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For the Defense: Non-Fatal Strangulation

Basic Propositions from Research Literature

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Non-fatal strangulation (NFS) is an extremely dangerous type of physical violence that signals a survivor is at extreme risk of being seriously injured or killed by their abusive partner. Despite this stark reality, NFS often goes unreported and undetected, and thus uninvestigated by defense teams at the trial level. As a result, attorneys representing survivors in post-conviction proceedings may be the first people to ever look into a defendant's experiences of being strangled.

Attorneys representing domestic violence survivors on post-conviction claims must investigate non-fatal strangulation because it may reveal critical evidence that was overlooked. Impaired executive functioning, memory, and emotional regulation are neurocognitive deficits that trial counsel routinely fail to investigate, directly supporting claims of ineffective assistance of counsel (IAC) in a post-conviction relief petition or serving as compelling mitigating evidence for a resentencing hearing.

Evidence of NFS is often relevant to several facets of a survivor's defense. Lay and expert evidence about a survivor's experiences of NFS may support a justification theory such as self-defense. Forensic evidence of prior strangulation demonstrates an objective, severe risk of imminent death, which fundamentally alters the legal viability of self-defense or duress defenses. It can also be used to provide context around a survivor's behavior that might otherwise appear inexplicable or suspicious. For example, evidence of NFS can help to explain

- Why a survivor reasonably believed their life was in imminent danger
- Why a survivor appeared to be drunk or otherwise impaired
- Why a survivor's report of abuse may not seem to "match" their injuries because of delayed onset of physical symptomology
- Why a survivor has memory gaps and how that may change over time

Despite the high prevalence of NFS in intimate partner abusive relationships, it often goes underreported or undisclosed. NFS is also likely to go untreated. Even when survivors do disclose their experiences of NFS to law



enforcement, they are frequently disbelieved, or their claims are minimized or dismissed altogether; this is especially true when the survivor has no visible injuries.

Attorneys who represent criminalized survivors on post-conviction claims should investigate NFS even when there is no evidence of it in the trial record. If such evidence was available but not presented, this may give rise to a post-conviction claim of ineffective assistance of counsel. NFS evidence may also support various elements of survivor's post-conviction resentencing petition under "survivor justice" resentencing laws.

This memorandum excerpts selected literature on strangulation in IPV. This resource is intended for defense attorneys and others involved in the representation of criminalized survivors. Bolded text has been added to call attention to key language. This memorandum is intended as a starting point for further research and is not to be used or interpreted as legal or medical advice.

Descriptions of "Strangulation" or "Non-Fatal Strangulation"

Definition of Strangulation

"For many years, medical experts and researchers referred to strangulation assaults as 'attempted strangulation...'. The belief, though unstated in most research, was that strangulation meant death... **Based on the current state of the law and the current research, any intentional effort to apply pressure to the neck in order to impede airflow or blood flow should be viewed as a felony strangulation assault. The perpetrator did not 'attempt' the assault. He completed it...The preferred terminology by our national faculty and experts is "strangulation" or "non-fatal strangulation."** When unconsciousness, urination, defecation and/or petechiae is/are present, then near-fatal or near-lethal strangulation would be the appropriate term as the victim suffered a severe, life-threatening injury" (Civic Research Institute, 2014).

"Strangulation describes compression of the neck. More precisely, strangulation interferes with oxygen flow to the brain, either by compression of the carotid arteries or jugular veins (leading to cerebral hypoxia) or by compression of the airways (causing asphyxia), and it may cause reflexory stimulation of the carotid sinus with subsequent bradycardia and hypotension. **According to this description, the definition of strangulation differs from the definition of suffocation, which denotes an accidental or intentional obstruction of the airway at the nose or the mouth.** While hanging involves the body weight of the person concerned, the term "strangulation" usually refers to manual strangulation using hand(s), an arm (e.g., chokehold), or leg(s) to put pressure on the neck or to ligature strangulation using any kind of material tightened around the neck. Partial or interrupted strangulation may be applied deliberately in choking games, erotic asphyxia or combat sports" (citations omitted). (Gascho et. al., 2020).

