Youth Firesetting Prevention and Intervention — Level 1

YFPI-1-Student Manual

1st Edition, 1st Printing-August 2013

FEMA/USFA/NFA
YFPI-1-SM
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FEMA

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COURSE GOAL

Empower learners with the knowledge, skills and abilities (KSAs) to perform the job performance requirements (JPRs) of a Level 1 Youth Firesetting Intervention Specialist (YFIS) as outlined in the National Fire Protection Association (NFPA) Standard 1035.

TARGET AUDIENCE

The target audience for this course is anyone who has or will have responsibility to prevent or mitigate the occurrence of youth firesetting. The audience could include volunteer and career firefighters, fire investigators, Fire and Life Safety Educators (FLSEs), and allied professionals from criminal justice, mental health, social services and juvenile justice.

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SCHEDULE

TIME	DAY 1	DAY 2
8:00 - 9:25	Introduction Activity I.1 Introductions	Unit 3: Identification, Intake, Screening, Disposition and Follow-up (cont'd) Activity 3.2: The Screening Forms
9:25 - 9:35	*Break*	*Break*
9:35 - 10:45	Unit 1: The Extent of the Youth Firesetting Problem	Unit 3: Identification, Intake, Screening, Disposition and Follow-up (cont'd) Activity 3.3: Determining Interventions
10:45 - 10:55	*Break*	*Break*
10:55 - 12:00	Activity 1.1: A Snapshot of Your Youth Firesetting Problem Unit 1: The Extent of the Youth Firesetting Problem (cont'd) Unit 2: Who Sets Fires and Why?	Activity 3.3: Determining Interventions (cont'd) Unit 3: Identification, Intake, Screening, Disposition and Follow-up (cont'd)
12:00 - 1:00	*Lunch Break*	*Lunch Break*
1:00 - 2:00	Unit 2: Who Sets Fires and Why? (cont'd)	Unit 4: Youth Firesetting Educational Intervention Activity 4.1: Education as a Primary Prevention Intervention
2:00 - 2:15	*Break*	*Break*
2:15 - 5:00	Activity 2.1: Typologies of Youth Firesetting Unit 2: Who Sets Fires and Why? (cont'd) Unit 3: Identification, Intake, Screening, Disposition and Follow-up Activity 3.1: Intake Instrument Review	Unit 4: Youth Firesetting Educational Intervention (cont'd) Activity 4.2: Stages of Development and Program Delivery Examination Evaluation

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FIREFIGHTER CODE OF ETHICS

Background

The Fire Service is a noble calling, one which is founded on mutual respect and trust between firefighters and the citizens they serve. To ensure the continuing integrity of the Fire Service, the highest standards of ethical conduct must be maintained at all times.

Developed in response to the publication of the Fire Service Reputation Management White Paper, the purpose of this National Firefighter Code of Ethics is to establish criteria that encourages fire service personnel to promote a culture of ethical integrity and high standards of professionalism in our field. The broad scope of this recommended Code of Ethics is intended to mitigate and negate situations that may result in embarrassment and waning of public support for what has historically been a highly respected profession.

Ethics comes from the Greek word ethos, meaning character. Character is not necessarily defined by how a person behaves when conditions are optimal and life is good. It is easy to take the high road when the path is paved and obstacles are few or non-existent. Character is also defined by decisions made under pressure, when no one is looking, when the road contains land mines, and the way is obscured. As members of the Fire Service, we share a responsibility to project an ethical character of professionalism, integrity, compassion, loyalty and honesty in all that we do, all of the time.

We need to accept this ethics challenge and be truly willing to maintain a culture that is consistent with the expectations outlined in this document. By doing so, we can create a legacy that validates and sustains the distinguished Fire Service institution, and at the same time ensure that we leave the Fire Service in better condition than when we arrived.

FIREFIGHTER CODE OF ETHICS

I understand that I have the responsibility to conduct myself in a manner that reflects proper ethical behavior and integrity. In so doing, I will help foster a continuing positive public perception of the fire service. Therefore, I pledge the following…

- Always conduct myself, on and off duty, in a manner that reflects positively on myself, my department and the fire service in general.
- Accept responsibility for my actions and for the consequences of my actions.
- Support the concept of fairness and the value of diverse thoughts and opinions.
- Avoid situations that would adversely affect the credibility or public perception of the fire service profession.
- Be truthful and honest at all times and report instances of cheating or other dishonest acts that compromise the integrity of the fire service.
- Conduct my personal affairs in a manner that does not improperly influence the performance of my duties, or bring discredit to my organization.
- Be respectful and conscious of each member's safety and welfare.
- Recognize that I serve in a position of public trust that requires stewardship in the honest and efficient use of publicly owned resources, including uniforms, facilities, vehicles and equipment and that these are protected from misuse and theft.
- Exercise professionalism, competence, respect and loyalty in the performance of my duties and use information, confidential or otherwise, gained by virtue of my position, only to benefit those I am entrusted to serve.
- Avoid financial investments, outside employment, outside business interests or activities that conflict with or are enhanced by my official position or have the potential to create the perception of impropriety.
- Never propose or accept personal rewards, special privileges, benefits, advancement, honors or gifts that may create a conflict of interest, or the appearance thereof.
- Never engage in activities involving alcohol or other substance use or abuse that can impair my mental state or the performance of my duties and compromise safety.
- Never discriminate on the basis of race, religion, color, creed, age, marital status, national origin, ancestry, gender, sexual preference, medical condition or handicap.
- Never harass, intimidate or threaten fellow members of the service or the public and stop or report the actions of other firefighters who engage in such behaviors.
- Responsibly use social networking, electronic communications, or other media technology opportunities in a manner that does not discredit, dishonor or embarrass my organization, the fire service and the public. I also understand that failure to resolve or report inappropriate use of this media equates to condoning this behavior.

Developed by the National Society of Executive Fire Officers

A Student Guide to End-of-course Evaluations

Say What You Mean ...

Ten Things You Can Do to Improve the National Fire Academy

The National Fire Academy takes its course evaluations very seriously. Your comments and suggestions enable us to improve your learning experience.

Unfortunately, we often get end-of-course comments like these that are vague and, therefore, not actionable. We know you are trying to keep your answers short, but the more specific you can be, the better we can respond.

Actual quotes from student evaluations:	Examples of specific, actionable comments that would help us improve the course:
1 "Update the materials."	• The (ABC) fire video is out-of-date because of the dangerous tactics it demonstrates. The available (XYZ) video shows current practices. • The student manual references building codes that are 12 years old.
2 "We want an advanced class in (fill in the blank)."	• We would like a class that enables us to calculate energy transfer rates resulting from exposure fires. • We would like a class that provides one-on-one workplace harassment counseling practice exercises.
3 "More activities."	• An activity where students can physically measure the area of sprinkler coverage would improve understanding of the concept. • Not all students were able to fill all ICS positions in the exercises. Add more exercises so all students can participate.
4 "A longer course."	• The class should be increased by one hour per day to enable all students to participate in exercises. • The class should be increased by two days so that all group presentations can be peer evaluated and have written abstracts.
5 "Readable plans."	• The plans should be enlarged to 11 by 17 and provided with an accurate scale. • My plan set was blurry, which caused the dotted lines to be interpreted as solid lines.
6 "Better student guide organization," "manual did not coincide with slides."	• The slide sequence in Unit 4 did not align with the content in the student manual from slides 4-16 through 4-21. • The instructor added slides in Unit 4 that were not in my student manual.
7 "Dry in spots."	• The instructor/activity should have used student group activities rather than lecture to explain Maslow's Hierarchy. • Create a pre-course reading on symbiotic personal relationships rather than trying to lecture on them in class.
8 "More visual aids."	• The text description of V-patterns did not provide three-dimensional views. More photographs or drawings would help me imagine the pattern. • There was a video clip on NBC News (date) that summarized the topic very well.
9 "Re-evaluate pre-course assignments."	• The pre-course assignments were not discussed or referenced in class. Either connect them to the course content or delete them. • The pre-course assignments on ICS could be reduced to a one-page job aid rather than a 25-page reading.
10 "A better understanding of NIMS."	• The instructor did not explain the connection between NIMS and ICS. • The student manual needs an illustrated guide to NIMS.

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UNIT 1: THE EXTENT OF THE YOUTH FIRESETTING PROBLEM

TERMINAL OBJECTIVE

The students will be able to:

1.1 Explain national trends in youth firesetting and compare those trends to the statistics from their home communities.

ENABLING OBJECTIVES

The students will be able to:

1.1 Explain national trends and types of fires set by youth.

1.2 Explain how youth are experimenting with explosive and pressure-creating devices.

1.3 Describe the youth firesetting problem in their community.

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UNIT 1:
THE EXTENT OF THE YOUTH FIRESETTING PROBLEM

Slide 1-1

ENABLING OBJECTIVES

- Explain national trends and types of fires set by youth.
- Explain how youth are experimenting with explosive and pressure-creating devices.
- Describe the youth firesetting problem in their community.

Slide 1-2

I. THE EXTENT OF THE YOUTH FIRESETTING PROBLEM

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM

- Seventy-seven percent of fire incidents occur outside, **but** 92 percent of youth firesetting-related deaths are in homes.
- Lighters/Matches still greatest ignition source.
- Children under age 5 are more than eight times as likely to die in a fire that they themselves cause.

Slide 1-3

A. Youth firesetting facts.

1. Whether a youth is experimenting or purposely setting a fire, youth firesetting can be costly. The costs associated with youth firesetting include injuries, deaths, property damage and criminal sanctions.

2. According to the National Fire Protection Association (NFPA), the majority of youth firesetting incidents (77 percent) occur outdoors.

3. However, 92 percent of deaths associated with youth firesetting occur in home structure fires (Hall, 2010).

4. Most child-related home fires are started with lighters or matches (Hall, 2010).

5. Children under age 5 are more than eight times as likely to die in a fire that they themselves cause.

6. Almost half (42 percent) of child-related home structure fires begin in the bedroom. The most commonly lit items in these fires are mattresses, bedding and clothing (Flynn, 2009).

Do you think youth firesetting may be underreported? Why or why not?

Slide 1-4

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

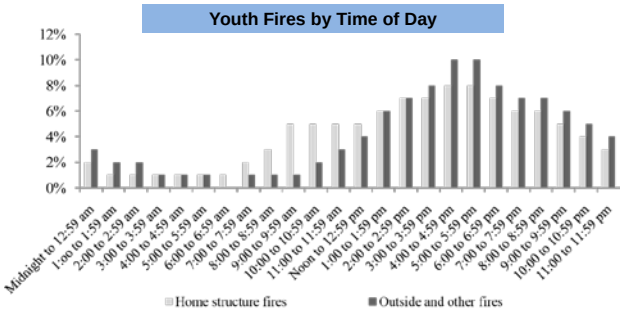
- Statistically speaking, youth between the ages of 11 and 14 are at the greatest risk for setting fires.
- Boys are at the greatest risk for setting fires.

Slide 1-5

7. One very noteworthy fact is that even though we have been discussing young children as firesetters, statistically speaking, youth between the ages of 11 and 14 are at the greatest risk for setting fires.

   Boys are at the greatest risk for setting fires. Annually, 80 to 85 percent of the identified firesetters are male (Boberg, 2006).

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)



Slide 1-6

8. Times, days and months of youth-set fires:

   a. There is no peak day for child-play home structure fires.

   b. The weekend is the clear peak time for outside and other fire types (Flynn, 2009).

   c. Both home structure and outside fires involving youth follow a similar trend, peaking in the after-school hours before dinner time (Flynn, 2009).

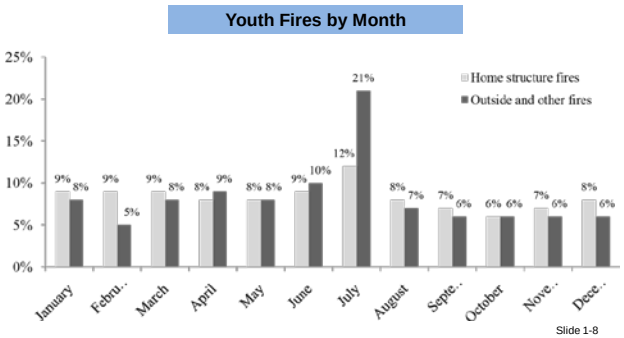
THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

- Youth-related fires peak during the month of July.
- One out of every four fires that occurred outside was in the month of July.
- More than two out of every three youth-related fires in July involved fireworks.

Slide 1-7

d. Youth fire incidents peak during the month of July. One out of every four youth-related incidents that occurred outside was in the month of July. More than two out of every three (67 percent) outside and other types of youth-related incidents in July involved fireworks (Flynn, 2009).

WHAT PATTERN MAY THESE STATISTICS INDICATE?



Slide 1-8

9. Fireworks and fires.

a. The risk of fireworks injury was the highest for teens ages 15 to 19 and children 5 to 9, both with at least 2 1/2 times greater risk than the general population (Hall, 2010).

b. Two out of five (40 percent) people injured by fireworks were under the age of 15 (Hall, 2010).

What are the fireworks laws in your state?

Slide I-9

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

- The good news:
  - Youth firesetting-related home fires down over 80 percent since 1980.
  - Civilian deaths reduced by 84 percent.
  - Injuries reduced by 61 percent.
  - Property loss cut by 38 percent.

Slide 1-10

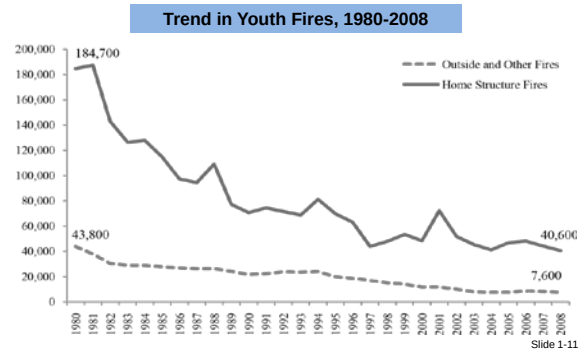
10. The good news about child-set fires:

    a. Since 1980, all child-related structure fires have decreased 79 percent, and home structure fires have decreased 81 percent (Flynn, 2009).

       - Civilian deaths caused by child-related fires have declined by 84 percent. Injuries have decreased by 61 percent (Hall, 2010).

       - Property loss (adjusted to inflation) has declined by 38 percent (Hall, 2010).

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

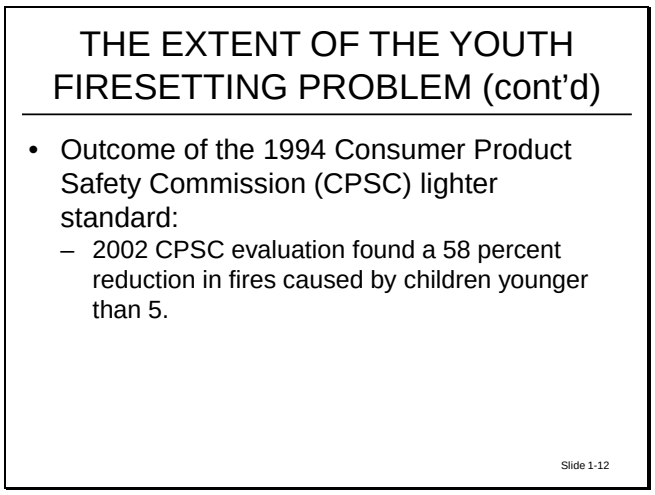


Slide 1-11

    b. Outside and other fires have decreased 95 percent since 1980 (Flynn, 2009).

c. Since 1995:

- Outside and other fires involving children have decreased 86 percent.
- Home structure fires have decreased 57 percent.
- Structure fires as a whole have decreased 42 percent (Flynn, 2009).



d. In 1994, the Consumer Product Safety Commission (CPSC) set a mandatory safety standard requiring the manufacturing and importation of cigarette lighters to be child-resistant. The standard requires that lighters resist the efforts of 85 percent of the children to operate them in a specified test. More than 95 percent of the estimated half-billion lighters purchased annually in the United States are covered by the standard (Flynn, 2009; CPSC, 1993).

e. In a 2002 evaluation of the effectiveness of the 1994 CPSC lighter safety standard, the CPSC found a 58 percent reduction in fires caused by children younger than 5 compared to children over the age of 5 (Smith, Greene and Singh, 2002).

Why do you think that the CPSC found a 58 percent reduction in fires caused by children younger than 5 as compared to children over 5?

Slide I-13

B. Youth firesetting and arson.

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

- The crime of arson has the highest rate of youth involvement as compared to all other crimes.
- The Federal Bureau of Investigation (FBI) identifies half of all arson arrests in the United States are youth under the age of 18.
- Nearly one-third of those arrested were under the age of 15, and 5 percent were under the age of 10.

Slide 1-14

1. The crime of arson has the highest rate of juvenile involvement compared to all other crimes.

2. According to the Federal Bureau of Investigation (FBI), nearly half of all arson arrests in the U.S. are of juveniles under the age of 18. Nearly one-third of those arrested were under the age of 15, and 5 percent were under the age of 10 (FBI, 2006).

3. Of the youth arrested for arson in the U.S. in 2006, 79 percent were white (FBI, 2006).

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

- In 2008, there was an estimated 6,600 youth arrested for arson in the U.S.
- Of those arrested, 56 percent were under age 15, and 12 percent were female.

Slide 1-15

4. In 2008, there was an estimated 6,600 juveniles arrested for arson in the U.S. Of those arrested, 56 percent were under age 15, and 12 percent were female (Office of Juvenile Justice and Delinquency Prevention (OJJDP), 2009).

5. After being relatively stable for most of the 1980s, the juvenile arrest rate for arson grew 33 percent between 1990 and 1994 (OJJDP, 2009).

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

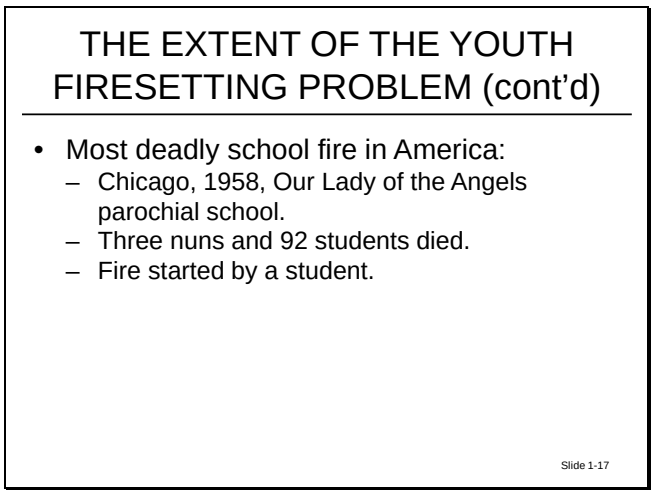
- The youth arrest rate for arson declined by 46 percent between 1994 and 2008.
- This rate is the lowest point since 1980.
- School issues continue.

Slide 1-16

6. The youth arrest rate for arson declined substantially between 1994 and 2008, falling 46 percent (OJJDP, 2009).

7. Following a 19 percent decline between 2006 and 2008, the juvenile arrest rate for arson in 2008 reached its lowest point since 1980 (OJJDP, 2009).

C. School fires.



1. The most deadly school fire in American history occurred on Dec. 1, 1958, at the Our Lady of the Angels parochial school on Chicago's West Side. Three nuns and 92 students were killed.

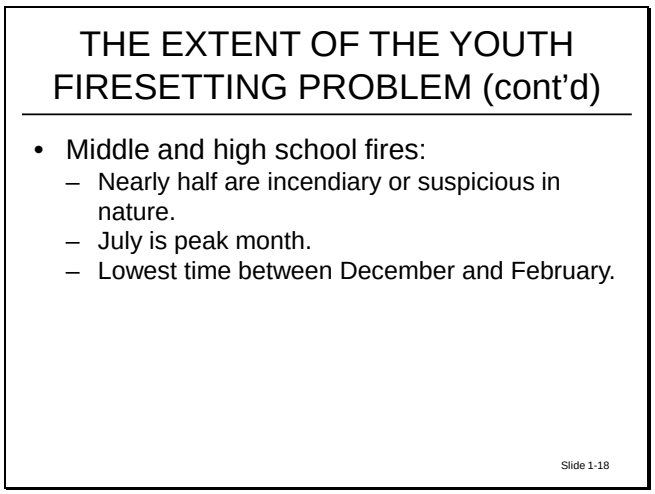
   The fire was started by an angry student.

2. According to the National Fire Data Center (NFDC) (2007), from 2003 to 2005 there was an estimated annual average of 14,700 fires on nonadult school properties which caused an average of 100 injuries and an estimated $85 million in property loss (Federal Emergency Management Agency (FEMA), 2007).

3. Causes of school fires:

   a. Structure fires in preschools and day care centers are predominantly due to cooking (64 percent), followed by heating (7 percent) and electrical distribution (6 percent) (FEMA, 2007).

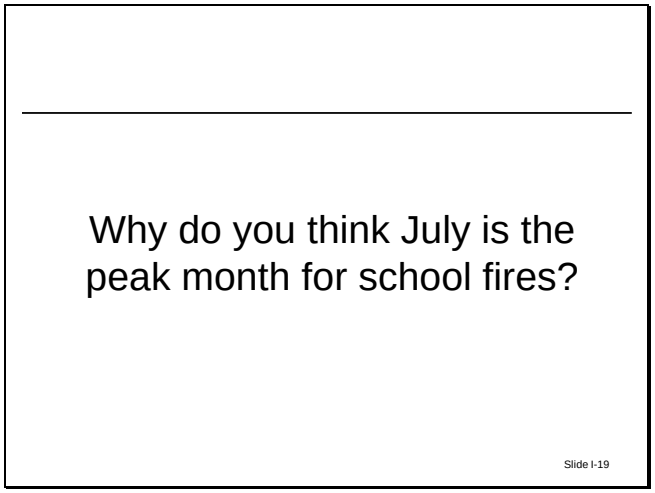
   b. The causes for fires in kindergarten or elementary schools mostly involve cooking (27 percent), incendiary or suspicious activity (25 percent), and heating (12 percent) (FEMA, 2007).



c. The primary cause of fires in middle, junior or senior high schools is due to incendiary or suspicious activity (47 percent), followed by cooking (15 percent) and heating (7 percent) (FEMA, 2007).

4. Time, day and month of school fires.

a. According to the NFDC, overall, the average peak month for school fires was July. The lowest incidence of school fires occurred between December and February (FEMA, 2007).



THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

- Elementary schools are summer targets.
- Middle and high schools peak in fall/spring.
- Half of school fires occur between 8 a.m. and 5 p.m.

Slide 1-20

b. The NFDC states that the sharp increase in July school fires is driven by the number of elementary school fires. This suggests that elementary schools may be more attractive targets for incendiary or suspicious fires during the summer when fewer staff members monitor the school campuses (FEMA, 2007).

c. Middle, junior and senior high schools had more fire incidents in the fall and spring, which are the beginning and end of the school year (FEMA, 2007).

5. Where school fires start:

a. The three leading areas where school fires begin are the bathroom, kitchen and small assembly areas (FEMA, 2007).

