of affection (love, care, emotionality) and aggression (arousal, desire) in the image and experience of own sexuality and the ability to implement them in relationship with the same person. The effect of developmental process is the same in both sexes, although the way to achieve it is different. In addition, mature sexual love in this concept is defined by: sexual desire for another person, mutual identification of sexual partners, accompanied by empathy, mature idealisation of a partner with trust in him/her and passion in 3 dimensions of the relationship — sexual, relationship with the object and engagement of the superego [7].

In the course of psychosexual development an individual acquires abilities to perceive, be aware of and interpret physiological changes in the body. A child learns to distinguish between sexual tension and other ones; experimenting with his/her own body he/she discovers that satisfying sexual needs leads to reduction of discomfort and/or pleasure. Gradually, among others, owing to the development of self-regulation processes develops the ability to defer gratification and impulsive actions give way to intentional satisfying of sexual needs [4].

Psychological sexual maturity can manifest itself as the ability to recognise sexual needs, to distinguish them from other experiences, postponing discharge of sexual tension and implementation of affectionate and aggressive component of sexuality in a sexual relationship with the same person.

Social recognition of psychosexual maturity

In the course of socialisation obtaining sexual satisfaction is adjusted to social values

and norms. In a family, by observing responses of caregivers to sexual behaviour (rewards and punishments), and later in school and peer group, children gain knowledge about rules they have to apply to. In contact with the areas covered by the family taboos, legal and moral prohibitions, children learn how to satisfy their sexual needs in a manner not exceeding those frameworks. Mature sexual expression is shaped in the context of moral development and its achievements such as: internalisation of norms, moral relativism and acceptation of norms as an autonomous value [4, 5].

Godlewski [9] indicates that sexual behaviour has a threefold function: psychological (pleasure), biological (reproductive) and social (relationship) function. Taking into consideration social function entails the need to analyze sexuality of a couple. Sexual behaviours presented in a dyad change with the dynamics of development of a relationship and on the basis of individual circumstances and preferences of partners. According to Sternberg [10, 11] simultaneous occurrence of three components of love: passion, intimacy and commitment, indicates that a pair enters the phase of complete relationship. Passion is directly related to sexual functioning because it contains a component of a strong physiological arousal, which can be (and often is) [11] identified, by partners, with desire, excitation, desire for physical contact and sexual connection with another person. It concerns experiencing intense emotions (both positive and negative) associated with its object, and allows to satisfy not only sexual needs but also needs which are competitive to them and/or equally important. Intimacy is recognised as closeness, affection and interdependence of partners; it is a result of their activities and experiencing positive emotions. Its peak often falls on the phase of complete relationship, when partners learned to recognise, communicate and satisfy the needs of the other person in a way which is acceptable and rewarding for both persons. Commitment (similarly to intimacy) is a factor responsible for stability of the relationship despite the natural decrease in the level of passion over time. This is effort, decisions, thoughts, feelings, activities focused on sustaining the relationship despite obstacles and frustration [10, 11].

Social aspect of sexual maturity is expressed in following passion and developing intimacy and commitment in a relationship with another (the same) person at the same time; in the ability to withdraw from a relationship that ceases to be rewarding (sexually and emotionally) for an individual and begins to lower the overall well-being and quality of life, and in the subordination of sexual expression to social norms and prohibitions and to internal values of an individual.

Integrative approach to psychosexual maturity

Bancroft's eclectic, integrative model of psychosexual development is a theoretical concept combining these three approaches to sexual maturity [1]. According to the author, the goal of development is to integrate three aspects: gender identity, sexual responsiveness and the ability to enter into close dyadic relationships. Thus, sexually mature person is:

1. a man or a woman (a person who fulfills the uniquely male or female gender pattern) with fully formed (based on the development of gender identity) sexual identity;
2. able to formulate a sexual response based on possessed sexual scripts;
3. capable of forming a dyadic relationship with another person (the same or the opposite sex, in accordance with sexual identity).

Re 1. According to Bancroft [1, p. 167], sexual identity, as "sexual self-identity" may be determined by the answer to the question: what kind of persons are sexually attractive to me and who I am in terms of sexuality. Sexual maturity consists in recognising one's own sexual preferences (as to the object and sexual activity) and orientation. These aspects were signaled in the introduction and description of the psychological approach to maturity.

