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Telephone scatologia
Comorbidity with other paraphilias and paraphilia-related disorders

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1. Introduction

The term scatologia is derived from the Greek word, skato, for dung and logos for speech (Gayford, 1997). Thus, telephone scatologia, also referred to as telephone scatophilia and telephonicophilia, is a paraphilia (PA) characterized by a pattern of sexual arousal associated with exposing an unsuspecting victim to sexual and obscene material over the phone (Milner & Dopke, 1997; Schewe, 1997). Telephone scatologia remains classified as a PA not otherwise specified (NOS) in the DSM-IV, because there has been insufficient description of the disorder in the literature to merit a separate category (American Psychiatric Association, 1994).

Although specific PAs are distinguished by a characteristic paraphilic focus, all PAs feature recurrent, socially deviant, highly arousing sexual fantasies, urges, and activities that have a duration of at least 6 months and cause clinically significant distress or impairment (American Psychiatric Association, 1994). These latter diagnostic criteria would distinguish true telephone scatologists (TS) from telephone callers who just make a few obscene calls as a prank.

Obscene telephone calling is a common behavior with more than 22,000 obscene phone call complaints filed in the Washington, DC area alone in 1989. This is particularly impressive considering that only 7–20% of sexually provocative calls are actually reported to the telephone company (Herold, Mantle, & Zemitis, 1979; Smith & Morra, 1994). Surveys

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offer some perspective on the percentage of people who admit either to being victimized or to placing these calls. As many as 6.2% of male students recruited from a student placement center and 14.3% of paid male volunteers recruited from a Canada Employment Center admitted having made obscene phone calls (Freund & Watson, 1990). Over 83.2% of Canadian working women had received obscene or threatening telephone calls (Smith & Morra, 1994). Forty-seven to 61% of female college students and 11% of male undergraduates had received obscene phone calls (Herold et al., 1979; Murray, 1967; Murray & Beran, 1968).

Even if one assumes that the majority of the callers would not meet the criteria for the diagnosis of telephone scatologia, these data would still suggest that telephone scatologia could be a common disorder. Inasmuch as obscene telephone calling is such a frequent behavior and one that is less likely to result in apprehension by the police, one may speculate that telephone scatologia represents a milder, more benign form of PA that occurs alone. Abel 1988, however, found only one subject out of 19 TS whose paraphilic behavior was limited to obscene telephone calling, thus, challenging the notion that telephone scatologia occurs commonly as a solitary disorder. In fact, the TS in Abel's study admitted to an average of 5.1 identified paraphilic disorders, while the average number of different PAs for all 561 subjects ranged between 3 and 5 (Abel, Becker, Cunningham-Rather, Mittleman, & Rouleau, 1988).

Telephone scatologia has remained a relatively neglected PA possibly because of this faulty perception that it is a benign and nonaggressive disorder that most often occurs alone. In fact, the largest samples of TS are not derived from research focusing on telephone scatologia. Rather, the largest samples may be extracted from Abel's (1988) and Bradford 1992 studies exploring the comorbidity of the PAs. Abel studied 561 nonincarcerated paraphiliacs seeking voluntary evaluation. His subjects were assured of confidentiality, as the material was gathered under a certificate of confidentiality that would prevent any federal, state, or city agency from accessing the data. About a third of the subjects were referred through mental health channels, a third from legal or forensic routes, and a third from other sources. Only 3% of the sample (19 subjects) were given the diagnosis of telephone scatologia.

Bradford 1992 studied 274 adult males who were consecutively admitted to a sexual behaviors clinic for forensic evaluation of suitability for a treatment program. A much higher percentage of Bradford's sample, 21%, admitted making obscene telephone calls and 14% (37 patients) were given diagnosis of telephone scatologia as their primary PA. Almost all of the subjects had some contact with the legal system; 67% were pretrial and 33% were posttrial. Because of this legal involvement and because there was no assurance of confidentiality as in the study of Abel et al. (1988), there was likely an underestimation of the admitted deviant acts. Yet, despite the variability in the distribution of the types of PAs, the assurance of confidentiality, and source of the subjects, both these studies were surprisingly consistent in showing that TS report multiple associated PAs, especially exhibitionism and voyeurism.