THE EXTENT OF THE YOUTH FIRESETTING PROBLEM (cont'd)

- Of school fires, 25 percent originate in bathrooms.
- Nearly 80 percent of bathroom fires are in middle and high schools.
- Need element of trust with school officials.

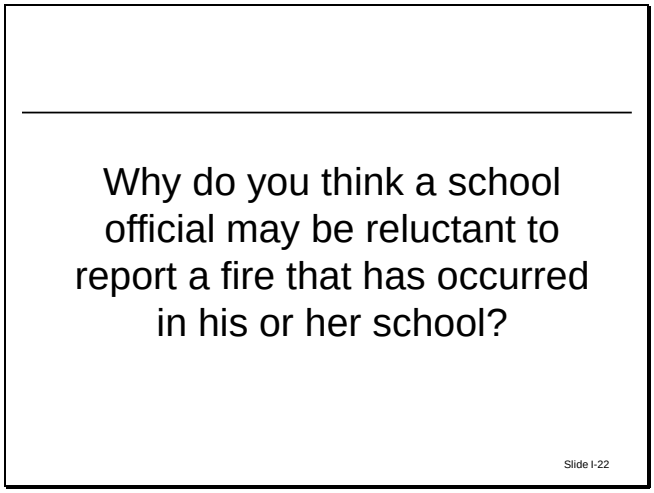
Slide 1-21

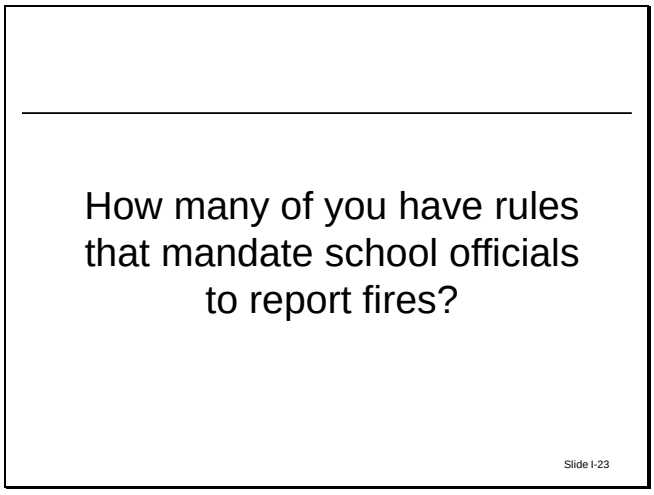
b. Of all school structure fires, 25 percent begin in bathroom trash cans, and they are of incendiary or suspicious nature (FEMA, 2007).

c. Of all school bathroom fires, 78 percent occur in middle, junior and senior high schools (FEMA, 2007).

6. It is very important that the youth firesetting intervention program personnel have a good working relationship with the schools and school district(s) in their community.

a. There has to be an element of trust formed between the youth firesetting intervention program and the school personnel, or the school personnel will be reluctant to contact the youth firesetting intervention program staff, the fire department, and law enforcement if there is a school fire situation.

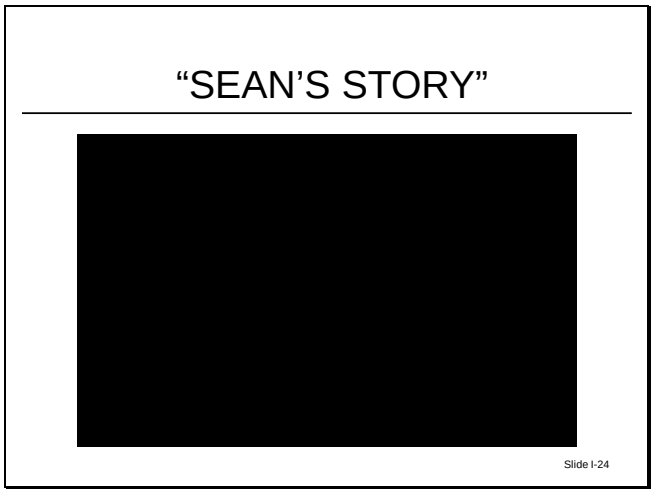




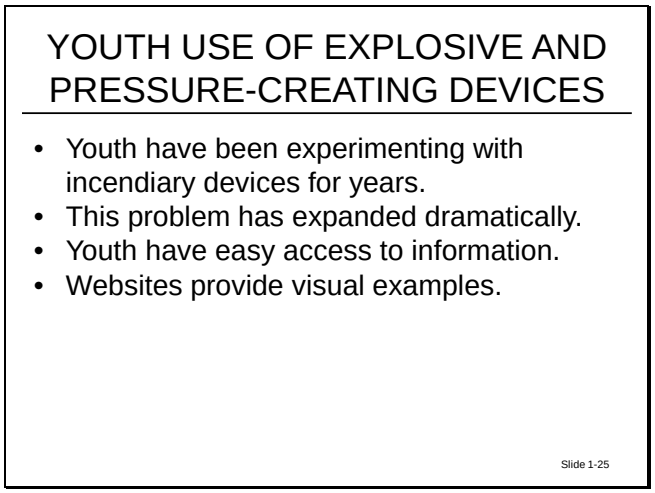
b. Many schools and school districts fear that if they report school fires, it will damage their reputation and cause the fear in their community that their school is a "bad" school, thus lowering the school's or district's rating. This might result in a loss of funding opportunities.

c. The following video explores how devastating a school fire can be not only for the school and community, but also for the firesetter.

II. "SEAN'S STORY"



III. YOUTH USE OF EXPLOSIVE AND PRESSURE-CREATING DEVICES



A. Youth have experimented with constructing and using incendiary/explosive/ pressure-creating devices for decades.

B. Experimentation and purposeful acts of destruction have expanded dramatically as a result of easy access to information.

C. Youth have easy access to instructions on how to make/use devices.

D. Many websites provide visual examples of youth engaged in dangerous behaviors involving incendiary/explosive devices.

Slide 1-26

Slide 1-27

E. Easy access to information combined with natural curiosity and peer influence can combine to create disastrous consequences.

Slide 1-28

IV. UNDERSTANDING YOUR LOCAL YOUTH FIRESETTING PROBLEM

A. Understanding the youth firesetting problem in your community is the first step in developing your firesetting intervention program.

B. Collecting the available information on the youth firesetting problem in your community will demonstrate to the community the need for a firesetting intervention program and will answer the following questions:

UNDERSTANDING YOUR PROBLEM

- Who is setting fires in your community?
- What kinds of fires are being set by youth?
- What costs are associated with these fires?
  - Injuries, lives lost, property damage, loss of environmental resources, etc.

Slide 1-29

1. Who is setting fires in your community?

2. What kinds of fires are being set by juveniles?

3. What costs are associated with these fires (injuries, lives lost, property damage, loss of environmental resources, etc.)?

C. The pre-course assignment for this course required you to conduct research on the topics listed above.

D. Finding data on the occurrence and effects of youth firesetting at the local level may have been a challenging process.

E. Knowing or attempting to discover the extent of the problem will encourage individuals and agencies to support a program to meet the needs of the community.

F. Demonstrating the need for a program based on current youth firesetting data from your community is the first step in identifying and justifying the need for a firesetter intervention program.

G. Remember, many youth who set fires never get reported to the fire or police departments. The development of your firesetting intervention program might be the catalyst to get these fires reported!

ACTIVITY 1.1

A Snapshot of Your Youth Firesetting Problem

Purpose

Compare your local youth firesetting problem with your peers'.

Directions

1. Individually locate and review the information collected as part of your pre-course assignment. (Five minutes are allotted for this task.)

2. In your table group, compare and contrast your **pre-course data** with that of your peers. You should also compare your data with national statistics presented earlier in this unit.

3. Compare and contrast the following similarities and differences of your youth firesetting problem. (There are 10 minutes allotted for these tasks.)

    a. Community demographics.

    b. Number of youth firesetting incidents and their locations.

    c. Ignition sources and types of fires.

    d. Common age groups/genders of firesetters.

    e. Number of youth arson arrests.

    f. State's Age of Accountability Law.

    g. Number of injuries/deaths/property loss from youth-set fires.

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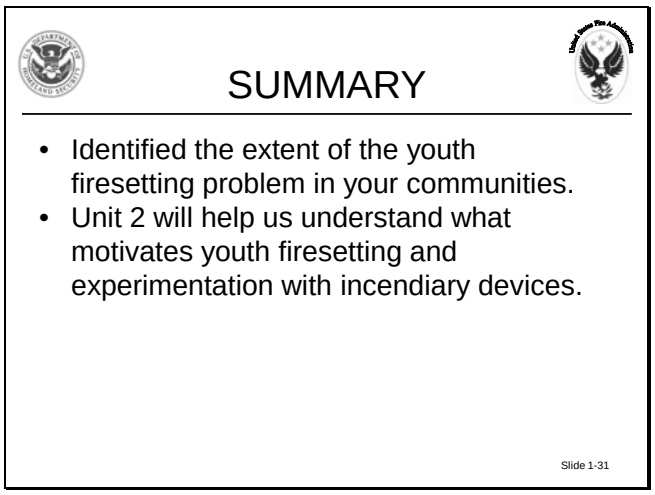
V. SUMMARY


SUMMARY
• Identified the extent of the youth firesetting problem in your communities.
• Unit 2 will help us understand what motivates youth firesetting and experimentation with incendiary devices.
Slide 1-31

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APPENDIX

READINGS

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A Brief History of Research on Juvenile Firesetting

The Elements of Arson

When a fire occurs, it is the responsibility of the fire investigator to determine the cause of the fire. The fire investigator looks for three elements to determine if the fire can be considered the crime of arson. DeHaan (2002) identified these as follows:

1. There has been a burning of property. This must be shown to the court to be actual destruction, at least in part, not just scorching or sooting (although some states include any physical or visible impairment of any surface).

2. The burning is incendiary in origin. Proof of the existence of an effective incendiary device, no matter how simple it may be, is adequate. Proof must be accomplished by showing specifically how all-possible natural or accidental causes have been considered and ruled out.

3. The burning is shown to be started with malice, that is with intent of destroying property (p. 508).

The Early Years of Arson Motives

According to Wooden and Berkey (1984), "Arson itself is as old as civilization, but it was not until the nineteenth century that there appeared to be much concern about the motivations for it or about the psychological stability of arsonists" (p. 12). As already reported, in the 1800s and early 1900s, considerable emphasis was placed on arsonists suffering from pyromania.

It was not until the mid-1960s that research on the motives of arsonists moved away from theories of a certain type of deviance. In 1966, McKerraccher and Dacre studied 30 adult male arsonists in a forensic psychiatric setting. They found that when compared with 147 adult non-arson offenders, the motives for the arsons were related to feelings of aggression, rather than from a certain type of deviance. In support of McKerraccher and Dacre's findings, Wolford (1972) reported that arsonists were unable to express their anger to others. Vreeland and Waller (1979) supported Wolford's findings when their research found that arsonists could not confront the object(s) of their anger/aggression, and instead the arsonists displaced that anger/aggression against property by starting fires.

In addition to the literature that focuses on pyromania, more current discussions of arson revolve around criminality. The National Center for the Analysis of Violent Crime (NCAVC) has identified six major categories of arson motives:

1. Profit.

2. Vandalism.

3. Excitement.

4. Revenge.

5. Crime concealment.

6. Extremism (cited by DeHaan, 2002, p. 509).

According to DeHaan (2002), of these six categories, the vandalism category is most closely associated with juvenile and adolescent firesetting. The fires are "set when the opportunity arises, often after school, work, or on weekends. Boredom and frustration among youth, sometimes leads to peer-group challenge to create some excitement" (p. 511).

O'Connor (1987) identified nine categories for the various motives for arson: (a) arson for profit, which would include insurance fraud and welfare fraud; (b) business-related fraud, which includes eliminating the competition and organized crime; (c) demolition and rehabilitation scams and building strippers; (d) revenge and prejudice fires; (e) vanity or hero fires; (f) crime concealment fires; (g) mass civil disturbances; (h) terrorism; and (i) juvenile firesetters and vandalism. Yet in focusing solely on juveniles, O'Connor stated that "a motive for juvenile firesetters is not always apparent" (p. 20), like it is with an adult. In support of O'Connor, Boudreau et al. (1977) stated,

Vandalism is a common cause ascribed to fires set by juveniles who seem to burn property merely to relieve boredom or as a general protest against authority. Many school fires as well as fires in abandoned autos, vacant buildings and trash receptacles are believed to be caused by this type of arsonist (p. 19).

In other words, according to Boudreau et al. (1977), O'Connor (1987), and DeHaan (2002), unlike arson in general, the motive is not always apparent as to juvenile firesetting and it could just be a symptom of boredom.

Juvenile Firesetting

In reviewing the literature that looks specifically at juvenile firesetting, four theoretical frameworks are evident: (a) Psychoanalytic Theory, (b) Social Learning Theory, (c) Dynamic-Behavioral Theory, and (d) Cycles of Firesetting Oregon Model. Each theory outlines the etiology for juvenile firesetting behavior based on the theoretical perspective of the researchers and three of the four are informed by a mental health perspective and have provided the foundation for the explanations of the motivations of firesetters to date.

Psychoanalytic Theory

Psychoanalytic Theory is a theory of human development that interprets human development in terms of motives and drives. Those that prescribe to Psychoanalytic Theory believe that human development is "primarily unconscious and heavily colored by emotion. Behavior is merely a surface characteristic, and it is important to analyze the symbolic meanings of behavior, and that early experiences are important to human development" (Berger, 2005, p. 35). Psychoanalytic Theory prescribes that firesetting is a child's desire to have power over something that he is able to extinguish himself.

Social Learning Theory

Bandura and Walters (1963) first introduced the Social Learning Theory as an extension of Miller and Dollard's (1941) research on the behavioral interpretation of modeling. Bandura's (1977) Social Learning Theory looked at the importance of learning through observation and modeling of behaviors, reactions, and attitudes of others. Bandura (1977) stated,

Learning would be exceedingly laborious, not to mention hazardous, if people had to rely solely on the effects of their own actions to inform them what to do. Fortunately, most human behavior is learned observationally through modeling: from observing others, one forms an idea of how new behaviors are performed, and on later occasions this coded information serves as a guide for action. (p. 22)

Bandura (1973) believed that anger and aggression, just like other types of behaviors, were learned through observational learning. An individual's observational learning comes from his or her family, cultural background, peer group, community, and mass media. According to Gaynor and Hatcher (1987), aggressive children come from families where one or more members also demonstrate aggressive behaviors. Through modeling, children learn to exhibit aggressive behaviors. As a result, poor social skills begin to develop within the family and continue to occur outside the family, for example, with peers and in school. Hence the family as well as the youngster's other primary environments reinforce the development of the socially deviant behavior of firesetting. (pp.46-47)

The link between Social Learning Theory and juvenile firesetting would come from a child seeing a family member or peer set a fire out of anger or aggression.

Current firesetter researchers Kolko and Kazdin (1986) drew on Social Learning Theory to develop a risk-factor model for juvenile firesetters. This model includes three domains: (a) learning experiences and cues, (b) personal repertoire, and (c) parent and family influences and stressors.

Learning experiences and cues would include the child's early modeling and vicarious experiences, early interest and direct experiences, and the availability of adult models and incendiary materials. The personal repertoire would include cognitive components such as limited fire and fire safety awareness, behavioral components such as interpersonal

ineffectiveness/skill deficits and antisocial behavior excesses, and motivational components. The parent and family influences and stressors would include limited supervision and monitoring, parental distance and un-involvement, parental pathology and limitations, and stressful external events.

Dynamic-Behavioral Theory

Dr. Ken Fineman (1980) introduced the Dynamic-Behavioral Theory of firesetting in 1980 as a way to show that certain factors predispose a child to firesetting. These factors include (a) personality characteristics, (b) family and social situations, and (c) environmental conditions (see Table 1 for a description of these factors).

Table 1

Dynamic-Behavioral Theory of Firesetting (Fineman, 1980)

Category	Description
Personality characteristics	Child's exhibited behaviors, school adjustment, physical problems, and organic dysfunctions.
Family and social situations	Information about the family system: how the child gets along with family members, how discipline is meted out, and if there is an ongoing crisis within the family.
Environmental conditions	The child receives encouragement to play with fire, models firesetting behavior identified in others, and deals with emotional distress, peer pressure, and stress.

Fineman (1995) introduced his Juvenile Firesetter Child and Family Risk Survey as a way to determine the future risk of firesetting of a child already determined to be a firesetter.

Cycles of Firesetting

Based upon years of experience working with juvenile firesetters, the Oregon State Fire Marshal's Office and the Oregon Treatment Strategies Task Force partnered to develop the Cycles Model of Firesetting. According to Stadolnik (2000), "The Cycles Model is visually represented by four concentric circles that represent the four dimensions of a juvenile's internal and external world that are considered to be related to their likelihood of firesetting" (p. 19). The cycle includes four circles: (a) the emotional/cognitive cycle, (b) the behavior cycle, (c) the family/household cycle, and (d) the community/social cycle. The four circles are described in Table 2.

Table 2

Cycles Model of Firesetting (Stadolnik, 2000)

Cycle	Description
Emotional/cognitive	Juvenile's thoughts and feelings after his or her firesetting event.
Behavior	Behaviors of the juvenile firesetter that coincide with his or her thoughts and feelings.
Family household	How the family responds to the firesetting event and the emotional environment of the juvenile's household.
Community/social	Responses by the community to the firesetting and what level of support or restriction the firesetter and family receive.

A vast number of empirical studies have been informed by these four theoretical frameworks of youth firesetting. The following section discusses this research timeline, beginning with the research of Dr. Helen Yarnell in the 1930s, through the current firesetter research of today. The chronology illustrates a move from studying institutionalized juvenile firesetters to the development of a series of typologies for non-institutionalized juvenile firesetters.

1930–1960

During 1937 and 1938, Dr. Helen Yarnell, working in the Psychiatric Division of Bellevue Hospital, undertook one of the very first studies on the phenomenon of juvenile firesetting. The reason for the study stemmed from her discovery that children who were referred to the Psychiatric Division of Bellevue Hospital for observation and firesetting tendencies showed a variation in their clinical firesetting background. Yarnell's study team observed 60 children between the ages of 6 and 15. Sixty percent were between the ages of 6 and 8 and 35 percent were between the ages of 11 and 15. Only two were girls, ages 6 and 7. The research team reviewed the children's clinical history and completed interviews with each child. According to Yarnell (1940), the adolescent group's findings were much different than that of the younger group; however, Yarnell's study with the adolescent group was incomplete at the time of the printing of her monograph.

In the first column of Table 3 is a list of the findings on the children ages 6 through 8, with the exception of five children who were deemed to be mentally defective. In the second column of Table 3 is a list of the findings on the adolescents, ages 11 through 15. Yarnell found that children aged 6-8 started fires because of a deprivation of love and security at home, whereas older children viewed fire as exciting and entertaining.

Table 3

Findings of Dr. Helen Yarnell's 1937-1938 Study (Yarnell, 1940, pp. 272-286)

	Ages 6 through 8		Ages 11 through 15
1.	All of the children are of average to dull normal intelligence, but many had some special educational disability such as reading or arithmetic. This made their school adjustment difficult.	1.	This group showed little anxiety or regret for their firesetting.
2.	In every case, the child had been deprived of love and security in his/her home life.	2.	Anxiety dreams were infrequent.
3.	They set fires only when under stress in their home situation.	3.	The fires were planned, set away from home, and many caused losses involving thousands of dollars.
4.	The children set fires with associated fantasies to burn some member of the family who had either withheld love from the child or become too serious a rival for the love of a parent.	4.	The adolescents waited to see the fires and enjoyed the noise and excitement from the fire engines.
5.	The fires are set in and around the home, cause little damage, and are usually put out by the child himself; significance is chiefly symbolic.	5.	The boys tended to go in pairs, with the exclusion of all other friends. The pairs included an aggressive and passive member, suggesting homosexual association; however, the researchers never proved this.
6.	The children show other types of asocial behavior such as running away from home, truancy, stealing, and general hyper kinesis and aggression.		
7.	All children show acute anxiety and suffer from terrifying dreams and fantasies, including vivid attacks by the devil, ghosts and skeletons.		
8.	All children have some sexual conflicts and many tell of active masturbation, sodomy, or fellatio; type of activity does not seem significant.		
9.	Enuresis was noted in only nine of the cases and seemed a part of the general picture rather than specifically associated with the fire motif.		
10.	A special group of children were orphans who had been placed in boarding homes but failed to make emotional adjustments.		

In a second study begun shortly after Yarnell's study of 1937-1938, Drs. Nolan Lewis and Helen Yarnell (1951) looked at a group of 238 child firesetters between the ages of 5 and 15. In this study, the case records were obtained from fire reports, insurance investigators, juvenile research centers and juvenile courts. The 1951 study included the 30 cases from Yarnell's previous 1937-1938 research study. In this study, Lewis and Yarnell reported a wide range of motivations for firesetting. That included:

1. With the exception of children who set fires against the school, the children's intelligence ranged from low average to superior.

2. Most of the fires occurred when the child was found to feel guilty over some type of sexual preoccupation.

3. A number of the fires were symbolic and directed specifically toward one member of the family.

4. Thirty-two percent of the firesetters set the fire because they liked fire and excitement.

5. Twenty-two percent of the firesetters set the fire as revenge against a parent or foster home.

6. Seventeen percent of the firesetters set the fire because they liked to see the fire engines.

7. Fifteen percent of the firesetters set the fire out of revenge against their employer.

8. Eight percent of the firesetters set the fire to be a hero.

9. Six percent of the firesetters set the fire to cover or be associated with stealing.

Both the Yarnell (1940) and the Lewis and Yarnell (1951) studies were the first studies that looked specifically at the child and adolescent firesetter. These studies were the groundwork for future research on child and adolescent firesetting. Unfortunately, it was not until the 1970s when research on juvenile firesetting resumed when fire departments and mental health professionals began to notice the increasing numbers of child and adolescent firesetting incidents.

1960–1980

There was little research, aside from that of Lewis and Yarnell, throughout the 1940s and 1950s. It was not until the late 1960s and early 1970s that the fire service and mental health took notice of the large number of reported youth who were setting fires and were appearing in the fire service statistics of that time.

Macht and Mack (1968) began the resurgence in firesetting research in 1968. They studied four adolescent firesetters ages 16 to 18. In this study, they found that all four boys came from

stressful home situations. The boys only set fires when they were away from their fathers, and each one of the boy's father had some type of significant job involvement with fire. Macht and Mack concluded from their study that:

Fire had come to have a special and pleasurable meaning in the lives of these patients. . . . In an important sense, the firesetting represents a call from the overburdened adolescent to the absent father in order to bring him to the rescue. . .The activity in connection with fire served to reestablish a lost relationship with the father. (p. 286)

Folkman and Siegelman (1971) undertook a pilot study to explore the firesetting behavior in 47 randomly selected normal children ages 6 and 7. In this study, Folkman and Siegelman found that only two boys had come to the attention of the fire service for setting fires. However, 60 percent of the boys and 33 percent of the girls were found to have an interest in fire, which was exhibited by either a self-report of previous firesetting or reporting they had asked to light matches. During this time, the focus expanded to identifying treatment options for juvenile firesetters.

