NATIONAL COALITION FOR SEXUAL FREEDOM

CHOKING SURVEY REPORT

2026

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EXECUTIVE SUMMARY

The Choking Survey Report (2026), conducted by the National Coalition for Sexual Freedom in collaboration with the UNC Charlotte Violence Prevention Center, presents findings from an anonymous online survey of 1,700 alt-sex practitioners. The study examines experiences, perceptions, and risks associated with sexual choking.

Prevalence and Early Experiences

This survey was specifically about sexual choking, and therefore drew respondents who largely have engaged in choking (87.8%). A majority of participants (60%) had not attended any community events before their first choking experience, indicating that exposure typically comes from intimate partners rather than formal education. Participants first learned about choking from online sex educators (19.2%), partners (14.6%), or kink education groups (13.8%).

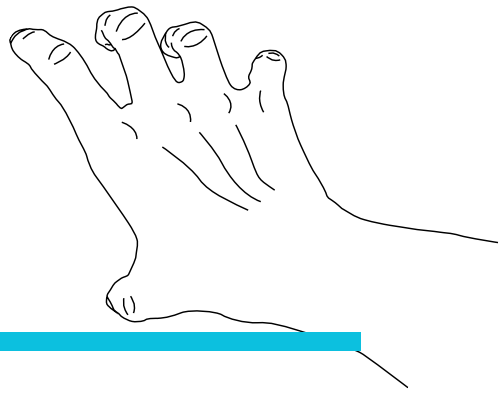
Power Dynamics and Demographics

Patterns of who chokes versus who is choked reflect broader social power dynamics. Nearly 75% of men reported doing the choking, while 68% of women reported being choked. Neurotypical individuals were more likely to choke, while neurodivergent individuals were more likely to be choked. Queer and gender-diverse participants were more likely to switch roles.

Risk Perception and Safety Practices

Although participants demonstrated awareness of serious health risks, many perceived these risks as manageable or less likely to occur in their own practices. **Nearly half had no safety or consent information before their first choking experience.** Over one-third reported no plan if something goes wrong.

Those who choke others tend to perceive lower risk than those who are choked. Among people who engage in choking, the most commonly recognized risks included brain damage, crushed larynx, and memory issues. Participants who had not engaged in choking were significantly more likely to rate death and brain damage as risks.



EXECUTIVE SUMMARY CONTINUED

Enjoyment and Motivations

Most participants (69.4%) reported enjoying choking, with motivations including dominance/submission dynamics, partner desire, and the “edgy feeling of risk”.

Professional and Community Implications

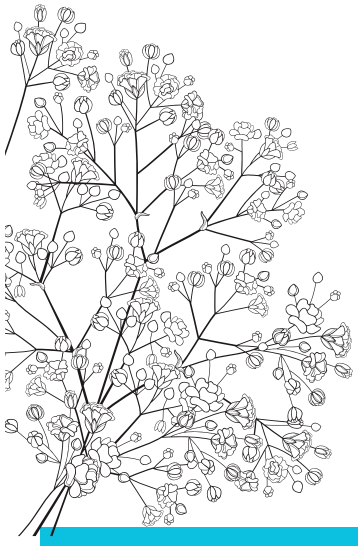
We emphasize that there is no safe way to engage in sexual choking, reiterating that any pressure on the neck carries unpredictable and potentially compounding health risks.

