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Research Article

Asphyxiophilia: A Series of Fourteen Living Cases with A Long Follow-Up

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Abstract

In contrast to fatal cases involving asphyxiophilic behaviours, reports of survivors are rare. This paper documents the characteristics of fifteen such survivors who presented to the author over a seventeen-year period. Clinical records of these patients who reported they had used self-asphyxiation, either in reality or, in one case persistent intense distressing masturbatory fantasies without actual asphyxiation, as a means of sexual gratification were scrutinized and recorded, applying DSM-III or DSM-IV criteria for inclusion in the study as these were the editions in use at the time.

Similarities between the patients in this series and the existing literature on both survivors and fatal cases are reported. Paradoxically, unlike fatal cases who are often described as having been cheerful and anticipating the future, survivors showed a high frequency of depression and suicidal behavior. Several survivors tended to perform their activities with a partner and to avoid self-hanging in preference to other asphyxiating methods such as suffocation. All the patients showed clear-cut masochistic interests and fantasies quite apart from their asphyxiophilic behavior.

Follow up of the patients over an average of 28 years showed that only one had died as a result of self-hanging, a counterintuitive finding given that this behaviour is widely believed to be inherently dangerous. However, this should not prevent those who desire sexual satisfaction in this way from educating themselves of the potential severe risks and modify their technique to take this into account.

Keywords: case histories; diagnostic; behavioral therapy

Introduction

Asphyxiophilia, also known as hypoxyphilia, and erotic or sexual asphyxia, is the pursuit of sexual arousal through the deliberate restriction of breathing [1]. The behaviour was known in ancient times and from lay accounts since the 18th century and in other cultures [2] [3]. However, most earlier reports in the medical literature have been of cases in which a person had died as a result of the activity and that remains so today. In contrast, there have been far fewer reports of survivors of the practice.

Typically, the individual controls the degree of asphyxiation by some means in order to avoid loss of consciousness and a possible fatal outcome [2]. The techniques described by survivors resemble the methods used by those who have died but reports of those cases sometimes do not report the method used to produce asphyxia [4]. Self-hanging is described in some [5][6][7][8] but suffocation with plastic bags and the like has also been described [9] and self drowning and other less common and more exotic methods have occasionally been documented [11].

The onset of the behavior is also often unclear from the available case reports [7][8][9][10][12], but it appears to arise usually around puberty though some reported an inordinate interest in ropes, chains, plastic bags, etc. from childhood [13].

Descriptions of how the behavior developed are very diverse and show no consistent pattern. In some cases, the origin is unknown or that the behaviour arose fortuitously [12][14]. One patient was first aroused by watching a cowboy movie on television [9] and another became sexually aroused during a previous suicide attempt [6]. Some are introduced to it by others [7][8]; another patient discovered it at age 13 while trying to reproduce the sexual arousal he had experienced during a dream in which he was being crushed by a snake [9] and another, while being hugged by his girlfriend [7].

As with fatal cases, most living practitioners are under age 30 when first interviewed, with reports ranging from age 12 to age 50 [17].

Very few living female cases have so far been reported [16]. A recent study enlisted a community sample of respondents to complete an anonymous online questionnaire about autoerotic asphyxia [15]. 165

respondents were identified as being aroused by autoerotic asphyxia but 54.1% had no actual experience with self-asphyxiation. Of those who had, 68% were females and they also did so more frequently than the men.

Most reported living subjects, like those who are deceased, have been unmarried. While ethnicity is rarely mentioned most appeared to be Caucasian with one Mexican-American case in the literature [10].

Because of their ages, many reports involve school children or students but, if working, they tend to have further education in teaching, engineering, or other professions rather than unskilled occupations [11][16].

The reasons for presenting to a mental health professional have varied. Litman and Swearingen's small series of nine men [17] had responded to their advertisement in an underground newspaper and four of Lunsen's came to attention following media coverage of the behaviour [11]. Some were referred after a spouse or family member discovered them in the act [7][11]. Others came to attention because of miscellaneous and related problems including "hysterical conversion" symptoms [10], "psychotic episodes" [6], marital problems [20], cross dressing, depression and interpersonal difficulties [13]. Another revealed his practice during police questioning about an unrelated matter [8].

