Autoerotic Asphyxia: The Development of a Paraphilia

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ABSTRACT

The authors studied five adolescent male practitioners of autoerotic asphyxia to determine contributors to its etiology. Extensive histories including detailed sexual histories were obtained from each boy. Their life histories suggested an early history of choking, in combination with physical or sexual abuse, was related to the development of autoerotic asphyxia. Each boy appeared to have paired choking with sexual arousal, and autoerotic asphyxia was a persisting behavior pattern for four of five boys. This sample is the largest study of living practitioners of this behavior and suggests the heretofore unmentioned history of either choking or abuse.


Autoerotic asphyxia is typically a solo sexual practice that seeks to induce hypoxia for a sexual euphoria. Extant literature on this topic consists of cases of accidental death associated with this ritualized behavior (Cesnick and Coleman, 1989). Etiological formulations are derived from psychological postmortem evaluations, made even more difficult by the victim’s family covering up the sexual nature of the accidental death (Hazelwood et al., 1983). Approximately five total cases of living practitioners of autoerotic asphyxia have been reported over the years in the medical literature (Wesselius and Bally, 1983).

As recently as 1983, Hazelwood and colleagues wrote that autoerotic asphyxia is not yet part of the standard nomenclature in psychiatry. However, DSM-III-R uses the term hypoxyphilia as a subtype of the paraphilia sexual masochism (American Psychiatric Association, 1987).

Resnik (1972) attempted to quantify eroticized, repetitive hangings as a syndrome. He listed 10 features, including (1) an adolescent or young adult male; (2) ropes, belts, and binding materials arranged so that constriction of the neck can be controlled voluntarily; (3) evidence of masturbation; (4) partial or complete nudity; (5) usually a solitary act; (6) repetitive behavior designed to produce no visible marks; (7) no apparent wish to die; and (8) the presence of erotic literature. Resnik wrote that two other elements are less frequent: further binding of the body/genitals/extremities and the presence of female attire. Many of these 10 features are supported by Hazelwood and colleagues’ (1983) 132 postmortem cases.

The literature deviates little from Resnik’s (1972) features. It is not exclusively a male phenomenon, and female victims have been identified (Hazelwood et al., 1983). Mortality ranges to as many as 2 to 4 deaths per million inhabitants per year in the United States (Hazelwood et al., 1983).

The usual etiological perspective suggested is psychoanalytic. In a study of eight cases of autoerotic asphyxia in Hawaii, the authors state “In reality, little is known about why people start to asphyxiate themselves or how this practice becomes eroticized” (Diamond et al., 1990, p. 15). Saunders (1989) suggests several rationales, including guilt associated with masturbation, castration anxiety, and risk-taking/thrill-seeking in general.

In two cases, childhood abuse was suggested as a possible etiological factor (Cesnick and Coleman, 1989; Wesselius and Bally, 1983). Cesnick and Coleman describe a 26-year-old patient who was physically and sexually abused. They suggest that childhood abuse could result in self-defeating activity relieved by engaging in sexually euphoric behavior. Wesselius and Bally
describe a 24-year-old male who was both physically abused and forced to cross-dress by his father.

Another etiological suggestion comes from John Money (Money and Lamacz, 1989). Autoerotic asphyxia is described as a sacrificial paraphilia. This type of behavior occurs in individuals who feel they must atone for their erotic behavior, thus pairing pleasure with threat or punishment.

The study of psychopathology is extremely important in illuminating etiological pathways. Through our clinical practice, we have evaluated and initiated treatment with five teenage males who have practiced autoerotic asphyxia. Although that was never the presenting complaint, the practice did emerge during the acquisition of a detailed sexual history. We understand that some teenagers may try autoerotic asphyxia and then move on, with no clear etiological elements (Saunders, 1989). In fact, Money (1993) suggested that autoerotic asphyxia is probably overrepresented among high achievers, persons with strict religious background, and people with a history of asthma. While a sample of five clinically referred cases most likely represents a significantly skewed sample, given the paucity of living cases in the literature, and the need to understand the etiology of autoerotic asphyxia, we believe that presenting their case histories and teasing out commonalities can be useful in understanding the etiology of this particular paraphilia.