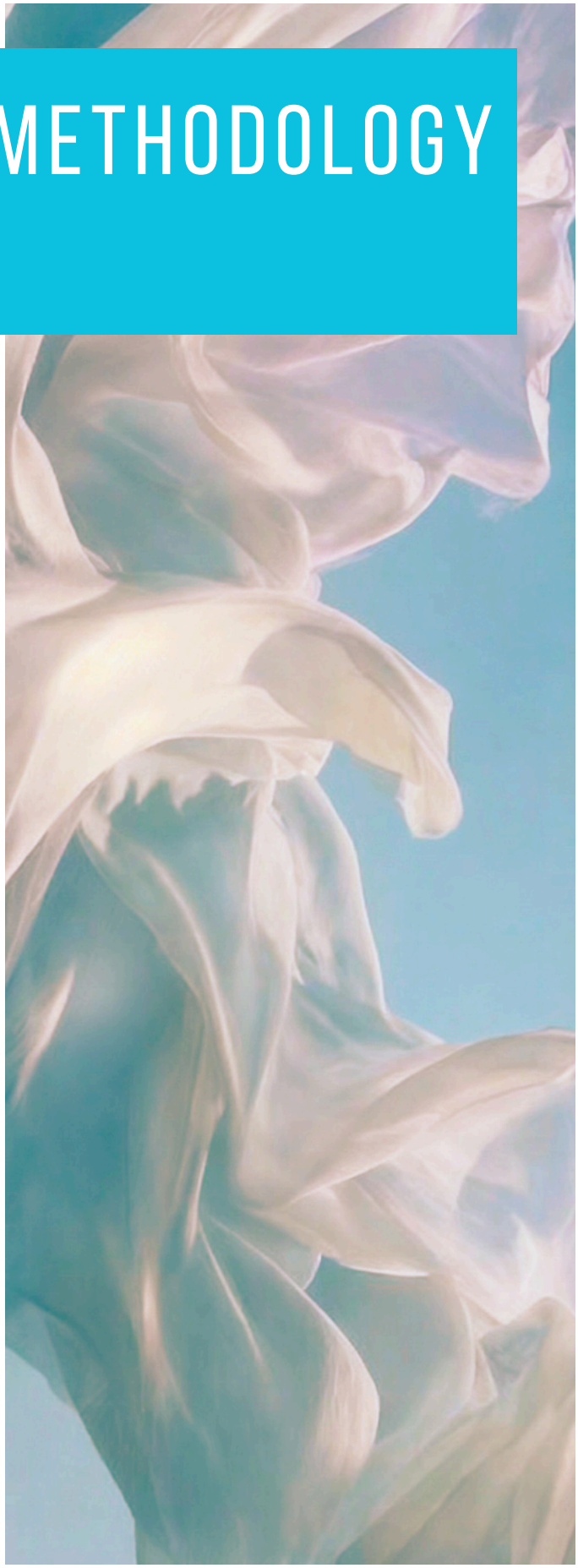
We recommend:

- Harm-reduction approaches tailored to participants’ motivations
- Increased education within alt-sex communities, especially to address misplaced confidence (e.g. martial arts training as equivalent in sexual choking)
- Improved awareness among health professionals, law enforcement, and the media
- Early conversations about risks and limits, given that many people engage before receiving any education

Future Directions

We call for longitudinal research, comparisons between alt-sex and non-alt-sex practitioners, and studies on effective educational messaging.





METHODOLOGY

In collaboration with UNC Charlotte Violence Prevention Center, the National Coalition for Sexual Freedom (NCSF) conducted an online survey of its members. The survey focused on experiences and knowledge related to sexual choking among alt-sex community (including polyamory, swingers, kink/BDSM, leather, fetish practitioners).

1,700 PARTICIPANTS

AUG.-DEC.2025

Anonymous cross-sectional survey collected via Qualtrics. The UNC Charlotte's institutional review board approved all protocols and procedures.

Data were analyzed by demographic groups, with appropriate statistical tests to examine significant differences among groups. In this report, we only include significantly different groups in our graphs. Open-ended responses were analyzed in Google Sheets using content analysis.

ACKNOWLEDGEMENTS

We appreciate the participants for sharing their experiences with us in this survey.

DEMOGRAPHICS 1,700 PARTICIPANTS

Most respondents identify as women 39%, while 32% identify as men (Table 1). The largest age categories of participants were 36-50 years (42%) and 51-69 years (29%). Most of the participants lived in the United States (90%).

Sexual identity was the most varied. The largest group being heterosexual individuals (23%) and bisexual (23%), with queer (16%) and pansexual (14%) following.

The majority of the sample practiced kink/BDSM (79%). Over one-third engage in fetish (35%) and 19% were in the leather community. Over half practiced non-monogamy (51%), with 42% reporting polyamory.

Survey respondents were primarily White (78%). In terms of neurodivergence, 47% of respondents report not being diagnosed, 27% report bing diagnosed with ADHD.