The current study was designed to evaluate whether there are any demographic variables or comorbid sexual disorders that distinguish TS from subjects with other PAs and paraphilia-related disorders (PRDs). PRDs were operationally defined as intensely arousing fantasies,

urges, and sexual activities that are nondeviant aspects of normal sexuality and become intensified or so frequent (for at least 6 months duration) as to interfere with the capacity for reciprocal affectionate activity (Kafka, 1991, 1994a, 1997a; Kafka & Prentky, 1992). Common PRDs include compulsive masturbation, protracted promiscuity (homosexual and heterosexual subtypes), pornography dependence, telephone sex dependence, severe sexual desire incompatibility, and dependence on sexual accessories such as drugs (e.g., nitrate inhalants and cocaine) or specific objects (e.g., dildoes). We explored the comorbid relationship among PA and PRD groups to assess whether a particular PA or PRD was statistically significantly associated with the telephone scatologia group compared to the group including the rest of the PAs. To our knowledge, there have been no studies measuring the association of telephone scatologia with the PRDs.

2. Method

2.1. Study definitions

Lifetime PA diagnoses (PAs) were assigned using DSM-IV criteria (American Psychiatric Association, 1994). Comorbidity was defined as the current or lifetime presence of two or more discrete psychiatric disorders in the same individual. Thus, the comorbid disorders may have occurred before, after, or during the course of the disorder that initially brought the subject into treatment. Lifetime PRDs were classified and diagnosed according to the criteria of Kafka and Prentky (1992) as described in Section 1.

2.2. Study population

Data were collected prospectively from 206 consecutively evaluated outpatient males (the combined sample [CS]), who were referred to a single psychiatrist (M.P.K.) practicing at a large private teaching hospital in the Northeast. The sample data from this study is also included in another publication examining the comorbid relationship between PAs and PRDs (Kafka & Hennon, 1999). Study subjects were obtained through self-referral, mental health channels, and legal and forensic sources. Subjects were considered sexual offenders if they had any form of contact with the legal system as the result of their paraphilic behavior. Contact may have involved arrest or conviction or may have just entailed being apprehended by police without formal charges being filed.

The TS accounted for 20 of the 206 outpatients (9.7% of CS). The entire study population, the CS ($N=206$), was subdivided into the PA group ($N=143$; 69.4% of CS), and the PRDs group ($N=63$; 30.6% of CS). All patients with at least one PA were categorized in the PA group even if their chief complaint related to a PRD. Patients without any PAs but at least one PRD were characterized in the PRD group. Thus, while the PRD group excluded any men with a comorbid PA, men in the PA group could also have comorbid PRDs. Only 20 PA subjects (9.7% of the CS) did not, in fact, report any PRDs.

For statistical testing, the CS was subdivided into the TS group ($N=20$) and CS − TS ($N=186$). Similarly, the PA group was further subdivided into the TS group ($N=20$) and PA group excluding the TS (PA − TS; $N=123$).

2.3. Study materials

Subjects were asked to complete an Intake Questionnaire that gathered demographic data. Lifetime sexual diagnoses were assessed using a structured Sexual Inventory (unpublished inventory, available from Dr. Kafka upon request) and confirmed by psychiatric interview.

2.4. Study statistics

The telephone scatologia group was compared both to the rest of the CS (CS − TS) and to the remaining PA group (PA − TS) when considering demographic variables and number of comorbid PRDs. The TS group was also compared to these groups in assessing whether telephone scatologia was statistically significantly associated with a particular PRD. Since by definition the PRD group did not contain any individuals with PAs, the telephone scatologia group was compared only to the PA − TS subgroup when evaluating whether telephone scatologia was statistically significantly associated with a particular PA. Statistical means are reported with standard deviations. Median values are included as well when indicated. Because continuous variables were nonnormally distributed (Shapiro–Wilk test, $P=.012$ for age, $P<.01$ for all others), the Wilcoxon rank-sum test rather than a t test was used to compare the TS to the CS − TS or PA − TS subgroups on the continuous dependent variables. Comorbidity of telephone scatologia with other PAs and PRDs was tested by forming a 2×2 contingency table and testing for the association with the chi-square statistic. In addition, Fisher's exact test was used when the cell frequencies were less than 5.

