

# Firesetting, Arson, Pyromania, and the Forensic Mental Health Expert

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Firesetting is a common behavior that is frequently encountered by forensic mental health experts when consulting on criminal and civil legal cases. Despite its prevalence, minimal attention has been paid in the literature to conducting firesetting-related forensic evaluations. In this article, we discuss the differences in the behavior of firesetting, the crime of arson, and the diagnosis of pyromania. The literature on adult firesetter characteristics, classification systems, recidivism, and treatment is reviewed. Several types of common criminal and civil firesetting-related evaluations referred to forensic mental health experts are discussed, along with case examples illustrating how the courts have approached such assessments. To our knowledge, this article is the first in 20 years to address firesetting-related forensic evaluations within the psychiatry literature. It also represents the first comprehensive discussion of civil evaluations related to firesetting.

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Firesetting is a common behavior that often results in legal and mental health system involvement. Over 62,000 arsons are committed annually in the United States, with nearly \$1 billion in losses per year.<sup>1</sup> Arson is one of the easiest crimes to commit; no weapon is needed, and it can be done impulsively without interpersonal interaction.<sup>2–4</sup> Fires are often set by individuals with psychiatric and substance use problems.<sup>5–7</sup> Thus, firesetting is frequently encountered by mental health experts in consulting on legal cases. Despite the prevalence of such cases in the courts, minimal attention has been paid in the literature to conducting firesetting-related forensic evaluations.

An effective expert must understand the forensic concerns surrounding firesetting. Therefore, in this article, we review the mental health literature on adult firesetting, arson, and pyromania. We also discuss several types of criminal and civil firesetting-related evaluations that are commonly referred to forensic mental health experts, with case examples illustrating how the courts have approached them.

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Relevant articles and legal cases were obtained via PubMed and LexisNexis. To our knowledge, this article is the first in 20 years<sup>8</sup> to address firesetting-related forensic evaluations in the psychiatry literature. It also represents the first comprehensive discussion of civil evaluations related to firesetting.

## The Behavior of Firesetting

It is important to differentiate several key terms related to firesetting, as not all firesetters have committed arson. Furthermore, most arsonists do not meet the diagnostic criteria for pyromania. In short, firesetting is a behavior, arson is a crime, and pyromania is a psychiatric diagnosis. Despite these distinctions, courts have erroneously applied these terms interchangeably.<sup>9–15</sup> The forensic expert can be of greater utility to the legal system by educating nonclinicians about the differences in the definitions of firesetting, arson, and pyromania.

In the broadest sense, firesetting is a behavior that includes both the accidental (e.g., falling asleep with a cigarette) and intentional setting of fires (with or without criminal intent). Intentional firesetting is not always a symptom of underlying psychiatric pathology, nor is it always a criminal act. For example, interest in fire is nearly universal in children, and firesetting is often due to curiosity in this age group.<sup>16</sup> An adult who intentionally sets a campfire that then spreads to a nearby structure may not be criminally charged if reasonable precautions were

taken. Pathological firesetting, which is the intentional setting of fires for psychological reasons, may be a symptom in a range of psychiatric disorders.<sup>17</sup> Pathological firesetting is not pathognomonic of pyromania<sup>18</sup> and does not always equate to arson.

### The Crime of Arson

Arson, a subtype of firesetting, is a criminal act in which one willfully and maliciously sets fire to or aids in setting fire to a structure, dwelling, or property of another.<sup>1,19</sup> By this definition, arson excludes accidental firesetting. The law presumes all burning to be accidental. The prosecution must overcome this presumption by proving that the fire was set by criminal design.<sup>19</sup> Further, this definition makes no reference to motive or psychiatric pathology.

Arson is defined in most jurisdictions as a general-intent crime. The prosecution only need prove that the accused willfully and maliciously started the fire, even if he was negligent or unaware of the circumstances surrounding the fire.<sup>19</sup> Criminal intent may be proved with circumstantial rather than direct evidence, as arson is often committed alone and without witnesses. Examples of circumstantial evidence could include threats to destroy property, the incendiary origin of the fire, and recently increased fire insurance coverage.<sup>19</sup>

The burning of an occupied dwelling often incurs more severe punishment than the burning of an unoccupied structure. Most jurisdictions provide that the crime is either first-degree or aggravated arson when there is a risk to human life because of the fire.<sup>19</sup> Risk is measured by the potential, not actual, harm to persons, including firefighters. Federal Bureau of Investigation data indicate that the rate of arson in urban communities is twice that in suburban or rural areas.<sup>20</sup> Most arson fires are set at night.<sup>7,21,22</sup> Buildings are the most common target of arson,<sup>23</sup> and accelerants are used in most cases.<sup>3</sup>