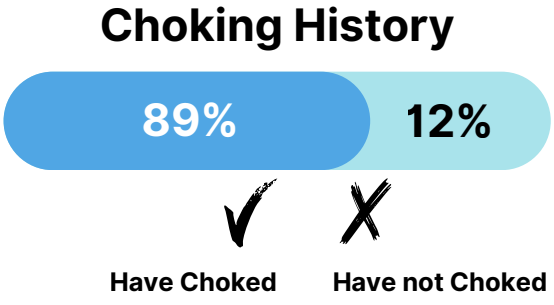


Table 1: Demographic characteristics

	n (%)
Gender	
Agender	38 (2.01)
Gender Queer	136 (7.19)
Man	610 (32.24)
Nonbinary	186 (9.83)
Questioning	39 (2.06)
Trans	120 (6.34)
Woman	736 (38.90)
Another Not Listed	27 (1.43)
Sexual Orientation	
Asexual	68 (3.34)
Bisexual	462 (22.68)
Gay	48 (2.36)
Heteroflexible	242 (11.88)
Heterosexual	462 (22.68)
Lesbian	52 (2.55)
Pansexual	283 (13.89)
Queer	333 (16.35)
Another not Listed	87 (4.27)
Race	
Asian	52 (3.07)
Black/African American	95 (5.61)
Latine/Hispanic	97 (5.73)
Native American	43 (2.54)
Native/Pacific Islander	11 (0.65)
White	1321 (77.98)
Another not Listed	75 (4.43)
Neurodiverse Diagnosis	
ADHD	492 (27.55)
Autism Spectrum Disorder	229 (12.82)
Dyscalculia	45 (2.52)
Dyslexia	52 (2.91)
Dyspraxia	11 (0.62)
Not Diagnosed	850 (47.59)
Other	107 (5.99)
Age	
18-24	71 (4.18)
25-35	359 (21.12)
36-50	717 (42.18)
51-69	494 (29.06)
70+	59 (3.47)
Lives in the U.S.	
Yes	1389 (90.14)
Another Country	152 (9.86)

EARLY CHOKING EXPERIENCES

87.8%

HAVE ENGAGED IN CHOKING SEXUALLY

60.7%

HAD NOT ATTENDED SEXUAL/ROMANTIC COMMUNITY EVENT BEFORE 1ST CHOKING EXPERIENCE

Of participants who have engaged in choking, 43.7% were between 36-50 years of age. However, these participants reported their engagement began at younger ages. For example, 27% of people reported the first time they engaged in sexual choking to be within the age range of 18-24.

Many (60.7%) participants have not attended any community events before their first choking experience. Exposure to choking seems to come from romantic/sexual partners. 20% reported their girlfriend/boyfriend being the first person they engaged with, and 28% reported it being their spouse partner.

The sources of learning about choking that participants reported were varied (see Figure 1). In learning about choking, online sex educators were the most common (19.2%) with partners following at nearly 15%.