During a California State Psychological Association conference in 1975, a group of fire service personnel and psychologists met to discuss the issue of juvenile firesetting. The reason for this discussion was the fact that both fire service and mental health had been receiving referrals on juvenile firesetters and neither group knew how to help these children. Out of this meeting, the Fire Service and Arson Prevention Committee were formed to design methods to work with the child firesetters. According to Gaynor and Hatcher (1987), this committee received a grant from the United States Fire Administration to begin work on designing and developing a method to classify juvenile firesetting behavior and to determine the risk of future firesetting in children who have been identified as firesetters. This committee's work provided the basis for the evaluation and classification system used today with youth firesetters.

Bernard Levin (1976) wrote about the psychological characteristics of firesetters. The main focus of this article was on the adult firesetter; however, he did discuss children and fire by stating: Most people are fascinated by fire. This fascination starts at an early age and manifests itself in young children playing with matches. While people may not outgrow their basic fascination with fire, normal children learn that playing with matches is not acceptable behavior and discontinue it by the age of five or six. A few children continue to play with matches or deliberately set destructive fires, and their chronic firesetting is an observable symptom of a psychological disturbance. (p. 38)

He went on to discuss two types of treatments used when working with chronic juvenile firesetters. The first treatment discussed by Welsh (1971) was stimulus satiation. This technique requires a firesetter to strike matches for an hour a day until the firesetter is sick of lighting the matches and stops match lighting and/or firesetting. The second treatment is through positive reinforcement that is accompanied with the threat of punishment by loss (Holland, 1969). This technique requires a child to bring any found match packages to his father, who would then give him a reward for his positive behavior. This treatment would cause the child to develop positive non-firesetting behaviors based on the positive reward.

The literature on juvenile firesetting from the 1940s through the 1970s focused either on diagnosis or treatment. During this time, Heath, Gayton, and Hardesty (1976) reviewed the literature on juvenile firesetting and found only six journal articles that exclusively discussed juvenile firesetting and 17 articles on issues related to juvenile firesetting. Unfortunately, they were unable to get their literature review article published in the United States, so they relied upon the Canadian Psychiatric Association to publish the literature review in their journal.

However, from the 1980s through today, the literature has proven to be ripe with research on juvenile firesetting, just not specific to the motivations of school firesetters or the phenomenon of school fires.

1980–Today

From the 1980s through today, there have been many different foci of youth firesetter research, including (a) the impact of the environment on the juvenile firesetter's behavior (Fineman, 1980; Gaynor & Hatcher, 1987; Vreeland & Waller, 1979); (b) psychiatric disorders as the catalyst for juvenile firesetting (Fineman, 1980; Freud, 1932; Heath et al., 1976; Kolko & Kazdin, 1986; Kuhnley, Henderson, & Quinland, 1982; Lewis & Yarnell, 1951; Williams, 2005; Wooden & Berkey, 1984; Yarnell, 1940); (c) firesetting as a learned behavior (Gaynor & Hatcher, 1987; Kolko & Kazdin, 1986; Vreeland & Waller, 1979); (d) juvenile firesetter assessment and evaluation instruments (Fineman 1980, 1995; Gaynor & Hatcher, 1987; Sakheim & Osborn, 1994; Slavkin, 2000; Stadolnik, 2000); (e) mental health and educational interventions (Bumpass, Fagelman, & Brix, 1983; Fineman, 1980, 1995; Kolko & Kazdin, 1986, 1991; Sakheim & Osborn, 1994; Stadolnik, 2000; Wooden & Berkey, 1984), and (f) juvenile firesetter motives and typologies (Cotterall, 1999; Fineman, 1980; Gaynor & Hatcher, 1987; Hall, 2006; Kolko & Kazdin, 1991; Meade, 1998; Sakheim & Osborn, 1994; Swaffer & Hollin, 1995; Terjestam & Ryden, 1996). Because the specific focus of this dissertation is on the self-reported motivations of students who set school fires, the following section focuses strictly on the literature regarding firesetter motives and typologies. While the typologies contain anywhere from three to nine categories of firesetter motives, they all range from the curious to the pathological firesetter.

School Fires and Firesetting

According to historical information on school fires, there have been three devastating school fires in the history of the United States. A synopsis of each of these school fires follows. The first school fire occurred on March 4, 1908 at the Lakeview Elementary School in Collinwood, Ohio. The cause of the fire was said to be wood joists coming in contact with an overheated steam pipe that started the fire. This fire killed 172 students and 2 teachers (Gottschalk, 2002). The second devastating school fire occurred on March 18, 1937, in New London, Texas. A disgruntled school employee who had been reprimanded for smoking and wanted to get back at the school administrators started the New London School fire. He tampered with the gas lines so as to run up the school gas bill. An explosion ensued which killed 294 students and staff (Gottschalk, 2002). The third school fire occurred on December 1, 1958 in Chicago, Illinois at

the Our Lady of the Angels School. A fifth grade student lighting a cardboard waste barrel in the school basement started this school fire. The fire claimed the lives of 92 students and 3 nuns.

All of these fires caused community devastation, millions of dollars in property loss, and the most precious loss of all, the loss of life. However, only the fire at Our Lady of the Angles School was started by a school student.

According to the National Fire Incident Reporting System (NFIRS) and the National Fire Protection Association (NFPA), in 2002, there were an estimated 14,300 fires in kindergarten through twelfth grade educational institutions, causing an estimated $103,600,000 in property damage and 122 injuries (FEMA, 2004).

The leading cause of these school fires was incendiary/suspicious activity accounting for 37 percent of all school structure fires. Fifty-two percent of all middle and high school fires have been attributed to incendiary/suspicious activity (FEMA, 2004). The NFIRS report stated that 78 percent of all school fires occur during the school week and 55 percent of these fires occur between the hours of 8 a.m. and 5 p.m. when youth are likely to be at school (FEMA, 2004). Today, deaths from school fires are rare, but injuries per fire were higher in school structure fires than nonresidential structure fires on average per the United States Fire Administration (2005). Also according to the USFA (2001), "Each year in the United States, there are an estimated 1,300 fires in high schools, private and prep schools and college dormitories. These fires are responsible for less than 5 deaths, approximately 50 injuries, and $4.1 million in property loss annually" (p. 1). But what about in Phoenix, Arizona?

In 2005, there were a total of 99 school fires occurring during school hours in K-12 educational institutions that were reported to the Phoenix Fire Department's Youth Firesetter Intervention Program (2006). These reports over the past five years along with the fire at Our Lady of the Angels School prompted this research on the motivations of students who set school fires. Are they troubled students who dislike school, as was the case with the fire set at our Our Lady of the Angels School? Do the motivations for student firesetters follow the motivation typologies found in previous research on firesetters? What does previous research say about school firesetters?

School Firesetters

In Lewis and Yarnell's (1951) study from 1937–1938, out of 238 child firesetters, 61 had set fires in either churches or schools (no differentiation between church or school was given). The reasons these firesetters gave for setting their school fires were predominately based on hatred, revenge, and the desire to destroy the school building, hoping that they would no longer have to attend school. Some of their other reasons included the following comments:

1. "We didn't like the looks of the teacher."

2. "I got a bad report card and thought I'd make a fire and blow it up."

3. "I was mad, because I didn't pass."

4. "I was tired of going to school."

5. "The teacher picked on me." (p. 300)

Some of the secondary reasons these students gave for setting the school fires was to see the fire, see the fire engines, and be the hero that discovers the fire. The researchers went on to say that these children might also vandalize school property, steal from teachers and staff, leave obscene notes on the teacher's desk, and mutilate the teacher's clothing. Their classroom behavior and schoolwork was poor at best and they showed a "predominately dull or borderline intelligence with special learning disabilities, and all of them were unable to compete in the classroom" (p. 300). Lewis and Yarnell (1951) also stated that children under age 10 rarely set school fires and the most frequent age group of school firesetters is between 12 and 14 years of age. In Wooden and Berkey's (1984) study, they found that the "greatest number of fires (37 percent) set by the delinquent firesetters" were school-related fires (p. 72). The motives for these school fires were found to be "revenge, spite, or disruption of classroom activities" (p. 77). The median age for the school firesetters in Wooden and Berkey's (1984) study was 14, and the fires were most often set in the classroom, school closets, under the teacher's desk, or in the wastebasket. They also found that most of the school firesetters were considered trouble-making students, and the fires occurred after being punished by a teacher or school administrator. In the body of current literature, only two examples of differing motives appear.

In an article written by Jeff Meade (1998) titled *Fire Power,* while not a study about school firesetters but rather a compilation of information about school fires written for *Education Week*, Meade discussed school firesetting with juvenile firesetter researcher Paul Schwartzman. Schwartzman suggested that there was no one main reason juvenile firesetters target schools; however, he did suggest the following possible motives behind school firesetting:

1. A prank.

2. To get out of final exams.

3. Peer pressure.

4. Seeking attention.

Other possible motives behind school firesetting discussed by Meade (1998) include revenge, school disruption, anger, or no explanation at all. Hall (2006) reported that "deliberate fires in schools are often a result of mucking about which gets out of hand" (p. 2). However, according to Hall's report, Dr. Jack Kennedy, a clinical forensic psychologist, reverted to a pathological explanation, asserting that there was a deeper reason for school fires. Kennedy stated:

For children, school is normally a focal point for their social world. So that's where they're going to be exposed to frustrations, to issues of tolerance, and anger. And because they place social controls on children, schools—unfortunately—often annoy them, cause them to be disgruntled, or to feel hard done by. The results can be starting a fire to vent anger, or exact revenge against the school, or against the teacher. It's rare that there is not some sort of trail or

story behind a fire at school. Fires may be like a friend to some of these children—the one thing they feel gives them some power. (Hall, 2006, pp. 2-3)

> As has been evidenced by the scant research that focuses specifically on school firesetters, little is known about the motivations behind school fires. In Lewis and Yarnell's (1951) research, all of the school firesetters had "predominately dull or borderline intelligence with special learning disabilities and all of them were unable to compete in the classroom" (p. 300). In Wooden and Berkey's study in 1984, all of the school firesetters were troubled students who set school fires after a teacher or school administrator had punished them. Meade and Hall speculated about the motives of school firesetters but undertook no actual research to support their hypotheses.

(This information was taken from the following source: Boberg, J. (2006). *An exploratory case study of the self-reported motivations of students who set school fire.* Flagstaff, AZ; NAU) (Chapter 2)

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UNIT 2:
WHO SETS FIRES AND WHY?

TERMINAL OBJECTIVE

The students will be able to:

2.1 Classify the typologies of youth firesetting.

ENABLING OBJECTIVES

The students will be able to:

2.1 Explain the significance of fire in America's culture and how children learn about fire.

2.2 Compare the myths and facts related to youth firesetting.

2.3 Describe the dangers and penalties of youth firesetting behaviors.

2.4 Classify the typologies of youth firesetting.

2.5 Describe the four common factors that contribute to firesetting behaviors involving children and adolescents.

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UNIT 2: WHO SETS FIRES AND WHY?

Slide 2-1

ENABLING OBJECTIVES

- Explain the significance of fire in America's culture and how children learn about fire.
- Compare myths and facts related to youth firesetting.
- Describe the dangers and penalties of youth firesetting behaviors.

Slide 2-2

ENABLING OBJECTIVES (cont'd)

- Classify the typologies of youth firesetting.
- Describe the four common factors that contribute to firesetting behaviors involving children and adolescents.

Slide 2-3

I. FIRE IN OUR SOCIETY

A. Fire has been a part of society since the beginning of mankind.

B. Fire is an essential part of our everyday life.

1. The fireplace, campfire and bonfire are all symbols of fire that are central to the soul of humankind.

2. Fire has been associated with religions and religious ceremonies worldwide.

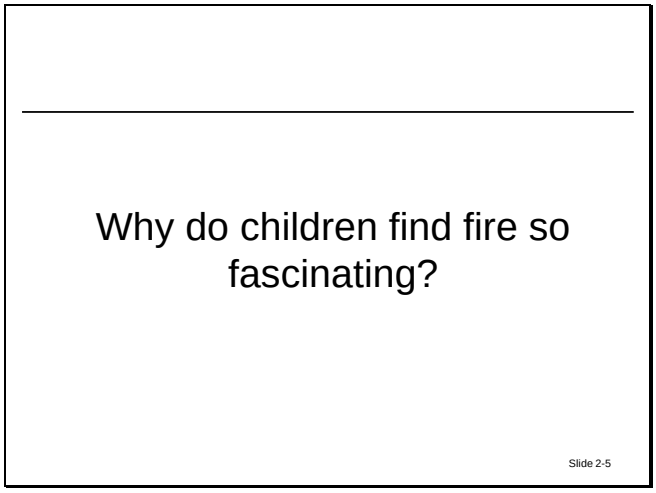
3. Fire also plays a large part in ceremonies such as birthdays, weddings, baptisms and funerals.

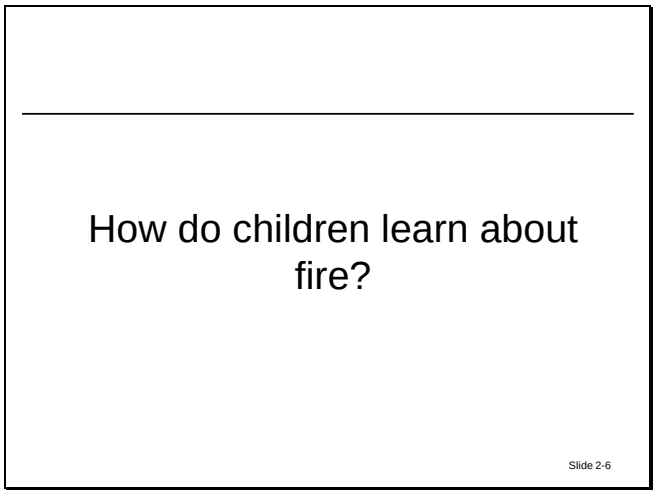
4. References to fire are found in many forms of entertainment such as movies, songs, Broadway musicals and sports.

5. Humans use fire in many different ways every day for cooking, heating, lighting, medicine, transportation and defense.

C. Fire carries an innate fascination and mysticism for most people — children included.

II. HOW CHILDREN LEARN ABOUT FIRE





Why children find fire fascinating and how they learn about it:

A. A child is celebrating his first birthday. There are balloons, presents, relatives and a birthday cake right in front of the child. His mother leans over and lights a match to a large candle in the shape of a number "1." Everyone is smiling and singing "Happy Birthday," and the child is told to blow the candle out.

B. Children see fire mostly controlled and for positive and pleasurable uses. It's natural for children as young as age 2 to become fascinated with the glow and warmth of fire.

C. The coloring and flickering of the flames provide a visual stimulus that serves as a form of entertainment and relaxation for the beholder. Its crackling sound appeals to the ear.

D. It is common for children to want to learn more about fire and even go so far as seeing if they can "make" fire.

E. The family goes on a camping trip. During the day, the family gathers plenty of firewood for the nightly campfire. At night, the family builds a campfire so they can roast marshmallows, stay warm and tell stories by the glow of the fire.

F. At a family gathering, a charcoal or gas grill is used to cook food.

G. It has been a stressful week at work, and a mother prepares a relaxing bath with candles, bubbles and hot water.

H. In a family where smokers are present, children may see lighters used many times each day.

I. It is July 4th, and there are numerous fireworks celebrations throughout the community. This pyrotechnical extravaganza sets the sky on fire.

J. In the winter, a family may use a wood-burning stove or fireplace.

K. A child sits down to watch his favorite television stunt show. The scene depicts a stuntman setting himself ablaze and then skateboarding over three parked cars.

L. Science class experiments show how different colored flames are created by burning different types of materials and how a combination of certain chemicals can cause an explosion.

M. To a child who is growing, developing and learning, fire may be misinterpreted as being safe; without supervision, it can be very dangerous.

1. A child (and even adolescents) might not understand the dangers of fire or may not have been taught fire safety.

2. Concepts like danger, what is real and not real, and their own invincibility are not easily understood by a child.

III. MYTHS AND FACTS ABOUT CHILDREN AND FIRE

MYTHS AND FACTS ABOUT CHILDREN AND FIRE

- Myth: A child can control a small fire.
- Fact: Most fires start small but can quickly become uncontrollable.

Slide 2-7

A. **Myth:** A child can control a small fire.

Fact: Most fires start small but can become uncontrollable quickly.

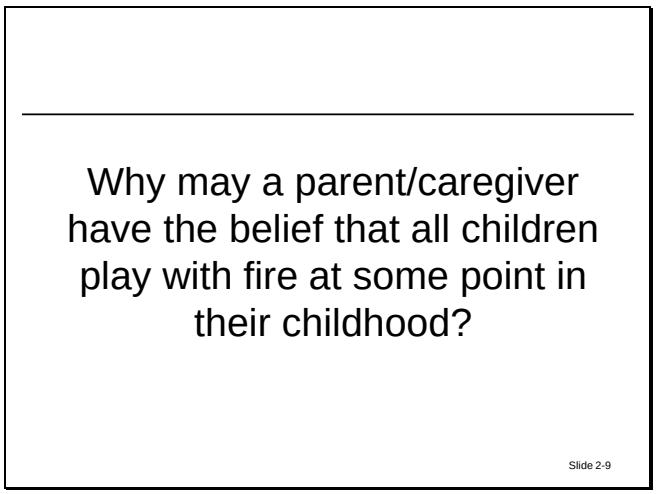
MYTHS AND FACTS ABOUT CHILDREN AND FIRE (cont'd)

- Myth: It is normal for children to play with fire.
- Fact: It is not normal for children to play with fire. Curiosity about fire is common. Use of fire without a parent/caregiver's knowledge, approval or supervision is dangerous.

Slide 2-8

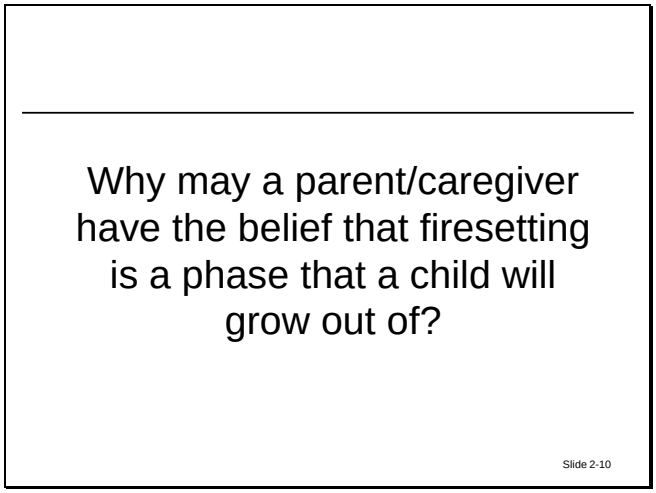
B. **Myth:** It is normal for children to play with fire.

Fact: It is not normal for children to play with fire. Curiosity about fire is common. Use of fire without a parent/caregiver's knowledge, approval or supervision is dangerous.



C. **Myth:** Firesetting is a phase that children will outgrow.

Fact: Firesetting is not a phase. If a child is not taught fire safety, firesetting can get out of control easily. It is a dangerous behavior; you can't afford to wait to change it.



D. **Myth:** Many children are obsessed with fire.

Fact: Very few children are obsessed with fire. There always is a reason for firesetting. That reason needs to be discovered and dealt with.

E. **Myth:** If you burn a child's hand, he or she will stop setting fires.

Fact: Purposely burning a child's hand is child abuse and is against the law. Burns only create fear and scars. The reason behind the fire use must be discovered and addressed.

F. **Myth:** If you take a child to the burn unit to see burn victims, he or she will stop playing with fire.

Fact: Going to the burn unit only instills fear and does not teach the child anything about fire and safety. More importantly, we need to be sensitive to burn survivors who are trying to recover (emotionally and physically) from their burns, and we should not put them on display.

G. **Myth:** Putting a child in the back of a police car or having a firefighter talk sternly to them will stop firesetting behaviors.

Fact: Police officers will put a child in the back of their patrol car only if they have legal authority and it is appropriate to do so. Scare tactics don't get to the root of the problem, and these kids typically continue to set fires.

MYTHS AND FACTS ABOUT CHILDREN AND FIRE (cont'd)

Slide 2-11

H. **Myth:** Firesetting is related to bedwetting.

Fact: This correlation has never been proven. It is based on Freudian Domination theory; prehistoric man showed power by urinating on fires and putting them out.

I. **Myth**: Over 50 percent of youth firesetters have mental health disorders and/or learning disabilities.

Fact: Current research reveals that fewer than 25 percent of youth firesetters have been diagnosed with a mental health disorder and/or learning disability. However, this is not to say that youth firesetters (and perhaps family members) are not challenged by some type of undiagnosed disorder.

IV. DANGERS AND PENALTIES OF YOUTH FIRESETTING

DANGERS AND PENALITIES OF YOUTH FIRESETTING

- A firesetter in an apartment complex or school can be likened to a serial sniper. Why could that statement be true?

Slide 2-12

A. The danger of fire today is greater than ever because of the high number of petroleum-based building materials.

B. Fires burn quicker and hotter, and smoke is more toxic than in the past because of these materials.

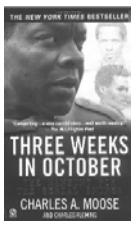
C. In the hands of a youth, fire can be more deadly than a loaded firearm. Consider the following analogy:

A firesetter in an apartment complex or school can be likened to a serial sniper. Here's why:

1. Fire can intensify quickly and can consume everything in its path, including life.

DANGERS AND PENALITIES OF YOUTH FIRESETTING (cont'd)

- A serial sniper kills those he or she comes in contact with, regardless of age, sex, ethnicity or socioeconomic status.



Slide 2-13

2. A serial sniper kills those he or she comes in contact with, regardless of age, sex, ethnicity or socioeconomic status.

D. In addition to the dangers of firesetting, many parents or caregivers are unaware that a youth can be prosecuted for starting a fire once he or she reaches the state's age of accountability.

E. Arson.

DANGERS AND PENALITIES OF YOUTH FIRESETTING (cont'd)

- What is arson?
  - Federal Bureau of Investigation's (FBI's) Uniform Crime Reporting (UCR) Program defines arson as "any willful or malicious burning or attempt to burn, with or without intent to defraud a dwelling house, public building, motor vehicle or aircraft, personal property of another, etc."

Slide 2-14

1. The Federal Bureau of Investigation's (FBI's) Uniform Crime Reporting (UCR) Program defines arson as "any willful or malicious burning or attempt to burn, with or without intent to defraud a dwelling house, public building, motor vehicle or aircraft, personal property of another, etc. Only fires determined through investigation to have been willfully or maliciously set are classified as arson" (FBI, 2002).