The research on arson offenders is primarily based on case series of individuals who have been arrested for arson or arrested for arson and subsequently committed to forensic hospitals. Thus, a limitation must be placed on generalizing the results of the current literature to all arsonists. This restriction becomes more pronounced when one considers that more than 80 percent of all arson cases in the United States do not result in arrest.<sup>23</sup>

Most arsonists are male,<sup>3,5-7,24-27</sup> although the proportion of female arsonists is increasing.<sup>24,26</sup> Fe-

males tend to set fire to their own property or the property of partners, relatives, or neighbors.<sup>28,29</sup> Late adolescence through early adulthood is a high-risk period for arson.<sup>3,5-7,25-27</sup> Arson offenders are often unmarried, poorly educated, living alone, and unemployed.<sup>3,4,6,21,22,24,28,30-35</sup> Those who are employed tend to be unskilled laborers.<sup>3,7,21,35</sup> Arsonists referred for forensic evaluation are more likely to be unemployed and less educated than are similarly referred homicide offenders.<sup>24,32</sup> They also are more socially isolated and introverted, less physically attractive, and less assertive than are other mentally disordered offenders.<sup>22</sup> Female arsonists are likely to have a history of being sexually abused.<sup>29</sup> Most arsonists have criminal histories before an arson arrest. However, most arson arrestees do not have prior arson convictions or a known history of firesetting.<sup>3,25-27,30,33</sup>

Mental illnesses are over-represented in arsonists compared to the general population and other offender groups.<sup>6,7,21,24,32</sup> Yesavage *et al.*,<sup>7</sup> reported that all convicted arsonists in France are required to undergo a psychiatric evaluation. In their study, 54 percent had a diagnosable mental illness. Further, the mentally ill arsonists set a greater number of total fires than did the non-mentally ill group. When compared with homicide offenders referred for psychiatric evaluation, more referred arsonists have diagnosed mental illnesses, histories of mental health treatment, and suicidal tendencies.<sup>24,32</sup> Between 19 and 56 percent of studied arsonists have a history of suicide attempts.<sup>3,21,22,24,29,32,36-38</sup>

Firesetters as a group exhibit diagnostic heterogeneity. Substance use disorders, particularly involving alcohol, are among the most frequently cited conditions associated with arson. Most individuals arrested for arson and referred for psychiatric evaluation have a history of substance use disorders.<sup>3,28,31,33,37-41</sup> Acute alcohol intoxication has been found to be associated with 20 to 86 percent of arsons in prison and forensic hospital studies.<sup>3,24,29-33,39-41</sup> Arson offenders referred for forensic evaluation are significantly more likely to have alcohol use problems than are referred homicide offenders.<sup>24,32</sup>

The likelihood that arson offenders have a diagnosis of schizophrenia has been estimated to be more than 20 times greater than that in the general population.<sup>6</sup> Yesavage *et al.*<sup>7</sup> found that 10 percent of all convicted arsonists had schizophrenia. In another study, the authors reported that arson offenders referred for pretrial psychiatric evaluation were four

times more likely to have a psychotic illness than were homicide offenders.<sup>32</sup> Of those arsonists referred for psychiatric assessment, between 8 and 76 percent have a diagnosis of schizophrenia or other psychotic disorders.<sup>21,28,30,31,33–35,38,40,42</sup>

Mental retardation and low intellectual functioning have also received considerable attention in the arson and firesetting literature.<sup>5,31,43,44</sup> In one study, arson was the most common offense committed by Finnish intellectually disabled criminal offenders.<sup>45</sup>

Personality disorders, in particular antisocial and borderline personality disorders, have also been commonly observed in populations of arsonists in correctional and forensic hospital settings.<sup>21,28–30,35,36</sup>

Other psychiatric disorders less commonly cited as being associated with arson include mood disorders, anxiety disorders, intermittent explosive disorder, pervasive developmental disorders, attention deficit hyperactivity disorder, and dementia.<sup>3,7,8,18,29–31,33,36,38,42,46–48</sup> Pyromania is uncommon.<sup>3,7,8,22,24,28,30–35,39,46,49,50</sup> Treatments of adult arsonists include addressing underlying mental illness and substance use disorders; use of social skills training, cognitive behavioral therapy, and relapse prevention techniques; and focusing on other factors that may precipitate the behavior.<sup>2,8,18,22,29,45,48,51,52</sup>

### The Diagnosis of Pyromania

Pyromania is a psychiatric diagnosis rather than a legal term. Individuals with pyromania engage in intentional and pathological firesetting, but do not always commit the crime of arson. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)<sup>53</sup> currently includes firesetting as a symptom in pyromania and conduct disorder. Although firesetting behavior accounts for only 1 of 15 potential symptoms of conduct disorder, it is central to the diagnosis of pyromania (Table 1).

