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The Concept of Sexocorporel

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Contents

1. Background

Professor Jean-Yves Desjardins developed Sexocorporel at the University of Québec in Montréal, Canada, where, in 1968, he co-founded the Department of Sexology with Professor Claude Crépault. Based on twenty years of clinical and scientific investigations, Desjardins conceptualized this model of sexual development and functionality and has continued to expand it in collaboration with sexologists incorporating current sexological research.

Sexocorporel is based on the inseparable unity of body and mind. This model permits the sexological evaluation of all components that interact in human sexuality. Based on this evaluation, clients can be provided with the abilities needed to improve their sexuality in areas that cause them concern.

2. "Brain – Body", "Body – Brain": An Inseparable Functional Unity

Body and mind are often considered to be two separate entities. This is an artificial separation, as the mind – which includes our thoughts, emotions, perceptions and fantasies – is located in the brain and is therefore part of our body, as well. This separation allows for the detailed examination of each entity as part of one inseparable whole. Historically, however, an antagonism has evolved from this dualistic perception in which the impulse driven impure body is seen as inferior and in opposition to the pure mind and soul.

This vertical perception -- psyche "on top"/superior and sexuality "below"/inferior – permeates our society as well as our psychotherapeutic models with judgmentalism. "Sexological evaluations" in many sex therapy schools are still conducted without including the person's physical sexual reality. Consequently, sexual problems are primarily understood to be symptoms of psychological conflicts or relationship disorders.

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Sexocorporel refers to these intrapsychic or relationship conflicts as indirect causes of sexual problems and focuses on the direct causes, taking into account that brain and body are a functional unity in which not only mental processes influence the body but, equally as important, bodily states and processes influence the brain, and hence our emotions, fantasies, thoughts and perceptions. For example, the arousal mode (the way people physically arouse themselves) directly influences their sexual experiences, as well as their sexual concepts and fantasies.

While Sexocorporel views the person as one physically and mentally inseparable unit, it, nonetheless, distinguishes the explicit body (the visible, movable body, physiological sensations, etc.) from the implicit mental processes (perceptions, emotions, thoughts, fantasies, etc.) to facilitate clearer understanding and for scientific purposes.

3. A Model of Sexual Development

Human sexual development, i.e. the sexualization process, begins in earliest childhood and lasts into old-age. It proceeds similarly to the development of motor action, affectivity, intelligence or language via a multitude of personal learning steps. In this process, both brain maturation and interaction with the environment play significant roles.

The sexualization process begins with the arousal reflex which is already present before birth. Throughout development this reflex combines with a growing number of motor, sensory, symbolic, cognitive and communicative skills that allow for variable sensations and perceptions and enable us to inhabit our genitals and to refine our sexual activities. These acquisitions are consolidated through repetition and are prerequisite for the experience of sexual pleasure.

Through the exploration of their own genitals and by playing genital games with the same and the opposite sex, children develop a perception of gender difference and gender identity. Concurrent socialization provides cultural concepts of "public" and "private", that is – of sexuality as intimacy with oneself and others. In role-playing games, games with rules, and initiation games, children connect sexual arousal with the socialization process, with communicative abilities and with emotional intensities.

Like every form of development, sexual development proceeds like a wave throughout our lifetime via new discoveries and the consolidation of acquired abilities through repetition or regression to earlier developmental stages. Physical changes in different life phases – for example, the "hormonal storm" that ushers in puberty –, illness, and disabilities require new sexual learning processes alone and with others.

No other human ability is so little supported, accompanied, and understood in its development by parents and society as that of sexuality. While our first walking attempts are intensely promoted and accompanied with great emotionality and acclaim, our first investigations on the genital level – to this day –

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cause ambivalent feelings, uncertainty or disapproval. Parents quickly become disturbed about delays in motor or language development because they are well-informed about these processes. However, most feel rather relieved if the child does not deal very much with his or her genitality.

