

COMMENTARY

“And then I got strangled”: Dangerous trends of sexual choking among young people

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Abstract

Sexual choking has become increasingly normalized among young people, largely driven by media, pornography, and peer norms. Although often framed as consensual, breath-control practices are physiologically unpredictable and can cause rapid loss of consciousness, brain injury, or even death within seconds. Once consciousness is lost, consent cannot be given or verified. Clinical and forensic experience in Finland indicates that choking is frequently reported in younger patients, yet national prevalence data are lacking. We argue that sexual choking is never medically safe, that clinicians should routinely ask about it, assess for injury, and provide clear risk counseling, and that medical ethics require engagement with harmful trends in patient care. Further research is needed to quantify prevalence and harms in Finland.

KEYWORDS

asphyxia-related risks, BDSM, breath-control, sexual choking, strangulation

A recent court decision in Sweden has highlighted the dangerous consequences of breath-control practices in sexual contexts. In June 2025, a 28-year-old man was convicted after his partner suffered severe brain damage from consensual erotic choking. She lost consciousness, went into cardiac arrest, and required months of intensive care. The court found the man guilty of aggravated assault and causing bodily harm. Despite their previous history of engaging in such acts, the ruling emphasized that consent cannot justify actions that cause grave bodily harm or risk death (Umeå tingsrätt B 418-24 Dom 20250605). This case forces a necessary confrontation with a disturbing question: How have dangerous behaviors like strangulation and choking become so widely accepted in contemporary sexual culture? Our concern also stems from clinical and forensic practice: Katja Kero serves as the responsible physician at the Seri Support Center (Center for Victims of Sexual Assault), and in forensic interviews and examinations choking emerges prominently, especially among young people. Pia Wahlsten's

forensic work underscores that choking cannot be performed safely, and Hannu Lauerma contributes a forensic psychiatric perspective on risk, consent, and trauma. Prevalence has not been studied in Finland, and larger studies are needed.

1 | CULTURAL NORMALIZATION AND MEDIA INFLUENCE

Sexual choking or strangulation during partnered sex has increased rapidly in prevalence, particularly among young adults. Popular culture, meme culture (#ChokeMeDaddy), and pornography have played a major role in the normalization and eroticization of these practices.^{1,2} Pornography that scripts rough sex can be addictive, creating tolerance to ordinary sexual practices and escalating to behaviors such as choking.³ In this commentary, we use the terms “sexual choking” or “strangulation” to reflect the language used by

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young people and the research cited here, which largely concerns manual pressure to the neck. We reserve “erotic asphyxiation” for deliberate oxygen deprivation and more extreme methods (e.g., ligatures, plastic bags, or autoerotic devices), which appear distinct from the peer-normalized practice and are not the focus of this paper. Rather than being a marginal practice, choking during sex reflects shifting sexual norms where risk and arousal increasingly intersect. In a national Australian survey ($n=1528$), over half of 18–35-year-olds reported having either choked a partner (51%) or been choked themselves (57%), with 44% experiencing both.⁴ The behavior was strongly gendered: women more often reported being choked, men reported choking a partner, and trans and gender-diverse individuals showed higher prevalence for both. Similarly, a U.S. study ($n=4168$) found that 26.5% of women, 6.6% of men, and 22.3% of trans and non-binary respondents had been choked during their most recent sexual encounter, while 5.7%, 24.8%, and 25.9%, respectively, reported choking a partner.⁵ In Iceland, choking has also emerged as a prominent feature of young adults' sexual experiences.⁶ Our clinical and forensic roles shape this perspective, but since Finland lacks prevalence data, larger studies are needed.

