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Client Attributions for Sexual Dysfunction

Catherine S. Fichten, Ilana Spector and Eva Libman

This investigation examined attributions for sexual dysfunctions made by 63 individuals and 21 of their partners who presented at a sex therapy service for the following problems: erectile dysfunction, premature ejaculation, and female orgasmic dysfunctions. All participants completed measures of marital adjustment, locus of control, depression and a questionnaire which assessed: attributions of responsibility for the sexual problem, perceived control over sexual functioning, distress, effort made to improve the sexual relationship, and expectations about the efficacy of sex therapy for the problem. Results indicate that both identified patients and their partners, regardless of the dysfunction, blamed the sexual problem on the "dysfunctional individual" rather than on the circumstances or the partner. With respect to the partners, husbands of women with orgasmic dysfunction were more likely to blame themselves than the circumstances, while the opposite was true for wives of males with erectile difficulties. Individuals experiencing the dysfunction perceived themselves and their partners as having little, but equal control over the identified patient's sexuality. Correlational analyses indicate that in identified patients, the better the quality of the marital relationship, the greater the self-blame and the lower the partner blame. Those with happy marriages also made greater efforts to improve their sexual relationship and had higher expectations of success with therapy. The implications of the results for research on the role of attributions in sexual dysfunction and for assessment of cognitive factors in sexually dysfunctional individuals and their partners is discussed.

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Clinical accounts of sexual dysfunction and sex therapy emphasize the importance of cognitive factors, especially the types of attributions made by dysfunctional individuals and their partners regarding the causes for their difficulties.[1,2] There has been, however, little systematic research on the nature of these attributions, and data which exist have limited generalizability because of methodological limitations.

A study by Jayne, Epstein and Robinson-Metz[3] investigated the impact of chronicity, type of sexual dysfunction and gender on attributions for sexual dysfunction. A nonclinical sample was used and subjects evaluated a range of hypothetical sexual disorders. The findings indicate that both individuals with inhibited sexual desire and their partners were seen as more responsible for their problem than were those with performance problems (anorgasmia or premature ejaculation). Moreover, individuals with inhibited sexual desire were perceived as having more control over their sexual functioning than those with performance problems. Those with performance disorders were seen as more distressed, putting more effort into resolving the problem, and more likely to improve. Greater responsibility for the problem was attributed to males than to females, regardless of the type of dysfunction. Such differential attributions of responsibility and control could have important implications for the understanding, prevention and treatment of sexual difficulties; however, the analogue nature of this study limits its generalizability.

A study by Rosen and Berry[4] examined the link between strength of religious affiliation and attribution of responsibility for sexual dysfunction in a heterogeneous sample of sexually dysfunctional couples. The results indicate that both men and women tended to attribute responsibility to the male partners, but only in nonreligious couples. Again, these results could have important implications, but methodological problems, such as not having examined attributions for different sexual dysfunctions and not having better specified the nature of the sample, make generalization of the result to other populations impossible.

A recent investigation by Loos, Bridges and Critelli[5] showed that women who rarely experienced coital orgasms took responsibility for failure by attributing this to internal factors such as lack of sexual responsiveness and not wanting an orgasm. When it came to success, however, they attributed orgasms to a combination of internal (sexual responsiveness) and external (partner) factors. This attributional pattern is in marked contrast to that of frequently orgasmic women, who generally took credit for success but attributed failure to unstable factors such as lack of interest or the partner. The results of this study have important implications for understanding and treating orgasmic dysfunction. However, the analogue nature of the sample, failure to separate partnered and unpartnered women, and the possibility that primary nonorgasmic young women were grouped with those who experienced orgasmic difficulty only during coitus may affect the generalizability of the findings.

In contrast to these results, a well-controlled study by Quadland[6] of men with erectile dysfunction found no significant difference in attributional tendency between men with and without erectile problems. How-

ever, in this study the general tendency to attribute responsibility to oneself was investigated rather than attributions concerning sexual functioning or the erectile problem.