Accompanying their asphyxiophilic rituals many individuals reported fantasies of being subservient, obedient, and humiliated or being raped or beaten [17]. The idea of being in danger is sexually exciting to many of them [17][18]. Certain cases showed a clearly sadistic component with fantasies of strangling or drowning others [10] as well as having this done to themselves [5].

In accordance with their rich fantasy lives, some survivors of asphyxiophilia report using pornography [7][10] while others simply imagined past episodes [13]. Some of Littman and Swearingen's cases reported no use of pornography but one employed it extensively and owned an expensive collection [17]. The man documented by Money, Wainwright and Hingsberger [19] reported that commercial pornography was of no interest to him, but he found many sources of stimulation in commercially available videos and prime time television, which sometimes depict women being drowned or strangled.

Concurrent paraphilias described among survivors include: transvestic fetishism [7][10][11]; fetishism for plastic [12], and rubber [10][14], self-photography and mirror gazing [18], klismaphilia (erotic interest in enemas) and coprophilia (arousal to feces or defecation) [7], possibly urophilia [14], voyeurism [6], and masochism [14]. Other than in the one highly selected sample [17], homosexuality is not noted to be overrepresented among existing case reports of survivors.

In contrast to fatal cases, in which the deceased is typically described as being "normal", optimistic, cheerful and looking forward to future activities before their demise, a number of survivors are reported to have been depressed [17] and sometimes suicidal [6][16]. Interestingly, Rosenblum and Faber [8] noted that their patient felt some improvement in his depression following each episode of autoerotic asphyxial activity.

The natural history and response to various treatments are not well documented in most of the case reports of living cases. Haydn-Smith and his colleagues [9] reported successful treatment using behavioral therapy techniques as did Martz [16]. Litman and Swearingen indicated among their small sample [17] there was a tendency over time to seek partners in order to allay a mishap during asphyxiophilic activities. Certainly, several living cases had experienced near catastrophe [9][10][14]. All five of Lunsen's cases were aware of the risk they were taking [11]. He states that three out of the five no longer practiced autoerotic asphyxia following counselling, another chose a less risky method of inducing asphyxia and yet another stopped altogether for fear of dying. Eber and Wetli's patient [18] subsequently died during an asphyxiophilic episode one year after discontinuing psychotherapy.

The rationale or motivation for autoerotic asphyxial behaviour has perplexed and/or defeated most authors. Speculation regarding the etiology, however, abounds and accompanies many of the existing reports even when the case descriptions themselves are quite superficial. Edmondson [7], for example, suggested that his patient was feeling guilty about masturbating and needed either to punish himself or induce a state in which he was not aware of what he was doing. Wesselius and Bally [10] speculated that their patient's behaviour was based upon hatred towards his parents or other family members. Some survivors have reported a background of childhood abuse by one or both parents and a history of parental discord or divorce [4][6][10][14]. Lunsen [11] noted a history of hypoxia due to medical conditions in three out of his five cases (1 congestive heart failure, 2 chronic respiratory problems) and also three out of the five had a history of neonatal asphyxia. Friedrich and Gerber [4] were also impressed that in their five cases "an early history of choking, in combination with physical or sexual abuse, was related to the development of asphyxiophilia". These observations are intriguing as a history of asthma was also noted in Money, Wainwright and Hingsberger's case and they claim, without supporting data, that many victims of autoerotic asphyxiation have a similar history [19]. Other authors however have found "no consistent pattern of family interaction or early traumatic experiences" among their cases [17].