4. Differentiation and Integration of the Components of Sexual Function

Sexocorporel distinguishes and examines the different components that play together in the practice and experience of sexuality. A person's sexual identity is determined at conception as are the body and its physiology. All other components involved in sexuality are parts of human sexual development. They develop as a result of personal and social learning processes.

Dividing the inseparable – the human person – into components allows for differentiated working hypotheses. Sexocorporel groups the components of human sexuality into four categories:

4.1. Physiological Components
- arousal function (4.1.1)
- arousal modes (4.1.2.)
- Sensual perceptions
- Biological base: Genes, hormones, blood vessels, nervous system etc.

4.2. Sexodynamic Components
- Sexual pleasure (4.2.1.)
- The feeling of belonging to one's biological sex (4.2.2)
- Sexual self-confidence (4.2.3)
- Sexual desire (4.2.4)
- Sexual and emotional attraction codes (4.2.5)
- Sexual imaginations, fantasies and dreams (4.2.6)
- Emotional intensity (4.2.7)

4.3. Cognitive Components
- Knowledge, values, norms, ideologies, ways of thinking, idealizations, mystifications etc.

4.4. Relationship Components
- Feelings of love, ability to attach
- Seduction skills
- Erotic communication
- Erotic competencies

In Sexocorporel, a model of sexual health and functioning is defined for each component. This forms the framework of the evaluation. Initially, a person's acquired abilities are evaluated, i.e. the person's strengths. Every person has limitations in their sexual development; Sexocorporel does not pathologize limitations or aim to produce new achievement norms. Limitations are not seen as deficits, but as challenges that stimulate new experiences.

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4.1 Physiological Components

4.1.1 Arousal Function

The arousal function can be divided in two components:

1. **Arousal reflex**
   This activates:

   a) vasocongestion (influx of blood through the genital organs/cavernous bodies) which is directed by the vegetative, involuntary nervous system and other physiological reactions that cannot be influenced at will.

   b) muscular activity in concert with the "Three Laws of the Body", i.e. the three basic elements of physical activity: movement (space), rhythm (temporal structuring) and muscle tone (muscular tension).

2. **Learning processes**
   Muscular activity can be intentionally influenced starting in the fifth to six months of life.

Using ultrasound technology, the arousal reflex can be observed in the male fetus while still in utero. All other components pertaining to sexuality, i.e. sexodynamic components, sexuality-related cognitions and the respective relationship components – develop in close interaction with the arousal function.

The wish of many men and women to enjoy sexuality and to live in a love relationship, that is, the wish to connect genitality with the experience of intimacy, is essentially based on the arousal reflex.

Once arousal is successfully elevated, the journey culminates in a second reflex, i.e. an involuntary process leading to orgasm. We can make the "space" between both reflexes "inhabitable" through learning processes. Learning activates higher brain centers, and enables the conscious experience of sexual arousal. Learning steps pertaining to the arousal reflex directly influence the quality of the erotic action and experience; hence, they are called direct causalities.

Thanks to learning processes, the intensity of sexual arousal, specifically vasocongestion, can be influenced at will by playing with changes in the accompanying muscular tension and rhythmic movements. All learning processes in the various human modes of expression (walking, speaking, making music, dancing, etc.) are based, ultimately, on the use of the three laws of the body – movement, rhythm, muscle tone – as well as, of course, breathing.

Sexual arousal can be influenced by consciously controlling or playing with the accompanying physical reactions – quantitatively (intensity) as well as qualitatively (pleasure). Our clients often wish to feel more sexual enjoyment and to reach orgasm. Learning steps, at the physical level, are required for this.

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On the one hand, diffusion – the ability to spread sexual arousal throughout the body – is prerequisite to intensifying the experience of sexually pleasurable sensations and sexual arousal. On the other hand, the ability to channel sexual arousal in the genitals facilitates reaching an orgastic discharge (physical discharge, ejaculation/spasmodic reaction) or an orgasm (physical and emotional discharge). Thus, every woman and man can learn to consciously influence the arousal reflex through physical learning steps.