3. Results

3.1. Comparison on demographic characteristics

Demographic characteristics of the study groups are summarized in Table 1. For the CS (the entire sample), the age ranged from 15 to 69 ($M=36.8$, S.D. = 9.5, median = 36). The level of education ranged from 8 to 24 years, ($M=15.4$, S.D. = 3.2, median = 16). Ninety-six percent of the sample ($N=198$) was White and 57.7% ($N=119$) had been married at least once. Of those who were employed, their income ranged from US$5000 to US$400,000 ($M=$ US$58,800, S.D. = US$5420, median = US$45,000). Employment status of all subjects indicated that 80.1% ($N=165$) were currently employed, 7.8% were students, 4.9% were unemployed, 6.3% were disabled, and 1% was retired. Excluding the students and retired subjects, 87.8% of the remaining patients were employed.

There significant difference between the PA group and PRD group in terms of the employment rate, 83% and 96%, respectively ($\chi^2(1)=6.03$, $P=.014$); and education, mean

Table 1
Characteristics of samples

	Combined sample (CS), $N=206$	CS – telephone scatologia (TS), $N=186$	Paraphilia group (PA), $N=143$	PA – TS, $N=123$	Paraphilia-related disorder (PRD), $N=63$	TS, $N=20$
Age (years)	36.8	37.1	36.7	37.1	37.0	34.6
Education (years)	15.4	15.6	15.0	15.3	16.2	13.2
Income of employed in thousands of dollars	58.8	58.7	54.7	53.9	66.8	59.9
Total PAs	1.2	1.08	1.73	1.62	0	2.55
Total PRDs	2.16	2.17	1.91	1.85	2.73	2.70
Sum PAs and PRDs	3.36	3.15	3.64	3.47	2.73	5.25

age are 15 and 16.2 years, respectively. The TS did not differ from the other paraphiliacs in employment rate but did have a significantly lower educational level even when compared to the rest of the paraphiliacs ($M=13.2$ vs. 15.3 years, Wilcoxon $Z=2.39$, $P=.017$).

There was no significant difference between the entire sample CS – TS group and the TS group on age ($M=37.1$ vs. 34.6 years), income ($M=58.7$ vs. 59.7 thousand dollars), and marital status (50% vs. 55% currently married). Similarly, comparisons on numeric variables between the TS group ($N=20$) and the paraphiliacs excluding TS (PA – TS group, $N=123$) indicated no significant difference in age ($M=34.6$ vs. 37.1 years) or income (59.8 vs. 53.8 thousand dollars).

Of the 143 patients in the PA group, 103 (72% of the PA group) were sexual offenders. All of the TS ($N=20$) fell into this offender group. In comparing the prevalence of sex offending to other specific paraphilic diagnoses, 30 out of the 32 pedophiles (93.8%) were offenders, 34 out of 35 (97.1%) voyeurs, 51 out of 52 (98%) exhibitionists, and all the 12 frotteurs were offenders. In contrast, only 3 out of 13 (23%) sadists, 5 out of 19 (26.3%) masochists, 8 out of 17 (47.1%) with a fetish, and 7 out of 20 (35%) with transvestic fetishism were offenders. Offender designation did not require apprehension for the specific paraphilic behavior associated with each disorder. Thus, given the frequency of comorbid disorders with high offender rates, TS need not have been arrested for obscene telephone calling to have been characterized as offenders. In fact, behavior associated with a comorbid disorder may have led to contact with the legal system.