To obtain further details about asphyxiophilia this paper reports on the characteristics, associated sexual and other mental disorders, early developmental influences and possible etiological factors in a consecutive series of individuals referred to the author over a period of nearly 20 years. All the cases were able to meet DSM-III or IV criteria for a paraphilia as they experienced recurrent, intense sexually arousing fantasies, sexual urges or behaviours involving the restriction of their air supply through hanging, strangulation, suffocation etc. These were experienced over at least six months and typically much longer. One patient had been experiencing auto-asphyxial sexual fantasies for many years but had always been afraid to act on them. All the rest had engaged in autoerotic asphyxiation for varying periods.

Method

The 15 patients described herein were referred to the author over a 17-year period. Case histories, based on personal interviews, were available for all of them. In some cases, the referring physician or psychiatrist provided some background information and an interview with a spouse or parent was also possible. A couple were patients of the author's for variable period; one was still in contact up to 2020. Most, however, attended for a single consultation interview and were not seen again.

Usually, a standard but detailed psychiatric interview was carried out with particular reference to the sexual history. In order to extract personal information data from the clinical files in a systematic and consistent fashion for analysis, a coding sheet was developed.

Results

Basic demographic characteristics of the sample are presented in Tables 1 and 2. There were fourteen males and one female with a mean age of 28 years (SD 8.5: range 17 to 45 years) at the time they were first seen. Twelve patients had never been married. Two patients were intellectually disabled; educational level and occupation among the rest were unremarkable.

Tables 1 and 2 about here

Variable	**Number of Patients (%)**
Age, years (Mean +/- S.D.)	28 +/- 9
Sex (male)	14 (93%)
Age of onset of asphyxiophilic activities, years	15+/- 6
Marital status (never married)	12 (80%)
Occupation	
Professional/Managerial	2 (13%)
Skilled	2 (13%)
Unskilled	3 (20%)
Student	3 (20%)
Disabled	2 (13%)
Other	2 (13%)
Unknown	1 (7%)
Intelligence	
Superior	3 (20%)
Above average	2 (13%)
Average	5 (33%)
Below average	3 (20%)
Intellectually disabled	2 (13%)
Education	
Graduate/professional training	3 (20%)
Post-secondary	2 (13%)
Grades 8-11	8 (53%)
< Grade 8	2 (13%)

Table 1: Demographic Features in 15 Living Asphyxiophiliacs.

Variable	**Number of Cases (%)**
Reason for initial presentation	
Asphyxiophilic activities	13 (87%)
Other sexual problems	8 (53%)
Depression	7 (47%)
Other psychiatric problems	6 (40%)
Anxiety	4 (27%)
Marital problems	2 (13%)
History of Psychiatric Problems	
Depression	11 (73%)
Drug/alcohol abuse	9 (60%)
Suicide attempt(s)	8 (53%)
Anxiety	2 (13%)
Antisocial Personality Disorder or Traits	2 (13%)
Attention Deficit Hyperactivity Disorder	1 (7%)
History of Criminal Behaviour	
Any criminal behaviour*	2 (13%)
Property crimes -1 ; sexual crimes – 2; violent crimes – 1; Other non-violent crimes - 1	

Table 2: Psychiatric and Criminological Aspects of 15 Living Asphyxiophiliacs.

Although several of the patients were referred for a combination of issues. Thirteen patients were referred specifically because of their self-asphyxiating practices and 11 were also suffering from anxiety or depressive episodes or other psychiatric problems. Indeed, 13 had

suffered from such conditions at some time in their lives. Eight had made suicide attempts in the past. Attention deficit hyperactivity disorder was reported in only one case but substance abuse histories were given by nine of the patients. Two patients had a formal criminal record and both showed evidence of antisocial personality disorder or traits.

As can be seen in Table 3, this series of patients employed a variety of asphyxiating methods; some used a combination of techniques or different ones at different times. However, most used some form of suffocation, including chest or abdominal compression, but fewer used self-hanging or self-strangulation. None used self-drowning, or inhalation of volatile chemicals, vapours or gases.