Unlike research on attributions for sexual dysfunctions, there is a large literature on attributions for positive and negative events and on pervasive and systematic differences in how individuals attribute causality for their own actions and for another's similar behavior.[7] This literature shows that people frequently make self-serving attributions.[8] People accept more responsibility for their successes than for their failures; others usually accord less credit and more blame than individuals attribute to themselves.[9] In intimate relationships, attributions have also been shown to be influenced by the quality of the relationship. Family conflict,[10] the impact of attributional processes in marriage,[11] and the differential attributions of spouses in distressed and nondistressed marital relationships[12-14] are among the contexts which have been examined.

Findings on attributions in marital relationships have generally shown that self-other attribution differences vary as a function of marital adjustment. Distressed couples tend to hold their partner responsible for negative events and to attribute the partner's negative behaviors to internal factors, while nondistressed spouses attribute the partners' positive behavior to internal causes.[15] Such differences in causal and responsibility attributions have numerous cognitive, affective and behavioral implications which can affect the nature of the relationship or the course of couple therapy.[11]

Data from the marital literature would suggest that attributions for sexual dysfunction should vary with the quality of the couple's overall relationship. Because of important differences between maritally and sexually dysfunctional couples, however, it is inappropriate to generalize from the marital area to a consideration of sexual dysfunctions.[16]

The central premise of attribution theory is that individuals search to understand why a particular event has occurred.[17,18] To account for seemingly identical events leading to dissimilar affective and behavioral responses, attributions have been classified according to three basic causal dimensions: locus (internal/external), stability (stable/unstable), and controllability (controllable/uncontrollable).[19] In a sexual situation, for example, causes such as genital sensitivity, effort, and sexual interest are commonly considered internal factors; life circumstances, partner attitude, and specific stresses are usually perceived as external determinants. Genital sensitivity and effort, although both considered properties of the individual (internal), nevertheless differ on the basis of their relative endurance (stability); genital sensitivity is believed to be a relatively permanent characteristic, while effort can change from moment to moment. Effort and sexual interest both may be conceived as internal and unstable causes. However, effort is subject to volitional control (controllable), while one cannot typically control sexual interest. The dimensions of locus, stability and controllability are used to describe the cause of an event. Once the cause is known, responsibility, credit, and blame can be attributed. In essence, responsibility attributions deal with accountability for

an event or behavior.[11] How individuals attribute responsibility and the extent to which they see events as controllable have a variety of consequences for cognition, affect and behavior.

The foregoing review highlights the multidimensional nature of attributions. The nature of the dyadic relationship, differences in attributions for one's own and for another's behavior and the differential consequences of different attributions are all relevant to a consideration of attributions in sexual dysfunction.

The present study was designed to shed light on the nature, role, and impact of attributions of responsibility and control in individuals and couples experiencing the most common sexual performance problems: erectile dysfunction, premature ejaculation, and orgasmic difficulty. Specifically, the following questions are explored:

1) Do individuals suffering from different types of sexual dysfunction (and their partners) differ in their attributions of responsibility for the problem and in their attributions of control over their sexual functioning?
2) Do happily married couples experiencing a sexual dysfunction attribute responsibility differently from unhappy spouses?
3) It has been suggested that the combination of self-blame and lack of perceived control over a stressor are associated with poor coping and depression;[20] therefore, we also examined how blame and control attributions are related and how these interact to affect distress, depression, efforts made to resolve the problem, and the expectancy that therapy will help.

METHOD

Subjects

The sample was selected by examining 150 consecutive charts of individuals and couples presenting for treatment at the Sexual Dysfunction Service of the Jewish General Hospital in Montreal between 1982 and 1986. Cases were excluded for the following reasons: 1) the chart did not contain all relevant measures; 2) one or both partners did not speak English; 3) there was a definite organic basis for the sexual problem; 4) fewer than 10 cases fell into a particular diagnostic group; 5) individuals did not have a current sexual partner; 6) both partners had sexual performance problems; 7) individuals suffered from two or more sexual performance problems. The therapist's assessment report was used to classify cases into diagnostic categories. When both a performance problem and inhibited sexual desire were present, the case was classified under the performance problem.

