ORIGINAL RESEARCH—EJACULATORY DISORDERS

Canadian and American Sex Therapists' Perceptions of Normal and Abnormal Ejaculatory Latencies: How Long Should Intercourse Last?

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ABSTRACT

Introduction. Lay public perceptions about how long intercourse should last are discrepant from objective data on ejaculatory latencies. This may be problematic as the subjective interpretation of latency is a factor related to perceived distress with length of intercourse.

Aim. Quantify the opinion of expert sex therapists as to what are "adequate," "desirable," "too short," and "too long" intravaginal ejaculatory latencies.

Method. A random sample of members of the Society for Sex Therapy and Research in the United States and Canada was surveyed.

Main Outcome Measure. Intravaginal ejaculatory latency, in minutes, for four different conditions: coitus that lasts an amount of time that is "adequate," "desirable," "too short," and "too long."

Results. The interquartile range for the sex therapists' opinions regarding an "adequate" length for ejaculatory latency was from 3 to 7 minutes; "desirable" from 7 to 13 minutes; "too short" from 1 to 2 minutes; "too long" from 10 to 30 minutes.

Conclusions. Therapists' beliefs about ejaculatory latencies were consistent with objective data on ejaculatory latency and were not affected by therapist demographic characteristics such as sex or experience. These results suggest that the average sex therapist believes that intercourse that lasts 3 to 13 minutes is normative and not prima facie worthy of clinical concern. Dissemination to the public of these results may change lay expectations for intravaginal ejaculatory latency and prevent distress. These results may also be beneficial to couples in treatment for sexual problems by normalizing expectations. **Corty EW, and Guardiani JM. Canadian and American sex therapists' perceptions of normal and abnormal ejaculatory latencies: How long should intercourse last? J Sex Med 2008;5:1251–1256.**

Key Words. Intravaginal Ejaculatory Latency; Male Orgasmic Disorder; Premature Ejaculation; Coitus; Intercourse; Prevention; Sexual Dysfunction; Sex Therapy

Introduction

In the fantasy model of male sexuality, men have large penises, rock-hard erections, and can sustain sexual activity all night long [1]. It appears that many men and women hold this fantasy. In an online survey, Ablow asked how long sex should last [2]. Though his survey was flawed as it did not define "sex" and did not report a response rate, the results were compelling: only 14% of men wanted sex to last 10 minutes or less, 50% wanted sex to last 30 minutes, and 36% wanted it to last 1 hour or longer. For women, the figures were 18%, 52%, and 29%, respectively. Overall, over 80% of men and women wanted sex to last 30 minutes or longer.

In a more methodologically rigorous study, Miller and Byers broke sex into two components, foreplay and intercourse, and asked both partners in heterosexual couples to report actual and desired length for each component [3]. Men

wanted sex, foreplay and intercourse combined, to last an average of 37 minutes and women an average of 33 minutes. Comparing actual to desired time, both sexes wanted an increase in length of both components, but wanted more of an increase in the length of intercourse than foreplay. The men wished an increase from a reported time of 7.86 minutes in intercourse to a desired length of 18.45 minutes; women wished an increase from 7.03 minutes to 14.34 minutes. With both men and women wanting intercourse to last more than twice as long as self-reported length, this seems a situation ripe for disappointment and dissatisfaction.

Miller and Byers used self-report to measure time and it is possible that this gives a biased estimate of intercourse length. Recently, there have been two large studies that have used stopwatches to time intravaginal ejaculatory latency, the time that elapses from penetration of the vagina by the penis to ejaculation, more objectively [4,5]. Waldinger et al. studied men from five countries, excluding those who were not in stable heterosexual relationships and having intercourse regularly. They found the overall median ejaculatory latency to be 5.4 minutes, though their sample underrepresented men with short ejaculatory latencies [4]. Based on these data, Waldinger et al. defined intravaginal latencies of less than 1 minute as "definite" premature ejaculation and latencies from 1 to 1.5, or perhaps 2, minutes as "probable" premature ejaculation [6].

Patrick et al. studied 1,587 heterosexual couples in the United States and, in addition to measuring ejaculatory latency, conducted clinical interviews to diagnose premature ejaculation. Thirteen percent of the men met American Psychiatric Association criteria for premature ejaculation: "Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it" (p. 249) [7]. Patrick et al. found that the median ejaculatory latency for men who did not meet criteria for premature ejaculation was 7.3 minutes; for men with premature ejaculation it was 1.8 minutes. Ejaculatory latencies for some of the men who met criteria for premature ejaculation were up to 20 minutes, showing that premature ejaculation in DSM-IV-TR is not defined solely by intravaginal latency.

Given the discrepancy between how long people think sex should last and the actual time from penetration to ejaculation, it is not surprising that ejaculatory latency is a common sexual concern. Almost 30% of 18–59-year-old men, in a representative U.S. sample, reported that in the previous year there had been a period of at least several months when they reached climax too quickly [8]. A similar epidemiological study in Britain found almost 12% of men reporting concerns about premature orgasm [9].

Being concerned about reaching climax too quickly is not the same as meeting criteria for premature ejaculation. Waldinger has suggested a new typology for rapid ejaculation, including the category "premature-like ejaculatory dysfunction" to capture men who, though their ejaculatory latencies are in the normal range, perceive themselves as having, and are preoccupied with, rapid ejaculation [10,11]. He suggests education and/or psychotherapy as the first-line treatment for these man, rather than medication.

Further evidence of how a person's evaluation of sexual functioning has an impact on sexual and relationship satisfaction comes from a study by Patrick et al. that used path analysis to explore distress in men with rapid ejaculation [12]. They found that ejaculatory latency played an *indirect* role, influencing perceived degree of control over ejaculation. Perceived degree of control over ejaculation then went on to influence both personal distress related to the speed with which ejaculation occurred and satisfaction with sexual intercourse. These two variables subsequently were associated with the degree to which the men perceived ejaculatory latencies to cause difficulty in relationships. Thus, ejaculatory latency was not directly associated with distress.

Purdon and Holdaway assessed the impact of nonerotic thoughts during sexual activity in undergraduate men and women and measured sexual functioning and sexual satisfaction.[13] They classified nonerotic thoughts into four categories: (i) performance concerns; (ii) external consequences (e.g., pregnancy); (iii) emotional consequences (e.g., guilt); and (iv) body image. They found that the more nonerotic thoughts reported during sex and the more anxiety over the thoughts, the poorer sexual function was for both men and women. Thought frequency and anxiety were also associated with impaired sexual satisfaction for women. This study shows the influences that subjective thoughts have on sexual function.

Aims

One important source of expectations regarding the length of intercourse is the opinion of experts, which may be disseminated through popular media or direct clinical contact. In the present