Table 3 about here

Variable	Number of Cases (%)
History of Other Paraphilias	
Sexual Masochism Disorder	14 (93%)
Fetishistic Disorder	9 (60%)
Other Specified Paraphilic Disorders*	9 (60%)
Transvestic Disorder	8 (53%)
Sexual Sadism Disorder	3 (20%)
Urophilia	3 (20%)
Biastophilia	2 (13%)
Exhibitionistic Disorder	2 (13%)
Voyeuristic Disorder	1 (7%)
Frotteuristic Disorder	1 (7%)
*paraphilic rapism - 2; necrophilia-1; and klismaphilia-6	
Sexual Orientation	
Heterosexual	7(47%)
Homosexual	4(27%)
Bisexual	0(0%)
Uncertain	4 (27%)
Gender Dysphoria	4 (27%)

Table 3: Details of Behaviours of 15 Living Asphyxiophiliacs.

Most of the patients remembered that their asphyxiating practices began in adolescence (mean 15.1 years; SD 6.3; range 7 to 30 one years).

None reported using self-asphyxiation daily but many nonetheless did so quite frequently with about two thirds performing the act between once a month and six times a week. All of them had engaged in masturbation while asphyxiating themselves.

Most used their own judgment of when they were about to lose consciousness and to cease asphyxiation. None employed any elaborate apparatus or special precautions. Four used partner to avoid a mishap. Eleven of the patients reported that others, such as family members or partners, were aware of their asphyxiophilic activities. Three indicated that they kept records of their activities in the form of self-made photographs, videos or diary entries. Eight were aware that their activities were potentially life-endangering and were concerned about their behaviour; another four were aware of the risk but were unconcerned about it. Seven out of the whole group had already experienced one or more close brushes with death. Only three engaged in other types of risky behaviour (fast driving, parachuting and stealing “for the thrill of it”).

Eight patients performed their activities while nude and three of the men would cross dress in women’s clothing. Table 3 lists a wide range of paraphernalia that was used during asphyxiating rituals. These included the use of mirrors or self photography, bondage, hoods and blindfolds, use of enemas or other anal stimulation, electrical stimulation of sensitive areas and nipple clamps and pins. Some beat themselves or were beaten by a partner. Given the frequency with which it is mentioned in fatal cases, it is surprising that only two men viewed pornography while engaging in self-asphyxiation.

Table 4 shows that seven out of the 14 men believed themselves to be heterosexual and four were homosexual in orientation; none described themselves as bisexual but in four cases the patient’s sexual orientation was either not recorded or was unclear.

Table 4 about here

Variable	Number of Cases (%)
History of Other Paraphilias	
Sexual Masochism Disorder	14 (93%)
Fetishistic Disorder	9 (60%)
Other Specified Paraphilic Disorders*	9 (60%)
Transvestic Disorder	8 (53%)
Sexual Sadism Disorder	3 (20%)
Urophilia	3 (20%)
Biastophilia	2 (13%)

Exhibitionistic Disorder	2 (13%)
Voyeuristic Disorder	1 (7%)
Frotteuristic Disorder	1 (7%)
*Paraphilic rapism - 2; necrophilia-1; and klismaphilia-6	
Sexual Orientation	
Heterosexual	7(47%)
Homosexual	4(27%)
Bisexual	0(0%)
Uncertain	4 (27%)
Gender Dysphoria	4 (27%)

Table 4: Other Sexological Variables in 15 survivors of Asphyxiophilia.

A wide range of associated paraphilic behaviours and interests were described. Excluding the self-asphyxiating processes themselves, unequivocally masochistic behaviour or fantasies, were described by all of the patients.

Sexual preferences closely related to masochism such as sadism, urophilia, coprophilia and klismaphilia were reported by some. Transvestic fetishism or fetishism were described by eight and nine patients respectively and the two behaviours essentially overlapped. Four of the men reported marked gender dysphoria to the extent that the diagnosis (or its earlier form of gender identity disorder) seemed justified.

