

ABSTRACT

Of the various types of abnormal sexual behavior, or “paraphilias” as defined by medicine, probably the most bizarre and dangerous is autoerotic asphyxiation, also known as sexual hanging. Autoerotic asphyxia is the practice of inducing cerebral anoxia, usually by means of self-applied ligatures or suffocating devices, while the individual masturbates to orgasm. The most common practitioners of this paraphilia are adolescent and young adult males. Despite its long documented history, this bizarre practice is still an enigma for most in society, including medical and law enforcement personnel. Tragically, the asphyxiator’s sexual practice is usually first discovered when he dies from accidental hanging.

Survivors of those who die by autoerotic asphyxiation are puzzled and troubled by what must seem to them bizarre behavior on the part of individuals whom they believed to be free of abnormal sexual behavior. The surviving family members and friends are left struggling with the sudden tragedy of death, along with having to cope with the bizarre, embarrassing practice of autoerotic asphyxiation. Families are left with lingering questions of; Why did he do this? Who taught him this? Why didn’t he get help? The grim task of answering these enigmatic questions is usually left to law enforcement investigators or medical professionals who, most likely, have only limited explanation for the autoerotic practice. There are psychoanalytic and physiological theories that can explain some of the reasons for the practice, however, families are still left with unanswered questions, along with feelings of guilt and embarrassment. This paper will attempt to explain the autoerotic asphyxiation syndrome, and suggest that through education, counseling and emotional support, family and friends can gain relief from this emotionally scaring experience.

INTRODUCTION

There is a portion of self-induced adolescent hanging deaths in which the goal of the victims was not self-destruction but self-sexual gratification. Although this behavior may seem unusual, it is far from uncommon. Autoerotic asphyxiation deaths account for 6.5 % of all self-induced adolescent deaths and 31% of all adolescent hanging deaths over a ten year period.¹ It is suggested that the incidents of autoerotic asphyxiation deaths are increasing. For example, in the US in 1979, 250 cases were reported. In 1983, 500-1000 cases were reported in the US, representing a two to four times increase. Autoerotic asphyxiation deaths have been reported in males as young as 9 and as old as 80 years. The most common age group is 12 to 25 years, with 71% of the victims less than 30 years old.² Due to the social stigma, lack of professional awareness, and few recorded experiences, the actual number of living asphyxiators is not known.

METHODOLOGY

The autoerotic asphyxiation syndrome has been described as "eroticized repetitive hanging". Also known as asphyxophilia or hypoxyphilia, it is a paraphilia of the sacrificial type in which sexueroptic arousal and attainment of orgasm depend on self-strangulation and asphyxiation up to, but not including, loss of consciousness.³ It has been proposed that the hanging might be used to produce physiological enhancement of sensation during masturbation, enhancement that is supposed to take place through interference with the blood supply to the brain, causing cerebral anoxia that is subjectively perceived as giddiness, lightheadedness, and exhilaration, which reinforces the masturbatory sensation.⁴ The most common physiological mechanism by which sexual arousal is obtained is by constriction of the neck. Other less common forms of autoerotic asphyxia are; compression of the abdomen, placing a plastic bag over the head, inhalation of aerosol propellants or chemical vapors, or passing electrical current through the body. These less common methods are known as "atypical autoerotic practices". Neck constriction, being most common, is accomplished by placing some form of ligature around the neck that is designed to give the victim control of the pressure and provide an escape mechanism. Transient cerebral hypoxia

during autoerotic manipulation combined with physical helplessness and self-endangerment to the degree that life is threatened, enhances sexual gratification—but it also weakens the victim’s self control and judgment, occasionally resulting in accidental death from the failure of or the victim’s inability to operate previously arranged self-rescue mechanisms.⁵