Explanation of terms

Orgastic Discharge:
Orgastic discharge is a reflexive response to a sufficient amount of arousal, on a purely physical level. During orgastic discharge, rhythmic contractions of the pelvic floor and abdominal musculature occur (every 0.8 seconds). With men, usually ejaculation occurs.

Orgasty:
By orgasty, we mean the ability to have an orgastic discharge. When this ability is absent in a woman, we call it anorgasty; in a man, the absence of ejaculation is called anejaculation.

Orgastic discharge can also take place without ejaculation – for instance, when (for medical reasons) no ejaculation is possible, or when ejaculation is consciously suppressed as in Taoism.

Orgasmic discharge (orgasm):
An orgasm is a complex psychophysiological phenomenon wherein orgastic discharge is accompanied by intense emotional feelings of pleasure and lust.

Orgasmy:
This means the ability to reach an orgasm. Sexual satisfaction is directly related to the intensity of the experience. Conditions for this include the ability to diffuse arousal throughout the body, channel it in the genital region, and to be able to "let go" – emotionally and genitally.

The transition from orgasty to orgasmy is fluid.

In anorgasmy, the pleasurable sensations accompanying the increase in sexual arousal and the orgastic discharge are absent. Women, in particular, may have an orgastic discharge without perceiving it at all. Or, they may be aware of certain muscular contractions, but they do not interpret this to be an orgastic discharge.

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4.1.2 Sexual Arousal Modes

In order to help men and women improve the quality of their sexual lives with appropriate learning steps, we must first evaluate the primary mode of arousal and any related limitations.

Laboratory observations and descriptions from numerous clients provide a basis for the typology of five arousal modes, i.e. five ways to increase arousal based on the three laws of the body.

Archaic arousal mode
This arousal mode is called archaic because it is the first arousal mode to be observed in babies (as early as three or four months after birth). It assumes a minimum of motor coordination. The archaic mode functions via stimulation of the proprioceptive receptors (deep sensory receptors) in the genital region.

It is more frequently utilized by women. Women increase their arousal by pressing their thighs together – with or without an object between (pillow, etc.) –, by strongly tensing the pelvic musculature or by pressing the genital region against a stationary base. Men clamp the penis between the thighs, press it with the hand or the weight of the body against a stationary base, strongly squeeze the glans with three fingers, etc.. The archaic mode is distinguished by intensive squeezing and pressure, often accompanied by strong rapid movements; the musculature of the entire body is rigid, and breathing is highly restricted.

The archaic mode allows for quick orgastic discharge. In order to increase arousal to the point of no return, all attention is concentrated on receptors in a small, specific area – which limits the perception of pleasurable sensations. The archaic mode is not well suited for fully experiencing all the pleasurable feelings available during intercourse. If a man arouses himself exclusively in the archaic mode, ejaculation problems (up to anejaculation) and erection problems frequently occur during intercourse. Women in the archaic mode tend to have difficulties with intercourse – often experiencing orgasm problems or pains resulting from tension of the pelvic floor, lack of lubrication etc.

The archaic mode, in men as in women, limits the experience of sexual pleasure and prevents the development of coital sexual desire (see below). The archaic mode often hides behind a diagnosis of "sexual aversion". Furthermore, it can lead to uncertainties in a person's feeling of belonging to one's biological sex.

Mechanical arousal mode
The name reflects the mechanically rhythmic movements typically associated with this method of raising arousal. This mode is used most often by men. The mechanical mode also facilitates a quick orgastic discharge. Superficial sensory receptors are rapidly and rhythmically stimulated. The muscles throughout the entire body or in the thighs, buttocks, abdomen or pelvic floor are often

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rigid. Movement and breathing become more restricted as arousal increases. Men who stimulate themselves using the mechanical mode generally grasp the penis in one hand and stimulate it with uniformly rapid strokes. Women stimulate themselves by rapidly and uniformly rubbing the clitoris or vulva. Some must utilize a very exact masturbation ritual in order to raise arousal to the point of orgastic discharge.