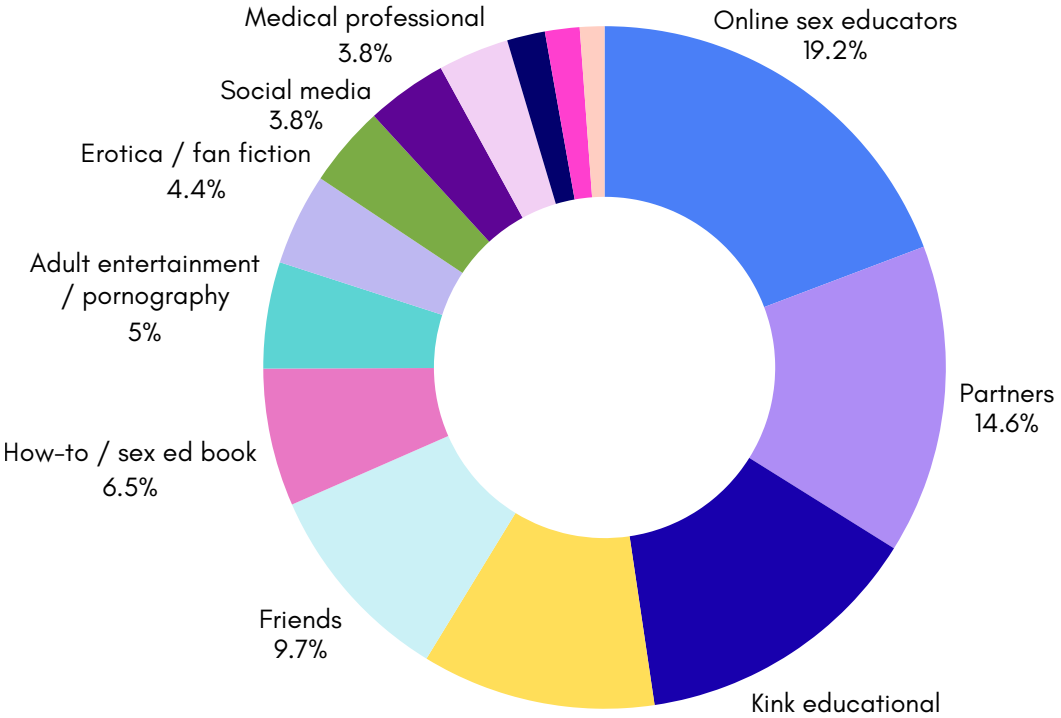


Figure 1: Sources of learning about sexual choking

TRENDS IN CHOKING

"I'M VERY CONCERNED ABOUT HOW PREVALENT IT IS IN VANILLA PORN AND PEOPLE THINKING IT'S NORMAL." #1030

There is very often societal power dynamics involved in who is choking vs being choked. This is seen with almost 75% of men reporting doing the choking, and 68% of women reporting being choked. Additionally, those who do the choking were more often neurotypical, but individuals who are choked were more often neurodivergent. People in queer relationships as well as genderqueer people reported engaging in both choking and being choked. This pattern of results suggests that individuals with more social power and privilege are more likely to do the choking, and individuals with marginalized identities tend to be the ones being choked. When societal power dynamics seem to blend, participants appear to switch roles.

25% of participants have engaged in choking for 2-5 years, and 24% for 6-10 years. 26% of participants have engaged in choking a few times in their life, while around 20% engage once every few months.

Participants who reported they perceived an increase in choking prevalence and conversations about it, reported the dominant influences of pornography, social media, and increasing mainstreaming of kink.

Primary Reason For First Choking Experience

ENJOYMENT IN CHOKING

69.4%

ENJOY CHOKING

"GIVING UP CONTROL CAN BE FREEING, BEING RISKY IS EXHILARATING, AND HAVING CONTROL IS EXHILARATING." #644

Among those who had engaged in choking, the majority of respondents enjoyed being choked (61%) compared to those who preferred to choke their partner (44%; see Figure 2). Nearly 70% of participants report enjoying choking and 22% report sometimes enjoying choking.
The reason for engaging in sexual choking varied. 32% of participants who engage want to feel dominant/submissive, and 31% of participants engaged because their partner wanted to.

Figure 2: Ways participants enjoy choking among those who have engaged in choking

BEING CHOKED	61%
CHOKING MY PARTNER	44%
BEING CHOKED DURING KINK ACTIVITIES	52%
CHOKING MY PARTNER DURING KINK ACTIVITIES	38%
BEING CHOKED OUTSIDE OF EROTIC ACTIVITIES	13%
CHOKING MY PARTNER OUTSIDE OF EROTIC ACTIVITIES	7%