Some of the patients made spontaneous statements about what drove them to engage in self asphyxiation. A surprisingly high number, seven out of the 15 reported fantasies of committing rape, rape-murder or other sadistic themes. Three indulged in fantasies of themselves as a woman (autogynephilia). Being in a risky situation was an obviously potent sexual stimulus for three men. One explained simply: "I do it for the danger… it turns me on sexually". Yet another similarly expressed sexual excitement by "being on the edge… putting it on the line". One man described his enjoyment at "being totally helpless … so I can't escape". Another young man indicated during our interview that he was "aroused by thinking about choking" and mused on "the strange relationship between sex and death through suicide".

Table 5 records early environmental influences that the patients described. Interestingly, some patients themselves thought there might be a connection between their sexual interests and these experiences. Sexual, emotional and physical abuse at the hands of their fathers or other family members were reported in four cases and five were exposed to other violence in their homes. Three recalled either suffering from asthma as children or experiencing some other episode of constrained breathing, such as one man who was choked by a babysitter, which remained vivid in their memories.

Table 5 about here

Variable	Number of Cases (%)
Parental separation before 16 years	1 (7%)
Father physically abusive to patient	4 (27%)
Father emotionally abusive to patient	4 (27%)
Father sexually abusive to patient	0 (0%)
Other family members abusive to patient	3 (20%)
Witnessed domestic violence	5 (33%)
Early history of asphyxia/lung disease	3 (20%)

Table 5: Early Environmental Influences in 15 Living Asphyxiophiliacs.

Follow-Up

As already noted, most of the patients were seen once only for a consultation and not seen again. One man remained in contact with the author even after he moved to another city but we lost contact after more than 40 years and it is unknown what happened to him.

It was possible to obtain follow up information from Provincial Death Records though the Ontario Chief Coroner's Office. The follow up period was an average of 28 years. During that time, only one patient, a young man, had died by autoerotic asphyxiation. The author had, in fact, been notified of his death only a few weeks after he was seen. Another former patient died of unrelated natural causes during the follow up period. The rest are presumed survivors.

Discussion

There appeared to be a number of similarities between the characteristics of the present sample of living asphyxiophiliacs and the sparse reports of cases in the literature. The average age of the patients was 28 years unlike most of the previously reported cases and most of them were unmarried. All but one was male. Many reports of both survivors and fatalities point to an association with higher levels of intelligence and occupational achievement but, in the present series this was not the case and two patients were intellectually disabled. The fact that these patients were referred to a forensic psychiatrist with special interest in sexual pathology no doubt makes this a highly selected series. The striking association with mood and anxiety disorders is similar to other studies. Most authors who have recommended criteria for identification of autoerotic fatalities have included the absence of suicidal intent. Those who have studied living asphyxiophiliacs have been so struck by their dysphoric features as to consider them "death oriented" [3] or suggested that asphyxiophilia should be regarded as a "suicidal syndrome" [17]. Even Hazelwood and his colleagues [2], who view asphyxiophiliac deaths as presumptive accidents, admit that the practice might be more akin to those who engage in highly risky activities such as hang gliding, rock climbing, heavy

cigarette smoking, fast driving, etc. This claim received some support from the findings in this study that sexual arousal to the risks associated with sexual self-asphyxiation noted by some of the subjects, or to being sexually aroused by being in dangerous situations. Among asphyxiophilic fatalities, self-hanging is the most common method used to produce asphyxia, with a smaller percentage employing strangulation, suffocation (including abdominal or chest compression), drowning or the use of volatile chemicals and gases to displace inspired air. Survivors reported in this paper used sometimes a combination of self asphyxiating methods. Among them hanging was less commonly used than suffocation, and drowning and volatile chemicals were not employed at all. Elaborate apparatus and self rescue devices, that are common among fatalities, were not found among the survivors who were sometimes accompanied by a partner during their asphyxiophilic activities. Although this was a small series of clinically referred cases several suggestions for risk management can be made on the basis of the findings. First, it appears that hanging, especially if used as part of some complicated apparatus or self-rescue strategy is a more lethal activity than suffocation. Complexity brings with it a greater opportunity for the strategy to misfire. Survivors who present for treatment should be encouraged to enlist a suitable willing partner or use a less risky technique to induce asphyxia. Both the asphyxiator and the partner to be fully aware of the risks being taken, not only of a fatal outcome but other serious sequelae due to cerebral hypoxia. Even when the practitioner of autoerotic asphyxia may have engaged in the activity more than a few times and survived, a false confidence is likely to develop and a reminder that, although this long term follow up might be reassuring, no method of self-asphyxiation is entirely free of risk.