"Strangulation is defined as "external compression of a person's neck and/or upper torso in a manner that inhibits that person's airway or the flow of blood into or out of the head" (Pritchard, Reckdenwald, & Nordham, 2017), and it **generally falls into one of three types: manual** (i.e., use of one's hands), **ligature** (i.e., use of a cord-like object), and **choke hold** (i.e., bent arm from behind (Faugno, Waszak, Strack, Brooks, & Gwinn, 2013)" (Messing, Thomas et. al., 2018).



Strangulation vs. “Choking”

“The act of strangulation is often described by the victim as “being choked.” In contrast to intentional strangulation, the term “choking” refers to internal blockage of the trachea by a foreign object that can occur accidentally or intentionally among individuals who participate in the ‘choking game’ (Strack et al., 2014). From a medicolegal perspective, it is critical that [emergency department] providers are precise in differentiating attempted strangulation from choking” (Jordan, 2020).

Prevalence of Strangulation in Intimate Partner Violence

“Among a sample of 1,008 survivors of IPV referred by police, of which 71.14% were interviewed, “...803 (79.66%) reported some form of strangulation: 118 (11.70%) reported attempted strangulation, 304 (30.16%) reported completed strangulation, and 381 (37.80%) reported multiple strangulation...” (Messing et. al., 2017).

“The high rates of strangulation in this sample, with 67.96% of the women reporting completed or multiple IPV strangulation (and an additional 11.70% reporting attempted strangulation), is similar to the prevalence found in a small study of women from two domestic violence shelters (Wilbur et al., 2001), but higher than the prevalence of strangulation (43%–45%) among a sample of urban women who were either killed or nearly killed by their intimate partners (Glass et al., 2008) and much higher than strangulation identified by police (e.g., 11.5% in Pritchard, Reckdenwald, Nordham, & Holton, 2016).” (Messing et. al., 2017).

“Research shows that NFS is common in relationships where there is IPV with studies reporting rates between 3% and 68% depending on the sample (Bendlin and Sheridan, 2019: 1529)” (Douglas and Fitzgerald, 2022).

“As we hypothesized, strangulation as a method of intimate partner violence is common (68%) among battered women who seek help from a hospital-based, advocacy-oriented medical treatment center and domestic violence shelters” (Wilbur et. al., 2001).

“Of the 494 women sampled as they came into Chicago hospitals and clinics for any reason and who said that they had experienced IPV in the past year, 47.3% had experienced at least one incident in the past year in which her partner had tried to choke or strangle her, and 57.6% had ‘ever’ experienced choking or strangulation by the abusive partner. There was no difference between women who were not killed and the women who were killed in having experienced prior choking or strangulation” (Glass et. al., 2007).

“A study of 300 consecutive cases of female attempted strangulations seen in the San Diego Domestic Violence Unit of the city prosecutor’s office found that in 89% of the cases there was a prior history of IPV” (Glass et. al., 2008).

“According to the National Intimate Partner and Sexual Violence Survey (NISVS), nearly 10% of heterosexual women in the general population report having been strangled by an intimate partner (Walters et al., 2012). However, among female heterosexual abuse survivors, estimates of nonfatal strangulation are much higher; for example, 61.3% of



women recruited from a hospital or shelter indicated that they had been strangled by an intimate partner (Wilbur et al., 2001) and nearly 68% of women interviewed after a police-involved intimate partner violence (IPV) incident reported strangulation (Messing, Patch, Wilson, Kelen, & Campbell, 2018)” (Messing, Thomas et. al., 2018).

Danger and Risks of Strangulation

Lethality

“Today, it is known unequivocally that strangulation is one of the most lethal forms of domestic violence. When a victim is strangled, she is at the edge of homicide. Unconsciousness may occur within seconds and death within minutes” (Strack & Gwinn, 2011).

“Using a case–control design, Glass et al. (2008) were the first to systematically examine strangulation in both attempted and completed femicide records between 1994 and 2000 in 11 cities and showed that prior nonfatal strangulation is an important risk factor for femicide (Glass et al., 2008). Specifically, they found that **the odds of being killed by an intimate partner were 7.48 times higher for women who had been previously strangled by their abusive partner than those who had not**” (Pritchard et. al., 2015).