The final sample consisted of 38 males with erectile dysfunction and 15 of their partners, 14 women with female orgasmic dysfunction and 6 of their partners, and 11 males with premature ejaculation, none of whom presented with a partner. All were heterosexual.

The 63 "identified patients" ranged in age from 21 to 71, with a mean of 36.5 for males and a mean of 44.5 for females. Educational level ranged from grade 6 to postgraduate degrees, with 50% of subjects having some university education. All but six subjects were married or indicated that they were involved in a stable relationship; the remaining six subjects either had multiple or occasional partners at the time of presentation at the Sexual Dysfunction Service. The age of partners ranged from 23 to 66, with a mean of 33.2 for the six male partners in the orgasmic dysfunction group and 42.9 for the 15 female partners in the erectile dysfunction group. Education of partners ranged from less than high school to university graduate.

Of those identified patients currently married or involved in a stable sexual relationship, length of the relationship ranged from under 1 year to 40 years, with a mean of 11.9 years. Sixty percent of subjects indicated that the sexual problem had been present for 1 to 15 years, with a mean duration of 10.2 years; the remaining subjects described the problem as "long-standing" or "lifelong."

Measures

Background Information Form. This form asks for personal and demographic information including age, sex, years of education, marital status, duration of the relationship, and the nature and duration of the sexual problem.

Rotter Locus of Control Scale. This frequently used 29-item measure, developed by Rotter,[21] evaluates people's beliefs about the degree of control they themselves and factors external to themselves exert over their lives. Scores range from 0 to 23, with a male mean of 8.2 and a female mean of 8.4 for college age samples. High scores indicate an external locus, while low scores indicate an internal locus of control orientation.

Minnesota Multiphasic Personality Inventory (MMPI). This 556-item inventory, developed by Hathaway and McKinley,[22] is the most frequently used measure in clinical assessment. It consists of 10 clinical and four validity scales. In the present investigation, only Scale 2 (Depression) scores were used.

Locke-Wallace Marital Adjustment Scale (MAS). The Kimmel and Van der Veen[23] version of the Locke-Wallace MAS[24] evaluates marital satisfaction. This version contains 23 items, with scores weighted to reflect current sex differences in response patterns. It is a highly reliable and well-validated measure of marital adjustment.[25] The mean score is generally considered to be 100. High scores are characteristic of happy relationships, while low scores are indicative of unhappy relationships.

Sex Attribution Questionnaire. This measure consists of two sections; items are a modification of questions used by Jayne, Epstein, and Robinson-Metz[3] to evaluate attributions for sexual dysfunctions. The seven items, which comprise the first section, consist of 7-point scales which measure attributions of responsibility (to the self, to the partner, and to the cir-

cumstances) and attributions of control over own and partner's sexuality (by the self, by the partner). The second section deals with nonattributional aspects of sexual dysfunction. Here, six questions inquire about amount of effort made to improve the sexual relationship (by the self, by the partner), the degree of distress experienced by both partners, and expectancies that the problem will improve with and without sex therapy.

Procedure

All subjects underwent the routine assessment procedure carried out by the Jewish General Hospital Sexual Dysfunction Service. This includes a brief telephone screening. At this time the importance of attending sessions as a couple is emphasized and an appointment is made to complete a consent form and the intake questionnaire battery. There is an assessment interview with a therapist 1–2 weeks later. The usual fee for screening and assessment is $70. As part of the screening battery, clients complete the Background Information Form, Locus of Control Scale, MMPI, MAS, and Sex Attribution Questionnaire in the presence of intake personnel. Those presenting as couples complete questionnaires without consulting each other.

RESULTS

Sample Characteristics

To determine whether the three groups of identified patients differed on Age, Marital Adjustment, Duration of Relationship, Education, Locus of Control, and Depression, a series of 1-way analysis of variance (ANOVA) comparisons were made. Results indicate no significant differences on any of the measures. A similar comparison on partners' scores showed only that wives in the Erectile Dysfunction group had significantly higher Marital Adjustment scores (M = 107.4) than husbands in the Orgasmic Dysfunction group (M = 76.5), $F(1, 13) = 7.69$, $p < .05$. Scores of identified patients and their partners were compared using t-tests. No significant differences on any of the variables were found. In general, subjects were middle-aged (M = 38.8), couples had been together for approximately 12 years, and the quality of the couple relationships was on the lower side of average (M = 95.7). Most subjects had some college education and, overall, were not clinically depressed (raw score M = 25.3).