Pyromania is not a recent addition to psychiatric diagnoses. The term was first used by Marc in 1833.<sup>8,30,46,51</sup> Kraepelin defined pyromania as an impulsive insanity, and Freud described it as resulting from aberrant psychosexual development.<sup>15,51</sup> A landmark study by Lewis and Yarnell<sup>5</sup> in 1951 heralded the modern age of pyromania and firesetting research. The Diagnostic and Statistical Manual of Mental Disorders, First Edition (DSM-I),<sup>54</sup> listed pyromania as an obsessive-compulsive reaction. There was no mention of it in the Diagnostic and

**Table 1** DSM-IV-TR Diagnostic Criteria for Pyromania

Deliberate and purposeful firesetting on more than one occasion.
Tension or affective arousal before the act.
Has a fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, and consequences).
Pleasure, gratification, or relief when setting fires or when witnessing or participating in their aftermath.
The firesetting is not done for monetary gain, as an expression of sociopolitical ideology, to conceal criminal activity, to express anger or vengeance, to improve one's living circumstances, in response to a delusion or hallucination, or as a result of impaired judgment (e.g., in dementia, mental retardation, or substance intoxication).
The firesetting is not explained by conduct disorder, a manic episode, or antisocial personality disorder.

Statistical Manual of Mental Disorders, Second Edition (DSM-II).<sup>55</sup> The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III),<sup>56</sup> included it as a disorder of impulse, not otherwise specified.<sup>15</sup> Pyromania currently is included in DSM-IV-TR<sup>53</sup> as an impulse-control disorder, and proposals for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), suggest that it will remain in this category.<sup>57</sup>

Pyromania is a rare diagnosis, even among first-time and recidivist arsonists.<sup>3,7,24,28,31,32,39,49</sup> Setting fires for sexual arousal is even rarer.<sup>5,7,21,30,31,58,59</sup> The overall prevalence of pyromania in adult populations is unknown, although three to six percent of psychiatric inpatients have been reported to meet the diagnostic criteria.<sup>60,61</sup> Research on pyromania has been limited by its estimated low prevalence and the reluctance of individuals to disclose their ongoing propensity to set fires.

Grant and Kim<sup>59</sup> reported on a community sample of patients with an established diagnosis of pyromania. Most subjects began to set fires in adolescence or early adulthood. The frequency and intensity of firesetting increased over time. Two-thirds engaged in planning behavior before setting the fires (e.g., collecting combustible items). Common triggers for firesetting included stress, boredom, feelings of inadequacy, and interpersonal conflict. One-quarter reported no triggers. All experienced a rush when watching or setting fires. None experienced sexual arousal. A fascination with fire was common, and more than one-third reported traveling to fires when they heard fire engines. Another study observed an association between pyromania and volunteer fire fighting.<sup>39</sup>

More than 90 percent of individuals with pyromania in the Grant and Kim study<sup>59</sup> had diagnoses of comorbid Axis I disorders, with mood, other impulse control, and substance use disorders being the most common. Symptoms of pyromania preceded the mood or substance use disorders in most cases. More than 90 percent reported experiencing severe distress after starting fires, and one-third considered suicide as a means of controlling firesetting.

Pyromania is chronic if left untreated. Most individuals with pyromania do not receive treatment for the disorder.<sup>59</sup> Individuals whose pyromania goes into remission often engage in other impulsive or compulsive behaviors (e.g., gambling, substance use). There have been no controlled trials of medication for pyromania.<sup>62</sup> Treatments with selective serotonin reuptake inhibitors (SSRIs), antiepileptic medications, atypical antipsychotics, lithium, or anti-androgens have been proposed.<sup>59,63–66</sup> Cognitive behavioral therapy has shown some promise.<sup>59,66</sup>

**Firesetting and Experts in the Criminal Courts**

The U.S. criminal courts have an extensive history of consulting mental health experts on arson cases.<sup>15</sup> The courts have struggled with conceptualizing firesetting and pyromania. Forensic experts may be asked to evaluate several areas related to the arson: state of mind at the time of the offense, risk of recidivism, suitability for treatment, and competency to stand trial. The following sections summarize important considerations for conducting such evaluations.