HISTORICAL

The practice of autoerotic asphyxia has been documented since the early 1600’s. It was first used as a treatment for erectile dysfunction and impotency. The idea for this most likely came from subjects who were executed by hanging. Observers at public hangings noted male victims developed an erection (priapism) and occasionally ejaculated when being hung.⁶ Anthropologists have long been aware of asphyxial practices among various cultures. For example, Orientals often strangle the throat to heighten sexual pleasure, as do the Yahgans in South America, and the Celts. Eskimo children play sexual games involving hanging and choking, and the Shoshone-Bannock Indian children play suffocating games such as “smoke-out” and “hang-up”.⁷ Literary works such as; the Marquis de Sade’s *Justine*, Melville’s *Billy Budd* and Becket’s *Gadot*, all illustrate sexual asphyxiation. The earliest medical publication of asphyxophilia is in 1856 by the French psychiatrist, DeBoismont. He reported 30% of men who died of hanging had associated erections or ejaculations.⁸ An Austrian encyclopedia of sexuality published from 1928-31 devoted chapters to strangulation and “penis strangulation” as autoerotic practices. In 1935, Bloch described the practice of choking women during intercourse, and in 1936, Ellis described the “impulse to strangle the object of sexual desire”. In 1940, Vance, Gonzales and Helpburn introduced sexual asphyxia to the forensic community for the first time by adding a single sentence about the subject in a textbook on forensic medicine. In 1953, Stearns published a review of 97 suicides occurring among young people in Massachusetts during 1941-1950. He found 25 of the 97 to be probable suicides in young persons without obvious motivation, suggesting accidental death or sexual hanging (Stearns 1953).⁹ Most

of today's literature on this topic is written in forensic and psychiatry journals. Because of the scarcity of these articles, society is for the most part, unaware of these practices.

VICTIMS

Autoerotic asphyxia is seen in all races, in all parts of the world, and in all socioeconomic levels. Typically, the asphyxiator is an adolescent or young adult male. Adult asphyxiators are found to have different characteristic practices from that of adolescent asphyxiators. Adults tend to be more sophisticated in their masturbatory ritual and are aware of the death orientation of the practice. This is probably due to elaboration over time. The adult practice of asphyxophilia has been named "terminal sex" or "scarfing" in the adult bondage community. Adult asphyxiators are predominantly heterosexual males and may weave sexual asphyxia into an elaborate sado-masochistic sexual repertoire involving bondage and pain.¹⁰ It is a common assumption that asphyxiators also display homosexual behavior. However, studies reveal a low prevalence of recognized homosexuality among decedents, concluding that autoerotic asphyxiation is not associated with homosexuality.¹¹

Autoerotic asphyxial behavior typically begins during adolescence. Most autoerotic deaths occur in this age group because the practitioners lack experience and are unaware of the dangers of hypoxia. Adolescent victims are described as otherwise well adjusted, high achievers, apparently sexually normal, and not perceived to be depressed or suicidal by friends and family.¹² Adolescents are more likely to be experimenting with their sexuality and have fewer, if any, related paraphilias. Adolescence is said to be a time of risk taking and experiencing the unfamiliar. For example, male adolescents may experiment with homosexual behavior, but this does not mean that they are gay, rather they are "thrill seeking". In the same manner, the majority of adolescents who try sexual asphyxia do so just for the experience.¹³ According to Rosenblum, the risks of sexual asphyxia are not well known and it could therefore be viewed as no more pathological than driving a car or motorcycle at high speeds.¹⁴ These types of risk

taking behaviors are prevalent among today's adolescents. It is not known what becomes of those adolescents who survive their repeated brushes with death. It is suggested that they simply outgrow the practice, or they continue until the odds of death catch up with them and they become one of the rarer adult autoerotic death victims.

Most often, the adult or adolescent asphyxiator has no known history of deviant sexual behavior. This practice is revealed only when the victim dies in an accidental hanging death. Studies have shown that as the age of the asphyxiator increases, so does the likelihood that the masturbatory ritual becomes more elaborate and involves other related paraphilias such as transvestitism and bondage.¹⁵ Transvestitism is the assumption of clothes of the opposite sex for sexual purposes.¹⁶ Bondage is the use of ropes, chains, cords, fabric, etc. to constrict the body in a superfluous manner for the purpose of sexual arousal.¹⁷ Most death scenes support these findings, revealing the presence of female clothing, props and bondage materials.