CASE STUDIES

Case 1

A.A. was a 17-year, 4-month-old boy referred from a county social services department. At the time of his referral, A.A. was a ward of the state and his family was receiving government assistance. He had recently disclosed that he was a victim of incest. He had been placed out of the home several times because of physical abuse and neglect when younger or because of disruptive behavior when older. A.A. also had several failed courses of therapy.

A.A.'s mother had a diagnosis of alcohol dependence and serious mental illness. A.A.'s mother abused him most severely during periodic psychotic episodes. His father had a diagnosis of organic personality disorder secondary to a closed head injury. While A.A. was being initially evaluated in the treatment program, his mother was stable enough to corroborate her sexual abuse of A.A. as well as confirm her husband's paraphilic tendencies.

A.A.'s sexual history included sexual intercourse with his mother beginning at the age of 5 years. He also observed sexual intercourse between his mother and father as well as between his mother and a variety of other men. By the age of 7 years, A.A. knew enough to engage a 10-year-old girl in sexual intercourse. A.A. had observed his father's sexual interaction with a female adult other than his mother. His father had immobilized the woman with ligatures, and then gradually involved A.A. in sadomasochistic acts with this woman. A.A. usually participated in a sexually passive, masochistic role. He reported times where he became so consumed by fear that he fled home.

He first ejaculated at the age of 11 and was masturbating daily with the aid of pornography. At age 12, he initiated sexual contact with a male age mate and he describes this experience as positive. The two boys were involved in 15 to 20 separate incidents involving mutual masturbation, anal intercourse, and fellatio. A.A. reported sexual intercourse with female age mates beginning at age 14, and he reported a total of five similarly aged female partners to the present.

When A.A. was 16, his father died. A.A. was told by his caseworker that his father was a hypoxyphilia fatality. His father's paraphilia was discussed in detail, and A.A. then began to practice hypoxyphilia, with a ligature. His hypoxyphilic practices were initially viewed as suicide attempts.

A.A.'s diagnoses included conduct disorder, solitary-aggressive type, alcohol dependence, and possible paraphilia. A.A. initially cooperated with individual and group therapy. Shortly after disclosing his hypoxyphilia, he left therapy and moved in with his mother. A 6-month follow-up found that he was living with his mother and her current lover.

Case 2

B.B. was a 14-year, 7-month-old boy. He was referred by county social services for both a diagnostic evaluation and family therapy. His caseworker was concerned about suicidal behavior and chronic truancy. B.B. had been hospitalized three times for broken bones, concussions, and severe lacerations, after "accidents" around the family farm. He lived with his mother and two older stepbrothers. B.B.'s caseworker reported that her supervisor had had B.B.'s mother as
one of her first cases. B.B.’s mother was an incest victim and at 12 was placed in a foster home setting.

In response to questions relating to “other ways you play with death,” B.B. began to talk about riding the family three-wheeler recklessly through the woods. He also reported that he and two of his stepbrothers engaged in a “choking game.” Apparently, this involved the use of a sleeper hold and B.B. reported that his older stepbrothers had choked him at least 100 times. He reported that he would choke himself to the point of passing out, but denied the use of ligatures. In the same interview, B.B. reported that the stepfather of these boys had anally raped him several times.

B.B.’s mother had a long social services involvement, as well as two state hospitalizations for psychotic depression. She had attempted to hang herself one time but it was unclear whether B.B. had witnessed that. She had been in chemical dependency treatment twice but had been sober for the previous 2 years. She had been married four times. B.B.’s biological father had served a total of 13 years in the state penitentiary for three different crimes and currently was living as a recluse in a neighboring, abandoned farmhouse. He came with his ex-wife and B.B. to one interview, and his speech and thinking were noted to be rambling and loose.