Attributions of Responsibility for the Sexual Problem

Identified Patients. To determine whether different sexual dysfunctions were related to specific attributions of responsibility, a 2-way [3 Dysfunctions (Ejaculatory/Erectile/Orgasmic) × 3 Responsibility Attributions (Self/Partner/Circumstances)] ANOVA comparison with repeated measures on the latter factor was made. Results show only a significant main

TABLE 1

Mean Attributions of Responsibility

Group	Dysfunction	*n*	Attributions of Responsibility to Self	Partner	Circumstances
Identified Patient	Ejaculatory	10	5.70	2.50	4.30
			(1.64)	(2.12)	(2.00)
	Erectile	38	5.24	3.11	4.58
			(1.92)	(1.77)	(2.16)
	Orgasmic	13	5.77	2.01	3.77
			(1.69)	(2.02)	(2.13)
Partner	Erectile	15	3.53	6.13	5.20
			(1.30)	(1.06)	(1.66)
	Orgasmic	6	4.67	6.17	3.50
			(1.86)	(1.17)	(1.87)

Note. Standard deviations are indicated in brackets. Possible scores range from 1 to 7, with high scores indicative of greater attributions of responsibility.

effect for Responsibility Attributions, $F(2, 116) = 18.962$, $p < .001$. The means in Table 1 and the Tukey HSD test show that Responsibility Attribution to the Self was significantly ($p < .05$) greater than to the Circumstances, which in turn was marginally ($p < .10$) greater than Attribution to the Partner. These results indicate that individuals with different dysfunctions do not differ from one another and that all three groups of identified patients blamed themselves for the sexual problem.

Partners. A similar analysis on partner data also revealed a significant Responsibility Attribution main effect, $F(2, 38) = 9.875$, $p < .001$, in this case showing that partners, too, generally blamed the identified patient. In this analysis, a significant interaction, $F(2, 38) = 4.027$, $p < .05$, was also found. Means in Table 1 suggest that the male partners of women with Orgasmic Dysfunction were relatively more likely to attribute responsibility to themselves, while the female partners of men with Erectile Dysfunction were more likely to blame the circumstances.

Attributions of Control

Identified Patients. The relation between type of sexual dysfunction and perceived control over one's sexuality was examined in a 2-way mixed design ANOVA comparison [3 Dysfunctions × 2 Attributions of Control (Self Over Self/Partner Over Self)]. Results show no significant interaction or main effects, indicating that individuals with different sexual dysfunctions did not differ in Attributions of Control and that identified patients did not attribute control differentially to themselves and to their partners. It should be noted, however, that in general, identified patients

believed that neither partner had much control (means ranged from 2.20 to 3.75 on a 7-point scale).

Partners. A similar analysis on partners' Attributions of Control over the identified patients' sexuality also revealed no significant interaction or main effects.

Blame and Control

Situational Control. A series of 2-way [2 Blame (Self/Non-Self) × 2 Control (High/Low)] ANOVA comparisons were conducted on scores of identified patients to examine the effects of Blame and Control on Distress, Depression, Effort made to resolve the sexual problem, and Expectancy that therapy will help. Because no significant differences among diagnostic groups were found on Attributions of Responsibility or Control, scores from individuals with the three types of dysfunctions were combined. Self-Blamers were defined as subjects who attributed more responsibility to themselves than to their partners or to the circumstances, while Non-Self-Blamers were defined as those who attributed more responsibility to their partners or to the circumstances than to themselves. High Control subjects were individuals who attributed more control over their sexuality to themselves than to their partners, and Low Control subjects were those who attributed more control to their partners than to themselves. Because of the small sample of partners and the finding that only one partner was a Self-Blamer, analyses on partners involving the Blame factor could not be carried out. Therefore, all analyses reflect data from identified patients.