The "clustering" of paraphilias is thought to occur when the asphyxiator encounters no adverse effects from his first paraphilic experience, which loosens his inhibitions about acting out other erotic fantasies.¹⁸ Bancroft (1989) suggested that the tendency of paraphilias to occur together suggests that the conditions necessary for the development of one paraphilia may facilitate the development of others. He conjectured that this potential might stem from some characteristics of the individual's nervous system that underlies sexual learning.¹⁹ Freund (1976) introduced the concept of "courtship disorder" to explain his finding that various combinations of paraphilias occur together. He theorized that courtship disorder results from the failure of some mechanism that coordinates normal human courtship behavior, and whose dysfunction allows various components of the normal sequence to erupt in fragmentary and unmodulated forms.²⁰ Another possibility is suggested in the work of LaTorre (1980), who produced an experimental model for

fetishism by showing that males who feel rejected by women show an enhanced response to women's clothing and a decreased response to women.²¹

THE DEATH SCENE

Autoerotic hanging victims are usually found by family members, making their deaths especially traumatic for the finders. The visual memory of the death scene becomes imprinted in the family member's mind forever. Impulsively, family members often hide the evidence of asphyxophilic deaths either out of embarrassment, or perceived social stigma.²² These death scene alterations make investigation and classification of the autoerotic death more difficult. However, some professionals that have investigated autoerotic death scenes in the past have little trouble recognizing the death scene as an accidental, sexual hanging. Researchers have identified the appearance of sexual activity in conjunction with the process of induced cerebral anoxia as the basic characteristics of most autoerotic death scenes.²³

According to Hazelwood (1981) the characteristics of most death scenes are:

1. Evidence of asphyxia produced by strangulation either by ligature or hanging, in which the position of the body or presence of protective means such as padding about the neck, indicate that the death was not obviously intended.
2. Evidence of a physiological mechanism for obtaining or enhancing sexual arousal and dependent on either a self-rescue mechanism or the victim's judgment to discontinue its effects.
3. Evidence of solo sexual activity.
4. Evidence of sexual fantasy aids, props or pornography.
5. Evidence of prior dangerous autoerotic practice.
6. No apparent suicide intent.²⁴

The circumstances and features of autoerotic deaths are not commonly known and, as a result, can be misrepresented as suicide or homicide. The fact that most autoerotic asphyxia victims are found alone in a

secluded location, such as a locked bedroom, garage, or an isolated outdoor area, and the fact that the victim died of hanging, can lead investigators to classify the death as suicide. Common features at death scenes such as; a blindfold, a gag, physical restraints, and other bondage items have lead to mistaken suspicions of homicide.²⁵ Educating law enforcement and medical professionals to identify the autoerotic death scene will help to accurately document these deaths as accidental.

ETIOLOGY

Families and friends trying to cope with an autoerotic asphyxia death are left with many questions about their loved one's bizarre sexual behavior. The task of answering these tough questions is usually left to law enforcement investigators or medical professionals who, most likely, have only limited explanation for the autoerotic practice. The most enigmatic question is: Why did he do it? To answer, it must first be understood that "abnormal sexual behavior" and "sexual perversions" are relative terms used to describe socially unacceptable or unlawful sexual practices. To the asphyxiator, his ritualistic hanging is a fixated and necessary sexueroetic practice. The term sexual perversion, used to describe autoerotic asphyxiation, suggests a deliberate, volitional deviation from normal sexuality and that being offered the chance at normal genital intercourse, the asphyxiator willfully takes the path of abnormality. Nothing is further from the truth. In most cases, there is no sexual satisfaction from, or the ability to indulge in, normal sexual behavior. The asphyxiator is forced into abnormal behavior by the same forces that drive a normal man into normal sexual activity.²⁶

Autoerotic asphyxia is probably the least understood of the paraphilias. There are many reasons this practice is so obscure. First, it is difficult to ascertain the number of practitioners of asphyxophilia due to the social stigma, lack of professional awareness, and few practitioners recorded experiences.²⁷ Also, there have been many studies done on autoerotic death victims, studies which do not fully reveal past histories of the asphyxiators. Conversely, there are relatively few studies available on living practitioners.