B.B.’s disclosure in the second interview that he masturbated while choking fit with his overly candid interactional style, i.e., revealing details of behaviors that would be extremely embarrassing to a boy of his age. He stated that no one had modeled autoerotic asphyxia, and he reported that he would use nylon ropes, with a goal to ejaculate as he was “fading out.” His safety mechanism was the fact that the nylon rope was slippery and would gradually loosen. He reported that he had used this technique a dozen times, but by the end of the interview had intimated that the frequency was quite a bit higher.

The family did not complete the evaluation nor did they return after two family interviews. B.B. was placed in a juvenile detention facility for theft of a car shortly thereafter.

Case 3

C.C. was a 16-year, 11-month-old boy currently in foster care. He was referred for an evaluation and therapy after a disclosure by a younger foster son that C.C. had molested him. C.C.’s parents’ parental rights had been terminated when he was 12. He had been in a total of nine foster placements. He had no prior juvenile record, was working at a local video store part time, and was maintaining average grades in high school. He was described by his foster mother as a loner, but he reported that his one friend was the teenage son of the video store owner.

Little information was available on the psychiatric status of C.C.’s parents, other than the fact that his father had abandoned the family when C.C. was 3 years old and his mother had been hospitalized twice, receiving a diagnosis of atypical psychotic episode.

One foster placement followed C.C.’s mother’s attempts to drown him in the bathtub. C.C. initially denied memory of this, but later recalled two drowning attempts around the age of 4 years. Several other instances of choking occurred when his mother was living with a farmer when C.C. was 8 years old. The farmer roped him several times and dragged him around the farm yard. He recalled that his mother and the man were laughing. He believes that twice he blacked out because the rope was around his neck. He denied sexual abuse but reported witnessing his mother have intercourse with at least two different men.

During an extended evaluation, C.C. admitted to masturbating 8 to 10 times daily and to a practice he called “choking.” Apparently, he would wedge his neck between the wall and a bedpost that he had positioned on an incline so that after release it would slide away from his neck. He denied having witnessed or heard about this practice. C.C. remained briefly in an adolescent sex offender’s treatment group before running away to another state.

Case 4

D.D. was a 15-year, 6-month-old boy evaluated while at a residential facility. D.D. was Asian and had been adopted by an American family before age 6 years. A preschool memory was of two instances of fellatio with his foster father. Between the ages of 7 and 11 years, D.D. reported extensive voyeurism, the use of pornography, and stealing his mother and sister’s underwear. He also was engaged in extensive sexual play with a same-aged female peer. At the age of 12 years, D.D. was masturbating to ejaculation with pornography, he began molesting his sister, and his adoptive father began to molest him as well.

Between the age of 12 to 14, D.D.’s sexual behavior with his sister advanced to oral-genital contact with
persisting, daily masturbatory behavior focused on underwear, and video or pictorial pornography. He also began to use alcohol, drugs, and inhalants on a daily basis, with his favorite part of intoxication the period just before becoming unconscious. One day he and a friend were choking each other as a contest of strength and he was choked to unconsciousness.

During the same time, D.D. began to pair choking while viewing pornography. He then experimented with a ligature and quickly, D.D. ritualized the autoerotic asphyxia, utilizing a sash so as not to leave abrasions, and constructing a place to affix the sash next to his door where there was a small stairwell. He began to associate pain with this act, inflicting superficial scratches on his hip or thigh. He reported 24 autoerotic episodes before hospitalization for chemical dependency treatment at the age of 14. D.D. was aware of a teenager in his geographic area who had died from hypoxyphilia, and this awareness of danger heightened his arousal.

During D.D.'s chemical dependency treatment, his sister disclosed his sexual abuse of her, and he then reported his adoptive father's molesting him. Diagnostic impression was of four paraphilias, including voyeurism, pedophilia, fetishism, and hypoxyphilia, as well as chemical dependency.

Case 5

E.E. was 14 years, 6 months old at the time of his placement in a residential treatment facility because of sexual abuse of his younger sister. E.E.'s parents divorced when he was 5 years old. He lived first with his mother, then father, and back with his mother before her death when he was 12 years old. At the time of his placement, he was living with his father, his father's girlfriend, and his younger sister. Neither parent had a psychiatric history.