Re 2. The sexual response consists of various components that appear in the course of sexual response cycle: cognitive (classification of visual, auditory, olfactory, and tactile stimulus as sexually stimulating, and focusing attention on the stimulus, focusing on sexual ideations and fantasies etc.), biological (anatomical and functional response of sexual organs as the effect of local vascular mechanisms, levels of hormones) and emotional-motivational component (arousal, desire). In the dual control model proposed by Bancroft [1], the occurrence of sexual response is determined by balance between the system of excitation/sexual activation (SES) and inhibition (SIS). Sexual maturity in this concept is expressed by the individual's ability to activate or inhibit sexual response in the event of a stimulus of a sexual nature (exciting) depending on the context in which it appears and cultural norms regulating sexual behaviour. Here one can find analogies to the aspects described above in the context of biological, psychological and social approach to maturity.

Re 3. There is a threefold justification for examination of the ability to establish dyadic relationship in terms of sexual maturity. Relational context: (1) allows people to take other forms of sexual activity than autoerotic behaviour; (2) allows people to pursue functions of sexual behaviour other than pleasure: biological and social one [see 9]; (3) in a stable relationship, ensures satisfying sexual needs of an individual in long term and increases the possibility of making contacts due to the availability of a partner. The above-mentioned concepts of Godlewski and Sternberg present a similar view.

Criteria for psychosexual immaturity

The above-mentioned concepts indicate that sexual maturity has a biological dimension; it is associated with intrapsychic processes and rooted in social reality. All three of these aspects are reflected in Bancroft's eclectic model [1]. Using its assumptions, on the principle of opposites, psychosexual immaturity can be assumed when a person is characterised by: 1. lack of a fully formed sexual identity; and/or 2. inability to formulate an adequate sexual response; and/or 3. inability to establish a dyadic relationship (Table. 1).

Table 1. **Indicators of psychosexual immaturity determined on the basis of Bancroft's model [1]**

Criterion / Level	1. Lack of a fully formed sexual identity	2. Inability to formulate an adequate sexual response	3. Inability to establish a dyadic relationship
Level A.	A.1. inconsistent pattern of male or female sex criteria	A.2.1. biological immaturity at the level of primary, secondary and tertiary sex characteristics	A.3. lack of integration of components of sexuality: aggression and affection, resulting in an inability to implement them in the relationship with the same partner
		A.2.2. biological immaturity at the level of hormones	
		A.2.3. biological immaturity at the level of genital response	
Level B.	B.1. unspecified sexual orientation	B.2.1. unrecognized sexual tension and/or lack of distinguishing it from other tensions	B.3. inability to experience passion simultaneously with developing intimacy and commitment in a relationship with the same partner
		B.2.2. lack of internalised social norms in the implementation of sexual behaviour	
Level C.	C.1. unspecified sexual preference (in terms of the object and course of sexual activity)	C.2.1. inability to defer discharge of sexual tension	C.3.1. experiences of inability to establish sexual relationship with another person in the history of life of individuals, despite their desire to establish and maintain such relationships, or staying in a relationship that does not bring sexual satisfaction
		C.2.2. poor control of sexual behaviour – imbalance of SIS and SES[5]	
		C.2.3. significant dominance of non-genital forms of sexual expression and autoeroticsm	

Source: own elaboration.

Indicator 1. is determined by the lack of the answer to the question: Who am I in terms of sexuality? at three levels: differentiation of sexes, sexual orientation and sexual preference. Indicator 2., concerning the lack of adequate sexual responsiveness in the event of an appropriate sexual stimulus, can be realized on three levels: biological, intrapsychic and

[5] SIS (Sexual Inhibition Scales) and SES (Sexual Excitation Scale) are components of Bancroft's dual control model [1]. According to the assumptions of this model, sexual response and excitement occur when there is a balance between brain systems of sexual inhibition and excitement.

behavioural one. Indicator 3. changes the approach to sexuality and transfers it from the individual to the level of dyad. Sexual relationship is defined as a relationship between two people (of the same or opposite sex), in which they satisfy each other's needs: sexual needs (through non-genital activity or penetration, leading to achieve sexual satisfaction), emotional needs (by growing intimacy and bond), social needs (support), and other. Indicators identified within each criterion can be arranged according to the level of accessibility of information (A–C). Diagnostic indicators from level A require access to specialist knowledge and skills to use it, e.g. knowledge of the results of medical tests of the diagnosed patient and the skills to interpret them. Indicators from level B are those which the diagnostician can indirectly deduce by referring the information obtained in the course of conversation with the patient to clinical knowledge. Availability of information from level C is the highest, these indicators manifest themselves in behaviours of the individual.