Because the focus of attention is restricted to sensory receptors in very precise and small areas of the body, the buildup of arousal in the mechanical mode is particularly easily disrupted, and sexual pleasure as well as the orgastic discharge are limited in intensity. The physical tension that accompanies increased arousal can be experienced as uncomfortable, and orgastic discharge may be sought primarily to relieve this tension.

People who function exclusively in the mechanical mode may experience problems during intercourse. Muscular rigidity in the pelvis and the back leads to the typical in-out thrusting motion by men that often does little in the way of stimulating the female partner. The increased muscular tension in the buttocks and pelvic floor further increases sexual arousal that can quickly cross the point of no return. Hence, difficulties with ejaculatory control are not uncommon. With aging, men will sometimes develop coital erectile dysfunction because the friction within the vagina no longer provides sufficient stimulation. Many women who use the mechanical mode do not find intercourse physically arousing because they are used to stimulating only their external superficial receptors. The mechanical mode does not support the sensory perceptions inside the vagina. Consequently, they may have difficulties reaching orgastic discharge or orgasm during intercourse and may not even enjoy or desire intercourse at all.

Archaic-mechanical arousal mode

This mode concurrently includes the superficial and deep receptors of the genital area. Stimulation is generated by pressure and friction, for instance with the shower head, a vibrator, or by strongly grinding the genitals on a firm base, cushion, etc.. The limits in experiencing the full pleasure of sexuality and the problems with intercourse are similar to those with the archaic mode.

Undulating arousal mode

In this mode, the person maintains a state of sexual fluidity, that is – their movements flow throughout the entire body; the muscles are not tense. Consequently, arousal diffuses throughout the entire body – leading to sensations full of pleasure and an intense erotic experience. Play with rhythms and movements is very diverse, and muscle tone varies, tending towards being low. This arousal mode occurs more frequently with women. The tension buildup – the ability to channel sexual arousal in the genitals through increased muscular tension – is not always enough, however, for an orgastic discharge.

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Arousal mode in waves
In this mode, superficial and deep sensory receptors in the whole body are activated by the „double swing". Here, the pelvis and shoulders swing simultaneously in the body axis, powered by profound respiration. The double swing is essentially a reflex movement (reflex arc) that can easily be observed when laughing, coughing or sobbing, particularly in children, or in copulating animals. For humans, its maintenance and application during sexual arousal is not preprogrammed (as in animals) and requires learning . A distinction is made between the pelvic swing (the pelvic movement) and the upper swing (movements of the chest, shoulders and head). The pelvic swing intensifies sexual arousal, the upper swing intensifies emotional sensations.

As in the undulating mode, in the arousal mode in waves there is an interplay of finer and more intense movements, as well as variations in rhythm and muscular tension. In the undulating mode, movement flows around the body axis: the double swing of the arousal mode in waves is in the body axis. It intensifies sexual arousal via the resonance caused by moving in increasing waves – up to the point of orgasm. Orgasm is reached through the combination of sexual arousal and intense feelings of pleasure and lust. During orgasm, a double release occurs: at the genital level, arousal is increased by the pelvic swing, and after diffusing throughout the entire body, it is channeled back into the genitals to allow discharge. On the emotional level, "letting go" via the upper swing induces perceptions of pleasurable feelings and lust that accompany this discharge.

The arousal mode in waves allows women to more intensely perceive sensations in the vagina and to be aware of their internal "cave". This "eroticizing" of the vagina is a necessary condition for developing coital sexual desire (see below). With men, the arousal mode in waves creates the physical conditions necessary for experiencing themselves as phallically penetrating. This "phallic eroticization" is the basis of coital sexual desire in men.

4.2 Sexodynamic Components

Perceptions, feelings, emotions, symbols, fantasies and imaginations that are directly connected with sexuality are called sexodynamic components. They develop via learning steps during the process of sexualization. The sexodynamic components correspond to mental processes in the brain. Because the brain is part of the body, bodily processes – particularly those elicited by the different arousal modes – have an essential influence on their development.