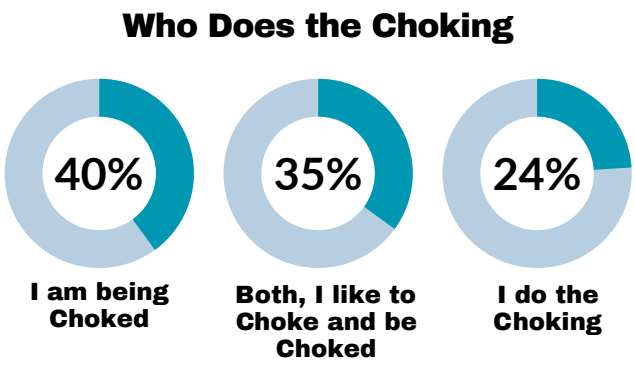


Figure 3: Engagement roles in choking

DISCUSSING CHOKING

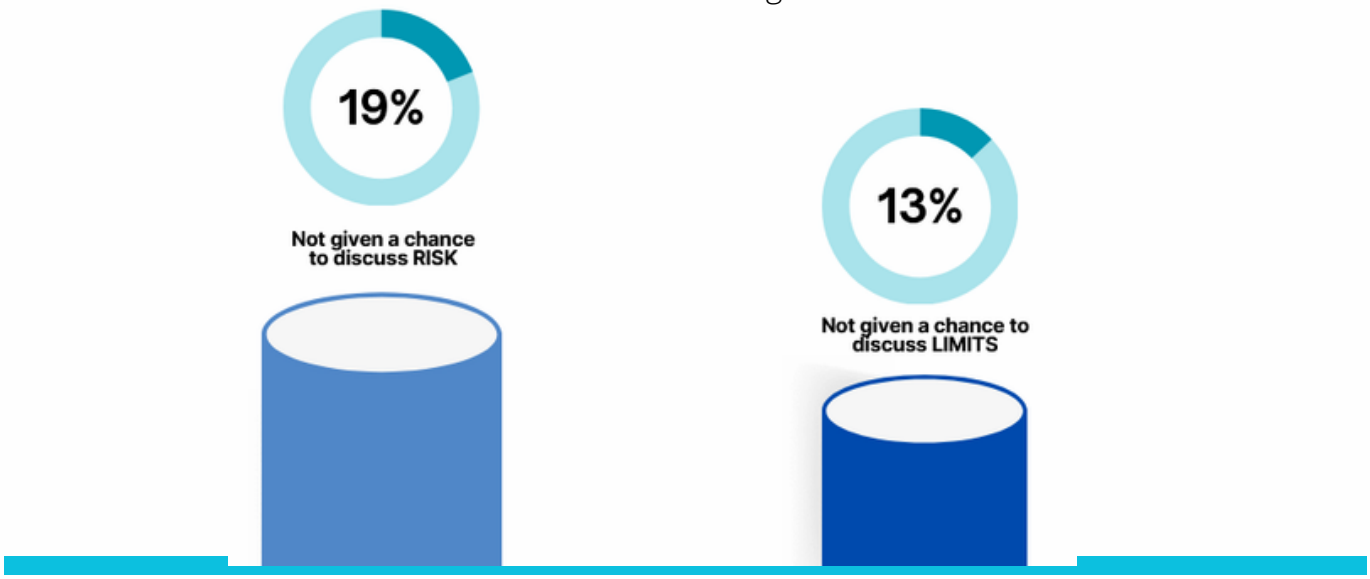
THOSE WHO ARE DOING THE CHOKING ARE LESS LIKELY TO REPORT HAVING DISCUSSIONS ABOUT RISKS

Nearly half (47.2%) reported that they hadn't gotten any safety or consent information before choking or being choked the first time. This means that nearly half of the respondents experienced sexual choking the first time without understanding the risks involved, which is not consensual.

Only about a fifth of respondents say they have a **thorough discussion of the health and mental health risks** prior to asking someone to choke them (22.2%) or choking someone (21.4%), or discuss that there is a risk from choking too hard, too long, or pressing on the windpipe before doing it (23.2%) or asking for it (19.0%). Nearly one-fifth of participants reported not being given a chance to **discuss risks of choking**, though it was slightly more common for participants to be given a chance to **discuss their personal limits** related to choking (at 13% not being given a chance; see Figure 4).

The most common practices to get consent included: "Tell them I want to/Ask them if they want to be choked" (42%/33%); "We agree on a safeword to stop what's happening" (38%); "Tell them how hard I want/Ask them how hard they want to be choked" (26/23%).

Figure 4: Opportunities for participants to discuss risks of choking and their personal limits related to choking



PERCEIVED RISKS RELATED TO CHOKING

35.8%
DON'T HAVE A PLAN IF SOMETHING GOES WRONG

Over one-third of those engaging in choking did not have a plan in case anything went wrong. For those with a plan, the elements of their mishap plan often included stopping choking (32%), calling an emergency service line (27%) and giving CPR (24%; see Figure 5). One-fifth of respondents viewed choking as low risk or no risk for loss of consciousness (see Figure 6).

Those not engaged in choking at all perceived higher risks: Of people who had engaged in choking, more than one-third perceived loss of consciousness as a "high risk" (n = 500, 36.7%) and more than one-quarter (n = 381, 28.0%) as a "medium risk." Conversely, of those who had not engaged in sexual choking, more than half (n = 108, 53.5%) perceive risk of lost consciousness as "high risk." Of people who had engaged in choking, the most commonly identified health risks were brain damage (n = 1,068, 71.5%), crushed larynx (n = 1,063, 71.2%), and memory issues (n =1,064, 71.3%). However, significantly more people who had not engaged in choking perceive brain damage (n =166, 80.2, $p < 0.01$), death (n = 167, 80.7%, $p<0.001$), and stroke (n = 131, 63.3%, $p < 0.05$) as health risks as compared to those who have choked.