Psychosexual immaturity of non-preferential paedophiles

Analysis of results of empirical research and own experience of clinical practice leads to the conclusion that psychosexual immaturity manifests itself in child sexual offenders primarily in the following dimensions:

- Unspecified sexual preferences in terms of the object (criterion 1). The offender may declare a preference for making sexual contact with an adult, while in certain situations (e.g. unavailability of the preferred object) satisfy his sexual needs with a child, so although he is not diagnosed with sexual preference disorder, one can talk about the presence of deviant sexual interest in children. However, studies using plethysmograph show that paedophiles are different[6] from rapists, non-sexual sexual offenders and a control group (non-offenders) in terms of phallometric sexual response to visual stimulus in the form of sexually immature and maturing child presented on the screen in the laboratory [12, 13];
- Difficulties in diagnosing and differentiating sexual tension from other tensions; lack of internalisation of social norms and poor self-control in the implementation of sexual behaviour and preference of non-genital forms of sexual expression (e.g. in offenders committing non-penetrating forms of sexual abuse) (criterion 2.) The literature describes

[6] For example, in Blanchard et al. [13] phallometric reactions of similar strength were observed in compared pairs of: non-offenders (1) and sex offenders against women (2), incest offenders — biological fathers (3) and stepfathers (4) as well as in a pair of offenders unrelated to victims (5) and those who were relatives of victims, but the relationship was not parental (e.g. a sister, niece etc. — 6). Groups 5 and 6 were more responding to the presented stimulus, compared to groups 1 and 2. In groups 3 and 4, means reached moderate values and did not differ significantly from other groups.

three types of dysfunctional self-regulation in sex offenders. Type 1. occurs when an individual manifests disinhibition or impulsivity because of inadequate control of feelings or behaviour. Type 2. is observed in people who are trying to take control over their feelings and behaviours, but they use ineffective coping strategies. Type 3 occurs when an offender reaches his valued goals using effective self-regulation strategies, however, these goals are socially unacceptable because they harm others [14]. Preference of non-genital forms of sexual expression may result from difficulty in formulating genital response due to existing sexual dysfunction, especially in the form of erectile dysfunction;

- Difficulties in establishing and maintaining adult relationships (criterion 3). A meta-analysis of 14 studies carried out by Dreznicka [15] indicated that paedophiles have lower heterosocial competence than rapists, non-sexual offenders and non-offenders. On the other hand, Hanson and Morton–Bourgon [16] (meta-analysis of 95 studies) showed that some measures of intimacy deficits in sex offenders are predictors of sexual recidivism. Deficits of social competence and loneliness proved to be insignificant, however, emotional identification with a child (friendship with a child, child-oriented lifestyle) and conflicts in a relationship with a partner were statistically significant. Early childhood relationships with parents [e.g. 17] and the way of perception an adult partner as threatening, frightening etc., in opposition to a distorted perception of a child as an emotionally congruent object and therefore more accessible and less frightening [18], are also believed to be sources of difficulties in establishing dyadic relationship with an adult object in paedophiles.

Methods of therapeutic work with psychosexual immaturity of child sex offenders

Table 2 summarizes the objectives and methods of therapeutic work with child sex offenders described in the literature and binds them to the areas of psychosexual immaturity identified above.

Table 2. **Psychotherapy of psychosexually immature child sex offender**

Area of psychosexual immaturity	Therapeutic objectives	Methods of work with a patient	Detailed discussion of methods of therapeutic work
Criterion 1.	Modification of sexual preferences: 1. reduction of inappropriate sexual interest 2. increase in non-deviant sexual interest	Cognitive behavioural therapy that uses the mechanism of conditioning: aversion therapy, satiation[7], biofeedback, orgasmic reconditioning and others.	Quinsey, Earls, 1990, as cited in: Marshall et al., 1990; Marshall, O'Brien, Marshall, 2009, as cited in: Beech et al., 2009.
Criterion 2.	Increasing emotional and behavioural self-control by: 1. Increasing frustration tolerance and extending the deferment of obtaining sexual gratification 2. Developing adaptation strategies to cope with negative emotions 3. Deepening empathy and understanding of social norms	Therapeutic programmes using of cognitive-behavioural techniques and social learning, created in accordance with the assumptions of the models of self-regulation or circular models depicting the course of the perpetration cycle	Pithers, 1990, as cited in: Marshall i in., 1990; Ward, Hudson, 2000 Ward, Polaschek, Beech, 2006.
Criterion 3.	1. Reducing intimacy deficits arising in relation with parental object 2. Changing the way of perceiving mature and immature object and the way of forming relationships with them 3. Development of the ability to establish and maintain relationships with mature object	Insight therapy, for example, psychodynamic. Cognitive-behavioural therapy: desensitisation of anxiety and avoidance of non-deviant sexual contact, social skills training and others. Systemic therapy of couples and marriages	McFall, 1990, as cited in: Marshall et al., 1990; Shursen et al., 2008.