DANGERS AND PENALITIES OF YOUTH FIRESETTING (cont'd)

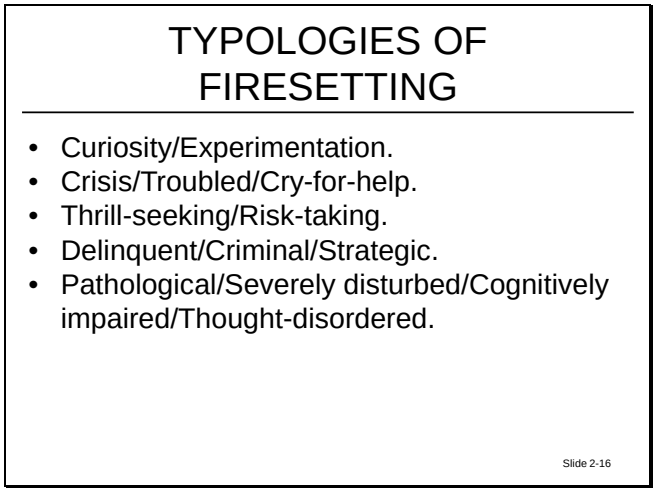
- Year after year, the FBI's UCR shows that between 50 and 60 percent of all arson arrests in the United States are of youth under the age of 18.
- How the crime of arson is defined, enforced and punished is up to each individual state.

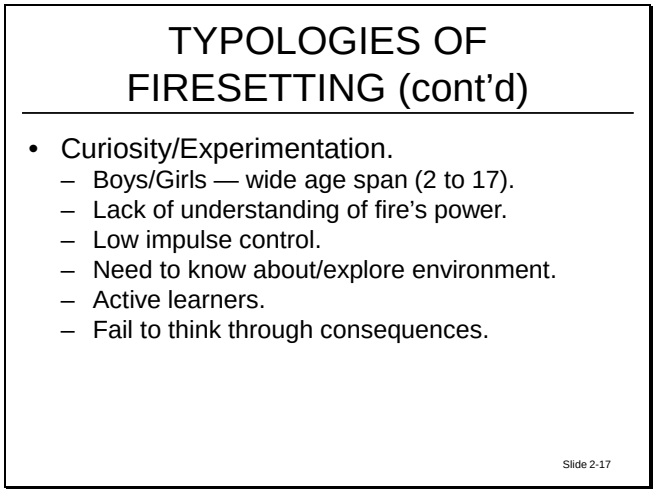
Slide 2-15

2. Year after year, the FBI's UCR shows that between 50 and 60 percent of all arson arrests in the United States are of youth under the age of 18 (FBI UCR, 2002-2007).

3. However, in the U.S., how the crime of arson is defined, enforced and punished is up to each individual state.

V. TYPOLOGIES OF FIRESETTING





A. Curiosity/Experimentation.

1. Most children experience fire interest between the ages of 3 to 5. This age group often asks questions focusing on the physical properties of fire, such as how hot fire is, its color, or what makes it burn.

2. Children often express their interest in fire through play by wearing fire hats, playing with toy firetrucks, and cooking food on their toy stoves.

3. Fire interest by young children is normal and can be effectively addressed through age-appropriate education by adults.

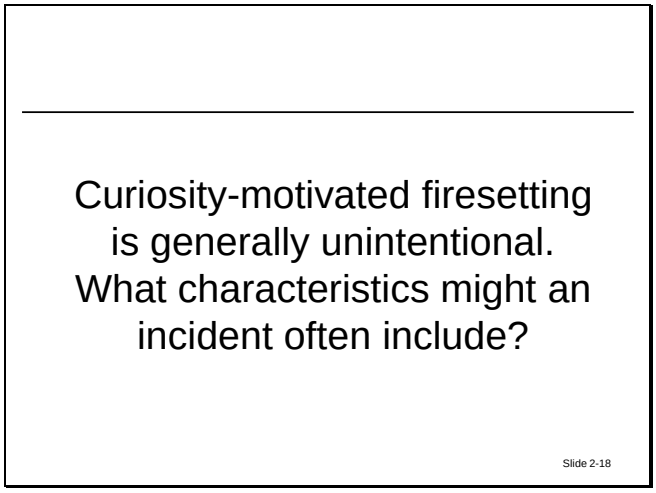
4. Children can be taught to understand fire as a productive and useful part of their lives.

5. Unfortunately, many adults fail to adequately address their children's interest in fire.

6. It has been estimated that curiosity-motivated firesetting represents greater than 60 percent of all fires set by children (National Fire Protection Association (NFPA) and U.S. Fire Administration (USFA)).

7. The curiosity-motivated firesetter is a child who is exploring his or her interest in fire through experimentation.

8. Curious and experimental firesetting refers primarily to young children, ages 2 through 10. The median (average) age of a curiosity-motivated firesetter is 5 years old (International Fire Service Training Association (IFSTA), 2010).



9. In general, curiosity-motivated firesetting by younger children is unintentional. Characteristics of the incident often include:

   a. Lack of adult supervision.

   b. Easy access to ignition materials.

   c. Unsophisticated planning of event.

   d. Ignition in hidden/remote location.

e. Indoor or outdoor fires.

f. Recent onset of firesetting behavior.

g. No identifiable target or fire pattern.

h. No past history of firesetting.

i. Lack of fire safety knowledge in the family.

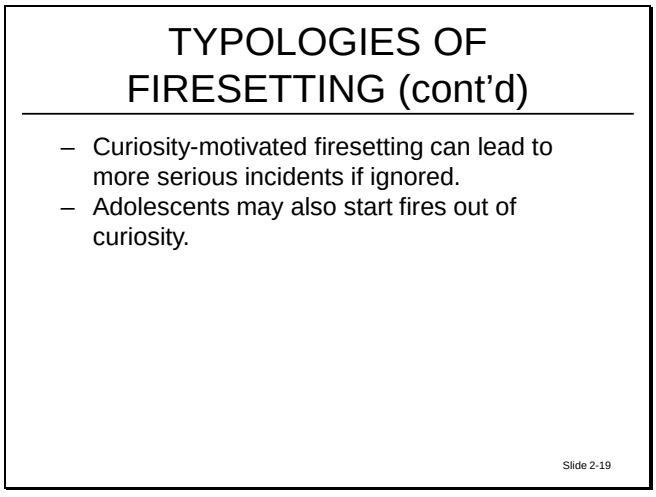
j. Failure to use safety knowledge in the family.

10. Three out of every five children set bedrooms on fire, involving the ignition of bedding, mattresses, upholstered furniture or clothing.

11. The curiosity-motivated firesetter comes from a variety of household profiles. He or she often has low impulse control and lacks an understanding of the destructive power of fire.

12. Cognitive challenges such as learning disabilities and attention-deficit hyperactivity disorder (ADHD) are factors that can influence poor decision-making and spontaneous behaviors such as spur of the moment fire experimentation.

13. Once curious firesetters realize the impact of their behavior, they often seek help and/or try to extinguish their fire. In some cases, firesetters may hide or exit the area of origin without seeking help.



14. A very important point: Curiosity-motivated firesetting can lead to more serious incidents if ignored. If a child or adolescent continues to participate in more than one unsupervised fire incident, the probability of starting a significant fire increases dramatically.

15. It is critical for parents, caregivers, the emergency services, schools and the health community to understand that all incidents should be reported and addressed immediately.

16. Careful screening of all firesetting incidents by a trained practitioner is critical in order to evaluate the potential for underlying psychological or social needs.

17. Most firesetters start their first fire while exploring a natural curiosity. If educational intervention does not take place, eight out of 10 children will continue to experiment, and the frequency of behavior may escalate (IFSTA Fire and Life Safety Educator (FLSE) Manual, 2010).

18. Adolescents may also start fires out of curiosity. Their actions are sometimes prompted by a desire to experiment and/ or by carelessness. Sometimes it's a simple wish to explore their environment with little understanding of the consequences or danger of starting a fire. As with younger children, cognitive challenges can influence poor decision-making and spontaneous behaviors.

19. Most adolescent firesetters who are truly prompted by curiosity do not intend to be destructive or to inflict damage on life or property. Many will try to extinguish the fire they start, and often it is the firesetters who initiate a call for help.

20. Experimenting adolescents may initially deny or lie about their involvement with fire. However, if confronted by officials using an appropriate demeanor, they often show remorse for the event.

21. Combined with education, holding adolescents accountable for their actions is a proven strategy to prevent/address firesetting behaviors.

TYPOLOGIES OF FIRESETTING (cont'd)

- Crisis/Troubled/Cry-for-help:
  - Firesetting is calling attention to a problem.
  - Youth may have poor coping/problem-solving skills.
  - Youth may have had a recent crisis or trauma.
  - Family dysfunction may be common.
  - Youth has access to ignition materials without supervision.
  - There may be a continuing series of firesetting.

Slide 2-21

B. Crisis/Troubled/Cry-for-help.

1. Be it sadness, anger or a signal to a problematic situation like abuse, firesetting can be a powerful way for youth to communicate a level of need for attention from adults.

2. The need to deliver a message requesting help is often a root factor contributing to crisis/troubled/cries-for-help firesetting.

3. Intentional firesetting may be influenced by cognitive, psychological or social problems. It can also be exacerbated by environmental factors, such as access to ignition materials, lack of adult supervision, and family dysfunction.

4. This type of firesetting is extremely dangerous because it often consists of a series of fire incidents, both planned and/ or spontaneous, that take place over several weeks, months or even years. The severity of fires may vary.

TYPOLOGIES OF FIRESETTING (cont'd)

- Fires are sometimes directed at specific targets/objects.
- Fire may be symbolic of what's causing problems.
- Physical, psychological, sexual abuse are possible.
- Youth may use fire to express anger, sadness, frustration, powerless feelings related to stress or major changes in their life.

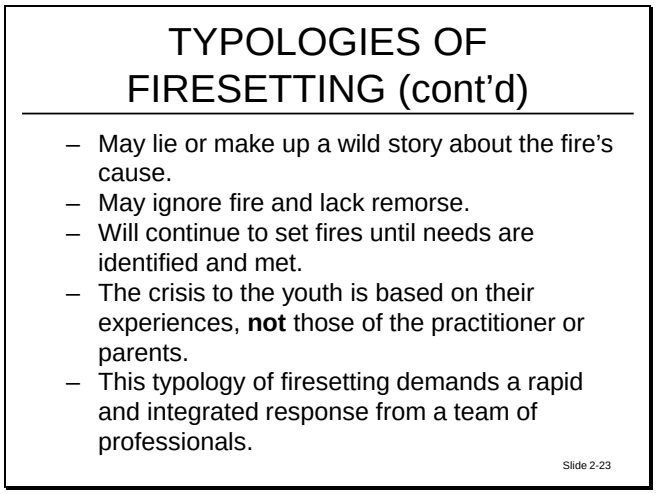
Slide 2-22

5. In some cases, there is intent to destroy or harm specific property and/or people. Once a fire is started, the firesetter may not make an attempt to extinguish the fire or seek help. The fire acts as a symbol of a problem and signals a cry for help in response to a stressful life experience or abuse.

6. The possible link between physical and/ or sexual abuse, neglect and firesetting has been investigated extensively by several states. Professionals in both Oregon and Massachusetts have empirically documented a strong connection between child abuse and firesetting behavior (Oregon Office of State Fire Marshal and Massachusetts State Police).

7. The crisis/troubled/cry-for-help firesetter often has poor coping and problem-solving skills. He or she is often unable to clearly identify or express his or her feelings in a socially appropriate manner.

8. As with curiosity-motivated firesetters, the attention-seeking youth may lack understanding of the speed, danger and destructive potential of fire.



9. When confronted, attention-seeking firesetters may lie about the cause of their fire, or make up wild stories about the event.

10. Of particular concern, this typology of firesetter may lack remorse for starting a fire and/or ignore the event once it has been initiated because he or she feels that the behavior was justified.

11. This typology of firesetter may continue to set fires until his or her need for attention is identified and appropriately addressed.

12. The attention-seeking firesetter (and family) needs immediate intervention from a team of experienced professionals who can intervene appropriately. Intervention may include a combination of education, clinical (mental health) and social service support. Adjudication (legal proceedings) by justice officials may also be necessary.

Slide 2-24

TYPOLOGIES OF FIRESETTING (cont'd)

- Thrill-seeking/Risk-taking:
  - Experimenting for adrenaline rush with fire and "other" devices.
  - Adolescents fail to think through possible consequences.
  - Peer influenced; enjoy attention.
  - Easy access to fire tools and "other" materials.

Slide 2-25

C. Thrill-seeking/Risk-taking.

1. In contrast to curiosity, some adolescent firesetters try to duplicate forms of dangerous behaviors seen in various mediums such as in person, through video gaming or on the Internet.

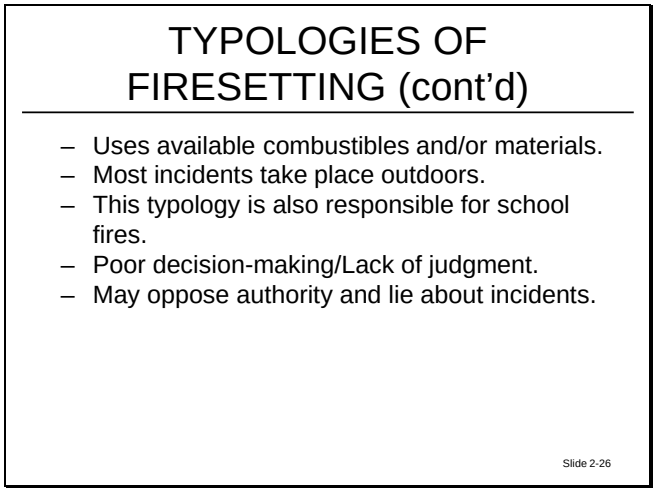
2. Experimentation with fire, explosives and other pressure-creating devices (bottle bombs) can serve as the "ultimate" risk for adolescents engaging in thrill-seeking/risk-taking behaviors.

3. Adolescents often take these risks without thinking through potential consequences such as injury, death, property damages or criminal sanctions.

4. As adolescents search for an adrenaline rush, today's rapidly expanding technology creates a surplus of opportunities for youth to learn what's being done by their peers worldwide.

5. Many parents/caregivers have no idea what their child has been researching, viewing or experimenting with until contact with public officials occurs.

6. Thrill-seeking/Risk-taking adolescents are often very peer-influenced and enjoy attention-getting behaviors.



7. Incidents are usually created with available combustibles/materials and ignition sources that are easily accessible.

8. While most thrill-seeking incidents occur outdoors, this typology of offender is responsible for the greatest number of school fires and fireworks incidents.

9. As with the other typologies, cognitive challenges such as learning disabilities and ADHD are factors that can influence poor decision-making and spontaneous behaviors such as spur of the moment fire experimentation or device manufacturing/detonation.

10. This typology of firesetters may oppose authority figures. When confronted about their behavior, they often lie about their involvement in illegal behavior or make up stories about why the event(s) occurred.

TYPOLOGIES OF FIRESETTING (cont'd)

- Adolescent may be afraid of consequences.
- May tell the truth if confronted in a respectful manner and presented with facts.
- Often embarrassed when caught.
- May try to extinguish the fire or summon help because their motive was not for the incident to get out of control.

Slide 2-27

11. However, thrill-seeking/risk-taking adolescents are usually afraid of potential legal consequences. They will often admit to their indiscretion if presented with facts about an incident and approached in a respectful manner.

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TYPOLOGIES OF FIRESETTING (cont'd)

- Delinquent/Criminal/Strategic:
  - Distinguished by motive of willful intent to cause destruction.
  - Targets are typically schools (after hours), abandoned buildings, open fields, dumpsters and abandoned structures.
  - Often influenced by peer-pressure, boredom or the desire to show off.

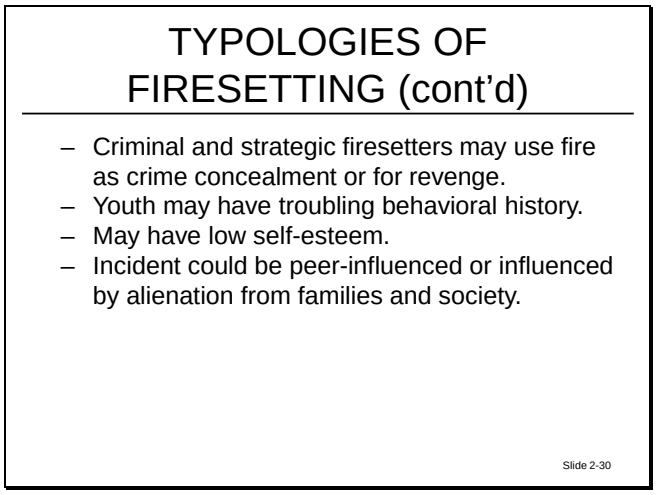
Slide 2-29

D. Delinquent/Criminal/Strategic.

1. What distinguishes the delinquent, criminal and strategic firesetters from thrill-seeking/risk-taking youth is the planned willful intent to cause destruction.

2. Purposeful destructive firesetting by adolescents often targets fields, mail boxes, dumpsters and abandoned structures.

3. Delinquent firesetters often set fires, discharge fireworks, or falsely activate fire alarms because of peer pressure, boredom, or the desire to show off. In many major cities, delinquent youth firesetting is often used as a rite of initiation for joining a gang.



4. Criminal and strategic firesetters may use fire to conceal a crime that has been committed.

5. Criminal and strategic firesetters sometimes target objects such as schools or other property as an act of revenge.

6. Regardless of the magnitude of an event, the motives behind these typologies of firesetting must be immediately addressed.

7. Delinquent, criminal and strategic firesetters often have a troubling behavioral history. Many experiment with alcohol/drugs, are often truant from school, and exhibit a wide range of anti-social behaviors.

8. These firesetters typically have low self-esteem, are peer dominated, and often alienate themselves from their family/society. Many view the legal system as a joke and brag about their acts of destruction to peers.

TYPOLOGIES OF FIRESETTING (cont'd)

- Incidents are often well-planned.
- Accelerants used with multiple points of origin.
- Fail to experience guilt for the fire they set.
- If left unchecked, these profiles have great potential for ascending to violent anti-social behavior.

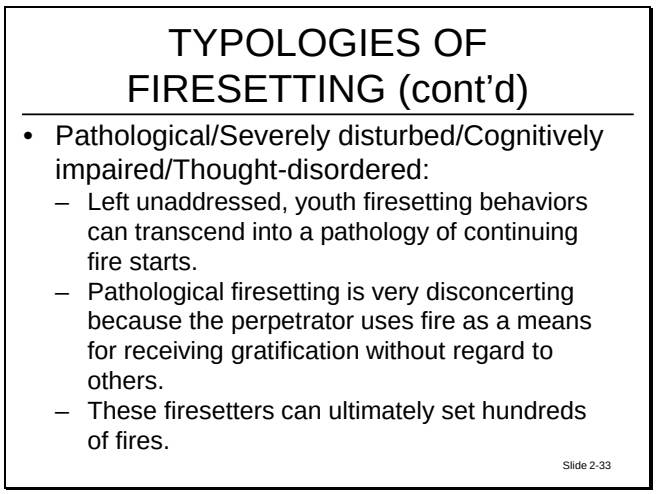
Slide 2-31

9. Fires set by delinquent, criminal and strategic firesetters are often well-planned and fueled by accelerants, and they have multiple points of origin. Many firesetters in this typology lack remorse for their actions.

10. Left unchecked, these profiles of firesetting have great potential for ascending into future acts of violence and other anti-social behavior.

11. Comprehensive interventions such as age-appropriate school-based educational programs coupled with punitive actions (that include potential legal ramifications) are proven measures that often deter delinquent, criminal and strategic firesetting.

Slide 2-32



E. Pathological/Severely disturbed/Cognitively impaired/Thought-disordered.

1. Left unaddressed, youth firesetting behaviors can transcend into a pathology of continuing fire incidents.

2. In epidemiology, pathology is referred to as the process of a disease. While youth firesetting is not a disease in itself, the behavior is a response to some level of need — be it curiosity, problem-driven, or criminal intent.

3. Pathological firesetting is very disconcerting because the perpetrator uses fire as a means for receiving gratification without regard to others.

4. A pathological firesetter may start hundreds of fires for a plethora of reasons. The term "pyromania" refers to a pathology whereby a person sets many planned fires for pleasure or to release stress.

5. While the mental health community tends to reserve the term "pyromaniac" for adult offenders, youth firesetting behaviors, when left unchecked, can transcend into a pathology carried by a perpetrator to adulthood.

TYPOLOGIES OF FIRESETTING (cont'd)

- May possibly have a high IQ but long history of disorders.
- Fires have distinct pattern and may be ritualistic.
- Firesetter denies or lies about involvement.
- Believe they are smarter than fire department or police department.
- May document fires.

Slide 2-34

6. Pathological firesetters may have a high IQ. Their fires are often sophisticated, very cleverly set and cause significant damage.

7. The fires will have a distinct pattern and may serve as a type of ritual for the firesetter.

8. If confronted, this typology of firesetter will deny involvement and lie about the cause of a fire. He or she is proud of the fires and believes he or she is smarter than police officers and fire investigators.

TYPOLOGIES OF FIRESETTING (cont'd)

- May interject themselves into investigation.
- Firesetter has a long history of dysfunction.
- They have difficulty establishing relationships.
- Home abuse is possible.
- Family may have their own issues.

Slide 2-35

9. These firesetters may photograph, video or create written documentation of their fires. They will sometimes interject themselves into the fire investigation process.

10. Pathological firesetters have a long history of emotional, physical and/or psychological disorders. They often have difficulty establishing relationships with peers and family. Their home life may be unstructured, with caregivers being neglectful, abusive or even incestuous. The caregivers of this type of firesetter may have their own psychological and/or substance abuse issues.

    Researchers provide the following descriptions of firesetters that may fall under the pathological typology:

    a. Disordered coping: Set fires in order to return to a state of emotional equilibrium after experiencing intense anxiety, rage or both (Williams, 2005).

    b. Pathological: Includes youth who are psychotic, paranoid or delusional, or who live in a chronically disturbed or bizarre environment (Stadolnik, 2002).

    c. Severely disturbed: Youth that have a paranoid, psychotic fixation on fire. They are controlled by sensory reinforcement. The sensory aspect of the fire is sufficiently reinforcing for them to set fires frequently (Slavkin, 2000).

    d. Thought-disordered: These firesetters suffer from some type of thought disorder such as schizophrenia and attribute their firesetting to hallucinations or delusions (Williams, 2005).

11. Pathological firesetters represent an extreme danger to themselves, the community and our industry. If a firesetter's behaviors are identified as being pathological in nature, immediate multidisciplinary intervention is required.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F. Not all firesetters have cognitive, behavioral or learning disorders.

TYPOLOGIES OF FIRESETTING (cont'd)

- Just because a youth has a cognitive, behavioral or learning disorder, it does not necessarily mean that he or she is predisposed to set a fire or that the fire he or she set was caused by the disorder.

Slide 2-37

1. Just because a youth firesetter has been diagnosed with a cognitive, behavioral or learning disorder, it does not necessarily mean that he or she is predisposed to set a fire or that the fire he or she set was caused by the disorder.