The comparisons on Distress and Depression revealed no significant main effects or interactions. On Effort, the main effect of Blame approached significance, $F(1, 39) = 3.839$, $p < .10$; the means suggest that Self-Blamers ($M = 5.72$) perceived themselves as putting more effort into improving the sexual relationship than Non-Self-Blamers ($M = 4.72$). On Therapy Expectancy, results show a significant Blame main effect, $F(1, 39) = 6.478$, $p < .05$, indicating that Self-Blamers ($M = 6.06$) had higher expectations than Non-Self-Blamers ($M = 5.16$) that therapy would help resolve the sexual problem. None of the interactions were significant.

Dispositional Control. Since it may be the locus of control personality dimension rather than beliefs about situational control that is operating in the area of blame and control, the 2-way ANOVA comparisons described above were repeated, using identified patients' Locus of Control rather than Attributions of Control scores. As in the previous analyses, none of the interactions of blame and control were significant.

Relationships Among Variables

Identified Patients. To evaluate the relationships between Attributions of Responsibility, Attributions of Control, Marital Adjustment, Depression, Locus of Control, Distress, Effort, and Therapy Expectancy scores,

TABLE 2

Relationships Among Variables: Pearson r Values

				Attributions of Responsibility					Attributions of Control Over One's Sexuality		
	Locus of Control	MMPI Depression	Marital Adjustment	To the Self	To the Partner	To the Circumstances	Distress	Effort	To the Self	To the Partner	Therapy Expectancy
Locus		.317**	−.056	.312**	.206†	.097	.045	.031	.081	.255*	.088
Depression	.075		−.390**	.069	.217*	−.070	.268*	.069	−.152	.097	−.092
Marital	.085	.106		.332*	−.415**	.109	.024	.378**	.317*	.122	.257†
To Self	−.085	−.189	−.441*		−.247*	−.002	−.083	−.163†	.111	.211*	.243*
To Partner	−.101	−.178	.011	−.172		−.097	.075	−.251*	−.029	−.155	−.097
To Circum.	.310†	.316†	−.361†	−.228	.149		−.021	−.040	.115	.110	.065
Distress	.523*	.009	−.280	−.130	.154	.198		.251*	−.266*	−.231*	−.019
Effort	.215	−.364†	−.197	.106	.293†	.124	.558**		.038	.143	.199†
Self-Control	.209	.024	.118	−.264	−.041	−.195	.347†	.193		.325**	.234*
Part. Cont.	.021	.189	.122	.100	−.312*	.423*	−.109	.197	−.249		.096
Expectancy	.105	−.267	.375†	−.224	−.190	.398*	−.077	−.021	−.308	.377*	

Note. Scores of Identified Patients above the diagonal (*ns* range from 40 to 63) and scores of Partners below (*ns* range from 15 to 21).
†$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

Pearson product-moment correlation coefficients were computed. Results are presented in Table 2. Of particular interest are findings that show that:

(a) higher Marital Adjustment is significantly related to lower Depression, increased Effort made to improve the sexual relationship, greater Attribution of Responsibility and Control to the Self, and lower Attribution of Responsibility to the Partner for the sexual problem;
(b) greater Attribution of Responsibility to the Self is related to stronger expectations that therapy will help;
(c) greater Attribution of Responsibility to the Partner is related to lesser Effort made to improve the sexual relationship;
(d) higher Distress is related to Depression as well as to greater Effort and lower Attribution of Control over one's sexuality to either partner; and
(e) a more external Locus of Control orientation is related to greater Attribution of Control to the Partner over one's sexuality.

Partners. The same correlation matrix on Partner scores is also presented in Table 2. The results show that:

(a) amount of Effort made to improve the sexual relationship is positively related to level of Distress;
(b) better Marital Adjustment is significantly related to lower Attribution of Responsibility to Oneself;
(c) External Locus of Control orientation is positively related to Distress; and
(d) the Expectancy that therapy will help is positively related to Attibution of Responsibility to the Circumstances.

Because the sample size in the partner group was small, caution should be exercised in interpreting the data.