Those who are doing the choking are perceiving less risk: Individuals who are choked (n = 220, 40.3%) and those who both choke and are choked (n = 187, 36.7%) were more likely to perceive the risk of loss of consciousness as high risk compared to individuals who do the choking (but do not get choked; n = 102, 30.7%).

Figure 5: Elements of a mishap plan for choking

"I DON'T CHOKE HARD AND AVOID ARTERIES AND WINDPIPE PRESSURE." #1004
"I TEND TO AVOID BREATH, PLAY, AND OBSTRUCTION OF THE AIRWAYS, AND PREFER TO FOCUS ON BLOOD CHOKES. DEPRIVING BREATH LOWERS OXYGEN IN THE BLOOD, AND THERE'S AN ACCUMULATIVE DELAY IN REFRESHING THAT WITH REPEATED ITERATIONS. BLOOD CHOKES ARE MUCH QUICKER IN EFFECT, AND HAVE A NEAR IMMEDIATE EFFECT ON RELEASE." #91

PERCEIVED HEALTH RISKS

AMONG THOSE WHO HAVE ENGAGED IN CHOKING:

May cognitively be unaware enough to safeword 11.6% (n = 1083)

Brain damage 11.4% (n = 1068)

Crushed larynx 11.4% (n = 1063)

Death 10.9% (n = 1019)

Headaches 10.2% (n = 956)

Petechiae (red spots in eyes/on face) 9.1% (n = 850)

Memory issues 8.8% (n = 824)

Stroke 8.8% (n = 828)

Motor control issues 8.5% (n = 794)

More likely to feel sad, lonely, anxious, and depressed 6.3% (n = 593)

Other 1.4% (n = 135)

AMONG THOSE WHO HAVE NOT ENGAGED IN CHOKING:

Death 12.2% (n = 167)

Brain damage 12.2% (n = 166)

Crushed larynx 11.7% (n = 11.7)

May cognitively be unaware enough to safeword 11.6% (n = 158)

Stroke 9.6% (n = 131)

Headaches 9.2% (n = 125)

Memory issues 9.1% (n = 124)

Motor control issues 8.1% (n = 111)

Petechiae (red spots in eyes/on face) 8.1% (n = 111)

More likely to feel sad, lonely, anxious, and depressed 6.1% (n = 83)

Other 1.6% (n = 22)

THOSE WHO HAD NOT ENGAGED IN CHOKING WERE STATISTICALLY SIGNIFICANTLY MORE LIKELY TO RATE DEATH AND BRAIN DAMAGE AS RISKS OF CHOKING.

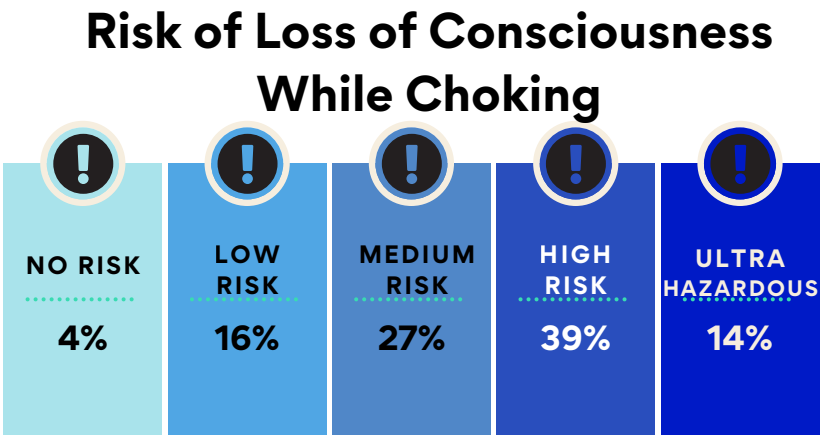


Figure 6: Risks of loss of consciousness while choking

RISK PERCEPTIONS EXAMPLE RESPONSES

INDIVIDUAL

Belief of overstated risks: All activities have a risk of death and the idea that we need to be informed anytime we do something that might kill us is silly (97; age: 25-35 trans/nonbinary man, queer, yes)

Insufficient risk perceptions: DON'T DO IT!! YOU CAN DIE (555; age: 70+, woman, heterosexual, no)

Trauma part of the risk: Besides physical harm, choking can trigger past traumatic memories. (1390; age: 36-50, man, heterosexual, yes)

One's own training influences risk: I have done BJJ [Brazilian Jiu Jitsu] and have been trained to choke people safely. A small woman has a more fragile neck than a large man- use common sense. (912; age: 51-69, man, heterosexual, yes)