**Criminal Responsibility: Not Guilty by Reason of Insanity**

Forensic experts should attempt to obtain detailed information about the mental state and behavior of the defendant at the time of the arson offense. Fire investigator reports may provide valuable information about how the fire was started and the degree of the arsonist’s impulsivity.<sup>67</sup> An appreciation of the known motives for firesetting would be of assistance in delineating the mental state at the time of the firesetting act. Numerous motivational classification systems have been proposed, which include combinations of the categories listed in Table 2.<sup>28,30,35,68–71</sup> Revenge is the most common motive for arson in both sexes.<sup>3,21,22,28–31,34,68,70</sup> Attention seeking, a cry for help, and a way to express a desire or need (i.e.,

**Table 2** Classification of Firesetters Based on Motive

Primary gain
Cathartic, excitement, sexual pleasure, boredom, relief of tension
Delusional, psychotic
Vindictive, revenge, jealousy
Instrumental (psychologic): self-destruction/suicide, heroism/recognition, cry for help, attention seeking
Secondary gain
Acquisitive, financial, insurance claim, profit, rehousing, extortion, professional
Instrumental (nonpsychologic): crime concealment, intimidation, facilitating other crimes, vandalism
Political protest, extremist causes, riot, terrorism
Other
Accidental, carelessness, curiosity, no obvious motive
Mixed motives

communicative arson) have been described among firesetting mentally ill offenders.<sup>35,72</sup>

It is not uncommon for arson defendants to plead not guilty by reason of insanity (NGRI).<sup>73–78</sup> The success of this defense appears to be higher for arson cases than it is for other crimes. In a Finnish study, arson offenders were significantly more likely to be found not to be responsible for arson compared with homicide offenders.<sup>32</sup> Successful NGRI pleas in arson cases usually involve defendants with psychotic disorders. For example, in *United States v. Carbulido*,<sup>78</sup> the defendant was found NGRI after a series of church arsons precipitated by his delusional belief that the religious community had implanted devices in his brain.

However, it is uncommon for an arson defendant to be found NGRI due to pyromania,<sup>79</sup> probably because the pyromania diagnostic criteria state that firesetting may not be due to delusional beliefs or impaired judgment.<sup>53</sup> Given these exclusionary criteria, it seems unlikely that an individual with pyromania would lack appreciation of the nature, quality, or wrongfulness of firesetting. The diagnostic criteria also include tension or affective arousal before the act, followed by pleasure, gratification, or relief during or after the fire.<sup>53</sup> Could these criteria amount to an irresistible impulse? Or is it rather an impulse not resisted?<sup>15</sup> This question is of importance in jurisdictions that include a volitional prong within their NGRI statutes. As Geller *et al.*<sup>15</sup> pointed out, pyromania has historically been a common example used in the debate over the legal standard for criminal responsibility.

The courts have offered differing opinions on whether pyromania constitutes an irresistible im-

pulse as it relates to NGRI defenses. For example, *Briscoe v. United States*<sup>80</sup> involved a defendant convicted of arson after initially entering a guilty plea. The lower court did not permit the defendant to withdraw his guilty plea and enter a NGRI plea after counsel learned about the defendant's symptoms of pyromania. In writing the opinion of the appeals court, Judge Bazelon gave an accurate definition of pyromania based on the psychiatric literature at the time. The arson conviction was reversed and the case remanded with instruction that the defendant be permitted to enter a NGRI plea.

*People v. Burress*<sup>81</sup> further highlights this debate. This case involved a defendant who drove to a barn and intentionally set it ablaze. He then drove to a nearby town to observe the fire, reported it to authorities, and asked if he could ride with them in a fire engine. He later confessed to arson and raised a criminal-responsibility defense. A psychiatrist testified that the defendant set the fire as a result of an "uncontrollable impulse" and a "neurologic compulsion." He also testified that the defendant acted on impulses "without much cerebral scanning." The defendant was found guilty. The appeals court affirmed the conviction in a two-to-one decision. The majority pointed to the defendant's organized behavior before setting the fire. As Judge Trapp stated, "The theory of an act of compulsion. . . is contradicted by the time involved in travel and the apparent planning in doing the act." In the dissent, Judge Craven stated that the psychiatric testimony was consistent with pyromania and that detailed planning of an act did not equate to an ability to conform behavior to the requirements of the law.

### **Criminal Responsibility: Diminished Capacity and Requisite Intent**

It is unlikely that American mental health experts will be retained in relation to an arson diminished-capacity defense. Many courts have ruled that a diminished-capacity defense does not apply to arson, because arson is a general-intent crime.<sup>82-85</sup> Most statutes include maliciousness as a prerequisite for the act of arson. However, for arson, malice usually implies deliberate and intentional firesetting as opposed to accidental firesetting.<sup>79</sup> The lack of required specific intent may also apply for charges of first-degree arson and felony murder, with arson as the underlying felony.<sup>86</sup> Although diminished-capacity defenses are unlikely, experts may be asked to assist in

the determination of whether the accused had formed the general *mens rea* (i.e., was the arson accidental or intentional). *Commonwealth v. Glenn*<sup>87</sup> provides an example of how the court may struggle with this distinction.