Comparisons of Identified Patients With Their Partners

The following comparisons were carried out only on Erectile Dysfunction group subjects, since this was the only group with sufficient partner data for meaningful analyses.

Similarities and Differences. Attributions of Control over sexual functioning in identified patients and their partners were examined in two 2-way ANOVA comparisons. The first analysis examined identified patients' and their partners' Attributions of Control over their own sexuality [2 Groups (Identified Patients/Partners) × 2 Attributions of Control (Self Over Self/Partner Over Partner)]. Results show a significant interaction, $F(1, 13) = 6.844, p < .05$. Means in Table 3 indicate that identified patients saw themselves as having the least control over their sexuality. In the analysis on Attributions of Control over each other's sexuality [2 Groups

TABLE 3

Mean Perceived Control Over Sexuality in the Erectile Dysfunction Group

Group	*n*	Attributions of Control Over Sexuality: Own Control Over One's Sexuality	Spouse's Control Over His/Her Sexuality	Own Control Over Spouse's Sexuality	Spouse's Control Over One's Own Sexuality
Identified Patient	14	3.29 (1.73)	5.00 (1.41)	3.79 (1.53)	3.79 (1.63)
Partner	14	4.79 (1.67)	4.64 (1.78)	4.07 (1.82)	3.64 (2.06)

Note. Standard deviations are indicated in parentheses. Possible scores range from 1 to 7. Higher scores are indicative of higher attributions of control.

× 2 Attributions of Control (Self Over Partner/Partner Over Self)], no significant interaction or main effects were found. The means, considered together, suggest that both the identified patient and his female partner believed that the identified patient has less control over his sexuality than does the nonaffected partner over hers, and that there is moderate reciprocal control over sexuality by spouses.

Relationships Between Spouses' Scores. A series of Pearson product-moment correlation coefficients were calculated to compare the scores of identified patients and their partners on: Depression, Locus of Control, Marital Adjustment, Distress, Effort, Therapy Expectancy, Attributions of Responsibility and Attributions of Control. Results indicate the following significant correlations: Marital Adjustment, $r\,(8) = .744$, $p < .01$, Attribution of Responsibility to one's Spouse, $r\,(13) = -.447$, $p < .05$, Attribution of Control by the Spouse over One's Sexuality, $r\,(12) = .671$, $p < .01$, Attribution of Responsibility to the Identified Patient, $r\,(13) = .412$, $p = .06$, Attribution of Responsibility to the Partner, $r\,(13) = .357$, $p < .10$, Attribution of Control by the male over his sexuality and by the female over hers, $r\,(12) = .386$, $p < .10$, and Attribution of Control over the male's sexuality by the spouses, $r\,(12) = .584$, $p < .05$. Generally, these results indicate good agreement between partners about attribution of responsibility for the problem and about control by spouses over sexuality.

Comparisons of Identified Patients Who Presented With and Without Partners

Since individuals who present for sex therapy with their partners and those who present alone could differ in important ways, 1-way ANOVA

comparisons [2 Presenting (Alone/With Partner)] were made on all variables for males presenting with Erectile Dysfunction. Results indicate that those who Presented With a Partner: (a) had somewhat higher Marital Adjustment scores (M = 105.36) than did those who Presented Alone (M = 91.67), $F(1, 21) = 4.106$, $p < .06$; (b) were more likely to accept responsibility for the sexual problem (M = 6.10, M = 4.43, respectively), $F(1, 34) = 8.244$, $p < .01$; and (c) were more likely to believe that their partner was experiencing greater distress (M = 6.00, M = 4.10, respectively), $F(1, 34) = 7.832$, $p < .01$.

DISCUSSION

Attributions of Responsibility and Control

The absence of differences between individuals with erectile, ejaculatory, or orgasmic disorders in attributions of responsibility was unexpected. These results are not consistent with the findings of either Jayne et al.[3] or Rosen and Berry,[4] both of which found sex differences. Nor do the results confirm commonsense beliefs, which suggest that erection problems are caused by the male's anxiety, orgasmic problems by clumsy partners and adverse social learning experiences, and premature ejaculation by a partner who is "too exciting." Moreover, both identified patients and their partners attributed most responsibility for the sexual problem to the identified patient; this was true for both male and female dysfunctions. These findings are consistent with those of Loos et al.,[5] who also found that women with orgasmic difficulties tend to blame themselves for the problem.