INTERPERSONAL

Choking triggers a lot of people and does not belong in a group sex environment where everyone has not specifically consented to witness it. (1257; age: 36-50, man, heterosexual, no)

Gender socialization influences prevalence of choking: I find straight folks don't discuss it and that's where I most frequently have had men not ask before doing it. (611; age: 25-35, genderqueer/trans, bisexual/queer, yes)

Other training builds confidence: I do regularly engage with choking with my partner who will choke me until the point of passing out. (This is fully consensual and we are fully aware of the consequences) I feel comfortable with this because of his medical training and background. (850; age: 25-35, woman, bisexual /queer/pansexual, yes)

RISK PERCEPTIONS EXAMPLES - CONTINUED

COMMUNITY

Need for reducing engagement: The risk is too high to promote or practice, especially when it seems paired with gender identity and promotes submission on behalf one of to another. (824; age: 51-69, gender queer, kinky, white, yes)

Exposure to others' deaths curtails choking: I have a best friend that was murdered by choking. After that, I was not sure i would be comfortable being choked in a sexual or kinky manner anymore. (781; age: 51-69; woman, pansexual, Eastern European, yes)

Sorry. I don't think the BDSM community can educate people how to play with breath play safely (1036; age: 51-69, man, bisexual, no)

Stigma as harmful: While I understand why so many people strongly discourage choking, we should avoid shaming people for it as that will lead to more people keeping it to themselves and doing it on their own, rather than looking for a partner with the same interest. (1046; age: 18-24, woman, heterosexual, yes)

POLICY

In Australia it [is] being framed as [a] health risk that is serious; it is frame[d] as violence; it is saying consent is being misunderstood within context of abusive partner encounters; that youth are trying this and it is not a game, it has serious health consequences. (597; age: 51-69, woman, heteroflexible, yes)

Illegality as risky: I think it is illegal in the UK and I'm not sure that dissuades people; I think it might make it even higher stakes for victims who are harmed. (288; age: 36-50, gender queer/nonbinary, bisexual/queer, white, no)

Risks related to stigmas within the judicial system: I also wish people understood the high likelihood that a judge or jury would consider choking reckless. (659; age: 36-50, man, gay, no)

Community policies: Local club bans anything looking like breath play or choking, likely for the best (805; age: 36-50, trans woman, queer, white, yes)

APPLICATIONS FOR PROFESSIONALS AND FUTURE DIRECTIONS

As ongoing research attests, there is no way to safely engage in choking. With burgeoning research on brain changes (Huibregtse et al., 2022) (Bichard et al., 2021), and risks that may only happen with continued choking, or be unpredictable (such as increasing stroke risk) (Hou et al., 2023) providing informed consent may be unlike other sexual or kink practices which don't carry the same ultrahazardous risks of death or permanent damage. We encourage efforts to raise awareness and endorsement of harm-reduction approaches. Scarleteen (2025) provides a number of suggested approaches depending on the desired effects of choking (e.g. power dynamics, neck stimulation, feelings of constraint, among others).

Avenues for education among alt-sex practitioners may be benefited from alt-sex community-focused approaches that explain the risks involved in choking (e.g. workshops at conferences, local trainings at munches/sips). However, given how many individuals engaged in choking before attending an event, there is a need to explore different approaches. Herbenick et al. (2025) have examined preferred general population educational messaging which may also reach alt-sex practitioners who may not attend community events prior to their choking engagement.

Law Enforcement and Judicial

1) Education about the serious legal risks involved in sexual choking is needed, since some participants perceive a lack of awareness of the legal repercussions people face if their behavior results in injury or criminal charges.

2) Some participants discussed how stigma and fear of legal repercussions can reduce their likelihood of contacting emergency services. This barrier to reporting needs to be explained to law enforcement through kink cultural competency education so they can respond to reports more sensitively.

3) Law enforcement personnel need education on the serious risks of nonfatal strangulation so they don't dismiss reports of sexual choking. Under Explicit Prior Permission for erotic force or restraint in the revised Model Penal Code on Sexual Assault (Schulhofer, 2023), consent is not a defense for sexual choking due to the risk of death or serious injury.