3.2. Comparison on total number of PAs and PRDs

The number of PAs per patient for the CS ranged from 0 to 6 ($M=1.2$, median = 1). The number of PRDs per patient ranged from 0 to 6 ($M=2.16$, median = 2). The total number of PAs plus PRDs per patient ranged from 1 to 9 ($M=3.36$, median = 3).

The PA group compared to the PRD group had a significantly increased total number of sexual impulsivity disorders (SIDs; PAs + PRDs) but a lower total number of PRDs per

Table 2
Distribution of total number of PAs

Total number of PAs per subject	Frequency in CS − TS, $N=186$	Frequency in PA − TS, $N=123$	Frequency in TS, $N=20$
0 (PRDs only)	63 (33.9%)	0 (0%)	0 (0%)
1	73 (39.2%)	73 (59.3%)	4 (20%)
2	32 (17.2%)	32 (26.0%)	6 (30%)
3	11 (5.9%)	11 (8.9%)	7 (35%)
4	5 (2.7%)	5 (4.1%)	2 (10%)
5	2 (1.1%)	2 (1.6%)	0 (0%)
6	0 (0%)	0 (0 %)	1 (5%)

subject ($M=1.91$ vs. 2.73, $P=.001$) than subjects with just PRDs (PRD group). Unlike the rest of the paraphiliacs (PA − TS), the TS did not share a decrease in number of associated PRDs compared to the group with just PRDs. Rather, there was no significant difference from the PRD group in total number of PRDs ($M=2.70$ vs. 2.73).

The telephone scatologia group compared to the remaining paraphilic group (PA − TS) disclosed an increase in comorbid SIDs. The TS had a significantly greater total number of PAs ($M=2.55$ vs. 1.62, Wilcoxon $Z=3.74$, $P=.0002$) as well as PRDs ($M=2.70$ vs. 1.85, Wilcoxon $Z=2.95$, $P=.003$). Thus, compared to the remaining paraphiliacs, TS also disclosed a significantly greater sum of PA and PRDs (5.25 vs. 3.41, Wilcoxon $Z=4.17$, $P=.0001$). Only four patients reported that telephone scatologia was their only PA. The distribution of numbers and frequencies of the PAs and the PRDs in the CS and the other study groups are summarized in Tables 2 and 3.

3.3. Comorbidity with PAs and PRDs

We compared the association between telephone scatologia (TS group, $N=20$) and each of the other PAs with the association of the other paraphiliacs excluding the TS, PA − TS group ($N=123$) with each disorder. This approach excluded subjects who did not have any PAs. We hypothesized that TS would display a specific pattern of comorbidity when compared to other paraphiliacs. The literature suggested both a theoretical and empirical association between telephone scatologia and exhibitionism and voyeurism. In addition, our data indicated that

Table 3
Distribution of total number of PRDs

Total number of PRDs per subject	CS − TS, $N=186$	TS, $N=20$
0 (PAs only)	20 (10.8 %)	0 (0%)
1	44 (23.7 %)	2 (10%)
2	50 (26.9 %)	7 (35%)
3	39 (21.0 %)	6 (30%)
4	23 (12.4 %)	5 (25%)
5	9 (4.8 %)	0 (0%)
6	1 (0.5 %)	0 (0%)

55% of TS had comorbid exhibitionism and 45% had comorbid voyeurism. We then evaluated whether there were any unexpected associations with other PAs. We confirmed a significant association with voyeurism ($\chi^2(1) = 5.30$, $P = .021$) but just a trend association with exhibitionism ($\chi^2(1) = 3.55$, $P = .062$). There were no unexpected findings. Absence of nonincestuous pedophilia ($\chi^2(1) = 4.93$, $P = .026$) and absence of any pedophilia ($\chi^2(1) = 6.70$, $P = .010$) were not significant when the Bonferroni adjustment was applied. There was no significant association with frotteurism, incestuous pedophilia, fetishism, transvestism, sadism, masochism, and PA NOS.