The attributional tendency for identified patients to blame themselves is not consistent with self-serving biases reported in the literature. A sexual dysfunction can certainly be classified as a negative event. Yet, dysfunctional individuals made internal attributions for the problem instead of external ones, which might have served to protect their self-esteem. Perhaps initially, individuals attribute more responsibility to their partners or to the circumstances. However, when a problem persists across situations and maybe even multiple partners, individuals may be forced to change their attributions to self-responsibility to better reflect reality. With respect to this latter hypothesis, it is noteworthy that at the time of this study, the identified patients had been experiencing sexual difficulties for a relatively long time. Indeed, the duration of the problem and its consistency across a variety of circumstances may well account not only for self-attributed responsibility but also for the absence of differences between diagnostic groups. Certainly, the development of attributions of responsibility in individuals experiencing sexual dysfunction deserves further investigation.

In the area of attributions of control, as well, individuals with the three types of dysfunctions did not differ, nor did their partners. Indeed, neither identified patients nor partners believed that they had much control over the identified patient's sexuality. A possible explanation for

these results is that the measure of control attributions used in this study did not provide an adequate measure of the construct. For example, only one of the four attribution of control scores was significantly correlated with Rotter's measure of dispositional control: amount of control identified patients attributed to their partners over the identified patient's sexuality. However, this does not necessarily invalidate the situational control measure used in the present study. First, the results are consistent with those of Quadland,[6] who showed that men with erectile dysfunction believed (a) that they had little control over erections and (b) that they had less control over their erections than did nondysfunctional males. Second, it is possible that, as Fiske and Taylor[26] suggest, Rotter's Locus of Control Scale is not appropriate for specific contexts such as sexual dysfunctions. Indeed, there may be a need to develop a measure of perceived control over sexuality, as has already been done in the areas of marital relationships[27] and health.[28]

Alternately, it is possible that by the time someone seeks sex therapy, there is a feeling of demoralization and lack of control over the problem in general. This explanation fits clinical impressions, since individuals seeking sex therapy have typically tried various means of resolving the problem before they finally decide to seek professional help. If it is indeed the case that those presenting for sex therapy feel that they exert little control over their sexual functioning, a cognitive-behavioral sex therapy program, which typically attempts to restore perceived and actual control to the patient, would be most appropriate and beneficial.

Marital Adjustment and Attributed Responsibility

Happily married dysfunctional individuals manifested less depression and partner blame. They also perceived themselves as more responsible for the sexual problem, having greater control over their own sexuality, and making greater effort to improve the sexual relationship. Happily married nondysfunctional partners, however, were less inclined to blame themselves for the sexual problem than were those whose relationships were less satisfactory.

The patient data are consistent with past findings which have shown that maritally satisfied individuals blame themselves rather than the spouse for negative events.[12,14] The partner data, however, are surprising, for here, happily married spouses did not experience self-blame but actually blamed their partners for the problem. It is possible that in a happy marriage, spouses have similar views about a variety of issues, including who or what is to blame for a problem. We believe, however, that the reason for spouse blame in happily married, nonaffected partners is that good relationships provide a context where it is difficult to blame the relationship or one's unwillingness to help resolve the problem. Analogue studies may be particularly useful in exploring the alternative possibilities.

Whether individuals with a sexual dysfunction present for therapy with or without their partners might be construed as one index of marital

harmony. Consistent with clinical impressions, the results show that partnered individuals presenting alone differed from those presenting as a couple. Those who came for therapy with their partners had happier marriages and believed that their partners were experiencing more distress. Perhaps good marriages exert a positive influence on the cognitive, affective, and behavioral aspects of coping with sexual dysfunction. Certainly, attending sex therapy as a couple is an adaptive coping strategy, since the problem usually manifests itself in interpersonal situations and is best resolved in a couple context.