References

1. (2022). American Psychiatric Association. Diagnostic and statistical manual of mental disorders : DSM-5-TR. 5th edition, text revision. Washington, DC: American Psychiatric Association Publishing.
2. Dietz, P.E. (1983). Recurrent Discovery of Autoerotic Asphyxia Ch. 2 in Autoerotic Fatalities Hazelwood, R., Dietz, P.E. and Burgess, A.W. (eds) Lexington Books, D.C. Heath, Lexington and Toronto.
3. Resnick, H.L.P. (1972) Erotized Repetitive Hangings: A Form of Self-Destructive Behavior. *American Journal of Psychotherapy*, 26, 4-21.
4. Friedrich, W.N. and Gerber, P.N. (1994). Autoerotic asphyxia: The development of a paraphilia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 33(7), 970-974.
5. Quinn, T. & Twomey, P. (1998). A case of autoerotic asphyxia in a long-term psychiatric setting. *Psychopathology*, 31, 169-173.
6. Shankel, L.W. & Carr, A.C. (1956) Transvestism and hanging episodes in a male adolescent. *Psychiatric Quarterly*, 30, 478-493.
7. Edmondson, J.S. (1972). A case of sexual asphyxia without fatal termination. *British journal of psychiatry*, 10, Vol.121 (563), p.437-438.
8. Rosenblum, S. & Faber, M.M. (1070). The adolescent sexual asphyxia syndrome. *Journal of the American Academy of Child Psychiatry*, Vol.18 (3), p.546-558.
9. Haydn-Smith, P.; Marks, I.; Buchaya, H.; (1987). Repper, D. British journal of psychiatry, Vol.150 (4), p.518-519.
10. Wesselius, C L; Bally, R. (1983). A male with autoerotic asphyxia syndrome *The American journal of forensic medicine and pathology*, Vol.4 (4), p.341-346.
11. Lunsen, H.W. (1991). van Auto-erotiche asfyxie: ervaringen met pratikanten van 'wurgseks' en neberstaanden van slachtoffers. *Nederlands Forensisch Tijdchrift*, 10(1), 5-10.
12. Diamond, M., Innala, S.M. & Ernulf, K.E. (1990). Asphyxiophilia and autoerotic death. *Hawai'i Medical Journal*, 49/10, 11-24
13. Cesnik, J A ; Coleman, E Use of lithium carbonate in the treatment of autoerotic asphyxia American journal of psychotherapy, 1989-04, Vol.43 (2), p.277-286. DOI: 10.1176/appi.psychotherapy.1989.43.2.277
14. Burch, P.M., Case, M.E., & Turgeon, R. (1995). Sexual asphyxiation: an unusual case involving four adolescents. Journal of Forensic Sciences, 40: 490-494
15. Baxendale, Emily; Roche, Kailey; Stephens, Skye. (2019). An examination of autoerotic asphyxiation in a community sample. *The Canadian journal of human sexuality*, Vol.28 (3), p.292-303.
16. Martz, D. (2003). Behavioral Treatment for a Female Engaging in Autoerotic Asphyxiation Clinical case studies, Vol.2 (3), p.236-242.
17. Litman, R.E; Swearingen, C. (1972). *Bondage and Suicide Archives of general psychiatry*, Vol.27 (1), p.80-85.
18. Eber, M.; Wetli, C. V. (1985). A case of autoerotic asphyxia. Psychotherapy (Chicago, Ill.), Vol.22 (3), p.662-668.
19. Money, J., Wainwright, G. & Hingsburger, D. (1991). The Breathless Orgasm: a lovemap biography of asphyxiophilia. Buffalo, N.Y.: Prometheus Books;

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