We then compared the association between telephone scatologia and each of the PRDs with the association of the entire sample excluding the TS CS – TS ($N = 186$) and each PRD. Using a Bonferroni adjustment, only P values less than .00625 were considered significant. Telephone scatologia group showed a trend association with compulsive masturbation ($\chi^2(1) = 6.03$, $P = .009$). Use of phone sex ($\chi^2(1) = 5.18$, $P = .023$) and absence of homosexual promiscuity ($\chi^2(1) = 0.134$, $P = .055$) were not significant when the Bonferroni adjustment was applied.

When the same chi-squares were run substituting the PA – TS group ($N = 126$), compulsive masturbation ($\chi^2(1) = 8.18$, $P = .004$) and phone sex ($\chi^2(1) = 10.36$, $P = .001$) became significant even with Bonferroni adjustment. There was no significant association with absence of homosexual promiscuity ($\chi^2(1) = 1.39$, 0.09). There was no significant association with heterosexual promiscuity, any promiscuity, use of pornography, use of accessories, and sexual

Table 4
Percentage with each PA or PRD

	CS – TS (%), $N = 186$	PA – TS (%), $N = 123$	TS (%), $N = 20$
Exhibitionism	22.0	33.3	55
Voyeurism	14.0	21.1	45
Nonincestuous pedophilia	13.4	20.3	0
Incestuous pedophilia	4.8	7.3	0
Any pedophilia	17.2	26.0	0
Fetishism	8.1	12.2	10
Transvestic fetishism	12.4	18.7	5
Sadism	7.0	10.6	0
Masochism	11.8	17.9	10
Frotteurism	4.8	7.3	15
Rape	2.9	4.3	5
Paraphilia NOS	9.1	13.8	15
Compulsive masturbation	66.7	62.6	95
Heterosexual promiscuity	35.9	28.5	40
Homosexual promiscuity	23.7	14.6	5
Any promiscuity	52.0	46.0	45
Pornography	49.5	42.3	60
Phone sex	22.0	14.6	45
Use of accessories	8.6	9.8	5
Sexual incompatibility	11.3	12.4	20
Telephone scatologia	0	0	100

Table 5
Comorbidity of TS

	Exhibitionism, %	Voyeurism, %	Fetish, %	Transvestic fetish, %	Sadism, %	Masochism, %	Frotteurism, %
Abel et al. (1988)	63	47	0	16	21	0	21
Bradford et al. (1992)	35.1	62.2	NA	18.9	NA	NA	46
Price et al.	55	45	10	5	0	10	15

incompatibility with partner. Table 4 reports the distribution of the PAs and PRDs in the sample. Table 5 illustrates the percentage of TS with select PAs across three studies; the current study, that of Abel (1988) and that of Bradford (1992). Since the category of pedophilia was not subdivided in the same manner across studies, pedophiles were not included in the chart.

4. Discussion

In this sample of 206 outpatients with PAs and PRDs, the PA and PRD group could not be distinguished by primary demographic variables except for educational achievement and current employment status. In those domains, the PAs differed from the PRDs by reporting fewer years of completed education and a greater likelihood of being currently unemployed or disabled. The TS group differed from the PA − TS group only in educational achievement, reporting even fewer years of completed education.

The PA group was also statistically significantly different from the PRD group by the disclosure of a greater number of total lifetime SIDs per subject. In this domain again, the TS differed from the PA − TS group by reporting even greater numbers of lifetime SIDs, reflecting elevations in both numbers of PAs and PRDs per subject (P=.0001). In addition, in comparison with the PA − TS group, the TS group was statistically significantly more likely to be comorbidly associated with voyeurism (P=.021). There was a trend association with exhibitionism (P=.062) but no other PA diagnoses. Telephone scatologia was also significantly associated with two PRDs, compulsive masturbation (P=.004) and telephone sex dependence (P=.001).