Even though arson is a general-intent crime, the defendant's past behavior is relevant for forensic examiners. In *People v. Ross*,<sup>88</sup> the California Court of Appeal held that evidence of a defendant's prior behavior was admissible if it assisted in distinguishing whether a fire was set willfully versus accidentally. The defendant in this case was convicted of arson after his family testified that he had a propensity to burn property when angry. The defendant argued that his prior uncharged acts and character traits had little relevance to the current case because arson is a general-intent crime. The court of appeal disagreed, stating that even though arson is a general-intent crime, it must be a deliberate and willful act rather than an accidental one. The probative value of the defendant's past behavior outweighed any potential for prejudice because it assisted in demonstrating his intent and in showing that the fire was not an accident.

In forming their opinions, the courts have also referenced alcohol use as a risk factor for arson. In *People v. Atkins*,<sup>89</sup> an intoxicated defendant set a fire and was convicted of arson. The defendant argued in his appeal that he lacked the requisite mental state for arson, given that he was voluntarily intoxicated with alcohol. The Supreme Court of California held that arson is a general-intent crime and that voluntary intoxication is inadmissible for negating the existence of general criminal intent. The court referenced psychiatric literature when stating that "a strong relationship" exists between alcohol intoxication and arson. The court argued that it would be "anomalous" to allow evidence of intoxication to relieve criminal responsibility, given the strong association between alcohol and arson.

### **Sentencing Evaluations and Recidivism Risk**

Mental health expert opinions are of utility to the court during the dispositional phase of arson trials.<sup>79</sup> Experts may be asked to opine on the individual's risk for recidivism and suitability for treatment. Thus, an understanding of the recidivism data of firesetters, arsonists, and pyromaniacs is essential.

Most individuals who commit arson do not engage in further arson offenses.<sup>17,25,26,40,90,91</sup> For ex-

**Table 3** Arson Recidivism Risk Factors in Mentally Disordered Arsonists

Childhood firesetting problems
Younger age at time of first firesetting
Younger age at time of instant arson
Total number of firesetting offenses
No concurrent charges other than arson
Verbalized threats to set fires
Setting fires alone
Unmarried
Low intelligence

ample, one study reported that only 4.5 percent of all individuals charged with arson committed another arson during a 20-year follow-up period.<sup>25</sup> However, arson recidivism rates have increased over the past 60 years,<sup>26</sup> which may be related to the deinstitutionalization of the mentally ill.<sup>31,44</sup> Arsonists are more likely to commit future non-arson offenses than arson offenses.<sup>25,26,37,76,90,91</sup>

Several risk factors have been identified for repeated firesetting. In a study of arsonists released from prison, the single best predictor of arson recidivism was the number of previous arson convictions.<sup>90</sup> Alcoholism has also been described in arson recidivist populations.<sup>31,39</sup> Mentally disordered firesetters have higher rates of arson recidivism but lower rates of non-arson recidivism when compared with non-mentally ill firesetters.<sup>27</sup> Risk factors for arson recidivism in mentally disordered arsonists have been described (Table 3).<sup>22,44,91</sup> Of note, a history of cruelty to animals, enuresis, violent offenses, elevated aggression scores, suicide attempts, and self-injurious behavior have not been shown to be associated with increased rates of arson recidivism.<sup>37,91,92</sup>

A limited number of prospective studies describe the psychiatric diagnoses or symptoms of mentally ill arson recidivists. In retrospective studies, there again appears to be diagnostic heterogeneity, with schizophrenia, mental retardation/intellectual disability, and antisocial personality disorder being the most cited diagnoses in recidivists.<sup>22,31,39,50</sup> Although psychosis appears to be a risk factor for arson, schizophrenic firesetters referred for psychiatric evaluation do not have higher rates of arson recidivism than do similarly referred nonschizophrenic firesetters.<sup>40</sup> Pyromania and pyromaniacal arson recidivists have been infrequently described in the literature.<sup>17,22,39</sup> However, alcohol intoxication and occupational interests in fire may increase recidivism risk in this group.<sup>39</sup>

Jackson *et al.*<sup>4</sup> proposed a functional model to describe recidivist arsonists. They argued that arsonists avoid interpersonal conflict, yet have high levels of hostility caused by psychosocial disadvantage, dissatisfaction with life, and interpersonal rejection and avoidance. Arsonists who feel powerless resort to firesetting as a way to gain control by releasing hostility on property rather than people.

Judges have looked for guidance in sentencing considerations for individuals with pyromania. In *State v. Bailey*,<sup>93</sup> the trial judge considered pyromania as a mitigating factor in sentencing after the defendant pleaded guilty to a series of arsons. The judge conducted his own research into pyromania and its treatments. He concluded, "There is virtually no cure, no treatment." No psychiatric testimony was introduced regarding risk assessment or potential treatment options for pyromania. The court of appeals determined that the judge erred in conducting this independent research, and the defendant's sentence was modified.