2 | MEDICAL RISKS AND LETHALITY

The central danger of sexual choking and other breath-control practices lies in physiological unpredictability and rapid lethality. Carotid sinus pressure, vagal inhibition, and hypoxia can all cause immediate loss of consciousness and in severe cases irreversible brain injury or death.⁷ Importantly, unconsciousness can occur already in less than 10s. Contrary to popular belief that relying on a “safe word” or a gesture previously agreed upon for use in an overwhelming situation is enough, common sense should be utilized in understanding that words or other signals have no meaning whatsoever when one can lose consciousness before being able to speak or otherwise communicate the distress. Over stimulation of the chemoreceptor system, leading to a parasympathetic (vasovagal) cardiac arrest without any warning signs can happen even in healthy young individuals.

In many reported incidents, individuals engaging in choking during sex “just to try it” were intoxicated at the time, raising serious concerns about their actual ability to assess danger and the legitimacy of consent. It is clear that alcohol and other psychoactive substances increase risk by impairing judgment and lowering inhibition. Substance-induced disinhibition, thus, may lead to impulsive decisions that have lifelong or even fatal consequences.⁸

Within the spectrum of homicidal crimes, several offenders have during recent years claimed that the crime committed was an accident during consensual “rough sex,” and thus an involuntary manslaughter instead of voluntary manslaughter or murder. Based on the clinical experience of 30 years of one of the authors (H. L.), this is a novel aspect of legal defense.

Key message

Sexual choking is increasingly normalized yet is never medically safe; unconsciousness can occur within seconds. Consent cannot be ensured once consciousness is lost. Clinicians should ask about choking, assess injuries, and counsel against breath-control practices.

3 | NEUROBIOLOGICAL EFFECTS AND LONG-TERM HARM

Emerging neuroimaging research indicates that repeated exposure to sexual choking may lead to structural and functional brain changes. A study published in 2023 using whole-brain surface morphometry found cortical thickening in young women repeatedly exposed to choking.⁹ Another study found altered resting-state functional connectivity, including hyperconnectivity in sensory and motor networks, possibly reflecting long-term neurophysiological adaptation or damage.¹⁰ These findings, although preliminary, suggest that what might have commenced as an “experiment” can leave lasting neurological imprints.

4 | PSYCHOLOGICAL TRAUMA AND REENACTMENT

Psychologically, sexual choking may be used by some individuals as a form of trauma reenactment, particularly among those with histories of sexual violence, dissociation, or complex post-traumatic stress disorder (PTSD).^{11–14} This is a clinical hypothesis rather than definitive evidence, and empirical data specific to choking are limited. Survey data show associations between repeated sexual choking and poorer mental health, which may reflect vulnerability, coercion, or trauma-related dynamics.¹² Based on our clinical experience, individuals with trauma histories may become accustomed to an addictive dopamine surge tied to repeated survival; the post-choking relief and aftercare can mimic long-standing cycles of violence. In clinical narratives, the illusion of intimacy, submission, or surrender often masks deeper dynamics of unresolved trauma or compulsion. Dissociation, emotional numbing, and people-pleasing tendencies may further obscure the ability to give or withdraw true consent. For some individuals, breath play may become their main route to arousal, not because it is inherently pleasurable, but because it replicates familiar states of powerlessness or danger.¹⁴

5 | THE LIMITS OF CONSENT

Consent is a fundamental ethical and legal principle, but it, too, has limits, especially when the behavior in question is inherently

dangerous. In Finland, sexual offences law rests on consent and its ongoing verification during the sexual act; if a person loses consciousness, consent cannot be given or confirmed.

In a recent Swedish study, Larsen et al. described temporal changes in the severity of physical violence and injury during sexual assaults among females aged 16–29 years.¹⁵ While Sweden has reported trends in strangulation and sexual violence based on clinic-based data, comparable longitudinal research from Finland is currently lacking, although SERI support centers (Centers for Victims of Sexual Assault) now collect detailed statistics on several other aspects of sexual violence.