Our major findings of greater numbers of associated PAs and PRDs and significant comorbid association with voyeurism, compulsive masturbation, phone sex dependence, and trend association with exhibitionism add to the growing body of empirically based research characterizing telephone scatologia. The TS in our outpatient sample did not limit their sexual impulsivity to obscene telephone calling. Rather, they had greater numbers of multiple lifetime deviant and non deviant SIDs even when compared to other paraphiliacs. Earlier studies by Abel (1988) and Bradford (1992) also suggest that telephone scatologia does not commonly occur as a solitary disorder in treatment settings. Abel's subjects

reported an even greater number of comorbid PAs, 5.1 PAs/TS. His subjects were assured of confidentiality so they may have been more willing to admit to an even wider variety of deviant behavior.

The TS's significantly increased number of comorbid disorders compared to other paraphiliacs, has both forensic and treatment implications. A forensic evaluator needs to question whether an evaluee referred for obscene telephone calling is engaging in other even more serious paraphilic behavior. This is particularly relevant when assessing the risk of recidivism. Treatment issues may also arise, as some modalities may require separate treatment for each paraphilic behavior. Alford (1980) has reported that when covert sensitization was used to treat a patient with both telephone scatologia and exhibitionism, both deviant behaviors needed to be addressed separately. There was only a partial response when treatment was directed at only the telephone scatologia. Pharmacological options would likely treat the comorbid disorders, but without knowledge of the other SIDs, it would be difficult to monitor treatment response meaningfully (Bradford, 1996; Kafka,1994b, 1997b).

We attempted to evaluate whether TS compared to other paraphiliacs had a pattern of comorbidity with particular PAs of PRDs rather than a nonspecific increase in SIDs. This preliminary analysis was limited by the small sample size of TS and the under representation of some PAs.

The finding of a statistically significant comorbidity with both compulsive masturbation and phone sex dependence was anticipated. The TS often masturbates during the call or later while recalling the call and telephone scatologia and phone sex dependence both rely on the use of the telephone (Hobson, 1983). In fact, 95% of the scatologists had comorbid compulsive masturbation and 45% had comorbid phone sex dependance. Matek (1988) has suggested that the telephone allows a mixture of anonymity and closeness. The TS fantasizes while masturbating and the ability to fantasize is also an essential component in telephone sex dependence although the object of the fantasy is a willing paid participant.

We anticipated an association with exhibitionism and voyeurism. The trend association with exhibitionism follows the traditional view of telephone scatologia as a "nonvisual analogue of exposing" (Freund, Watson, & Rienzo, 1988; Goldberg & Wise, 1985; Hobson, 1983). Both disorders involve sudden attempts to provoke fear, shock or aversion in strangers, and physical contact with the victim is not required for the sexual gratification of the perpetrator (Bloch, 1932 in Alford, Webster, & Sanders, 1980; Dalby, 1988). The classic link between exhibitionism and telephone scatologia is here less pronounced than voyeurism (Nadler, 1968); this may reflect the central role of fantasy in the obscene telephone calling as "acoustic voyeurism."

The correlation of telephone scatologia with both voyeurism and exhibitionism would also lend support to Kurt Freund's courtship disorder model. He identified four stages of a normal courtship pattern and predicted comorbidity among the courtship disorders (Freund, Scher, & Hucker, 1983; Freund, Scher, & Hucker, 1984; Freund, Seto, & Kuban, 1997; Freund & Watson, 1990). The correlation with exhibitionism and voyeurism also supports John Money's "lovemap" theory, which suggests that telephone scatologia occurs when an

abnormal lovemap develops that interferes with the ability to participate in loving sexual intercourse. In this model, telephone scatologia, exhibitionism, and voyeurism are all classified as allurement PAs involving the preparatory or courtship phase prior to genital intercourse (Bergner, 1988; Money, 1984, 1988).

In comparing this study with those of Abel (1988) and Bradford (1992), one might expect that the comorbid profile would vary because of the differences in the relative distribution of the PAs, the assurance of confidentiality, and the referral sources. There was a surprising consistency in the comorbidity of telephone scatologia with exhibitionism, voyeurism, and frotteurism (Table 5). Our findings indicate that 55% of the TS were also exhibitionists, 45% were voyeurs, and 15% were frotteurs. Bradford's (1992) sample of TS reported a greater comorbidity with voyeurism and frotteurism and a lower comorbidity with exhibitionism compared to our sample and that of Abel (1988). Bradford's sample differed from the others in that virtually all of his subjects were either pre- or posttrial, predisposing to a different mix of subjects.