In *Faulkenberry v. State*,<sup>94</sup> an army private with a "proclivity to set fires" since childhood was invited to a woman's apartment. The man intentionally set the apartment on fire after the woman fell asleep. He was convicted of first-degree arson and second-degree murder. An expert diagnosed the defendant with pyromania. In the sentencing hearing, the expert testified that pyromaniacs set fires without specific motives beyond the gratification of starting and observing fire. The trial court sentenced the defendant to 60 years. Both sides appealed the length of the sentence. The appeals court cited the psychiatric evidence as "support[ing] an inference that he had little control over his compulsion to set fires" and held that this information was relevant in the trial judge's decision to reduce the sentence. The prosecution's appeal to increase the sentence was dismissed. The appeals court also stated that pyromania is a condition not readily amenable to treatment and control. Thus, the defendant's appeal to reduce the sentence was dismissed.

Felony murder during the commission of arson is a capital offense in many states. In the case of *Toole v. State*,<sup>95</sup> the Florida Supreme Court affirmed the conviction of a first-degree felony murder during the commission of arson. However, the death sentence was vacated. The state supreme court found that the trial court erred in failing to instruct the jury on the potential mitigating factor of whether the defendant

was experiencing extreme mental or emotional disturbance. The defense had produced evidence that the defendant had pyromania and “the overwhelming impulse to set fires” to facilitate “an overwhelming need to release tension.” The case was remanded to the trial court for the jury to consider pyromania as a potential mitigating factor for sentencing.

### **Criminal Competency Evaluations**

Competency to stand trial evaluations are not uncommon in arson cases. Studies have shown that anywhere from 20 to 80 percent of arsonists referred for competency-to-stand-trial evaluations have been found incompetent.<sup>34,35</sup> Further, arsonists are found incompetent to stand trial at a higher rate than are other types of offenders.<sup>35</sup> Other criminal competency assessments may also be requested.<sup>34,96,97</sup>

### **Firesetting and Experts in the Civil Courts**

Given fire’s prevalence and propensity for damage, it comes as no surprise that civil courts have frequently dealt with firesetting-related litigation.<sup>8</sup> Malpractice claims against clinicians may occur if their patients set fires. Mental health providers come into frequent contact with patients who have a history of firesetting or arson. As described, a disproportionate number of apprehended arsonists are mentally ill.<sup>6,7,21,24,32</sup> At the time of the act of arson, most mentally ill arsonists are either receiving mental health treatment, have recently discontinued treatment, or have been unsuccessful in initiating treatment.<sup>31</sup> Mentally ill arsonists are more likely to have a history of psychiatric hospitalization than are other mentally ill offender groups.<sup>22,32</sup> Further, up to one-sixth of state psychiatric hospital inpatients have a history of firesetting.<sup>49,98,99</sup> When a clinician is sued for negligence after firesetting by a patient, experts are often retained to determine whether the care received leading up to the fire adhered to the community standard.

### **Negligence: Liability After Inpatient Discharge**

Clinicians may be subject to civil lawsuits alleging negligent discharge of inpatients from hospitals who later set fires that harmed others. Experts who are asked to opine regarding whether the standard of care was met may consider such questions as whether risk was adequately assessed and managed before discharge. Risk assessments for future acts of firesetting

are not routinely performed on all patients. Rather, they are typically reserved for cases in which a firesetting history is known. These risk assessments are hindered by the following: the absence of actuarial instruments for risk of firesetting,<sup>92</sup> the heterogeneous nature of firesetters, a biased minority of arsonists included in research studies,<sup>2</sup> and reluctance of evaluatees to disclose histories of firesetting. Given the destructiveness of fires, little solace is obtained from noting that most firesetters do not engage in recidivist firesetting. Professional concern about recidivism is evident, in that a history of firesetting is an exclusion criterion for admission to many residential and treatment facilities. Patients with a history of firesetting are difficult to place. It is clear that more research is needed into risk assessment for firesetting.

Nevertheless, research demonstrates that one of the best predictors of future firesetting is a history of such behavior.<sup>90,91</sup> Therefore, taking a detailed firesetting history is prudent in a patient who has set fires. Table 4 includes a list of variables that the above-mentioned review of research supports as relevant to consider in a firesetting history and risk assessment.