2. It is also important to remember that youth firesetting behavior can be influenced by the youth's social, cultural and environmental circumstances.

TYPOLOGIES OF FIRESETTING (cont'd)

- Households with few rules or consequences for inappropriate behavior.
- Smokers present in home.
- Lack of fire safety knowledge (youth/family).
- Lack of parental skill/supervision.

Slide 2-38

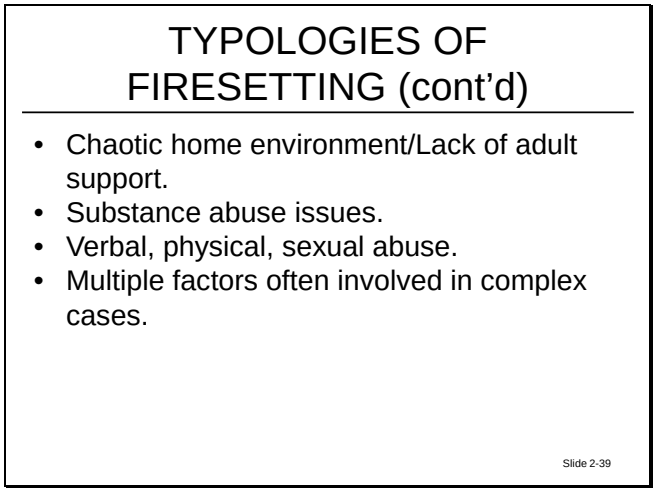
3. Sometimes children grow up in a family environment with few rules or consequences for inappropriate behavior.

4. Many firesetters reside in a household where one or multiple family members smoke and access to ignition materials is readily available.

5. In some cultures, children are taught at a very young age how to light fires for heating, cooking or religious purposes.

6. Many parents/caregivers have never been taught fire safety practices; therefore, they do not pass fire safety information to their children. It may be difficult to explain to the parent/caregiver why certain behaviors regarding fire may be dangerous because the parent/caregiver has never learned about or experienced the dangers associated with firesetting behavior.

7. Family influences can impact whether or not a child will set a fire. While youth firesetting can occur in any household, research indicates that the behavior occurs more frequently in homes where a lack of supervision and parenting skills are evident.

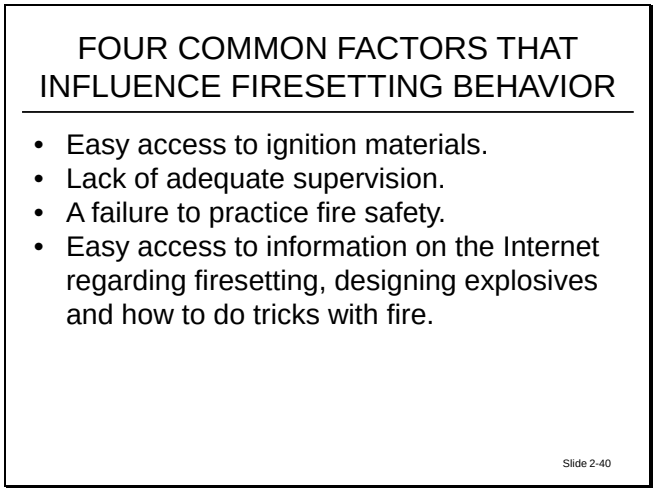


8. Family dysfunction and/or lack of adult support can be factors that influence firesetting behaviors. Parents or legal guardians may be physically present in a home but emotionally absent. The family may be experiencing a recent trauma or crisis.

9. In more extreme cases, drug and/or alcohol abuse may be evident among family members, including the firesetter. Physical and/or sexual abuse, neglect and other anti-social adult behaviors may be occurring. Prior contact between the family and police is common. In summary, the home environment of many firesetters is chaotic. This is especially true in problematic, complex cases.

10. It is important for the youth firesetter interventionist to remember that there are many circumstances that can influence youth firesetting behavior and that these children do not always fit into a neatly defined typology.

VI. FOUR COMMON FACTORS THAT INFLUENCE FIRESETTING BEHAVIOR



While social, cultural and environmental circumstances may influence firesetting behaviors, empirical evidence identifies four common factors that directly contribute to youth firesetting behavior. These factors impact all typologies of firesetters and include:

A. Easy access to ignition materials.

Easy access to ignition materials often proves deadly during child fire-play incidents. In many homes where fire-play has occurred, the child easily discovered the ignition source or already knew where it was located and how to obtain it.

B. Lack of adequate supervision.

The lack of adequate supervision is a factor that can influence each typology of firesetters. Panicked once they discover their child has engaged in firesetting or the manufacture of explosive/pressure-creating devices, parents often discover the experimentation has been occurring over a prolonged period of time.

C. A failure to practice fire safety.

A failure to practice fire safety is a factor that often affects youth and their parents/caregivers in the following ways:

1. Young children often lack understanding of the dangers associated with firesetting and safety rules about fire.

2. Older children and adolescents may not have received school-based primary prevention about the dangers of fire-play/firesetting, penalties for inappropriate behavior, and direction of what to do if a fire happens.

3. Parents/caregivers may not be aware of the significance of youth firesetting, appropriate safety education, penalties, or what action to take in the event that a fire occurs. They also may not be aware of local youth firesetting prevention/intervention programs.

D. Easy access to information on the Internet regarding firesetting, designing explosives and how to do tricks with fire is a problem that demands proactive attention.

1. The Internet, cellphones, web-based and interactive television shows, games, etc. have made explicit media available to youth on many dangerous (and often illegal) activities.

2. Youth are able to experiment with fire or incendiary materials and instantaneously post results for the world to see and replicate.

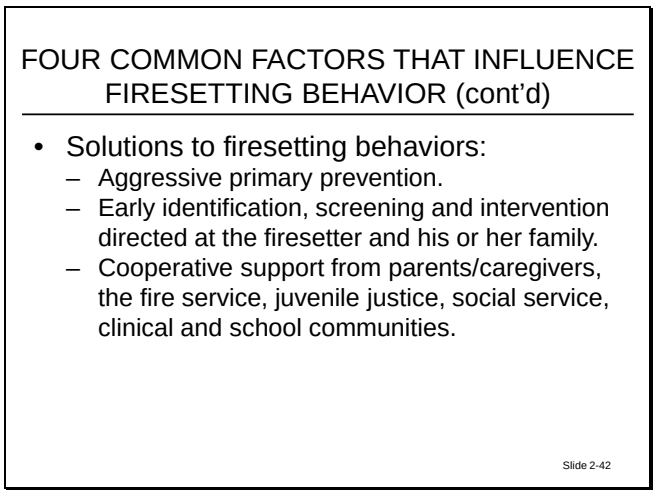
3. As an example: In 2002, a major lighter manufacturing company provided instantaneous access to a section on its website dedicated to showing more than 550 lighter tricks. It also provided an area for individuals who developed and designed their own lighter tricks to download their newly designed lighter trick.

4. Other issues associated with the easy access to information through social media, the Internet, cellphones, etc. is the idea of "one-upmanship" through risk-taking contests, dares and the idea of being the individual who has the most "hits" on YouTube and other social media sites.

5. As newer forms of communication are designed, the ease and instantaneous nature of communication becomes more compelling. How this will affect youth firesetting behavior in the future remains to be seen.

FOUR COMMON FACTORS THAT INFLUENCE FIRESETTING BEHAVIOR (cont'd)

Slide 2-41



E. Solutions to firesetting behaviors.

1. Aggressive primary prevention that includes school and community-based education is the first line of defense in preventing all typologies of youth firesetting.

2. Early identification, screening and intervention directed at the firesetter and his or her family is a critical form of secondary prevention that demands cooperative support from parents/caregivers and the fire service, juvenile justice, social service, and clinical and school communities.

ACTIVITY 2.1

Typologies of Youth Firesetting

Purpose

Given three case studies, discuss the possible classification of the youth into one of the firesetting typologies previously discussed.

Directions

Part 1

1. The class at large will view the 12-minute video "In Their Own Words." The purpose of viewing the video is to gain an understanding of the many factors that may influence youth firesetting behaviors.

2. Upon completion of the video, the instructor will pose the following questions to the class at large for discussion:

    a. What typology of firesetting would you assign to Domingo and why?

    b. What typology of firesetting would you assign to Amy and why?

    c. What typology of firesetting would you assign to Jason and why?

    d. Why is it sometimes complicated to understand the motives behind youth firesetting?

    e. What facts must be taken into consideration when categorizing or typing firesetting behaviors?

3. There are 20 minutes allotted for the tasks listed above.

4. **Do not read the Part 2 section until Part 1 has been completed.**

Part 2

1. Please read the three case studies (Amy, Domingo and Jason) located at the end of this activity.

2. In your table group, discuss if any group members would change their opinion on the typology they selected for each youth.

3. In your table group, please attempt to reach consensus on a typology/category for each youth and justify why you placed him or her into the specific typology.

4. Each group has five minutes to present a summary of what they discussed to the class at large.

5. There are 20 minutes allotted for these tasks.

ACTIVITY 2.1 (cont'd)

Case Study Profiles

Domingo's Profile

Background: Domingo is 17 years old and is a senior in high school. He lives with his parents and younger sister. When Domingo was eight years old, he found an M-100 in his older brother's room. He lit it. The M-100 exploded, seriously injuring Domingo. Over the next two years, he underwent a series of surgeries on his hands and arms. By working daily for three months with a physical therapist, Domingo regained some of the strength in his hands. However, he is still unable to use his left hand to grip objects or hold things securely.

Dealing with it: Feeling angry at himself for the mistake he made, Domingo suffered from periods of depression following his injury. His parents became concerned as Domingo lost interest in all the things he used to enjoy. He became increasingly withdrawn and, by the time he was 13, Domingo no longer participated in school events or wanted to spend time with his old friends. He was angry most of the time. Then, in the summer before he entered high school, Domingo committed a series of thefts. He was apprehended by a police officer and required to participate in weekly counseling sessions as part of his court ordered probation. Domingo was defiant and unwilling to talk to counselors. Eventually, with the help of one counselor in particular, Domingo came to deal with his anger. Over time, he has become more active in school again, and he says that today he accepts himself more than he did before.

Looking ahead: His mother attributes Domingo's more positive outlook to the fact that he was apprehended before things "became too serious." She is proud that Domingo has become a counselor at the burn camp he attended the summer of his injury. Domingo agrees that the worst is over, and he is planning to attend college next year, where he wants to major in sports journalism.

Amy's Profile

Background: Amy is 16 years old. She is a sophomore in high school. Amy was close to her mother, so it was a very difficult period for Amy when her mother died of breast cancer.

Amy's father and mother were divorced shortly after she was born, and her father relocated to another state. After her mother's death, Amy lived with her aunt (her mother's sister) until she was 12. It was during this time that Amy began setting small fires — mostly around the house. One of the fires severely damaged the garage. Amy's aunt, frightened and unable to deal with the firesetting, found out where Amy's father was living and put her on a bus to go live with him. That was four years ago.

It's been difficult for Amy living with her father. He has two other children, seven and five years old, who stay with him on the weekends (their mother and Amy's father are separated). Amy often feels left out.

Amy's favorite thing to do is design clothes, and her dream is to become a fashion designer. She argues with her father because he sees no future in Amy's dream. He wants her to become something more "realistic," like a nurse.

Firesetting: Amy hadn't set a fire since she was 12. But last year, after a big argument with her father, Amy set a fire behind the apartment building where she lives. She doesn't know why, really. She feels maybe she was just depressed about the way things were going at home. Anyway, it damaged three units. Amy was caught by a neighbor and turned in to the police: A very scary experience … going to court, being treated like a criminal, spending 30 days in juvenile hall, having everyone at school know about it.

The court has ordered Amy to repay $11,000 in damages to the landlord at $150 per month. (She'll have it all paid back by the time she is 22 years old.) If Amy doesn't pay as ordered by the court, her father will be held responsible. He is not happy about that prospect, so he's making sure Amy earns enough at her job to stay current with the payments. Amy is trying to be responsible.

Amy's job (with a graphic design firm) is the one bright spot in her life because she can see that it is leading her closer to her goal of fashion designing. Amy's counselor at school helped her get the job, and she is very encouraging and supportive. Amy works at the design firm after school and on Saturdays. She is paid $7 per hour, and she works 18 hours each week. Amy's weekly take-home pay is $78.42, so about half of her money goes to repay the damage resulting from the fire.

Amy's outlook: Amy's relationship with her father is still strained, but she hopes that eventually things will work out. Both of them are working at it. Amy's been in counseling for the last year, and it's helped her understand how her frustrations at home led her to set fires. She feels pretty confident that she won't do it again.

Jason's Profile

Background: Jason is 14 years old, and he lives with his foster parents. When he was five, his biological parents were divorced. Jason lost track of his father, and he stayed with his mother until he was 10. By then, Jason had set 27 fires and his mother felt that Jason needed more help than she could give him. (She was also caring for Jason's two half-sisters.) As a result, Jason has been living with his foster parents for the past four years. They've tried to give him guidance, but he's been pretty wild and hard to control: skipping school, sometimes not coming home for a day or two, etc.

Until Jason was arrested, he saw himself as pretty tough and able to take care of himself. Now, he is beginning to see all the hassles he has created for himself and his family. Jason alternates between being angry at having been arrested and trying to take some responsibility for his actions. (He has put his foster parents through a lot, and he regrets that.)

Friends: Some of Jason's friends have been arrested more than once, and most of them are older than Jason. Part of his probation is that he is not permitted to hang out with his old friends. Jason sees this as unfair, but, at the same time, he knows that they are probably headed for some serious jail terms. It's a good thing that he's not involved with them now.

Firesetting history: Jason has set dozens of fires, dating back to the first one in his backyard at age 6. The last fire (which was the one he was arrested for) was set at school, late at night. It was a storage unit, and it caused $35,000 in damages. Jason's not sure why he set the fire, but it was exciting to see the flames shooting in the air. A teacher saw Jason leaving the scene, and the police arrested him two hours later.

Current legal status: Because he had set so many previous fires, Jason feels that he was made an example of. He was convicted of a felony and served two months in jail. That was five months ago. He was also ordered to serve 300 hours of community service at a youth center for disabled kids. Actually, Jason likes this work, and he hopes to continue in a paid position when the community service is completed. This depends on whether Jason's supervisor will recommend him to the head administrator when Jason's service is completed.

Plans for the future: Jason had planned to go into the army after school, but with the felony conviction, he can't serve in the armed forces. The first thing he has to do is repay the $35,000 damage caused by the fire. Jason figures that will take four years. After that, he's not sure what he'll be doing.

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VII. SUMMARY

SUMMARY

- Curiosity about fire is natural, firesetting is not.
- It is important to understand myths/facts related to firesetting.
- There has been an abundance of research conducted by the mental health community on youth firesetting.

Slide 2-46

SUMMARY (cont'd)

- There are five typologies of youth firesetting.
- Understanding typologies helps us design intake, screening and intervention strategies.
- Social, cultural and environmental influences may impact youth firesetting.
- There are four common factors influencing firesetting behavior.

Slide 2-47

SUMMARY (cont'd)

- Two key concepts of this unit:
  - Don't get hung-up trying to identify a precise typology of firesetter.
  - Know when the situation is more than curiosity and needs referral to a partner agency.

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APPENDIX A

COMMONLY SEEN MENTAL HEALTH DISORDERS

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An Overview of Commonly Seen Mental Health Disorders in Children and Youth

Attention Deficit Hyperactivity Disorder

Does your child have trouble paying attention? Does he or she talk nonstop or have trouble staying still? Does your child have a hard time controlling his or her behavior?

For some children, these may be symptoms of **attention deficit/hyperactivity disorder**, or **ADHD**.

What is attention deficit/hyperactivity disorder, or ADHD?

ADHD is a common childhood disorder, and it may affect children differently. ADHD makes it hard for a child to focus and pay attention. Some kids may be hyperactive or have trouble being patient. ADHD can make it hard for a child to do well in school or behave at home.
ADHD can be treated. Doctors and specialists can help.

Who can develop ADHD?

Children of all backgrounds can have ADHD. Teens and adults can have ADHD, too.

What causes ADHD?

No one knows for sure. ADHD probably comes from a combination of things. Some possibilities are:

1. Genes, because the disorder sometimes runs in families.

2. Lead in old paint in and plumbing parts.

3. Smoking and drinking alcohol during pregnancy.

4. Certain brain injuries.

5. Food additives like artificial coloring, which might make hyperactivity worse.

Some people think refined sugar causes ADHD. But most research does not support the idea that sugar causes ADHD.

What are the symptoms of ADHD?

1. ADHD has many symptoms. Some symptoms at first may look like normal behaviors for a child, but ADHD makes them much worse and more frequent.

2. Children with ADHD have at least six symptoms that start in the first five or six years of their lives.

3. Children with ADHD may:

    a. Get distracted easily and forget things often.

    b. Switch too quickly from one activity to the next.

    c. Have trouble with directions.

    d. Daydream too much.

    e. Have trouble finishing tasks like homework or chores.

    f. Lose toys, books and school supplies often.

    g. Fidget and squirm a lot.

    h. Talk nonstop and interrupt people.

    i. Run around a lot.

    j. Touch and play with everything they see.

    k. Be very impatient.

    l. Blurt out inappropriate comments.

    m. Have trouble controlling their emotions.

How do I know if my child has ADHD?

Your child's doctor may make a diagnosis. Sometimes the doctor may refer you to a mental health specialist who is more experienced with ADHD to make a diagnosis. There is no single test that can tell if your child has ADHD.

It can take months for a doctor or specialist to know if your child has ADHD. He or she needs time to watch your child and check for other problems. The specialist may want to talk to you, your family, your child's teachers and others.

Sometimes it can be hard to diagnose a child with ADHD because symptoms may look like other problems. For example, a child may seem quiet and well-behaved, but in fact he or she is having a hard time paying attention and is often distracted. Or, a child may act badly in school, but teachers don't realize that the child has ADHD.

If your child is having trouble at school or at home and has been for a long time, ask his or her doctor about ADHD.

How do children with ADHD get better?

Children with ADHD can get better with treatment, but there is no cure. There are three basic types of treatment:

1. **Medication.** Several medications can help. The most common types are called stimulants. Medications help children focus, learn and stay calm. Sometimes medications cause side effects, such as sleep problems or stomachaches. Your child may need to try a few medications to see which one works best. It's important that you and your doctor watch your child closely while he or she is taking medicine.

2. **Therapy.** There are different kinds of therapy. Behavioral therapy can help teach children to control their behavior so they can do better at school and at home.

3. **Medication and therapy combined.** Many children do well with both medication and therapy.

ANXIETY DISORDERS

Introduction

Anxiety disorders affect about 40 million American adults age 18 years and older (about 18%) in a given year,[1] causing them to be filled with fearfulness and uncertainty. Unlike the relatively mild, brief anxiety caused by a stressful event (such as speaking in public or a first date), anxiety disorders last at least 6 months and can get worse if they are not treated. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder.

Effective therapies for anxiety disorders are available, and research is uncovering new treatments that can help most people with anxiety disorders lead productive, fulfilling lives. If you think you have an anxiety disorder, you should seek information and treatment right away.

Panic Disorder

"For me, a panic attack is almost a violent experience. I feel disconnected from reality. I feel like I'm losing control in a very extreme way. My heart pounds really hard, I feel like I can't get my breath, and there's an overwhelming feeling that things are crashing in on me."

"It started 10 years ago, when I had just graduated from college and started a new job. I was sitting in a business seminar in a hotel and this thing came out of the blue. I felt like I was dying."

"In between attacks there is this dread and anxiety that it's going to happen again. I'm afraid to go back to places where I've had an attack. Unless I get help, there soon won't be any place where I can go and feel safe from panic."

Panic disorder is a real illness that can be successfully treated. It is characterized by sudden attacks of terror, usually accompanied by a pounding heart, sweatiness, weakness, faintness or dizziness. During these attacks, people with panic disorder may flush or feel chilled; their hands may tingle or feel numb; and they may experience nausea, chest pain or smothering sensations. Panic attacks usually produce a sense of unreality, a fear of impending doom, or a fear of losing control.

A fear of one's own unexplained physical symptoms is also a symptom of panic disorder. People having panic attacks sometimes believe they are having heart attacks, losing their minds or on the verge of death. They can't predict when or where an attack will occur, and between episodes many worry intensely and dread the next attack.

Panic attacks can occur at any time, even during sleep. An attack usually peaks within 10 minutes, but some symptoms may last much longer.

Panic disorder affects about 6 million American adults[1] and is twice as common in women as men.[2] Panic attacks often begin in late adolescence or early adulthood,[2] but not everyone who experiences panic attacks will develop panic disorder. Many people have just one attack and never have another. The tendency to develop panic attacks appears to be inherited.[3]

People who have full-blown, repeated panic attacks can become very disabled by their condition and should seek treatment before they start to avoid places or situations where panic attacks have occurred. For example, if a panic attack happened in an elevator, someone with panic disorder may develop a fear of elevators that could affect the choice of a job or an apartment and restrict where that person can seek medical attention or enjoy entertainment.

Some people's lives become so restricted that they avoid normal activities, such as grocery shopping or driving. About one-third become housebound or are able to confront a feared situation only when accompanied by a spouse or other trusted person. [2] When the condition progresses this far, it is called agoraphobia, or fear of open spaces.

Early treatment can often prevent agoraphobia, but people with panic disorder may sometimes go from doctor to doctor for years and visit the emergency room repeatedly before someone correctly diagnoses their condition. This is unfortunate, because panic disorder is one of the most treatable of all the anxiety disorders, responding in most cases to certain kinds of medication or certain kinds of cognitive psychotherapy, which help change thinking patterns that lead to fear and anxiety.

Panic disorder is often accompanied by other serious problems, such as depression, drug abuse, or alcoholism.[4,5] These conditions need to be treated separately. Symptoms of depression include feelings of sadness or hopelessness, changes in appetite or sleep patterns, low energy, and difficulty concentrating. Most people with depression can be effectively treated with antidepressant medications, certain types of psychotherapy, or a combination of the two.

Obsessive-Compulsive Disorder

"I couldn't do anything without rituals. They invaded every aspect of my life. Counting really bogged me down. I would wash my hair three times as opposed to once because three was a good luck number and one wasn't. It took me longer to read because I'd count the lines in a paragraph. When I set my alarm at night, I had to set it to a number that wouldn't add up to a 'bad' number."

"I knew the rituals didn't make sense, and I was deeply ashamed of them, but I couldn't seem to overcome them until I had therapy."

"Getting dressed in the morning was tough, because I had a routine, and if I didn't follow the routine, I'd get anxious and would have to get dressed again. I always worried that if I didn't do something, my parents were going to die. I'd have these terrible thoughts of harming my parents. That was completely irrational, but the thoughts triggered more anxiety and more senseless behavior. Because of the time I spent on rituals, I was unable to do a lot of things that were important to me."

People with obsessive-compulsive disorder (OCD) have persistent, upsetting thoughts (obsessions) and use rituals (compulsions) to control the anxiety these thoughts produce. Most of the time, the rituals end up controlling them.