The interaction of different sexodynamic components constitutes sexodynamics. Sexodynamics are:

- The art of recognizing what attracts and arouses us sexually
- The ability to express this attraction and arousal through sexual desire

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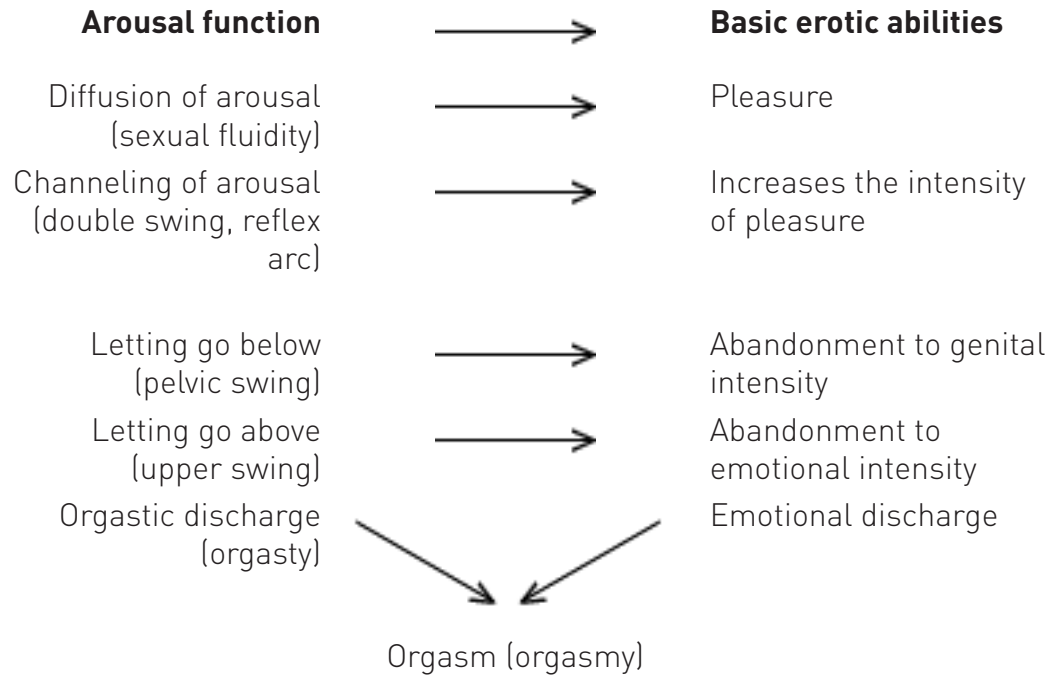
- The ability to connect this attraction and arousal to erotic images, fantasies and feelings, as well as to the experience of one's own masculinity and femininity
- The ability to enjoy the pleasure of sexual arousal alone or with others

We will now discuss the sexodynamic components.

4.2.1 Sexual Pleasure

Sexual pleasure is the ability to enjoy sexual arousal. Most men, women and couples consult us because they would like to fulfill their dream of a more pleasurable sexual experience. But, is this possible without fluidity of movement to allow for the diffusion of sexual arousal through the body, or if the arousal cannot be channeled in the pelvis, or if one lacks the ability to let go? In other words, since the brain and body form a functional unity, an improvement of the arousal function will directly affect sexual pleasure and, consequently, the ability to orgasm.

The following table illustrates how physical abilities facilitate good sexual functioning:



Thus, physical abilities directly influence the emotional experience. For example, high muscle tension inhibits pleasurable perceptions. The more abilities a person attains by enhancing their arousal function, the more they can influence and modulate their arousal – thus, intensifying their experiences of sexual pleasure and orgasm.

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Cognitions – i.e. what a person knows about sexuality, the norms that he or she hold, and their beliefs – support or inhibit learning steps, thus influencing the pleasure and arousal functions.

Regarding the experience of pleasure, sexual health presupposes the ability to intensely enjoy sexual arousal and self abandonment (letting go) on both the genital and emotional levels. The basis for this is the combining of pleasant emotional feelings with physical arousal. This is not always the case, however. Sometimes sexual arousal is accompanied by unpleasant feelings. In the extreme case, during a rape experience, for example, physical sexual arousal may occur, but the accompanying (emotional) feelings are painful. Hence, in contrast to Masters and Johnson's depiction of the sexual response cycle on a single curve, we distinguish two curves: a physical arousal curve as well as a curve describing the emotional experience i.e. sexual pleasure.