APPLICATIONS CONTINUED

Health Professionals

1) Health professionals' awareness of harm-reduction approaches for sexual choking, and being able to tailor messaging to meet patient reasons for engagement, may be a critical strategy in reducing sexual choking injuries or fatalities. The perceptions, knowledge, and confidence of health professionals can be a barrier for implementing harm-reduction approaches (e.g. Gugala et al., 2022), and should be addressed in any approach for sexual choking harm reduction.

2) Many participants stated they stopped engaging in choking after they discovered the health risks involved, therefore sex therapists and sex coaches should refrain from normalizing and encouraging sexual choking from fear of "kink shaming" clients. Instead, they need to clearly distinguish between nonharmful kink practices and those that can seriously injure someone.

Lay Public (Non-Alt-Sex-Practitioners)

1) In order to reduce social stigma and promote public awareness of sexual choking risks, those employed by media may aid in correcting misrepresentations that foster stereotypes about sexual choking being an "introductory" kink practice. This includes journalists, screenwriters and authors refraining from referring people to the kink community to get "how-to" information, and conflating sexual choking with mild kink activities.

2) Participants who felt that their own risk was mitigated often cited educational sources from martial arts and combat sports. Although arm-chokes are often perceived as safer than hand choking due to structured training environments and the presence of observers, severe injury and death have been documented (Stellpflug et al., 2022), and the long-term consequences of repeated neck compression is currently being examined using scientific research methods (Zwank et al., 2023). More discussion is needed about these risks within martial arts and combat sports environments, as well as in the media.

3) The results indicate that many individuals did not get the chance to discuss risks and/or limits before engaging in choking. Although informed consent may be challenging due to the still growing body of research on the risks of choking, as well as the unpredictable and compounding nature of the risks (Zwank et al., 2023), it is still an essential component of engagement in any use of erotic force or restraint. Elevating discussions of the necessity of consent dialogues is a helpful strategy in building a culture of normalizing conversations around consent and reducing harm between intimate partners (We Can't Consent to This, 2026).

4) Some respondents pointed out the prevalence of sexual choking in pornography, and that regulating how choking is portrayed may be a way to reduce its acceptability or normality. The adult industry could also include disclaimers that choking depictions are only simulated, and that putting pressure on the neck can cause serious harm, including death.

APPLICATIONS CONTINUED

Alt-Sex Practitioners

1) For those who enjoy the sensations they get from sexual choking, NCSF (2026) provides resources describing harm reduction alternatives with the aim of mitigating risk. These alternatives include: rebreathing breath play, jaw holding, the non-asphyxiating use of gags, hoods, or collars, pressure on the collar bone as opposed to the neck, hand placement on the neck without applied pressure in order to simulate the act of choking, as well as the use of corseting to replicate the light-headed feeling often sought through sexual choking.

2) Education must address the fact that many participants seemed to understand that choking is dangerous in general, while simultaneously believing that their own abilities such as knowledge, communication practices, training, or experience have reduced their personal likelihood of harm. This education should explore how beliefs of exceptionalism can lead to complacency, which was found in these results in the reported lack of a risk mitigation plan specific to choking in case something goes wrong.

3) Some participants expressed anger when they discovered there is no safe way to choke someone, contrary to what their partners told them. Education should include the fact that informed consent requires legitimate, scientific information be provided to everyone involved about the risks before they can make a decision. Debunk the concept that it is consensual if someone agrees to engage in choking without understanding the risks involved, or if they allow it to happen without any discussion.

4) Some participants note that kink groups typically don't allow sexual choking or provide education about how to choke someone due to the risks involved. Publicizing these event rules and expectations within kink community spaces can help influence behavior in private.

FUTURE DIRTECTIONS

Additional research can also provide more detailed information on alt-sex practitioners' engagement with choking. Examples include:

1) Longitudinal examinations about how individuals change their behaviors based on information and information sources would highlight which turning points could be amplified. This might also include which choking experiences were nonconsensual.

2) Comparing sexual choking practitioners in the general population with alt-sex practitioners who engage in sexual choking regarding their conversations about risks and limits with regards to sexual choking. Similarly, examining how alt-sex practitioners' preferred educational messaging related to choking may reveal differences from those who do not practice BDSM.

3) Exploring the content of the education that participants are getting from online and kink groups about choking: is it risk awareness information, how-to instruction, harm reduction alternatives, breath play workshops, or a combination?

4) Examining those who once engaged in sexual choking but have since stopped to understand why that happened and what messaging can be used to create a similar response in current practitioners.

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