Relation of Blame and Control to Distress, Depression, Problem Solving, Effort and Therapy Expectancy

Self-blame and perceived control over sexuality did not interact in a significant way to affect distress, depression, effort made to resolve the problem, or therapy expectancies. This was true using both Rotter's dispositional measure of control and attributions of situational control over sexuality. These results are not consistent with predictions based on differences between characterological and behavioral self-blamers[20,29] and highlight the need for a better conceptualization of blame and control attributions.

As Michela and Wood[30] note, blaming oneself, whether characterologically or behaviorally, does not necessarily imply perceived control over the *future* course of an illness. This observation is corroborated by the present study in that attributions of control and responsibility to oneself were not significantly correlated. It should also be noted that if perceptions of control are unrealistic (i.e., in spite of attempts to exercise control the condition does not improve and may even deteriorate), there would certainly be no reason to expect positive affect or optimism. Furthermore, control attributions can arise from successful coping rather than the reverse. Therefore, blame and control do not always interact in a predictable way to influence coping style. In the case of sexual dysfunction, it may be necessary to add stability (of the sexual problem) to the locus (internal/external) and controllability dimensions typically studied in order to establish more clearly the relationship between attributional style and the individual's cognitive affective and behavioral responses.

Consistent with the literature on the benefits of self-blame, among dysfunctional individuals self-blamers tended to perceive themselves as putting more effort into the sexual relationship and to believe more in the efficacy of sex therapy than did non-self-blamers. Certainly, it would be interesting to determine whether self-blamers, in fact, do better in therapy and whether variables such as effort and therapy expectancies influence sex therapy process and outcome.

Limitations of the Present Study and Conceptual Issues

There are few available data on attributions of responsibility and control in sexual dysfunctions; the present study represents one of the few non-

analogue investigations in this area. Nevertheless, a number of problems pose limits on the generalizability of the results. First, because individuals on limited incomes were not sampled (there was a fee for assessment and services at the clinic), it is possible that social class differences may exist in attributions of responsibility and control in sexual dysfunction. Second, since unpartnered patients were not included in the investigation, it is not possible to generalize to single individuals.

A thorny problem in the literature noted by Shaver and Drown[31] involves confounding the notions of responsibility, causality, and blame. An example of this distinction is as follows. X is late for a meeting because the bus broke down. He is, therefore, *responsible* for delaying the meeting. But he is not the *causal* agent for the bus breaking down. Therefore, is he to *blame* for delaying the meeting? Our own study, as well as those of others, has confounded these factors, in part because the evaluation of blame poses a difficult problem for measurement. This is not merely a semantic issue since it is certainly conceivable that blame and responsibility for a negative event have different impact on cognitions, affect and behavior. For example, the blame attribution "He is ejaculating quickly because he is a withholding individual who does not want to give me pleasure" would be expected to have different affective and behavioral consequences than the responsibility attribution "He has not learned effective techniques for delaying ejaculation."

The present results show that attributional tendencies differ in sexually dysfunctional individuals and their partners and in happy and unhappy spouses. It is also possible that distinctive attributional patterns may be associated with good and poor compliance with therapeutic assignments and with favorable and unfavorable prognosis. Certainly, as clinicians we inwardly cringe when we hear patients state, "I'm only here to avoid a fight—it's her problem" or "Yeah, sure things were better last night—but this won't last. My partner is simply not capable of changing. He only did this (desirable behavior) because you told him to" or "What would we do without you? Since we have started to see you things have been so much better. We can't possibly stop coming. You did it all."

Exploration of the effects of blame, responsibility, causal, and control attributions in sexual dysfunction is urgently needed to better understand and treat sexual difficulties. Since such attributions may play a role in the genesis, maintenance and resolution of sexual problems, they can have important implications for the nature, process, and outcome of cognitive-behavioral sex therapy. Furthermore, attributional variables might be useful as risk predictors for sexual dysfunction and as prognostic factors in the maintenance of gains after therapy. They may also serve as intervention targets, markers for sex therapy progress, and measures of the outcome of sex therapy.

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