“Strangulation is used as a ‘mechanism of coercive control to instill compliance and dependency over time through a pattern of malevolent conduct’ (Brady et al., 2021, p. 2) – it is also a common cause of “domestic violence-related homicide” (Douglas & Fitzgerald, 2014 at p. 231). **Non-fatal strangulation is recognised as a ‘red flag’ for future serious abuse and fatality** (Douglas & Fitzgerald, 2014, p. 231)” (Lowik et. al., 2022).

“Strangulation, regardless of type, can lead to death within minutes (Hawley, McClane, & Strack, 2001); in the United States, **strangulation is the cause of death for an estimated 10% to 19% of women** and 1% to 9% of men (Sorenson et al., 2014)” (Messing, Thomas et. al., 2018).

Physical Health Effects

“A person who is being strangled can lose consciousness after four to 10 seconds of arterial pressure and have anoxic seizures after six to eight seconds (Kabat & Anderson, 1943); **lose bladder control after 15 seconds and bowel control after 30 seconds; and sustain brain stem damage after 20 seconds and brain death after one to six minutes of pressure** (De Boos, 2019)” (Lowik et. al., 2022).

“Delayed consequences may not emerge for days or weeks after a strangulation episode (Carlson, 2014; Douglas & Fitzgerald, 2020). When the brain is starved of blood and oxygen, different areas of the brain react to different time scales (Birchard et al., 2021). The brain stem and hippocampus are particularly sensitive to a lack of blood flow (Hawley et al., 2001); some cells can survive for days then die, with reports of stroke being delayed for almost two weeks (Levack et al., 2009)” (Lowik et al., 2022).

“Various studies have identified women’s loss of consciousness following strangulation: Wilbur et al. (2001) found loss of consciousness in 17% of strangulation cases; Malec et al. (2007) reported loss of consciousness in 76%



strangulation cases; Shields et al. (2010) detailed loss of consciousness in 38% of strangulation cases; and Zilkens et al. (2016) recounted loss of consciousness in 8.9% of strangulation cases. **These statistics indicate that many victim/survivors of strangulation have likely acquired a brain injury (Rajaram, 2020; Valera et al., 2003) - ‘neurological damage, leading to possible cognitive and behavioural changes’ along with ‘the risk of significant psychological trauma’ (Birchard et al., 2021, p. 4)” (Lowik et. al., 2022).**

“Surviving strangulation is not without consequence. Nonfatal strangulation is associated with a variety of immediate and persistent negative health effects. Physical health effects include traumatic brain injury (Kwako et al., 2011); stroke (Joshi, Thomas, & Sorenson, 2012; Malek et al., 2000); miscarriage (Strack et al., 2001); memory and neurological difficulties (Mcquown et al., 2016; Pritchard et al., 2016; Strack et al., 2001; Wilbur et al., 2001); and neck, throat, and respiratory problems (e.g., pain, difficulty breathing, and swallowing) (Joshi et al., 2012; Mcquown et al., 2016; Strack et al., 2001; Wilbur et al., 2001)” (Messing, Thomas et. al., 2018).

Mental Health Consequences and Other Detrimental Effects

“In many [strangulation] patients, a social services consult will be appropriate, as many chronically battered patients suffer from profoundly poor self-esteem and major depression. These women may experience overwhelming despair after the violent act of being strangled and may even exhibit suicidal ideation; suicide precautions in these patients are prudent” (McClane et. al., 2001).

“Victims of domestic violence routinely experience psychological disorders. Anxiety, depression, substance abuse, suicidal ideation, and sleep disorders are common among this population. The study subjects reported depression, personality changes, memory loss, insomnia, nightmares, and anxiety; symptoms associated with Post Traumatic Stress Disorder (PTSD). Many of the first time strangulation victims reported that they had experienced one or more of the symptoms following the first attack” (Smith et. al., 2001).

“Furthermore, experiencing nonfatal strangulation can have devastating psychological effects (Smith et al., 2001). Not only is strangulation a symbol of power and control over the victim’s life or death but being strangled is incredibly painful as well. Following the assault victims report experiencing nightmares, depression, post-traumatic stress disorder, and suicide ideation (Smith et al., 2001). Smith, Mills, and Taliaferro (2001) also considered the long-term effects of repeated strangulation, suggesting that multiple strangulation attempts on separate occasions are associated with increased frequency of negative symptomology that affects physical and mental health” (Pritchard et. al., 2015).