Source: own elaboration on the basis of: [14, 19, 20, 21, 22].

Modern therapeutic programmes implemented in ambulatory and stationary treatment of offenders integrate techniques and approaches listed in the table above, adjusting them individually to a patient taking into account the context of his functioning [see 23].

Discussion

Defining criteria for diagnosing psychosexual immaturity generates some controversy. Firstly, there is the issue of changeability of mature sexual behaviour depending on life context, possibility of development or age. Marcinek et al. [24] indicate that most of immaturity characteristics can manifest themselves only in the presence of another person (in

[7] *satiation* — technique that consists in the fact that the patient masturbate fantasising aloud about non-deviant stimuli to reach orgasm, and does not cease to masturbate, but continues changing fantasies to paraphilic ones [19].

the context of dyadic relationships). The authors suggest to treat it as a continuum, not a zero-one category, due to the need for a qualitative consideration of specific symptoms. Secondly, there are difficulties in the differential diagnosis, because psychosexual immaturity may be accompanied by other disorders, particularly personality and behavioural disorders of adults (F60–69 according to ICD-10). A possible solution to this problem is making functional diagnoses, the part of which is nosological diagnosis. They show the aetiology of occurrence and mechanism of maintenance of difficulties in patient's overall functioning in such a way that psychosexual immaturity finds its place among other disorders. This perspective corresponds to the holistic recognition of sexuality as one aspect of human life. Thirdly, there is a dilemma concerning ICD-10 criteria regarding experiencing suffering because of having a disorder. This issue should be considered individually in the course of diagnosis. E.g. in case when a woman prefer non-genital forms of contact while her partner prefers genital contact, suffering can occur as a result of emerging conflicts in dyad and not be directly related to immaturity. Fourthly, there is an important question concerning setting boundaries and scope of definitions of terms that correspond with the concept of psychosexual maturity and immaturity, e.g. sexological norms (developmental, partnership, medical) or sexual health [see 24].

Diagnostic criteria identified by the authors use the model of sexuality assuming such characteristics of sexual functioning which are not required by all sexologists — such as a condition of functioning in relationship with a stable sexual partner — as desirable. Moreover, they have not been empirically verified, hence they should be regarded rather as a voice in the discussion on psychosexual immaturity and introduction to research. However, clinicians may find them useful in therapeutic work with child sex offenders, especially at the stage of diagnosis and determining the problem areas, therapy planning and integration of available methods of intervention.

Therapeutic recommendations included in this paper do not always find application in the treatment of psychosexual immaturity of paedophiles. Not all methods listed in Table 2 can be implemented, e.g. in case of offenders additionally burdened with deficits in cognitive functioning, mental illnesses or personality disorders [see 22]. Forms of therapeutic work indicated in this paper differ in effectiveness. A meta-analysis conducted by Lösel and Schmucker [25] shows that the use of cognitive-behavioural techniques has the strongest effect on reducing the rate of recidivism in the treatment of sex offenders. Not every intervention works in each therapeutic situation, hence its implementation in a particular case depends on the therapist.

Conclusions

1. The classification of psychosexual immaturity presented in this paper may be useful for practitioners because of its integrative and holistic character.

2. The classification does not have a universal character — maturity and immaturity refers to biological age of the individual. The criteria were defined for the period of adulthood.

3. The classification is contextual — the importance of context (internal and external), in which sexual behaviour is presented, is emphasised. Sexual behaviour is immature if a person having the ability to take different kinds of sexual activity — do not use this potential, preferring the more infantile behaviour and/or less satisfying one. The evaluation of the adaptability of sexual behaviour for the overall functioning of the individual is also important.

4. The diagnosis of psychosexual immaturity using the proposed classification requires the cooperation of a psychologist-sexologist or doctor-sexologist with doctors of various specialties (including urologist, gynaecologist, endocrinologist).

5. The diagnosis of psychosexual immaturity of child sex offender directs the plan of his treatment. Identified deficit areas can be reformulated to therapeutic targets for developing psychosexual maturity, which, equipping the patient with new competences, would increase the attractiveness of non-deviant sexual behaviour and thus would reduce the risk of return to crime.

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address: marta.szymanska-pytlinska@amu.edu.pl