For example, if people are obsessed with germs or dirt, they may develop a compulsion to wash their hands over and over again. If they develop an obsession with intruders, they may lock and relock their doors many times before going to bed. Being afraid of social embarrassment may prompt people with OCD to comb their hair compulsively in front of a mirror—sometimes they get "caught" in the mirror and can't move away from it. Performing such rituals is not pleasurable. At best, it produces temporary relief from the anxiety created by obsessive thoughts.

Other common rituals are a need to repeatedly check things, touch things (especially in a particular sequence) or count things. Some common obsessions include having frequent thoughts of violence and harming loved ones, persistently thinking about performing sexual acts the person dislikes, or having thoughts that are prohibited by religious beliefs. People with OCD may also be preoccupied with order and symmetry, have difficulty throwing things out (so they accumulate), or hoard unneeded items.

People without OCD also have rituals, such as checking to see if the stove is off several times before leaving the house. The difference is that people with OCD perform their rituals even though doing so interferes with daily life and they find the repetition distressing. Although most adults with OCD recognize that what they are doing is senseless, some adults and most children may not realize that their behavior is out of the ordinary.

OCD affects about 2.2 million American adults,[1] and the problem can be accompanied by eating disorders,[6] other anxiety disorders, or depression.[2,4] It strikes men and women in roughly equal numbers and usually appears in childhood, adolescence or early adulthood.[2] One-third of adults with OCD develop symptoms as children, and research indicates that OCD might run in families.[3]

The course of the disease is quite varied. Symptoms may come and go, ease over time or get worse. If OCD becomes severe, it can keep a person from working or carrying out normal responsibilities at home. People with OCD may try to help themselves by avoiding situations that trigger their obsessions, or they may use alcohol or drugs to calm themselves.[4,5]

OCD usually responds well to treatment with certain medications and/or exposure-based psychotherapy, in which people face situations that cause fear or anxiety and become less sensitive (desensitized) to them. NIMH is supporting research into new treatment approaches for people whose OCD does not respond well to the usual therapies. These approaches include combination and augmentation (add-on) treatments, as well as modern techniques such as deep brain stimulation.

Post-Traumatic Stress Disorder

"I was raped when I was 25 years old. For a long time, I spoke about the rape as though it was something that happened to someone else. I was very aware that it had happened to me, but there was just no feeling."

"Then I started having flashbacks. They kind of came over me like a splash of water. I would be terrified. Suddenly I was reliving the rape. Every instant was startling. I wasn't aware of anything around me; I was in a bubble, just kind of floating. And it was scary. Having a flashback can wring you out."

"The rape happened the week before Thanksgiving, and I can't believe the anxiety and fear I feel every year around the anniversary date. It's as though I've seen a werewolf. I can't relax, can't sleep, don't want to be with anyone. I wonder whether I'll ever be free of this terrible problem."

Post-traumatic stress disorder (PTSD) develops after a terrifying ordeal that involved physical harm or the threat of physical harm. The person who develops PTSD may have been the one who was harmed, the harm may have happened to a loved one, or the person may have witnessed a harmful event that happened to loved ones or strangers.

PTSD was first brought to public attention in relation to war veterans, but it can result from a variety of traumatic incidents, such as mugging, rape, torture, being kidnapped or held captive, child abuse, car accidents, train wrecks, plane crashes, bombings, or natural disasters such as floods or earthquakes.

People with PTSD may startle easily, become emotionally numb (especially in relation to people with whom they used to be close), lose interest in things they used to enjoy, have trouble feeling affectionate, become irritable, become more aggressive, or even become violent. They avoid situations that remind them of the original incident, and anniversaries of the incident are often very difficult. PTSD symptoms seem to be worse if the event that triggered them was deliberately initiated by another person, as in a mugging or a kidnapping.

Most people with PTSD repeatedly relive the trauma in their thoughts during the day and in nightmares when they sleep. These are called flashbacks. Flashbacks may consist of images, sounds, smells or feelings, and are often triggered by ordinary occurrences, such as a door slamming or a car backfiring on the street. A person having a flashback may lose touch with reality and believe that the traumatic incident is happening all over again.

Not every traumatized person develops full-blown or even minor PTSD. Symptoms usually begin within 3 months of the incident but occasionally emerge years afterward. They must last more than a month to be considered PTSD. The course of the illness varies. Some people recover within 6 months, while others have symptoms that last much longer. In some people, the condition becomes chronic.

PTSD affects about 7.7 million American adults,[1] but it can occur at any age, including childhood.[7] Women are more likely to develop PTSD than men,[8] and there is some evidence that susceptibility to the disorder may run in families.[9] PTSD is often accompanied by depression, substance abuse, or one or more of the other anxiety disorders.[4]

Certain kinds of medication and certain kinds of psychotherapy usually treat the symptoms of PTSD very effectively.

Social Phobia (Social Anxiety Disorder)

"In any social situation, I felt fear. I would be anxious before I even left the house, and it would escalate as I got closer to a college class, a party, or whatever. I would feel sick in my stomach-it almost felt like I had the flu. My heart would pound, my palms would get sweaty, and I would get this feeling of being removed from myself and from everybody else."

"When I would walk into a room full of people, I'd turn red and it would feel like everybody's eyes were on me. I was embarrassed to stand off in a corner by myself, but I couldn't think of anything to say to anybody. It was humiliating. I felt so clumsy; I couldn't wait to get out."

Social phobia, also called social anxiety disorder, is diagnosed when people become overwhelmingly anxious and excessively self-conscious in everyday social situations. People with social phobia have an intense, persistent and chronic fear of being watched and judged by others and of doing things that will embarrass them. They can worry for days or weeks before a dreaded situation. This fear may become so severe that it interferes with work, school and other ordinary activities, and can make it hard to make and keep friends.

While many people with social phobia realize that their fears about being with people are excessive or unreasonable, they are unable to overcome them. Even if they manage to confront their fears and be around others, they are usually very anxious beforehand, are intensely uncomfortable throughout the encounter, and worry about how they were judged for hours afterward.

Social phobia can be limited to one situation (such as talking to people, eating or drinking, or writing on a blackboard in front of others) or may be so broad (such as in generalized social phobia) that the person experiences anxiety around almost anyone other than the family.

Physical symptoms that often accompany social phobia include blushing, profuse sweating, trembling, nausea and difficulty talking. When these symptoms occur, people with social phobia feel as though all eyes are focused on them.

Social phobia affects about 15 million American adults.[1] Women and men are equally likely to develop the disorder,[10] which usually begins in childhood or early adolescence.[2] There is some evidence that genetic factors are involved.[11] Social phobia is often accompanied by other anxiety disorders or depression,[2,4] and substance abuse may develop if people try to self-medicate their anxiety.[4,5]

Social phobia can be successfully treated with certain kinds of psychotherapy or medications.

Specific Phobias

"I'm scared to death of flying, and I never do it anymore. I used to start dreading a plane trip a month before I was due to leave. It was an awful feeling when that airplane door closed and I felt trapped. My heart would pound, and I would sweat bullets. When the airplane would start to ascend, it just reinforced the feeling that I couldn't get out. When I think about flying, I picture myself losing control, freaking out, and climbing the walls, but of course I never did that. I'm not afraid of crashing or hitting turbulence. It's just that feeling of being trapped. Whenever I've thought about changing jobs, I've had to think, 'Would I be under pressure to fly?' These days I only go places where I can drive or take a train. My friends always point out that I couldn't get off a train traveling at high speeds either, so why don't trains bother me? I just tell them it isn't a rational fear."

A specific phobia is an intense, irrational fear of something that poses little or no actual danger. Some of the more common specific phobias are centered around closed-in places, heights, escalators, tunnels, highway driving, water, flying, dogs, and injuries involving blood. Such phobias aren't just extreme fear; they are irrational fear of a particular thing. You may be able to ski the world's tallest mountains with ease but be unable to go above the 5th floor of an office building. While adults with phobias realize that these fears are irrational, they often find that facing, or even thinking about facing, the feared object or situation brings on a panic attack or severe anxiety.

Specific phobias affect an estimated 19.2 million adult Americans[1] and are twice as common in women as men.[10] They usually appear in childhood or adolescence and tend to persist into adulthood.[12] The causes of specific phobias are not well understood, but there is some evidence that the tendency to develop them may run in families.[11]

If the feared situation or feared object is easy to avoid, people with specific phobias may not seek help; but if avoidance interferes with their careers or their personal lives, it can become disabling and treatment is usually pursued.

Specific phobias respond very well to carefully targeted psychotherapy.

Generalized Anxiety Disorder (GAD)

"I always thought I was just a worrier. I'd feel keyed up and unable to relax. At times it would come and go, and at times it would be constant. It could go on for days. I'd worry about what I was going to fix for a dinner party, or what would be a great present for somebody. I just couldn't let something go."

When my problems were at their worst, I'd miss work and feel just terrible about it. Then I worried that I'd lose my job. My life was miserable until I got treatment.

"I'd have terrible sleeping problems. There were times I'd wake up wired in the middle of the night. I had trouble concentrating, even reading the newspaper or a novel. Sometimes I'd feel a little lightheaded. My heart would race or pound. And that would make me worry more. I was always imagining things were worse than they really were. When I got a stomachache, I'd think it was an ulcer."

People with generalized anxiety disorder (GAD) go through the day filled with exaggerated worry and tension, even though there is little or nothing to provoke it. They anticipate disaster and are overly concerned about health issues, money, family problems or difficulties at work. Sometimes just the thought of getting through the day produces anxiety.

GAD is diagnosed when a person worries excessively about a variety of everyday problems for at least 6 months.[13] People with GAD can't seem to get rid of their concerns, even though they usually realize that their anxiety is more intense than the situation warrants. They can't relax, startle easily, and have difficulty concentrating. Often they have trouble falling asleep or staying asleep. Physical symptoms that often accompany the anxiety include fatigue, headaches, muscle tension, muscle aches, difficulty swallowing, trembling, twitching, irritability, sweating, nausea, lightheadedness, having to go to the bathroom frequently, feeling out of breath and hot flashes.

When their anxiety level is mild, people with GAD can function socially and hold down a job. Although they don't avoid certain situations as a result of their disorder, people with GAD can have difficulty carrying out the simplest daily activities if their anxiety is severe.

GAD affects about 6.8 million American adults,[1] including twice as many women as men.[2] The disorder develops gradually and can begin at any point in the life cycle, although the years of highest risk are between childhood and middle age.[2] There is evidence that genes play a modest role in GAD.[13]

Other anxiety disorders, depression, or substance abuse[2,4] often accompany GAD, which rarely occurs alone. GAD is commonly treated with medication or cognitive-behavioral therapy, but co-occurring conditions must also be treated using the appropriate therapies.

Treatment of Anxiety Disorders

In general, anxiety disorders are treated with medication, specific types of psychotherapy, or both.[14] Treatment choices depend on the problem and the person's preference. Before treatment begins, a doctor must conduct a careful diagnostic evaluation to determine whether a person's symptoms are caused by an anxiety disorder or a physical problem. If an anxiety disorder is diagnosed, the type of disorder or the combination of disorders that are present must be identified, as well as any coexisting conditions, such as depression or substance abuse. Sometimes alcoholism, depression or other coexisting conditions have such a strong effect on the individual that treating the anxiety disorder must wait until the coexisting conditions are brought under control.

People with anxiety disorders who have already received treatment should tell their current doctor about that treatment in detail. If they received medication, they should tell their doctor what medication was used, what the dosage was at the beginning of treatment, whether the dosage was increased or decreased while they were under treatment, what side effects occurred, and whether the treatment helped them become less anxious. If they received psychotherapy, they should describe the type of therapy, how often they attended sessions, and whether the therapy was useful.

Often people believe that they have "failed" at treatment or that the treatment didn't work for them when, in fact, it was not given for an adequate length of time or was administered incorrectly. Sometimes people must try several different treatments or combinations of treatment before they find the one that works for them.

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Autism Spectrum Disorders (Pervasive Developmental Disorders)

Introduction

Not until the middle of the twentieth century was there a name for a disorder that now appears to affect an estimated 3.4 of every 1,000 children ages 3-10, a disorder that causes disruption in families and unfulfilled lives for many children. In 1943 Dr. Leo Kanner of the Johns Hopkins Hospital studied a group of 11 children and introduced the label early infantile autism into the English language. At the same time a German scientist, Dr. Hans Asperger, described a milder form of the disorder that became known as Asperger syndrome. Thus these two disorders were described and are today listed in the Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (fourth edition, text revision)[1] as two of the five pervasive developmental disorders (PDD), more often referred to today as autism spectrum disorders (ASD). All these disorders are characterized by varying degrees of impairment in communication skills, social interactions, and restricted, repetitive and stereotyped patterns of behavior.

The autism spectrum disorders can often be reliably detected by the age of 3 years, and in some cases as early as 18 months.[2] Studies suggest that many children eventually may be accurately identified by the age of 1 year or even younger. The appearance of any of the warning signs of ASD is reason to have a child evaluated by a professional specializing in these disorders.

Parents are usually the first to notice unusual behaviors in their child. In some cases, the baby seems “different” from birth, unresponsive to people or focusing intently on one item for long periods of time. The first signs of an ASD can also appear in children who seem to have been developing normally. When an engaging, babbling toddler suddenly becomes silent, withdrawn, self-abusive, or indifferent to social overtures, something is wrong. Research has shown that parents are usually correct about noticing developmental problems, although they may not realize the specific nature or degree of the problem.

The pervasive developmental disorders, or autism spectrum disorders, range from a severe form, called autistic disorder, to a milder form, Asperger syndrome. If a child has symptoms of either of these disorders, but does not meet the specific criteria for either, the diagnosis is called pervasive developmental disorder not otherwise specified (PDD-NOS). Other rare, very severe disorders that are included in the autism spectrum disorders are Rett syndrome and childhood disintegrative disorder. This brochure will focus on classic autism, PDD-NOS, and Asperger syndrome, with brief descriptions of Rett syndrome and childhood disintegrative disorder below.

Prevalence

In 2007 (the most recent government survey on the rate of autism) the Centers for Disease Control (CDC) found that the rate is higher than the rates found from studies conducted in the United States during the 1980s and early 1990s (survey based on data from 2000 and 2002). The CDC survey assigned a diagnosis of autism spectrum disorder based on health and school records of 8 year olds in 14 communities throughout the U.S. Debate continues about whether this represents a true increase in the prevalence of autism. Changes in the criteria used to diagnose autism, along with increased recognition of the disorder by professionals and the public

may all be contributing factors. Nonetheless, the CDC report confirms other recent epidemiologic studies documenting that more children are being diagnosed with an ASD than ever before.

Data from an earlier report of the CDC's Atlanta-based program found the rate of autism spectrum disorder was 3.4 per 1,000 for children 3 to 10 years of age. Summarizing this and several other major studies on autism prevalence, CDC estimates that 2-6 per 1,000 (from 1 in 500 to 1 in 150) children have an ASD. The risk is 3-4 times higher in males than females. Compared to the prevalence of other childhood conditions, this rate is lower than the rate of mental retardation (9.7 per 1,000 children), but higher than the rates for cerebral palsy (2.8 per 1,000 children), hearing loss (1.1 per 1,000 children), and vision impairment (0.9 per 1,000 children). The CDC notes that these studies do not provide a national estimate.

For additional data, please visit the autism section of the CDC Web site.

RARE AUTISM SPECTRUM DISORDERS

Rett Syndrome

Rett syndrome is relatively rare, affecting almost exclusively females, one out of 10,000 to 15,000. After a period of normal development, sometime between 6 and 18 months, autism-like symptoms begin to appear. The little girl's mental and social development regresses—she no longer responds to her parents and pulls away from any social contact. If she has been talking, she stops; she cannot control her feet; she wrings her hands. Some of the problems associated with Rett syndrome can be treated. Physical, occupational and speech therapy can help with problems of coordination, movement and speech.

Scientists sponsored by the National Institute of Child Health and Human Development have discovered that a mutation in the sequence of a single gene can cause Rett syndrome. This discovery may help doctors slow or stop the progress of the syndrome. It may also lead to methods of screening for Rett syndrome, thus enabling doctors to start treating these children much sooner, and improving the quality of life these children experience.[1]

Childhood Disintegrative Disorder

Very few children who have an autism spectrum disorder (ASD) diagnosis meet the criteria for childhood disintegrative disorder (CDD). An estimate based on four surveys of ASD found fewer than two children per 100,000 with ASD could be classified as having CDD. This suggests that CDD is a very rare form of ASD. It has a strong male preponderance.[2] Symptoms may appear by age 2, but the average age of onset is between 3 and 4 years. Until this time, the child has age-appropriate skills in communication and social relationships. The long period of normal development before regression helps differentiate CDD from Rett syndrome.

The loss of skills such as vocabulary is more dramatic in CDD than in classical autism. The diagnosis requires extensive and pronounced losses involving motor, language and social skills.[3] CDD is also accompanied by loss of bowel and bladder control and oftentimes seizures and a very low IQ.

[1]*Rett syndrome*. NIH Publication No. 01-4960. Rockville, MD: National Institute of Child Health and Human Development, 2001. Available at http://www.nichd.nih.gov/publications/pubskey.cfm?from=autism

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What Are the Autism Spectrum Disorders?

The autism spectrum disorders are more common in the pediatric population than are some better known disorders such as diabetes, spinal bifida, or Down syndrome.[2] A recent study of a U.S. metropolitan area estimated that 3.4 of every 1,000 children 3-10 years old had autism.[3] The earlier the disorder is diagnosed, the sooner the child can be helped through treatment interventions. Pediatricians, family physicians, daycare providers, teachers and parents may initially dismiss signs of ASD, optimistically thinking the child is just a little slow and will "catch up."

All children with ASD demonstrate deficits in 1) social interaction, 2) verbal and nonverbal communication, and 3) repetitive behaviors or interests. In addition, they will often have unusual responses to sensory experiences, such as certain sounds or the way objects look. Each of these symptoms runs the gamut from mild to severe. They will present in each individual child differently. For instance, a child may have little trouble learning to read but exhibit extremely poor social interaction. Each child will display communication, social, and behavioral patterns that are individual but fit into the overall diagnosis of ASD.

Children with ASD do not follow the typical patterns of child development. In some children, hints of future problems may be apparent from birth. In most cases, the problems in communication and social skills become more noticeable as the child lags further behind other children the same age. Some other children start off well enough. Oftentimes between 12 and 36 months old, the differences in the way they react to people and other unusual behaviors become apparent. Some parents report the change as being sudden and that their children start to reject people, act strangely, and lose language and social skills they had previously acquired. In other cases, there is a plateau, or leveling, of progress so that the difference between the child with autism and other children the same age becomes more noticeable.

ASD is defined by a certain set of behaviors that can range from the very mild to the severe. The following possible indicators of ASD were identified on the Public Health Training Network Webcast, Autism Among Us.[4]

Possible Indicators of Autism Spectrum Disorders

- Does not babble, point, or make meaningful gestures by 1 year of age
- Does not speak one word by 16 months
- Does not combine two words by 2 years
- Does not respond to name
- Loses language or social skills

Some Other Indicators

- Poor eye contact
- Doesn't seem to know how to play with toys
- Excessively lines up toys or other objects
- Is attached to one particular toy or object
- Doesn't smile
- At times seems to be hearing impaired

Social Symptoms

From the start, typically developing infants are social beings. Early in life, they gaze at people, turn toward voices, grasp a finger and even smile.

In contrast, most children with ASD seem to have tremendous difficulty learning to engage in the give-and-take of everyday human interaction. Even in the first few months of life, many do not interact and they avoid eye contact. They seem indifferent to other people and often seem to prefer being alone. They may resist attention or passively accept hugs and cuddling. Later, they seldom seek comfort or respond to parents' displays of anger or affection in a typical way. Research has suggested that although children with ASD are attached to their parents, their expression of this attachment is unusual and difficult to "read." To parents, it may seem as if their child is not attached at all. Parents who looked forward to the joys of cuddling, teaching and playing with their child may feel crushed by this lack of the expected and typical attachment behavior.

Children with ASD also are slower in learning to interpret what others are thinking and feeling. Subtle social cues—whether a smile, a wink, or a grimace—may have little meaning. To a child who misses these cues, "Come here" always means the same thing, whether the speaker is smiling and extending her arms for a hug or frowning and planting her fists on her hips. Without the ability to interpret gestures and facial expressions, the social world may seem bewildering. To compound the problem, people with ASD have difficulty seeing things from another person's perspective. Most 5-year-olds understand that other people have different information, feelings and goals than they have. A person with ASD may lack such understanding. This inability leaves them unable to predict or understand other people's actions.

Although not universal, it is common for people with ASD also to have difficulty regulating their emotions. This can take the form of "immature" behavior such as crying in class or verbal outbursts that seem inappropriate to those around them. The individual with ASD might also be

disruptive and physically aggressive at times, making social relationships still more difficult. They have a tendency to "lose control," particularly when they're in a strange or overwhelming environment or when angry and frustrated. They may at times break things, attack others or hurt themselves. In their frustration, some bang their heads, pull their hair or bite their arms.

Communication Difficulties

By age 3, most children have passed predictable milestones on the path to learning language: one of the earliest is babbling. By the first birthday, a typical toddler says words, turns when he hears his name, points when he wants a toy, and when offered something distasteful, makes it clear that the answer is "no."

Some children diagnosed with ASD remain mute throughout their lives. Some infants who later show signs of ASD coo and babble during the first few months of life, but they soon stop. Others may be delayed, developing language as late as age 5 to 9. Some children may learn to use communication systems such as pictures or sign language.

Those who do speak often use language in unusual ways. They seem unable to combine words into meaningful sentences. Some speak only single words, while others repeat the same phrase over and over. Some ASD children parrot what they hear, a condition called echolalia. Although many children with no ASD go through a stage where they repeat what they hear, it normally passes by the time they are 3.

Some children only mildly affected may exhibit slight delays in language, or even seem to have precocious language and unusually large vocabularies, but have great difficulty in sustaining a conversation. The "give and take" of normal conversation is hard for them, although they often carry on a monologue on a favorite subject, giving no one else an opportunity to comment. Another difficulty is often the inability to understand body language, tone of voice, or "phrases of speech." They might interpret a sarcastic expression such as "Oh, that's just great" as meaning it really IS great.

While it can be hard to understand what ASD children are saying, their body language is also difficult to understand. Facial expressions, movements, and gestures rarely match what they are saying. Also, their tone of voice fails to reflect their feelings. A high-pitched, sing-song, or flat, robot-like voice is common. Some children with relatively good language skills speak like little adults, failing to pick up on the "kid-speak" that is common in their peers.

Without meaningful gestures or the language to ask for things, people with ASD are at a loss to let others know what they need. As a result, they may simply scream or grab what they want. Until they are taught better ways to express their needs, ASD children do whatever they can to get through to others. As people with ASD grow up, they can become increasingly aware of their difficulties in understanding others and in being understood. As a result they may become anxious or depressed.