Use of Strangulation to Exert Power and Control

“Survivors of non-fatal strangulation have known for years what prosecutors and civil attorneys are only recently learning: Many domestic violence offenders and rapists do not strangle their partners to kill them; they strangle them to let them know they can kill them—any time they wish. Once victims know this truth, they live under the power and control of their abuser day in and day out” (Civic Research Institute, 2014).



“With nonfatal strangulation, it is possible to bring someone to the point of believing death is imminent, but then stop, either before or immediately after they lose consciousness (McClane et al., 2001; Thomas et al., 2014; Vella et al., 2017). In doing so, the abusive partner conveys a powerful and credible threat of harm—in this case, death—which is an essential element of establishing and maintaining coercive control (Dutton & Goodman, 2005)” (Messing, Thomas et. al., 2018).

“Nonfatal strangulation has been identified as a form of coercive control (Thomas et al., 2014). Based on the findings of this study, strangulation is associated with coercive control; the odds of police officers identifying at least one coercive controlling behavior (i.e., intimidation, harassment, terrorizing pets/children, stalking, or restricting use of communication) are 70% higher in cases where they also identify strangulation” (Messing, Thomas et. al., 2018).

“Using Dutton and Goodman’s (2005) conceptualization of coercive control, Thomas, Joshi, and Sorenson (2014) conducted focus groups and interviews with 17 women staying at a domestic violence shelter. Jealousy, fear of ending the relationship, and failure to meet the offender’s demands were common triggers of strangulation by their partners. Strangulation was not always an attempt to kill the victim. The women perceived their partners using strangulation as a way to exert power and control over them during and after the assault. Research has shown that experiencing strangulation once can instill enough fear in the victim that the abuser can maintain control without ever having to commit subsequent abuse (Johnson & Leone, 2005)” (Pritchard et. al., 2017).

“Nonfatal strangulation is a way an abusive partner can “set the stage” by sending the message that he can and perhaps will kill the victim—a credible threat that is intended to induce compliance. The process can be illustrated through statements made by men while strangling their female partners: ‘I can easily cut off your air supply by shutting off your carotid artery’ (perpetrator was a physician); ‘I am going to commit an OJ on you and leave no marks’ (perpetrator was in the military); ‘I am going to pop your neck’” (perpetrator was a laborer) (Strack et al., 2001). Knowing that he has the knowledge and skills to follow through with the threat can contribute to her appraisal of the threat as credible” (Thomas et. al., 2014).

“By confirming an empirical link between death threats and ongoing use of nonfatal strangulation, the present research illustrated how this violent behavior is part of a system of coercive control used to dominate intimate partners through intimidation and fear, a compelling argument developed by Dutton and Goodman (2005). Previous research used this conceptualization of nonfatal strangulation (i.e., Thomas et al., 2014), but the present research is unique in using a large sample of IPV perpetrators, tracking their extreme forms of coercive control over the course of 18 months. The results consistently showed a robust empirical relation between perpetrators’ death threats and subsequent escalation into nonfatal strangulation as a way of maintaining control through fear and intimidation. Taken together with prior research on this form of violence (e.g., Anderson, 2009; Joshi et al., 2012), it seems clear that nonfatal strangulation is part of a dynamic mechanism of coercive control that fosters domination in intimate relationships (Stark, 2007)” (Stansfield and Williams, 2018).

Escalation of Violence in Intimate Partners



“[In the 300 attempted strangulation cases a] significant number (89%) of these couples also had a prior history of domestic violence. The prior history finding suggests that victims in this study had experienced **repeated violence over a significant period of time and that the violence had escalated to the point of attempted strangulation—a potentially lethal level of violence**. Given that most victims were still living with the suspect in ongoing relationships with children, the victims in the study were clearly at high risk for future violence. **In the first case that prompted this study, the suspect’s violence escalated to murder when ‘choking’ didn’t control the victim**” (Strack, McClane, et. al., 2001).