Erotic choking cannot be compared with other consensual BDSM practices such as bondage or role play. Interest in BDSM itself is not a risk factor but once oxygen deprivation is involved, the risk profile shifts dramatically. Moreover, in clinical and legal settings, consent given under trauma-compelled circumstances or altered mental states may not be valid. As clinicians, we must remain aware that expressed consent can also coexist with psychological coercion.

6 | CLASSIFICATION AND CLINICAL FRAMING

In the ICD-11, erotic asphyxiation has been retained as a paraphilic disorder and not merely a benign and acceptable variation of sexual expression.¹¹ This classification is grounded in the behavior's inherent medical risk, regardless of context or perceived consent. While society increasingly seems to adopt an “anything consensual goes” stance, this perspective can dangerously obscure real harm.

7 | CLINICAL IMPLICATIONS AND RESPONSIBILITIES

Healthcare providers, particularly in gynecology, psychiatry, and sexual health, must proactively recognize and address sexual choking. Clinicians should integrate frank questions about choking or strangulation into routine sexual history taking, especially when patients describe injury, blackout, or memory loss during sex and document any injuries observed.

Especially in gynecological care or during clinical forensic medicine examination, patients are usually required to undress, so clinicians are in a unique position to observe physical indicators of harm that might otherwise go unnoticed. We do not equate consensual choking with strangulation during sexual assault, but the physical signs overlap, and disclosure may be incomplete. Therefore, clinicians should assess for strangulation injuries in forensic and gynecologic exams when risk is present. Recognizing sometimes very subtle signs of strangulation or suffocation is critical. These can include petechiae on the face, eyelids, or inside the mouth; bruising, abrasions, or redness on the neck, behind the ears, around the mouth or under the jaw; and voice changes, hoarseness, or difficulty swallowing.

Subconjunctival hemorrhage and neurological symptoms such as confusion, headache, or memory gaps may also appear.⁷ In many cases, patients may not spontaneously disclose these symptoms unless directly asked and may not even themselves be able to connect them to prior choking during sex.

Clinicians should respond to these cases with trauma-informed sensitivity, avoiding judgment while clearly communicating the physiological dangers and lethality of breath-control practices. It is equally important to offer alternatives for sexual connection that do not rely on thrill seeking with extreme risk. Sexual health counseling and education must be updated to reflect contemporary behaviors and to dismantle the myth that choking or strangulation is safe simply because it is apparently consensual.

8 | CONCLUSION

Sexual choking or strangulation is neither normal nor safe; in our clinical experience, it is never medically safe. No medically safe method exists for restricting oxygen during sexual activity. Healthcare professionals have a responsibility to identify breath-control practices as potentially lethal and to counsel patients clearly against them. It is consistent with medical ethics to study and address harmful trends in patient care, and ultimately, the law defines the boundaries of what is right and what is wrong. These are not harmless acts, but behaviors with outcomes comparable with Russian roulette, carrying the risk of permanent brain injury or death. Trust in “safe words” is inadequate when loss of consciousness can occur within seconds. Sexual choking must be clearly communicated as an inherently high-risk behavior with no reliably safe execution.

Sexual counseling should promote alternative avenues for intimacy, arousal, and exploration that do not entail significant health risks. The increasing presence of oxygen deprivation in sexual contexts reflects a cultural moment in which danger and desire have become dangerously conflated. This trend can and should be challenged by emphasizing safety, defining the limits of consent, and encouraging erotic practices grounded in care, mutual respect, and wellbeing.

AUTHOR CONTRIBUTIONS

All authors jointly conceived and designed the commentary. All authors contributed to the literature review and interpretation of the clinical concerns addressed. The manuscript was written collaboratively, and all authors critically revised and approved the final version for publication.

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CONFLICT OF INTEREST STATEMENT

Katja Kero is the responsible physician at the Seri Support Center (Center for Victims of Sexual Assault) and encounters choking

frequently in clinical and forensic work. Pia Wahlsten is a forensic physician, and Hannu Lauerma is a forensic psychiatrist. The authors have no financial conflicts to disclose.

DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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