Repetitive Behaviors

Although children with ASD usually appear physically normal and have good muscle control, odd repetitive motions may set them off from other children. These behaviors might be extreme and highly apparent or more subtle. Some children and older individuals spend a lot of time repeatedly flapping their arms or walking on their toes. Some suddenly freeze in position.

As children, they might spend hours lining up their cars and trains in a certain way, rather than using them for pretend play. If someone accidentally moves one of the toys, the child may be tremendously upset. ASD children need, and demand, absolute consistency in their environment. A slight change in any routine—in mealtimes, dressing, taking a bath, going to school at a certain time and by the same route—can be extremely disturbing. Perhaps order and sameness lend some stability in a world of confusion.

Repetitive behavior sometimes takes the form of a persistent, intense preoccupation. For example, the child might be obsessed with learning all about vacuum cleaners, train schedules or lighthouses. Often there is great interest in numbers, symbols or science topics.

Problems That May Accompany ASD

Sensory problems. When children's perceptions are accurate, they can learn from what they see, feel or hear. On the other hand, if sensory information is faulty, the child's experiences of the world can be confusing. Many ASD children are highly attuned or even painfully sensitive to certain sounds, textures, tastes and smells. Some children find the feel of clothes touching their skin almost unbearable. Some sounds—a vacuum cleaner, a ringing telephone, a sudden storm, even the sound of waves lapping the shoreline—will cause these children to cover their ears and scream.

In ASD, the brain seems unable to balance the senses appropriately. Some ASD children are oblivious to extreme cold or pain. An ASD child may fall and break an arm, yet never cry. Another may bash his head against a wall and not wince, but a light touch may make the child scream with alarm.

Mental retardation. Many children with ASD have some degree of mental impairment. When tested, some areas of ability may be normal, while others may be especially weak. For example, a child with ASD may do well on the parts of the test that measure visual skills but earn low scores on the language subtests.

Seizures. One in four children with ASD develops seizures, often starting either in early childhood or adolescence. [5] Seizures, caused by abnormal electrical activity in the brain, can produce a temporary loss of consciousness (a "blackout"), a body convulsion, unusual movements, or staring spells. Sometimes a contributing factor is a lack of sleep or a high fever. An EEG (electroencephalogram—recording of the electric currents developed in the brain by means of electrodes applied to the scalp) can help confirm the seizure's presence.

In most cases, seizures can be controlled by a number of medicines called "anticonvulsants." The dosage of the medication is adjusted carefully so that the least possible amount of medication will be used to be effective.

Fragile X syndrome. This disorder is the most common inherited form of mental retardation. It was so named because one part of the X chromosome has a defective piece that appears pinched and fragile when under a microscope. Fragile X syndrome affects about two to five percent of people with ASD. It is important to have a child with ASD checked for Fragile X, especially if the parents are considering having another child. For an unknown reason, if a child with ASD also has Fragile X, there is a one-in-two chance that boys born to the same parents will have the syndrome. [6] Other members of the family who may be contemplating having a child may also wish to be checked for the syndrome.

A distinction can be made between a father's and mother's ability to pass along to a daughter or son the altered gene on the X chromosome that is linked to fragile X syndrome. Because both males (XY) and females (XX) have at least one X chromosome, both can pass on the mutated gene to their children.

A father with the altered gene for Fragile X on his X chromosome will only pass that gene on to his daughters. He passes a Y chromosome on to his sons, which doesn't transmit the condition. Therefore, if the father has the altered gene on his X chromosome, but the mother's X chromosomes are normal, all of the couple's daughters would have the altered gene for Fragile X, while none of their sons would have the mutated gene. Because mothers pass on only X chromosomes to their children, if the mother has the altered gene for Fragile X, she can pass that gene to either her sons or her daughters. If the mother has the mutated gene on one X chromosome and has one normal X chromosome, and the father has no genetic mutations, all the children have a 50-50 chance of inheriting the mutated gene.

The odds noted here apply to each child (the parents have 7 in terms of prevalence). The latest statistics are consistent in showing that 5% of people with autism are affected by fragile X and 10% to 15% of those with fragile X show autistic traits.

Tuberous Sclerosis. Tuberous sclerosis is a rare genetic disorder that causes benign tumors to grow in the brain as well as in other vital organs. It has a consistently strong association with ASD. One to 4 percent of people with ASD also have tuberous sclerosis.[8]

The Diagnosis of Autism Spectrum Disorders

Although there are many concerns about labeling a young child with an ASD, the earlier the diagnosis of ASD is made, the earlier needed interventions can begin. Evidence over the last 15 years indicates that intensive early intervention in optimal educational settings for at least 2 years during the preschool years results in improved outcomes in most young children with ASD.[2]

In evaluating a child, clinicians rely on behavioral characteristics to make a diagnosis. Some of the characteristic behaviors of ASD may be apparent in the first few months of a child's life, or they may appear at any time during the early years. For the diagnosis, problems in at least one of the areas of communication, socialization, or restricted behavior must be present before the age of 3. The diagnosis requires a two-stage process. The first stage involves developmental screening during "well child" check-ups; the second stage entails a comprehensive evaluation by a multidisciplinary team.[9]

Screening

A "well child" check-up should include a developmental screening test. If your child's pediatrician does not routinely check your child with such a test, ask that it be done. Your own observations and concerns about your child's development will be essential in helping to screen your child.[9] Reviewing family videotapes, photos, and baby albums can help parents remember when each behavior was first noticed and when the child reached certain developmental milestones.

Several screening instruments have been developed to quickly gather information about a child's social and communicative development within medical settings. Among them are the Checklist of Autism in Toddlers (CHAT),[10] the modified Checklist for Autism in Toddlers (M-CHAT),[11] the Screening Tool for Autism in Two-Year-Olds (STAT),[12] and the Social Communication Questionnaire (SCQ)[13] (for children 4 years of age and older).

Some screening instruments rely solely on parent responses to a questionnaire, and some rely on a combination of parent report and observation. Key items on these instruments that appear to differentiate children with autism from other groups before the age of 2 include pointing and pretend play. Screening instruments do not provide individual diagnosis but serve to assess the need for referral for possible diagnosis of ASD. These screening methods may not identify children with mild ASD, such as those with high-functioning autism or Asperger syndrome.

During the last few years, screening instruments have been devised to screen for Asperger syndrome and higher functioning autism. The Autism Spectrum Screening Questionnaire (ASSQ),[14] the Australian Scale for Asperger's Syndrome,[15] and the most recent, the Childhood Asperger Syndrome Test (CAST),[16] are some of the instruments that are reliable for identification of school-age children with Asperger syndrome or higher functioning autism. These tools concentrate on social and behavioral impairments in children without significant language delay.

If, following the screening process or during a routine "well child" check-up, your child's doctor sees any of the possible indicators of ASD, further evaluation is indicated.

Comprehensive Diagnostic Evaluation

The second stage of diagnosis must be comprehensive in order to accurately rule in or rule out an ASD or other developmental problem. This evaluation may be done by a multidisciplinary team that includes a psychologist, a neurologist, a psychiatrist, a speech therapist or other professionals who diagnose children with ASD.

Because ASDs are complex disorders and may involve other neurological or genetic problems, a comprehensive evaluation should entail neurologic and genetic assessment, along with in-depth cognitive and language testing.[9] In addition, measures developed specifically for diagnosing autism are often used. These include the Autism Diagnosis Interview-Revised (ADI-R)[17] and the Autism Diagnostic Observation Schedule (ADOS-G).[18] The ADI-R is a structured interview that contains over 100 items and is conducted with a caregiver. It consists of four main factors—the child's communication, social interaction, repetitive behaviors and age-of-onset symptoms. The ADOS-G is an observational measure used to "press" for socio-communicative behaviors that are often delayed, abnormal or absent in children with ASD.

Still another instrument often used by professionals is the Childhood Autism Rating Scale (CARS).[19] It aids in evaluating the child's body movements, adaptation to change, listening response, verbal communication and relationship to people. It is suitable for use with children over 2 years of age. The examiner observes the child and also obtains relevant information from the parents. The child's behavior is rated on a scale based on deviation from the typical behavior of children of the same age.

Two other tests that should be used to assess any child with a developmental delay are a formal audiologic hearing evaluation and a lead screening. Although some hearing loss can co-occur with ASD, some children with ASD may be incorrectly thought to have such a loss. In addition, if the child has suffered from an ear infection, transient hearing loss can occur. Lead screening is essential for children who remain for a long period of time in the oral-motor stage in which they put any and everything into their mouths. Children with an autistic disorder usually have elevated blood lead levels.[9]

Customarily, an expert diagnostic team has the responsibility of thoroughly evaluating the child, assessing the child's unique strengths and weaknesses, and determining a formal diagnosis. The team will then meet with the parents to explain the results of the evaluation.

Although parents may have been aware that something was not "quite right" with their child, when the diagnosis is given, it is a devastating blow. At such a time, it is hard to stay focused on asking questions. But while members of the evaluation team are together is the best opportunity the parents will have to ask questions and get recommendations on what further steps they should take for their child. Learning as much as possible at this meeting is very important, but it is helpful to leave this meeting with the name or names of professionals who can be contacted if the parents have further questions.

Available Aids

When your child has been evaluated and diagnosed with an autism spectrum disorder, you may feel inadequate to help your child develop to the fullest extent of his or her ability. As you begin to look at treatment options and at the types of aid available for a child with a disability, you will find out that there is help for you. It is going to be difficult to learn and remember everything you need to know about the resources that will be most helpful. Write down everything. If you keep a notebook, you will have a foolproof method of recalling information. Keep a record of the doctors' reports and the evaluation your child has been given so that his or her eligibility for special programs will be documented. Learn everything you can about special programs for your child; the more you know, the more effectively you can advocate.

For every child eligible for special programs, each state guarantees special education and related services. The Individuals with Disabilities Education Act (IDEA) is a Federally mandated program that assures a free and appropriate public education for children with diagnosed learning deficits. Usually children are placed in public schools and the school district pays for all necessary services. These will include, as needed, services by a speech therapist, occupational therapist, school psychologist, social worker, school nurse or aide.

By law, the public schools must prepare and carry out a set of instruction goals, or specific skills, for every child in a special education program. The list of skills is known as the child's Individualized Education Program (IEP). The IEP is an agreement between the school and the family on the child's goals. When your child's IEP is developed, you will be asked to attend the meeting. There will be several people at this meeting, including a special education teacher, a representative of the public schools who is knowledgeable about the program, other individuals invited by the school or by you (you may want to bring a relative, a child care provider, or a supportive close friend who knows your child well). Parents play an important part in creating the program, as they know their child and his or her needs best. Once your child's IEP is developed, a meeting is scheduled once a year to review your child's progress and to make any alterations to reflect his or her changing needs.

If your child is under 3 years of age and has special needs, he or she should be eligible for an early intervention program; this program is available in every state. Each state decides which agency will be the lead agency in the early intervention program. The early intervention services are provided by workers qualified to care for toddlers with disabilities and are usually in the child's home or a place familiar to the child. The services provided are written into an Individualized Family Service Plan (IFSP) that is reviewed at least once every 6 months. The plan will describe services that will be provided to the child, but will also describe services for parents to help them in daily activities with their child and for siblings to help them adjust to having a brother or sister with ASD.

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Bipolar Disorder

Introduction

All parents can relate to the many changes their kids go through as they grow up. But sometimes it's hard to tell if a child is just going through a "phase" or perhaps showing signs of something more serious.

Recently, doctors have been diagnosing more children with bipolar disorder,[1] sometimes called manic-depressive illness. But what does this illness really mean for a child?

This booklet is a guide for parents who think their child may have symptoms of bipolar disorder, or parents whose child has been diagnosed with the illness.

This booklet discusses bipolar disorder in children and teens. For information on bipolar disorder in adults, see the National Institute of Mental Health (NIMH) booklet "Bipolar Disorder."

What is Bipolar Disorder?

Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood and energy. It can also make it hard for someone to carry out day-to-day tasks, such as going to school or hanging out with friends. Symptoms of bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. They can result in damaged relationships, poor school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives.

Bipolar disorder often develops in a person's late teens or early adult years, but some people have their first symptoms during childhood. At least half of all cases start before age 25.[2]

What are common symptoms of bipolar disorder in children and teens?

Youth with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes." An overly joyful or overexcited state is called a manic episode, and an extremely sad or hopeless state is called a depressive episode. Sometimes, a mood episode includes symptoms of both mania and depression. This is called a mixed state. People with bipolar disorder also may be explosive and irritable during a mood episode.

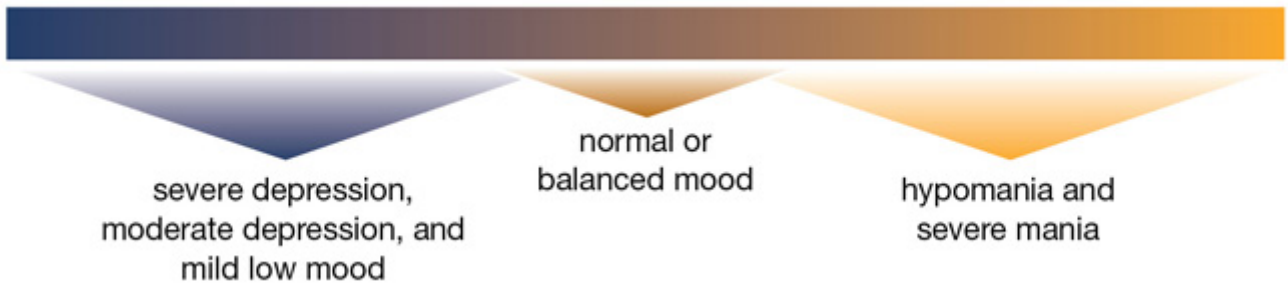
Extreme changes in energy, activity, sleep and behavior go along with these changes in mood. Symptoms of bipolar disorder are described below.

Symptoms of mania include:	Symptoms of depression include:
Mood Changes Being in an overly silly or joyful mood that's unusual for your child. It is different from times when he or she might usually get silly and have fun. Having an extremely short temper. This is an irritable mood that is unusual **Behavioral Changes** Sleeping little but not feeling tired Talking a lot and having racing thoughts Having trouble concentrating; attention jumping from one thing to the next in an unusual way Talking and thinking about sex more often Behaving in risky ways more often, seeking pleasure a lot, and doing more activities than usual	**Mood Changes** Being in a sad mood that lasts a long time Losing interest in activities they once enjoyed Feeling worthless or guilty **Behavioral Changes** Complaining about pain more often, such as headaches, stomach aches and muscle pains Eating a lot more or less and gaining or losing a lot of weight Sleeping or oversleeping when these were not problems before Losing energy Recurring thoughts of death or suicide

It's normal for almost every child or teen to have some of these symptoms occasionally. These passing changes should not be confused with bipolar disorder.

Symptoms of bipolar disorder are not like the normal changes in mood and energy that everyone has now and then. Bipolar symptoms are more extreme and tend to last for most of the day, nearly every day, for at least one week. Also, depressive or manic episodes include moods very different from a child's normal mood, and the behaviors described in the chart above may start at the same time. Sometimes the symptoms of bipolar disorder are so severe that the child needs to be treated in a hospital.

In addition to mania and depression, bipolar disorder can cause a range of moods, as shown on the scale below. One side of the scale includes severe depression, moderate depression and mild low mood. Moderate depression may cause less extreme symptoms, and mild low mood is called dysthymia when it is chronic or long-term. In the middle of the scale is normal or balanced mood.



Sometimes, a child may have more energy and be more active than normal but not show the severe signs of a full-blown manic episode. When this happens, it is called hypomania, and it generally lasts for at least four days in a row. Hypomania causes noticeable changes in behavior, but does not harm a child's ability to function in the way mania does.

What affects a child's risk of getting bipolar disorder?

Bipolar disorder tends to run in families. Children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness compared with children who do not have a family history of bipolar disorder.[3] However, most children with a family history of bipolar disorder will not develop the illness. Compared with children whose parents do not have bipolar disorder, children whose parents have bipolar disorder may be more likely to have symptoms of anxiety disorders and attention deficit hyperactivity disorder (ADHD).[4]

Several studies show that youth with anxiety disorders are more likely to develop bipolar disorder than youth without anxiety disorders. However, anxiety disorders are very common in young people. Most children and teens with anxiety disorders do not develop bipolar disorder.[5, 6]

At this time, there is no way to prevent bipolar disorder. NIMH is currently studying how to limit or delay the first symptoms in children with a family history of the illness.

Also see the section in this booklet called "What illnesses often co-exist with bipolar disorder in children and teens?"

How does bipolar disorder affect children and teens differently than adults?

Bipolar disorder that starts during childhood or during the teen years is called early-onset bipolar disorder. Early-onset bipolar disorder seems to be more severe than the forms that first appear in older teens and adults.[7, 8] Youth with bipolar disorder are different from adults with bipolar disorder. Young people with the illness appear to have more frequent mood switches, are sick more often, and have more mixed episodes.[8]

Watch out for any sign of suicidal thinking or behaviors. Take these signs seriously. On average, people with early-onset bipolar disorder have greater risk for attempting suicide than those whose symptoms start in adulthood.[7, 9] One large study on bipolar disorder in children and teens found that more than one-third of study participants made at least one serious suicide

attempt.[10] Some suicide attempts are carefully planned and others are not. Either way, it is important to understand that suicidal feelings and actions are symptoms of an illness that **must** be treated.

For more information on suicide, see the NIMH publication, Suicide in the U.S.: Statistics and Prevention.

How is bipolar disorder detected in children and teens?

No blood tests or brain scans can diagnose bipolar disorder. However, a doctor may use tests like these to help rule out other possible causes for your child's symptoms. For example, the doctor may recommend testing for problems in learning, thinking, or speech and language.[11] A careful medical exam may also detect problems that commonly co-occur with bipolar disorder and need to be treated, such as substance abuse.

Doctors who have experience with diagnosing early-onset bipolar disorder, such as psychiatrists, psychologists or other mental health specialists, will ask questions about changes in your child's mood. They will also ask about sleep patterns, activity or energy levels, and if your child has had any other mood or behavioral disorders. The doctor may also ask whether there is a family history of bipolar disorder or other psychiatric illnesses, such as depression or alcoholism.

Doctors usually diagnose mental disorders using guidelines from the Diagnostic and Statistical Manual of Mental Disorders, or DSM. According to the DSM, there are four basic types of bipolar disorder:

1. **Bipolar I Disorder** is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior.

2. **Bipolar II Disorder** is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes.

3. **Bipolar Disorder Not Otherwise Specified (BP-NOS)** is diagnosed when a person has symptoms of the illness that do not meet diagnostic criteria for either bipolar I or II. The symptoms may not last long enough, or the person may have too few symptoms, to be diagnosed with bipolar I or II. However, the symptoms are clearly out of the person's normal range of behavior.

4. **Cyclothymic Disorder, or Cyclothymia**, is a mild form of bipolar disorder. People who have cyclothymia have episodes of hypomania that shift back and forth with mild depression for at least two years (one year for children and adolescents). However, the symptoms do not meet the diagnostic requirements for any other type of bipolar disorder.

When children have manic symptoms that last for less than four days, experts recommend that they be diagnosed with BP-NOS. Some scientific evidence indicates that about one-third of these young people will develop longer episodes within a few years. If so, they meet the criteria for bipolar I or II.[12]

Also, researchers are working on whether certain symptoms mean a child should be diagnosed with bipolar disorder. For example, scientists are studying children with very severe, chronic irritability and symptoms of ADHD, but no clear episodes of mania. Some experts think these children should be diagnosed with mania. At the same time, there is scientific evidence that suggests these irritable children are different from children with bipolar disorder in the following key areas: the outcome of their illness, family history and brain function.[13-16]

When you talk to your child's doctor or a mental health specialist, be sure to ask questions. Getting answers helps you understand the terms they use to describe your child's symptoms.

What illnesses often co-exist with bipolar disorder in children and teens?

Several illnesses may develop in people with bipolar disorder.

Alcoholism. Adults with bipolar disorder are at very high risk of developing a substance abuse problem. Young people with bipolar disorder may have the same risk.

ADHD. Many children with bipolar disorder have a history of ADHD.[17] One study showed that ADHD is more common in people whose bipolar disorder started during childhood compared with people whose bipolar disorder started later in life.[7] Children who have co-occurring ADHD and bipolar disorder may have difficulty concentrating and controlling their activity. This may happen even when they are not manic or depressed.

Anxiety Disorders. Anxiety disorders, such as separation anxiety and generalized anxiety disorder, also commonly co-occur with bipolar disorder. This may happen in both children and adults. Children who have both types of disorders tend to develop bipolar disorder at a younger age and have more hospital stays related to mental illness.[18]

Other Mental Disorders. Some mental disorders cause symptoms similar to bipolar disorder. Two examples are major depression (sometimes called unipolar depression) and ADHD. If you look at symptoms only, there is no way to tell the difference between major depression and a depressive episode in bipolar disorder. For this reason, be sure to tell a diagnosing doctor of any past manic symptoms or episodes your child may have had. In contrast, ADHD does not have episodes. ADHD symptoms may resemble mania in some ways, but they tend to be more constant than in a manic episode of bipolar disorder.

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Borderline Personality Disorder

Raising questions, finding answers

Borderline personality disorder (BPD) is a serious mental illness characterized by pervasive instability in moods, interpersonal relationships, self-image and behavior. This instability often disrupts family and work life, long-term planning, and the individual's sense of self-identity. Originally thought to be at the "borderline" of psychosis, people with BPD suffer from a disorder of emotion regulation. While less well known than schizophrenia or bipolar disorder (manic-depressive illness), BPD is more common, affecting 2 percent of adults, mostly young women.[1] There is a high rate of self-injury without suicide intent, as well as a significant rate of suicide attempts and completed suicide in severe cases.[2,3] Patients often need extensive mental health services and account for 20 percent of psychiatric hospitalizations.[4] Yet with help, many improve over time and are eventually able to lead productive lives.

Symptoms

While a person with depression or bipolar disorder typically endures the same mood for weeks, a person with BPD may experience intense bouts of anger, depression and anxiety that may last only hours, or at most a day.[5] These may be associated with episodes of impulsive aggression, self-injury, and drug or alcohol abuse. Distortions in cognition and sense of self can lead to frequent changes in long-term goals, career plans, jobs, friendships, gender identity and values. Sometimes people with BPD view themselves as fundamentally bad or unworthy. They may feel unfairly misunderstood or mistreated, bored, empty, and have little idea who they are. Such symptoms are most acute when people with BPD feel isolated and lacking in social support, and may result in frantic efforts to avoid being alone.

People with BPD often have highly unstable patterns of social relationships. While they can develop intense but stormy attachments, their attitudes towards family, friends and loved ones may suddenly shift from idealization (great admiration and love) to devaluation (intense anger and dislike). Thus, they may form an immediate attachment and idealize the other person, but when a slight separation or conflict occurs, they switch unexpectedly to the other extreme and angrily accuse the other person of not caring for them at all. Even with family members, individuals with BPD are highly sensitive to rejection, reacting with anger and distress to such mild separations as a vacation, a business trip or a sudden change in plans. These fears of abandonment seem to be related to difficulties feeling emotionally connected to important persons when they are physically absent, leaving the individual with BPD feeling lost and perhaps worthless. Suicide threats and attempts may occur along with anger at perceived abandonment and disappointments.