4.2.2 Feeling of Belonging to One's Biological Sex

The development of a feeling of belonging to one's biological sex is linked to learning steps on the genital level. A man can learn to eroticize his intrusivity, his ability to penetrate. This is called phallic eroticization. A woman can eroticize her vagina, that is, she can develop her receptivity, i.e. the desire to actively take something into her vagina, arouse herself with it, and be filled by it. Phallic eroticization and eroticization of the vagina are personal abilities that are reflected in a person's internal pictures, sexual fantasies, posture and behavior.

Intrusivity and receptivity represent a continuum to which both sexes have access: Men, too, can enjoy receptivity and women can enjoy intrusivity. In therapy, the development of a man's intrusivity or a woman's receptivity is often a topic with clients who have reached limits in their sexuality or have problems with their feelings of belonging to their biological sex.

The feeling of belonging to one's biological sex is also reflected in the ability to adapt oneself, at least minimally, to gender specific social and cultural roles and norms. For some time now, critical discussions have taken place concerning intersexuals (persons with ambiguously assignable male or female genital organs), transsexuals, and persons calling themselves gender queer. The term gender queer describes a variety of sexual ways of life that often run counter or crosswise to traditional gender roles or norms.

As a therapeutic instrument, Sexocorporel does not assume that there is a "right" or "wrong" feeling with regard to belonging to one's biological sex. It addresses the concerns, wishes, and requests of each client individually.

4.2.3 Sexual Self-Confidence

Sexual self-confidence means showing oneself with pride in one's masculinity or femininity and showing one's sexual arousal with pride.

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4.2.4 Sexual Desire

Sexual desire is the pleasant anticipation of erotic experiences accompanying or helping to trigger the arousal reflex. We distinguish different forms of sexual desire, based on the various personal needs that motivate sexual acts. These needs may be primarily sexual in nature or not. We distinguish between:

1. Emotionally triggered desire
Here, sexual intercourse is motivated by intense emotional needs, being "in love", fusion wishes, the fear of loss.

2. Biologically triggered desire
The physiologically based desire for procreation is partially hormonally triggered (e.g. during ovulation). In women, periodic vasocongestion (e.g. premenstrual) may also trigger a wish for orgastic discharge.

3. Sexual desire
Various sexual play forms and interactions are motivated by the search for sexual arousal and its accompanying pleasure, as well as orgastic discharge or orgasm – alone or with a partner. Sexual desire is often accompanied by the wish for validation of one's own masculinity or femininity.

4. Coital sexual desire
Here, sexual intercourse is primarily motivated by the search for sexual arousal through coitus, the pleasurable emotions and fantasies linked with it, and the self-abandonment that occurs during orgasm.

Coital sexual desire is based on differentiated personal learning steps:

- The development of adequate sexual arousal, corresponding sources of arousal, and an arousal mode that includes variations in intensity, rhythm and movement facilitating the channeling and diffusion of arousal, i.e. an undulating mode or arousal mode in waves.
- For women: the development of vaginality, that is discovering and developing the vagina as a space of female eroticism, and a space for the pleasurable experience of meeting with another person's eroticism – and that person's penetrating penis, finger, etc.
- For men: learning to eroticize the ability to penetrate, that is, to desire and experience pleasure in penetrating another person's body with penis, finger, etc.
- Eroticization of the difference and the distance: developing the ability to eroticize another in his/her differentness, as well as in spatial distance. For heterosexuals, it is the ability to let oneself get aroused by the differentness of the other's sex and to eroticize it.

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- Eroticization of intimacy: developing the ability to eroticize closeness, attachment, love, tenderness, etc.
- Developing a feeling of belonging to one's biological sex and sexual self-confidence
- Development of sexual and emotional attraction codes regarding other people.