The courts have recognized that firesetting can occur despite the best efforts of clinicians. In *Seavy v. State*,<sup>100</sup> the Supreme Court of New York reviewed a case involving a young man with mental retardation who had been housed within state facilities for most of his life. The man had previously burned his body by spilling cleaning fluid on himself. The intentionality of this act was unclear. Six years later, psychiatrists decided that the man was eligible for community placement after an extended period of stability. A farmer accepted custody of the man as a reduced-wage worker after having been informed of his condition. The patient burned down the farmer’s barn 11 days later. The farmer filed suit, claiming that the state misrepresented the patient’s “pyromaniacal propensities,” as evidenced by the previous self-inflicted burns. The state supreme court affirmed the lower court’s decision that the man’s condition was not misrepresented and therefore the state was not liable for the fire damages. The court reviewed the man’s records and concluded that even if the psychiatrist made a mistake in professional judgment, it was a reasonably valid decision. The court noted that “the boy’s history is devoid of pyromaniacal tendencies” and pyromaniacs do “not have an inclination to self-destruction by fire.”

**Table 4** Suggested Variables for Firesetting Risk Assessments

<p>Firesetting history</p> <ul style="list-style-type: none"> <li>Age first set fires</li> <li>Number of previously set fires</li> <li>Frequency of previously set fires</li> <li>Duration of firesetting history</li> <li>Intensity/quality of previously set fires</li> <li>Impulsivity of past firesetting</li> <li>Motives for past firesetting</li> <li>Psychosocial circumstances precipitating past fires</li> </ul> <p>Psychiatric comorbidities</p> <ul style="list-style-type: none"> <li>Substance use disorders (alcohol)</li> <li>Psychotic disorders</li> <li>Intellectual impairment/mental retardation</li> <li>Personality disorders (ASPD, BPD)</li> <li>Mood disorders</li> <li>Impulse-control disorders</li> <li>Pyromania</li> </ul>	<p>Current firesetting ideation</p> <ul style="list-style-type: none"> <li>Firesetting ideation, intent, plan</li> <li>Access to firesetting materials</li> <li>Presence/Absence of stressors/circumstances similar to past fires</li> </ul> <p>Personality variables</p> <ul style="list-style-type: none"> <li>Assertiveness impairments</li> <li>Overall degree of impulsivity</li> <li>Level of insight</li> </ul> <p>Other variables</p> <ul style="list-style-type: none"> <li>Compliance with treatment recommendations</li> <li>Current stressors/coping techniques</li> <li>Available support system</li> <li>Marital status</li> <li>Feasibility of plan after discharge</li> </ul>
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In contrast, in *Onofrio v. Department of Mental Health* (DMH),<sup>8,101</sup> a patient receiving DMH care was referred by a housing contractor to a boarding house. The contractor and DMH failed to inform the landlord that the patient was under DMH care and had a history of firesetting, destruction of property, and violence. The patient set fire to the residence. The landlord brought an action against the contractor and DMH. The trial and appeals courts found both respondents negligent because they owed the landlord a duty of reasonable care by taking actions that exposed the landlord to risk. They failed to meet that duty.

#### **Negligence: Firesetting During an Inpatient Admission**

Courts have held psychiatrists to a higher standard when fires are set by hospitalized or institutionalized patients as opposed to outpatients. In *Rum River Lumber Co. v. State*,<sup>10</sup> a hospitalized mentally ill youth with an extensive history of elopement and violence set fire to a lumber yard during an unauthorized absence from the hospital. The lumber company sued the hospital, arguing that the patient's potential for harm created a foreseeable risk and that the hospital was negligent in its duty to exercise reasonable control over the patient. The hospital argued that the risk of firesetting was not foreseeable, as the patient had only twice set fires, and those were accidental. The hospital also argued that the standard of care should be equivalent to malpractice cases in which physicians allegedly were negligent after discharging a patient who subsequently caused harm. The trial and state supreme courts of Minnesota found the

hospital liable, because the overall pattern of the patient's behavior created a foreseeable unreasonable risk, the hospital failed to exercise reasonable control over the patient, and the standard of care following discharge is different from that for elopement.

The case of *Hilscher v. State*<sup>102</sup> provides examples of how courts emphasize a history of firesetting to inform risk assessments and thus decisions of negligence. In this case, a boy with intellectual deficiency who lived at a state facility set two residences on fire on two separate occasions. Following the first arson at the Hilscher residence, police apprehended the boy, and he confessed to setting the fire. No charges were pressed. Rather, the facility was informed that the boy was suspected of setting the fire. Facility staff, including a psychiatrist, questioned the boy and concluded that he had probably not set the fire, because police had not pressed charges. Three months later, the boy destroyed the Meyers residence via arson. Both residence owners brought suit against the state claiming negligent supervision of the boy. The claims court held that the state's only duty is to take precautions against reasonably perceived risks. The suit filed by the Hilschers was dismissed, as the state did not have knowledge of the boy's proclivity to set fires at that time. Therefore, the arson was unforeseeable. However, the claim filed by the Meyers was upheld. This arson was deemed to be attributable to the negligence of the state in its failure to supervise the boy properly, given his history.