“In addition to prevalence estimates, Wilbur et al.’s (2001) study was also influential in defining the occurrence of strangulation within the cycle of violence. Their results indicated that **abuse escalates over time, with strangulation typically occurring later in the progression of violence in the relationship**. Threats of death were common among the women who had been strangled, with 87% reported being threatened. The majority experienced physical and verbal abuse in addition to the strangulation (68%). **Threats and co-occurrence of other forms of violence along with strangulation is also evident in more recent studies** (Messing et al., 2014). For instance, in their study of 432 women recruited at the scene of police-involved intimate partner violence incidents, Messing, Thaller, and Bagwell (2014) found that **those who had experienced sexual abuse or forced sex were also more likely to experience strangulation and have their life threatened**” (Pritchard et. al., 2015).

Multiple Strangulation Assaults

“Strangulation of IPV victims may be particularly concerning because evidence suggests that many victims are strangled multiple times. An emergency-department study found that 36% of patients who were strangled were strangled more than once by their intimate partner (Mcquown et al., 2016). Studies that examined multiple strangulation found that female victims reported being strangled between three and three hundred times by abusive partners (Vella et al., 2017; Wilbur et al., 2001). The few available studies suggest that immediate symptoms and long-term sequelae of strangulation are dose-related, with an increased risk of lethality in the hours, days, and months following the strangulation event. One study found that women who had been strangled five times or more by their partner reported significantly more physical injury and post-traumatic symptoms in the two weeks following the last strangulation event compared to women who were strangled less frequently (Smith et al., 2001). Further, women strangled more than once were significantly more likely to lose consciousness due to head injury and to have a miscarriage owing to violence (Messing et al., 2018a).” (Messing et. al., 2020).

“Multiple strangulation has been identified as being associated with risk factors for homicide and severe forms of abuse (e.g., being “beat up,” threats with a deadly weapon, sexual assault), severe health outcomes, and with survivors’ feelings of powerlessness and a belief that her partner is capable of killing her (Messing et al., 2018a).” (Messing et. al., 2020).

“Patients who return to the same abuser probably will be strangled again, as abusers tend to perpetrate the same type of violence over and over, often with ever increasing rage and worsening injury toward the victim. Unfortunately,



a subsequent act of strangulation on the same patient-victim may result in a much more tragic fate” (McClane et. al., 2001).

“Moreover, several aspects of nonfatal strangulation compound its negative effects. First, it is rarely a one-time occurrence (Breiding, Chen, & Black, 2014; Joshi et al., 2012; Mcquown et al., 2016); instead, survivors often are strangled repeatedly—in some cases more than 50 times within a relationship (Breiding et al., 2014). Second, nonfatal strangulation co-occurs with other forms of serious physical violence, including sexual assault (Messing, Thaller, & Bagwell, 2014). Finally, nonfatal strangulation is, in and of itself, a risk factor for intimate partner homicide (Glass et al., 2008)” (Messing, Thomas et. al., 2018).

Underreporting of Strangulation

“Among the multiple strangulation victims, the population most at risk for serious harm, only one in four reported any medical problems, despite the injuries that were significant enough to be visible to friends and family for every two of three respondents. Yet, the victims still do not seek professional medical care. Less than one of five attack victims experiencing five or fewer attacks sought medical care; a frequency that increases to only two of five survivors of more than five attacks” (Smith et. al., 2001).

“Depending on the study, 30%-60% of domestic violence victims are strangled by their partner during a domestic violence assault. By the time officers respond, victims are often already recanting, minimizing, or are simply unaware of the seriousness of their assault, especially if strangulation is involved” (Civic Research Institute, 2014).

“Symptoms of hypoxia or asphyxia (a lack of oxygen to the brain) will likely cause the victim to be restless or hostile at the scene. The victim may appear to be under the influence of drugs or alcohol, or appear to have stroke-like symptoms. Evidence of temporary or permanent brain injury may include problems with memory, inability to concentrate, headaches, anxiety, depression, and/ or sleep disorders. The victim may be embarrassed or minimize the incident, and she will likely be traumatized from the attack” (Civic Research Institute, 2014).

“The combination of limited visible injuries, a poor understanding of the medical significance of symptoms, the victim’s failure to report symptoms, and the victim’s unwillingness to seek medical attention may have caused police and prosecutors to unintentionally minimize or trivialize the seriousness of the actual violence” (Strack et. al., 2001).

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