Freund (1988) did confirm a stronger relationship between exhibitionism and telephone scatologia compared to other PAs. He found that 28.7% of exhibitionists in his study engaged in making obscene telephone calls compared to 13% of nonexhibitionist sex offenders (Freund et al., 1988). Saunders and Awad found that in their sample of 19 male adolescent sexual offenders who had engaged in exhibitionism or telephone scatologia, a majority had committed numerous sexual offences (Saunders & Awad, 1991).

While Abel and Bradford did not perform the same type of analysis as in our study, their data do suggest correlation with a wider range of PAs, particularly rape and pedophilia. None of the TS in our study were pedophiles and only one patient had admitted to rape. These results were inconsistent with the earlier studies. In contrast, Abel noted that 42% of the scatologists admitted to female nonincestuous pedophilia, 16% to male nonincestuous pedophilia, and 26% to female incestuous pedophilia. Thirty-seven percent admitted having committed rape and 21% were sadists. Bradford reported co-occurrence with pedophilia although offences involving incest were not included. He reported that 24.3% had attempted rape and 13.5% acknowledged committing rape. Twenty-seven percent were diagnosed with heterosexual pedophilia, 24.3% with heterosexual hebephilia, 24.3% homosexual pedophilia, 8.1% with heterosexual hebephilia, and 18.9% as cross-dressers (Bradford, Boulet, & Pawlak, 1988). Part of the observed difference may be attributed to the paucity of rapists and pedophiles in our sample; there were only 32 pedophiles and 7 rapists in the entire sample.

While our own data did not support a clustering with sadism or rape, further studies do support an association of obscene telephone calling with aggressive sexual deviancy. In a study of 36 murderers who had raped and mutilated their victims, 22% of the subjects admitted making obscene telephone calls. This group could be further differentiated on the basis of a history of sexual abuse. Of the sexually abused murderers, 36% had engaged in obscene phone calling compared to only 15% of the group of murderers who denied a history of sexual abuse (Ressler, Burgess, Hartman, Douglas, & McCormick, 1986). Sexually sadistic offenders had a significant history of telephone scatologia (Gratzer & Bradford, 1995). Warren found that 45% of sexually sadistic murderers had a paraphilic

interest in peeping, indecent exposure or obscene telephone calling (Warren, Hazelwood, & Dietz, 1996).

One of the major limitations of our study is that all of the TS in our sample were in the offender group and may not be typical of TS in the community. Conceivably, there is a potentially large group of TS who have never been apprehended, do not seek treatment and may not have multiple PAs. Dalby (1988) reported on several cases of exclusive obscene telephone callers who do not complain of any other form of sexual deviancy including concomitant traditional exhibitionism.

Furthermore, the TS in our sample were not questioned about the order in which the PAs arose and whether any particular factor favored a shift to telephone scatologia. Matek (1988) has questioned whether the TS may have more anxiety about actual sexual contact than other paraphiliacs or may just be responding to a greater fear of apprehension. This would imply that there could be a subgroup of TS who substitute obscene telephone calling for more risky paraphilic behavior to avoid further legal difficulties. Thus, the higher rates of comorbidity that we observed may reflect an overrepresentation in our sample of this subgroup of TS who already have multiple SIDs and are more likely to be referred for treatment.

More research is needed to assess whether TS in the community do differ from our sample. It is unclear how often telephone scatologia does arise as the initial PA, perhaps as an extension of occasional obscene telephone calling. These TS, who limit their paraphilic behavior to obscene telephone calling, are likely to escape police involvement and may not present for treatment. This subgroup may not have comorbid PAs or develop other PAs later in the course. Alternatively, telephone scatologia may arise in an individual who already manifests multiple other deviant behaviors, as a safer alternative of a SID.