4.2.5 Sexual and Emotional Attraction Codes

Sexual and emotional attraction codes represent what attracts and arouses a person. They refer to physical attributes and the person of the other. They also include objects, scenarios, etc. Attraction codes allow for a more precise evaluation of a person's sexual orientation than categories like "homosexual", "heterosexual", etc.. We distinguish attraction codes on the levels of reality, fantasies and dreams.

A person can be disposed to a wide and variable spectrum of attraction codes. Sometimes they are restricted, and then a person's arousability is limited to certain body parts, objects or scenarios. Attraction codes are influenced by physical perceptions and by arousal modes. They can become restricted or broaden throughout a lifetime and are always accessible to learning processes and therapy.

4.2.6 Sexual Fantasies and Dreams

Sexual fantasies encompass images, memories and anticipations in all sensory modalities (pictures, smells, etc.). They can trigger and/or accompany the arousal reflex.

In sexual fantasies, personal (especially sexual) development is reflected, i.e. learning steps on the levels of cognitions, arousal function, sexodynamics and relationship abilities. The contents of fantasies include very narrow to very extensive scenarios. They are metaphors for the relationship one has with one's own masculinity/femininity, intrusivity/receptivity, attraction codes, sexual desires, needs, wishes and fears.

4.2.7 Emotional Intensity

The ability to express one's sexual needs and wishes, sexual desire, and erotic actions with emotional intensity enables a lively and profound experience of one's sexuality.

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4.3 Cognitive Components

The cognitive components are comprised of knowledge, values, norms, belief systems, ways of thinking, idealizations, mystifications and ideologies pertaining to sexuality. Cognitions reflect a person's learning history and the social sphere he or she grew up in and now lives in. Cognitive components steer and promote (e.g. through knowledge) or inhibit (e.g. via feelings of guilt and shame) sexual learning steps. They influence the role and meaning sexuality has in our lives, and modify the ways we perceive sexual experiences and sexual pleasure.

4.4 Relationship Components

Relationship components are comprised of the abilities:

- to fall in love
- to enjoy intimacy
- to love and attach oneself
- of seduction: to entice another person into an erotic encounter based on the perception of one's own needs
- of erotic communication: to communicate one's sexual needs, wishes, ideas, boundaries and fears

5. Clinical Significance of Differentiating Between a model of Mental Health and a model of Sexual Health

Although the arousal function is the foundation of our sexuality, and stands in direct causal connection with more than 50 percent of the sexual problems of our clients, it is our least understood and evaluated function. Clinical experiences show quite clearly that disorders of the arousal function (rapid ejaculation, anorgasmy, erectile dysfunction, etc.), of sexual desire and, in part, of our experience of gender identity are connected to learning steps at the level of the arousal function.

One basic problem inherent in many so-called sex therapies is the failure to evaluate the direct causalities i.e. the sexual learning steps. Lack of awareness of their direct causal effects leads to the search for indirect causes – like relationship problems, emotional conflicts, a "difficult childhood", or sexual abuse – which are then connected to the sexual disorder via some hypothetical construct. In this "naturalistic" concept of sexuality, after removing the "obstacles", sexuality is supposed to develop spontaneously. Our clinical experience shows, however, that when the arousal function is not taken into consideration, this is often not the case. Of course, indirect causes are evaluated in Sexocorporel, as well, because they can certainly hinder sexual learning steps or may call for specialized treatment.

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Lack of sexological knowledge has led to the unnecessary "psychopathologizing" (analogous to "medicalization") of many clients with sexual problems. However, the majority of clients that seek therapeutic help for sexual problems are psychologically healthy. Long-standing clinical experiences by other authors, such as Helen Kaplan, also confirm these findings.

That in mind, sexual dysfunction occurs frequently in people with mental illnesses, and on the other hand, sexual dysfunction can significantly impair a person's mental health or a couple's relationship.

A standalone model of sexual health is required for accurate and independent evaluations of mental and sexual health. This distinction helps facilitate precise diagnostics prerequisite for the therapeutic project and helps prevent unnecessary confusion posed by unclear causal interrelations.