Mental health professionals mostly agree that paraphilias, or deviant sexual behaviors are generally thought to be caused by some form of disruption of the normal sexual development during adolescence. The asphyxiator may be compelled to engage in this practice as a result of arrested development during a stage of sexual development.²⁸ In writings by Dr. Ernest Jones (1926) of sexual development, he states that during early adolescence, males go through the “autoerotic phase”. During this phase, the adolescent has the tendency toward introversion and a richer life of secret fantasy, together with a preoccupation of self and the varying degrees of shyness and self-consciousness.²⁹ A traumatic experience during this stage may cause dysregulation and disrupt the sexual development.

Many theories have been suggested for the autoerotic asphyxial practice. The usual causative factors suggested are psychoanalytic. Saunders (1989) suggests several rationales for the practice, including guilt associated with masturbation, castration anxiety, and risk-taking/thrill-seeking in general.³⁰ In two cases, childhood abuse was suggested as a possible etiological factor. They suggest that childhood abuse could result in self-defeating activity relieved by engaging in sexually euphoric behavior.³¹ Money (1989) suggested that autoerotic asphyxia is 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.³² Psychoanalytic formulations have viewed victims of autoerotic death in terms of an eroticization of helplessness, weakness, and a threat to life, which is overcome through survival thus creating a sense of success.³³

In the book, *Autoerotic Fatalities* (Dietz et. al., 1983) the authors suggest that the most common psychological processes underlying autoerotic asphyxia are the desire for the subjective experience of hypoxia, the acting out of a masochistic fantasy that includes being abused, tortured, or executed, and the desire to be sexually aroused through risk-taking. A patient interviewed in connection with the study done

by Dr. Dietz illustrated these processes. The patient indicated that his autoerotic asphyxiation began at age twelve, though he could not recall how he first came to use it. He said that in the early years of his practice, he enjoyed the subjective experience of hypoxia and passing out, which was always associated with a fantasy that powerful women were doing this to him. Often he tied himself up or cross-dressed and fantasized that the women had done this to him as well. His history illustrates the elements of hypoxia-seeking and masochistic fantasies.³⁴

In 1994, Friedrich and Gerber studied five adolescent male practitioners of autoerotic asphyxia. This is one of the few studies done on living practitioners. The sample of five living practitioners is, however, thought to be significantly skewed because of the insufficient number of practitioners studied, and because there was clinical referral of these cases for other presenting problems. The authors of this study understand that some teenagers may try autoerotic asphyxia and then move on with no clear reasons why. However, they believe that presenting the commonalities of these case histories will be useful in understanding the etiology of this paraphilia.³⁵

Several characteristics were reported in the five boys studied. They include a history of choking, physical abuse, sexual abuse, other risk-taking behaviors, and pairing of sexual arousal with the choking experience. Their behavior was found to be ritualistic and compulsive and most likely the result of more significant etiological precursors.³⁶ Physical and sexual abuse can be precursors to the abnormal sexual behavior. An important factor of abuse is dysregulation, including altered psychophysiology as well as a paired capacity for self-soothing. Persistent dysregulation can lead to chronic over-arousal and set the stage for repetitive, risk-taking behaviors driven possibly by the child's need to undo or master the trauma.³⁷

While these theories are useful in explaining some autoerotic asphyxial behavior by paired-associate learning³⁸, and psychological processes, there still remains questions of how young males begin the practice. Why the asphyxiator develops this bizarre practice is mostly unknown. Do these individuals find the pain and humiliation of hanging stimulating, or are they masochistic, dealing out a degrading punishment to a victim whose simulated death they witness taking place before them?³⁹ A 1990 study in Hawaii concluded, "In reality, little is known about why people start to asphyxiate themselves or how the practice becomes eroticized."⁴⁰ It is, however, thought that many asphyxiators learn of the practice by word of mouth, sex manuals, medical books, pornographic literature, or detective magazines, as well as through the media.⁴¹ Another possibility is that asphyxiators begin the practice by accidental discovery or by self-generated experiences.