Last, it is possible that there are subgroups of males whose sexual arousal and motivation associated with telephone scatologia differ. For example, it has been reported that the males with telephone scatologia and comorbid exhibitionism may utilize the telephone to shock, surprise, or seduce an unsuspecting female, while TS with comorbid voyeurism could be primarily motivated to "peep" by soliciting information as a primary component of sexual arousal (Almansi, 1979, 1985; Ellis, 1978; Kentsmith & Bastani, 1972; Moergen, Merkel, & Brown, 1990; Shengold, 1982; Silverman, 1982a, 1982b; Socarides, 1988). Thus, the TS with comorbid exhibitionism may use a lewd remark as an analogue for exposing. In contrast, the obscene telephone call of the voyeur may reflect elements of traditional voyeurism. He may pretend to conduct a survey about sexual behavior, while keeping his true motive hidden. The link between telephone scatologia, voyeurism, exhibitionism, and other PAs is likely to be complex with different elements dominating in a particular behavioral pattern. Such subtyping of telephone scatologia, determined by the pattern of association with other PAs and/or PRDs, has been suggested as an alternative to Mead's (1975) and Masters, Johnson, and Kolodny's (1982) classifications (Price, Gutheil, Commons, Kafka, & Dodd-Kimmey, in press; Price, Gutheil, Kafka, Commons, & Dodd-Kimmey, 1998). Future research with this population of understudied paraphiliacs may profitably be directed at defining subtypes of telephone scatologia based on comorbidity and lifetime sequence of paraphilic behavior.

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The paraphilia-related disorders: An empirical investigation of nonparaphilic hypersexuality disorders in 206 outpatient males. Journal of Sex and Marital Therapy, 25, 305-319. Krueger, R.B., & Kaplan, M.S. (2000).Â Telephone scatologia: Comorbidity with other paraphilias and paraphilia-related disorders. International Journal of Law and Psychiatry, 25, 37-49. Share this Telephone scatologia is a type of paraphilia categorized as â€˜Other specified paraphilic disorderâ€™ in DSM-5. This group includes necrophilia (corpses), zoophilia (animals), coprophilia (feces), klismaphilia (enemas), urophilia (urine) and other types of paraphilic disorders which are less frequent and do not meet diagnostic criteria for one of the specific categories. Obscene and sexual phone calls, sexually arousing fantasies, sexual urges or behaviors are present at least for six months in telephone scatologia. It is often accompanied by masturbation.Â 9.Price M, Kafka M, Commons ML, Gutheil TG, Simpson W. Telephone scatologia: comorbidity with other paraphilias and paraphilia-related disorders. Int J Law Psychiatry 2002; 25:37-49. [CrossRef]. Thus, telephone scatologia remains classified as a paraphilia not otherwise specified (NOS) in the DSM-P/,1 a category reserved for sexual disorders that either are uncommon or have been so inadequately described in the literature that a separate category is not warranted. The term scatologia is derived from the Greek words skato, for dung, and logos, for speech.3 The disorder is also referred to as telephone scatophilia, and telephomcophilia.4.Â These demographic studies have strongly suggested an association with other paraphilias and a grouping among the paraphilic courtship disorders.10'12 However, to date, there has been no attempt to link the content of the call to comorbid disorders. The American Psychiatric Association, in its Diagnostic and Statistical Manual, Fifth Edition (DSM), draws a distinction between paraphilias (which it describes as atypical sexual interests) and paraphilic disorders (which additionally require the experience of distress or impairment in functioning).[1][2] Some paraphilias have more than one term to describe them, and some terms overlap with others.Â Telephone scatologia. Obscene phone calls, particularly to strangers; also known as telephonicophilia[2][14] and scatophilia[54]. T[edit].Â "DSM to Distinguish Paraphilias From Paraphilic Disorders". Psychiatric News. American Psychiatric Association. Retrieved 16 June 2013.Â "Amputee identity disorder and related paraphilias". Psychiatry. 3 (8): 27â€“30. doi:10.1383/psyt.3.8.27.43394.