E.E.'s earliest sexual experience started at age 5 and continued to age 11. His significantly older maternal cousin would grab his genitals or apply makeup to E.E.'s face or force him to wear dresses. E.E. then began to expose himself and would penetrate his anus with objects. He also wore female underwear.

After age 11, sexual contact began again with his cousin, and proceeded to fellatio involving sadism, including being choked. E.E. reported that he had attempted autoerotic asphyxia on five different occasions. He learned of this behavior through a newspaper article reporting a man who had killed himself with this action. He stopped the practice because it was too difficult to both choke himself and masturbate at the same time.

Before being placed for treatment, E.E. continued stealing underwear, and twice he reported entering the bedroom of a neighbor woman and fondling her while she slept. In addition to his conduct disorder diagnosis, his paraphilias included fetishism, hypoxyphilia, as well as pedophilia.

E.E. was interviewed by both authors and we were struck by E.E.'s behavior during the interview. He carried a pine cone into the interview room, and as he broke the pine cone apart, he pressed his thumbs into the sharp tip of each pine cone piece. At no time did he evidence any pain.

DISCUSSION

Several features characterize these boys (Table 1). They include a history of choking, physical abuse, sexual abuse, other risk-taking behaviors, other trauma, and whether or not paired-associate learning, in which pairing of arousal with the choking experience (van der Kolk, 1988) was clearly evident. We realize that there are benign instances of teenage boys engaging in occasional pairings of choking with sexual arousal, and these boys do not necessarily have the features in this table (Saunders, 1989). However, the compulsivity and ritualistic behavior exhibited here is unusual, and most likely it is a function of more significant etiological precursors.

The majority of the features in the summary table are related to extreme arousal and feeling out of control. Physical and/or sexual abuse characterized each boy. For each boy except C.C., the sexual abuse involved...
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direct contact including penetration. An important consequence of severe abuse is dysregulation, including altered psychophysiology (van der Kolk, 1988) as well as an impaired capacity for self-soothing (Braun, 1988). Persistent dysregulation can lead to chronic overarousal and set the stage for repetitive, risk-taking behaviors driven possibly by the child’s need to undo or master the trauma (Braun, 1988).

The other traumatic events in the lives of these boys are also consistent with dysregulation. The events include parental chemical dependency or mental illness, emotional abuse and neglect, violence between parents, or the early loss of a parent. It is possible that the earlier traumatic experiences predisposed these boys toward a greater likelihood of deviant sexual arousal after sexual abuse. Early trauma predisposing to impaired arousal patterns has been suggested (van der Kolk, 1988).

Other risk-taking behavior was also evident. It is unlikely that sexual risk-taking would emerge unless other behavioral pathways regarding risk-taking had already been established. Four of five boys also had a direct experience of being choked. In each case, the choking was accompanied by either fear or sexual arousal, again adding to dysregulation and feeling out of control. Even the first boy, A.A., witnessed bondage activities and was told in some detail about his father’s death due to hypoxyphilia. E.E. described in his interview repeated and pronounced sensations of choking while performing oral sex on his older cousin.

Our finding of choking overlaps with the asthma suggested by Money (1993). An asthmatic who is having trouble breathing experiences arousal, i.e., panic, and may seek to recreate the experience as a way to master it.

Not surprisingly, paired-associate learning, or the pairing of arousal and masochism (van der Kolk, 1988), appeared to be evident in each case. The boys’ early traumas predisposed them to even greater arousal. In all cases, choking and sexual arousal were part of each boy’s emotional substrate. Because of the out-of-control nature of this arousal, some effort at mastery or undoing is to be expected. The unique pairing of dysregulation that included both choking and sexual arousal contributed to the emergence of hypoxyphilia, a persisting pattern of behavior in at least four of the five boys discussed.

In summary, the etiology of severe and persisting autoerotic asphyxia appears to include the pairing of choking with sexual arousal. This pairing was facilitated by earlier traumatic and abusive events in the lives of these boys. Autoerotic asphyxia was usually not their only masochistic behavior as well. The learning theory of paired-associate learning appears to be a useful concept for understanding this dynamic.

REFERENCES


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