INTERVENTION STRATEGIES

Autoerotic asphyxia can be a devastating problem for practitioners, especially adolescents, their families and friends. From a public health perspective, the most concerning are the adolescent deaths. Most agree there is a need for intervention, however, there are many barriers to successful intervention. One is the difficulty in identifying practitioners. Because of the embarrassment or perceived social stigma, asphyxiators are not likely to visit a clinician for treatment. Also, for most practitioners, accidental hanging death is the first presenting sign of autoerotic asphyxiation. Although case studies on autoerotic death victims are useful, they shed little light on the psychological factors for starting the practice. Making it even more difficult, teens have the tendency to live for the present and not see the risks or consequences of their actions. They therefore are not likely to see their practices as problematic or life threatening, and thus not seek help.⁴²

The few asphyxiators that seek professional help usually present different problems for their seeking clinical treatment. When asphyxophilia is diagnosed, clinicians can recommend drug therapy. This

treatment is directed at substituting the hypoxic effects of hanging with drugs that cause hypoxic feelings and are less dangerous. However, this treatment has only limited potential. There is only a portion of asphyxiators whose single goal is the physical sensation of cerebral anoxia. These cases could be treated by prescribing medications such as amyl nitrate or lithium carbonate. For other asphyxiators, the purely physical sensation of anoxia is not the only source of sexual stimulation. In such cases, the hypoxia may merely be incidental to the sexual stimulation achieved by the act of self-strangulation or hanging.⁴³ For those, education about sexual physiology and its legitimate enhancement through socially and physically acceptable means could have a preventative impact.⁴⁴

In spite of the barriers, there are intervention strategies that are suggested. Education is thought to be the best chance at intervention. Uva (1995) suggests many different intervention strategies. One is: including the dangers of practicing autoerotic asphyxia in school sex education classes. Also suggested, is education for medical and law enforcement professionals about asphyxophilia and the need for accurate reporting, regardless of the social stigma. In addition to education, there is a need to support research aimed at identifying the risk factors and etiological factors that contribute to the autoerotic asphyxiation practice. This includes support for the identification of biomedical, behavioral and environmental risk factors and how they interact with age.⁴⁵

The autoerotic death victim's family and friends must be offered counseling to understand and cope with the death of their loved one. Counseling can be provided by professionals dealing with the autoerotic asphyxia syndrome or through support/focus groups. Education should be directed at the various disciplines that may encounter the syndrome. This includes the clergy as well as law enforcement and medical professionals. Families often turn to their church to answer questions about their loved one's death. The clergy should be educated on autoerotic asphyxiation to help families of victims cope with the guilt and associated emotional trauma of the death.⁴⁶

In addition to intervention efforts, efforts must be made to limit children's exposure to the syndrome. Risk-taking youth experimenting with their sexuality run a high risk of imitative practices. Limiting children's exposure to pornography should be strictly enforced. There is also a need to limit mass media exposure and coverage of the autoerotic asphyxia syndrome. Dr. Park Dietz co-author of *Autoerotic Fatalities* (Dietz et. al., 1983) has been invited many times to appear on television discussing the subject. He has refused every time because of his belief that the media is not a suitable medium for discussion of this syndrome, citing the high risk of imitative behavior.⁴⁷ In fact, a show on autoerotic asphyxia was aired on May 10, 1988, against Dr. Dietz's advice. Since the airing, there have been two adolescent deaths attributed to the victim's viewing of the show.⁴⁸

CONCLUSION

The bizarre nature of an autoerotic asphyxiation death can leave a void in the lives of the surviving family and friends. When these deaths occur, victim's families and friends are left with questions about the bizarre practice of asphyxophilia. Studies of living practitioners and autoerotic death victims have suggested some psychological as well as physiological answers to the questions of why and how the practice starts. Many valid etiological theories have been put forth, however, each case is unique, and may not have clear etiological factors. Each family has the need to understand their loved one's behavior. Law enforcement and medical professionals should be able to explain the autoerotic asphyxia syndrome without being judgmental or bias. They should be able to direct survivors to support groups in which families and friends can discuss their tragedy with others who have had similar experiences.

Until there is an increased awareness of the dangerous practice of autoerotic asphyxiation, the untimely and tragic death of adolescents and young adults will continue to occur. Through increased awareness and better documentation of autoerotic asphyxial practices, society will be better able to understand and cope with the complex environmental and behavioral factors that lead to this dangerous syndrome.

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