A negligence suit was brought by the parents of a patient who set fire to an inpatient psychiatric unit in *Vattimo v. Lower Bucks Hospital*.<sup>103</sup> The patient was



admitted for schizophrenia and “an abnormal fascination with fire.” Shortly after admission, he set fire to his room, causing the death of another patient. The patient was criminally charged. The family of the firesetting patient brought a suit against the hospital for negligent supervision and claimed damages incurred by legal costs and mental anguish. The state supreme court held that the hospital was not responsible for the legal costs. However, it said that a jury should decide to what degree the hospital was negligent regarding the mental anguish damages. The majority opinion and minority dissent illustrate the legal complexities involved in determining the extent of a hospital’s duty to a patient, whether the duty was breached, and whether the breach caused specific damage.

### **Negligence: Duty to Warn and Protect**

In many jurisdictions, psychiatrists and psychologists have a duty to warn and protect third parties from reasonably foreseeable harm caused by their patients. Firesetting was central to the Vermont Supreme Court’s decision to extend the *Tarasoff* duty to protect third parties from harm to include a duty to protect third parties from property damage.<sup>104</sup> In *Peck v. Counseling Services of Addison County*,<sup>105</sup> a man disclosed to his psychologist that he was considering burning down his father’s barn because he was angry with him. The therapist took no action to warn the parents, and the man set fire to the barn six days later. The parents brought a suit against the counseling service to recover damages for their property loss, claiming they resulted from therapeutic negligence. The trial court agreed and found the counseling service negligent, although Vermont had no law requiring duty to protect third parties at the time. On appeal, the state supreme court created that duty and stated that “arson is a violent act and represents a lethal threat to human beings.”

### **Negligence: After Criminal Conviction**

It is difficult for individuals criminally convicted of arson to bring a negligence claim against their psychiatrists in relation to the arson. *Burcina v. City of Ketchikan*<sup>106</sup> illustrates this point. Mr. Burcina had a long history of psychosis, substance use, and violence. He was receiving psychiatric treatment at a community clinic and requested that his antipsychotic dose be lowered. Following a trial of reduced dosage, the psychiatrist recommended that the dose

be increased, as the patient had become more delusional. The patient refused. Shortly afterward, he set fire to the psychiatric clinic. He pleaded no contest to arson charges and was sentenced to state prison. He then brought a civil claim against the psychiatric clinic, arguing that the psychiatrist’s decision to decrease his medication dosage was negligent and contributed to his firesetting behavior. The Alaska Supreme Court affirmed the lower court’s dismissal of the claim on the grounds that an individual convicted of a crime cannot impose liability on others for consequences of this antisocial act. Mr. Burcina argued that there should be an exception because there was a question of his sanity at the time of the instant offense. The court did not agree with this exception, holding that he was convicted of the crime and not deemed legally insane. *Veverka v. Cash*<sup>82</sup> provides a similar example.

### **Other Civil Evaluations**

There are other civil evaluations in which forensic mental health experts may play a crucial role. Is a hospital negligent for failing to admit patients with firesetting histories who subsequently injure themselves or others via firesetting?<sup>107</sup> Conversely, are histories of firesetting overly influential, resulting in improper commitment?<sup>108</sup> To what degree should a diagnosis of pyromania or history of firesetting influence one’s eligibility for insurance coverage or disability benefits?<sup>109</sup> Does an insured’s mental condition affect the application of a fire insurance policy’s intentional-act exclusion clause?<sup>110,111</sup> To what extent are psychiatric records privileged during fire insurance company investigations?<sup>110</sup> How severe is the emotional or psychic damage resulting from a fire, and to what extent are a fire victim’s symptoms attributable to the fire versus other stressors or comorbidities?<sup>112</sup> These are some examples of the many areas in which forensic experts could be asked to opine.

### **Conclusion**

Humankind’s history has been intimately influenced by the constructive and destructive properties of fire. The legal system is no exception. The courts often rely on the opinions of mental health experts in fire-related cases. Because of this reliance, it is important for experts to be aware of the clinical and forensic aspects of firesetting, arson, and pyromania. Increased collaboration among forensic mental health

experts, fire investigators, and law enforcement would aid in future research efforts.

The courts emphasize an individual's history of firesetting when rendering decisions about criminal intent and civil negligence. Similarly, the mental health literature demonstrates that one predictor of future firesetting is past firesetting. Therefore, taking a firesetting history and conducting a risk assessment is prudent in both clinical and legal arenas when a patient or evaluatee is known to have set fires.

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