People with BPD exhibit other impulsive behaviors, such as excessive spending, binge eating and risky sex. BPD often occurs together with other psychiatric problems, particularly bipolar disorder, depression, anxiety disorders, substance abuse and other personality disorders.

Treatment

Treatments for BPD have improved in recent years. Group and individual psychotherapy are at least partially effective for many patients. Within the past 15 years, a new psychosocial treatment termed dialectical behavior therapy (DBT) was developed specifically to treat BPD, and this technique has looked promising in treatment studies.[6] Pharmacological treatments are often prescribed based on specific target symptoms shown by the individual patient. Antidepressant drugs and mood stabilizers may be helpful for depressed and/or labile mood. Antipsychotic drugs may also be used when there are distortions in thinking.[7]

Recent Research Findings

Although the cause of BPD is unknown, both environmental and genetic factors are thought to play a role in predisposing patients to BPD symptoms and traits. Studies show that many, but not all, individuals with BPD report a history of abuse, neglect or separation as young children.[8] 40 to 71 percent of BPD patients report having been sexually abused, usually by a non-caregiver.[9] Researchers believe that BPD results from a combination of individual vulnerability to environmental stress, neglect or abuse as young children, and a series of events that trigger the onset of the disorder as young adults. Adults with BPD are also considerably more likely to be the victim of violence, including rape and other crimes. This may result from harmful environments as well as impulsivity and poor judgment in choosing partners and lifestyles.

NIMH-funded neuroscience research is revealing brain mechanisms underlying the impulsivity, mood instability, aggression, anger and negative emotion seen in BPD. Studies suggest that people predisposed to impulsive aggression have impaired regulation of the neural circuits that modulate emotion.[10] The amygdala, a small almond-shaped structure deep inside the brain, is an important component of the circuit that regulates negative emotion. In response to signals from other brain centers indicating a perceived threat, it marshals fear and arousal. This might be more pronounced under stress or the influence of drugs like alcohol. Areas in the front of the brain (pre-frontal area) act to dampen the activity of this circuit. Recent brain imaging studies show that individual differences in the ability to activate regions of the prefrontal cerebral cortex thought to be involved in inhibitory activity predict the ability to suppress negative emotion.[11]

Serotonin, norepinephrine and acetylcholine are among the chemical messengers in these circuits that play a role in the regulation of emotions, including sadness, anger, anxiety and irritability. Drugs that enhance brain serotonin function may improve emotional symptoms in BPD. Likewise, mood-stabilizing drugs that are known to enhance the activity of GABA, the brain's major inhibitory neurotransmitter, may help people who experience BPD-like mood swings. Such brain-based vulnerabilities can be managed with help from behavioral interventions and medications, much like people manage susceptibility to diabetes or high blood pressure.[7]

Future Progress

Studies that translate basic findings about the neural basis of temperament, mood regulation and cognition into clinically relevant insights which bear directly on BPD represent a growing area of NIMH-supported research. Research is also underway to test the efficacy of combining medications with behavioral treatments like DBT and gauging the effect of childhood abuse and other stress in BPD on brain hormones. Data from the first prospective, longitudinal study of BPD, which began in the early 1990s, is expected to reveal how treatment affects the course of the illness. It will also pinpoint specific environmental factors and personality traits that predict a more favorable outcome. The institute is also collaborating with a private foundation to help attract new researchers to develop a better understanding and better treatment for BPD.

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What Is Depression?

Everyone occasionally feels blue or sad, but these feelings are usually fleeting and pass within a couple of days. When a person has a depressive disorder, it interferes with daily life, normal functioning, and causes pain for both the person with the disorder and those who care about him or her. Depression is a common but serious illness, and most who experience it need treatment to get better.

Many people with a depressive illness never seek treatment. But the vast majority, even those with the most severe depression, can get better with treatment. Intensive research into the illness has resulted in the development of medications, psychotherapies, and other methods to treat people with this disabling disorder.

What are the different forms of depression?

There are several forms of depressive disorders. The most common are major depressive disorder and dysthymic disorder.

Major depressive disorder, also called major depression, is characterized by a combination of symptoms that interfere with a person's ability to work, sleep, study, eat and enjoy once–pleasurable activities. Major depression is disabling and prevents a person from functioning normally. An episode of major depression may occur only once in a person's lifetime, but more often, it recurs throughout a person's life.

Dysthymic disorder, also called dysthymia, is characterized by long–term (two years or longer) but less severe symptoms that may not disable a person but can prevent one from functioning normally or feeling well. People with dysthymia may also experience one or more episodes of major depression during their lifetimes.

Some forms of depressive disorder exhibit slightly different characteristics than those described above, or they may develop under unique circumstances. However, not all scientists agree on how to characterize and define these forms of depression. They include:

Psychotic depression occurs when a severe depressive illness is accompanied by some form of psychosis, such as a break with reality, hallucinations and delusions.

Postpartum depression is diagnosed if a new mother develops a major depressive episode within one month after delivery. It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth.[1]

Seasonal affective disorder (SAD) is characterized by the onset of a depressive illness during the winter months, when there is less natural sunlight. The depression generally lifts during spring and summer. SAD may be effectively treated with light therapy, but nearly half of those with SAD do not respond to light therapy alone. Antidepressant medication and psychotherapy can reduce SAD symptoms, either alone or in combination with light therapy.[2]

Bipolar disorder, also called manic-depressive illness, is not as common as major depression or dysthymia. Bipolar disorder is characterized by cycling mood changes-from extreme highs (e.g., mania) to extreme lows (e.g., depression). Visit the NIMH website for more information about bipolar disorder.

What are the signs and symptoms of depression?

People with depressive illnesses do not all experience the same symptoms. The severity, frequency and duration of symptoms will vary depending on the individual and his or her particular illness.

Symptoms include:

- Persistent sad, anxious or "empty" feelings.
- Feelings of hopelessness and/or pessimism.
- Feelings of guilt, worthlessness and/or helplessness.
- Irritability, restlessness.
- Loss of interest in activities or hobbies once pleasurable, including sex.
- Fatigue and decreased energy.
- Difficulty concentrating, remembering details and making decisions.
- Insomnia, early–morning wakefulness, or excessive sleeping.
- Overeating or appetite loss.
- Thoughts of suicide, suicide attempts.
- Persistent aches or pains, headaches, cramps or digestive problems that do not ease even with treatment.

What illnesses often co-exist with depression?

Depression often co–exists with other illnesses. Such illnesses may precede the depression, cause it, and/or be a consequence of it. It is likely that the mechanics behind the intersection of depression and other illnesses differ for every person and situation. Regardless, these other co–occurring illnesses need to be diagnosed and treated.

Anxiety disorders, such as post–traumatic stress disorder (PTSD), obsessive–compulsive disorder, panic disorder, social phobia and generalized anxiety disorder often accompany depression.[3,4] People experiencing PTSD are especially prone to having co-occurring depression. PTSD is a debilitating condition that can result after a person experiences a terrifying event or ordeal, such as a violent assault, a natural disaster, an accident, terrorism or military combat.

People with PTSD often re–live the traumatic event in flashbacks, memories or nightmares. Other symptoms include irritability, anger outbursts, intense guilt, and avoidance of thinking or talking about the traumatic ordeal. In a National Institute of Mental Health (NIMH)–funded study, researchers found that more than 40 percent of people with PTSD also had depression at one-month and four-month intervals after the traumatic event.[5]

Alcohol and other substance abuse or dependence may also co–occur with depression. In fact, research has indicated that the co–existence of mood disorders and substance abuse is pervasive among the U.S. population. [6]

Depression also often co–exists with other serious medical illnesses such as heart disease, stroke, cancer, HIV/AIDS, diabetes and Parkinson's disease. Studies have shown that people who have depression in addition to another serious medical illness tend to have more severe symptoms of both depression and the medical illness, more difficulty adapting to their medical condition, and more medical costs than those who do not have co–existing depression.[7] Research has yielded increasing evidence that treating the depression can also help improve the outcome of treating the co–occurring illness.[8]

What causes depression?

There is no single known cause of depression. Rather, it likely results from a combination of genetic, biochemical, environmental and psychological factors.

Research indicates that depressive illnesses are disorders of the brain. Brain-imaging technologies, such as magnetic resonance imaging (MRI), have shown that the brains of people who have depression look different than those of people without depression. The parts of the brain responsible for regulating mood, thinking, sleeping, appetite and behavior appear to function abnormally. In addition, important neurotransmitters–chemicals that brain cells use to communicate–appear to be out of balance. But these images do not reveal why the depression has occurred.

Some types of depression tend to run in families, suggesting a genetic link. However, depression can occur in people without family histories of depression as well.[9] Genetics research indicates that risk for depression results from the influence of multiple genes acting together with environmental or other factors.[10]

In addition, trauma, loss of a loved one, a difficult relationship, or any stressful situation may trigger a depressive episode. Subsequent depressive episodes may occur with or without an obvious trigger.

How do women experience depression?

Depression is more common among women than among men. Biological, life cycle, hormonal and psychosocial factors unique to women may be linked to women's higher depression rate. Researchers have shown that hormones directly affect brain chemistry that controls emotions and mood. For example, women are particularly vulnerable to depression after giving birth, when hormonal and physical changes, along with the new responsibility of caring for a newborn, can be overwhelming. Many new mothers experience a brief episode of the "baby blues," but some will develop postpartum depression, a much more serious condition that requires active treatment and emotional support for the new mother. Some studies suggest that women who experience postpartum depression often have had prior depressive episodes.

Some women may also be susceptible to a severe form of premenstrual syndrome (PMS), sometimes called premenstrual dysphoric disorder (PMDD), a condition resulting from the hormonal changes that typically occur around ovulation and before menstruation begins. During the transition into menopause, some women experience an increased risk for depression. Scientists are exploring how the cyclical rise and fall of estrogen and other hormones may affect the brain chemistry that is associated with depressive illness.[11]

Finally, many women face the additional stresses of work and home responsibilities, caring for children and aging parents, abuse, poverty, and relationship strains. It remains unclear why some women faced with enormous challenges develop depression, while others with similar challenges do not.

How do men experience depression?

Men often experience depression differently than women and may have different ways of coping with the symptoms. Men are more likely to acknowledge having fatigue, irritability, loss of interest in once–pleasurable activities and sleep disturbances, whereas women are more likely to admit to feelings of sadness, worthlessness and/or excessive guilt.[12,13]

Men are more likely than women to turn to alcohol or drugs when they are depressed, or become frustrated, discouraged, irritable, angry and sometimes abusive. Some men throw themselves into their work to avoid talking about their depression with family or friends, or engage in reckless, risky behavior. And even though more women attempt suicide, many more men die by suicide in the United States.[14]

How do older adults experience depression?

Depression is not a normal part of aging, and studies show that most seniors feel satisfied with their lives, despite increased physical ailments. However, when older adults do have depression, it may be overlooked because seniors may show different, less obvious symptoms and may be less inclined to experience or acknowledge feelings of sadness or grief.[15]

In addition, older adults may have more medical conditions such as heart disease, stroke or cancer, which may cause depressive symptoms, or they may be taking medications with side effects that contribute to depression. Some older adults may experience what some doctors call vascular depression, also called arteriosclerotic depression or subcortical ischemic depression. Vascular depression may result when blood vessels become less flexible and harden over time, becoming constricted. Such hardening of vessels prevents normal blood flow to the body's organs, including the brain. Those with vascular depression may have, or be at risk for, a co–existing cardiovascular illness or stroke.[16]

Although many people assume that the highest rates of suicide are among the young, older white males age 85 and older actually have the highest suicide rate. Many have a depressive illness that their doctors may not detect, despite the fact that these suicide victims often visit their doctors within one month of their deaths.[17]

The majority of older adults with depression improves when they receive treatment with an antidepressant, psychotherapy, or a combination of both.[18] Research has shown that medication alone and combination treatment are both effective in reducing the rate of depressive recurrences in older adults.[19] Psychotherapy alone also can be effective in prolonging periods free of depression, especially for older adults with minor depression, and it is particularly useful for those who are unable or unwilling to take antidepressant medication.[20, 21]

How do children and adolescents experience depression?

Scientists and doctors have begun to take seriously the risk of depression in children. Research has shown that childhood depression often persists, recurs and continues into adulthood, especially if it goes untreated. The presence of childhood depression also tends to be a predictor of more severe illnesses in adulthood.[22]

A child with depression may pretend to be sick, refuse to go to school, cling to a parent, or worry that a parent may die. Older children may sulk, get into trouble at school, be negative and irritable, and feel misunderstood. Because these signs may be viewed as normal mood swings typical of children as they move through developmental stages, it may be difficult to accurately diagnose a young person with depression.

Before puberty, boys and girls are equally likely to develop depressive disorders. By age 15, however, girls are twice as likely as boys to have experienced a major depressive episode.[23]

Depression in adolescence comes at a time of great personal change–when boys and girls are forming an identity distinct from their parents, grappling with gender issues and emerging sexuality, and making decisions for the first time in their lives. Depression in adolescence frequently co–occurs with other disorders such as anxiety, disruptive behavior, eating disorders or substance abuse. It can also lead to increased risk for suicide. [22, 24]

An NIMH–funded clinical trial of 439 adolescents with major depression found that a combination of medication and psychotherapy was the most effective treatment option.[25] Other NIMH–funded researchers are developing and testing ways to prevent suicide in children and adolescents, including early diagnosis and treatment, and a better understanding of suicidal thinking.

How is depression detected and treated?

Depression, even the most severe cases, is a highly treatable disorder. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that recurrence can be prevented.

The first step to getting appropriate treatment is to visit a doctor. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. A doctor can rule out these possibilities by conducting a physical examination, interview and lab tests. If the doctor can eliminate a medical condition as a cause, he or she should conduct a psychological evaluation or refer the patient to a mental health professional.

The doctor or mental health professional will conduct a complete diagnostic evaluation. He or she should discuss any family history of depression and get a complete history of symptoms, e.g., when they started, how long they have lasted, their severity, and whether they have occurred before and, if so, how they were treated. He or she should also ask if the patient is using alcohol or drugs and whether the patient is thinking about death or suicide.

Once diagnosed, a person with depression can be treated with a number of methods. The most common treatments are medication and psychotherapy.

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What is Schizophrenia?

Schizophrenia is a chronic, severe and disabling brain disorder that has affected people throughout history. About 1 percent of Americans have this illness.[1]

People with the disorder may hear voices other people don't hear. They may believe other people are reading their minds, controlling their thoughts or plotting to harm them. This can terrify people with the illness and make them withdrawn or extremely agitated.

People with schizophrenia may not make sense when they talk. They may sit for hours without moving or talking. Sometimes people with schizophrenia seem perfectly fine until they talk about what they are really thinking.

Families and society are affected by schizophrenia too. Many people with schizophrenia have difficulty holding a job or caring for themselves, so they rely on others for help.

Treatment helps relieve many symptoms of schizophrenia, but most people who have the disorder cope with symptoms throughout their lives. However, many people with schizophrenia can lead rewarding and meaningful lives in their communities. Researchers are developing more effective medications and using new research tools to understand the causes of schizophrenia. In the years to come, this work may help prevent and better treat the illness.

What are the symptoms of schizophrenia?

The symptoms of schizophrenia fall into three broad categories: positive symptoms, negative symptoms, and cognitive symptoms.

Positive symptoms

Positive symptoms are psychotic behaviors not seen in healthy people. People with positive symptoms often "lose touch" with reality. These symptoms can come and go. Sometimes they are severe and at other times hardly noticeable, depending on whether the individual is receiving treatment. They include the following:

Hallucinations are things a person sees, hears, smells or feels that no one else can see, hear, smell or feel. "Voices" are the most common type of hallucination in schizophrenia. Many people with the disorder hear voices. The voices may talk to the person about his or her behavior, order the person to do things, or warn the person of danger. Sometimes the voices talk to each other. People with schizophrenia may hear voices for a long time before family and friends notice the problem.

Other types of hallucinations include seeing people or objects that are not there, smelling odors that no one else detects, and feeling things like invisible fingers touching their bodies when no one is near.

Delusions are false beliefs that are not part of the person's culture and do not change. The person believes delusions even after other people prove that the beliefs are not true or logical. People with schizophrenia can have delusions that seem bizarre, such as believing that neighbors can control their behavior with magnetic waves. They may also believe that people on television are directing special messages to them or that radio stations are broadcasting their thoughts aloud to others. Sometimes they believe they are someone else, such as a famous historical figure. They may have paranoid delusions and believe that others are trying to harm them, such as by cheating, harassing, poisoning, spying on, or plotting against them or the people they care about. These beliefs are called "delusions of persecution."

Thought disorders are unusual or dysfunctional ways of thinking. One form of thought disorder is called "disorganized thinking." This is when a person has trouble organizing his or her thoughts or connecting them logically. They may talk in a garbled way that is hard to understand. Another form is called "thought blocking." This is when a person stops speaking abruptly in the middle of a thought. When asked why he or she stopped talking, the person may say it felt as if the thought had been taken out of his or her head. Finally, a person with a thought disorder might make up meaningless words, or "neologisms."

Movement disorders may appear as agitated body movements. A person with a movement disorder may repeat certain motions over and over. In the other extreme, a person may become catatonic. Catatonia is a state in which a person does not move and does not respond to others. Catatonia is rare today, but it was more common when treatment for schizophrenia was not available.[2]

"Voices" are the most common type of hallucination in schizophrenia.

Negative symptoms

Negative symptoms are associated with disruptions to normal emotions and behaviors. These symptoms are harder to recognize as part of the disorder and can be mistaken for depression or other conditions. These symptoms include the following:

- "Flat affect" (a person's face does not move or he or she talks in a dull or monotonous voice)
- Lack of pleasure in everyday life
- Lack of ability to begin and sustain planned activities
- Speaking little, even when forced to interact

People with negative symptoms need help with everyday tasks. They often neglect basic personal hygiene. This may make them seem lazy or unwilling to help themselves, but the problems are symptoms caused by the schizophrenia.

Cognitive symptoms

Cognitive symptoms are subtle. Like negative symptoms, cognitive symptoms may be difficult to recognize as part of the disorder. Often, they are detected only when other tests are performed. Cognitive symptoms include the following:

- Poor "executive functioning" (the ability to understand information and use it to make decisions)
- Trouble focusing or paying attention
- Problems with "working memory" (the ability to use information immediately after learning it)

Cognitive symptoms often make it hard to lead a normal life and earn a living. They can cause great emotional distress.

When does schizophrenia start and who gets it?

Schizophrenia affects men and women equally. It occurs at similar rates in all ethnic groups around the world. Symptoms such as hallucinations and delusions usually start between ages 16 and 30. Men tend to experience symptoms a little earlier than women. Most of the time, people do not get schizophrenia after age 45.[3] Schizophrenia rarely occurs in children, but awareness of childhood-onset schizophrenia is increasing.[4,5]

It can be difficult to diagnose schizophrenia in teens. This is because the first signs can include a change of friends, a drop in grades, sleep problems, and irritability—behaviors that are common among teens. A combination of factors can predict schizophrenia in up to 80 percent of youth who are at high risk of developing the illness. These factors include isolating oneself and withdrawing from others, an increase in unusual thoughts and suspicions, and a family history of psychosis.[6] In young people who develop the disease, this stage of the disorder is called the "prodromal" period.

Are people with schizophrenia violent?

People with schizophrenia are not usually violent. In fact, most violent crimes are not committed by people with schizophrenia.[7] However, some symptoms are associated with violence, such as delusions of persecution. Substance abuse may also increase the chance a person will become violent.[8] If a person with schizophrenia becomes violent, the violence is usually directed at family members and tends to take place at home.

The risk of violence among people with schizophrenia is small. But people with the illness attempt suicide much more often than others. About 10 percent (especially young adult males) die by suicide.[9,10] It is hard to predict which people with schizophrenia are prone to suicide. If you know someone who talks about or attempts suicide, help him or her find professional help right away.

People with schizophrenia are not usually violent.

What about substance abuse?

Some people who abuse drugs show symptoms similar to those of schizophrenia. Therefore, people with schizophrenia may be mistaken for people who are affected by drugs. Most researchers do not believe that substance abuse causes schizophrenia. However, people who have schizophrenia are much more likely to have a substance or alcohol abuse problem than the general population.[11]

Substance abuse can make treatment for schizophrenia less effective. Some drugs, like marijuana and stimulants such as amphetamines or cocaine, may make symptoms worse. In fact, research has found increasing evidence of a link between marijuana and schizophrenia symptoms.[12,13] In addition, people who abuse drugs are less likely to follow their treatment plan.

Schizophrenia and smoking

Addiction to nicotine is the most common form of substance abuse in people with schizophrenia. They are addicted to nicotine at three times the rate of the general population (75 to 90 percent vs. 25 to 30 percent).[14]

The relationship between smoking and schizophrenia is complex. People with schizophrenia seem to be driven to smoke, and researchers are exploring whether there is a biological basis for this need. In addition to its known health hazards, several studies have found that smoking may make antipsychotic drugs less effective.

Quitting smoking may be very difficult for people with schizophrenia because nicotine withdrawal may cause their psychotic symptoms to get worse for a while. Quitting strategies that include nicotine replacement methods may be easier for patients to handle. Doctors who treat people with schizophrenia should watch their patients' response to antipsychotic medication carefully if the patient decides to start or stop smoking.

What causes schizophrenia?

Experts think schizophrenia is caused by several factors.

Genes and environment. Scientists have long known that schizophrenia runs in families. The illness occurs in 1 percent of the general population, but it occurs in 10 percent of people who have a first-degree relative with the disorder, such as a parent, brother or sister. People who have second-degree relatives (aunts, uncles, grandparents or cousins) with the disease also develop schizophrenia more often than the general population. The risk is highest for an identical twin of a person with schizophrenia. He or she has a 40 to 65 percent chance of developing the disorder.[15]

We inherit our genes from both parents. Scientists believe several genes are associated with an increased risk of schizophrenia, but that no gene causes the disease by itself.[16] In fact, recent research has found that people with schizophrenia tend to have higher rates of rare genetic mutations. These genetic differences involve hundreds of different genes and probably disrupt brain development.[17]

Other recent studies suggest that schizophrenia may result in part when a certain gene that is key to making important brain chemicals malfunctions. This problem may affect the part of the brain involved in developing higher functioning skills.[18] Research into this gene is ongoing, so it is not yet possible to use the genetic information to predict who will develop the disease.

Despite this, tests that scan a person's genes can be bought without a prescription or a health professional's advice. Ads for the tests suggest that with a saliva sample, a company can determine if a client is at risk for developing specific diseases, including schizophrenia. However, scientists don't yet know all of the gene variations that contribute to schizophrenia. Those that are known raise the risk only by very small amounts. Therefore, these "genome scans" are unlikely to provide a complete picture of a person's risk for developing a mental disorder like schizophrenia.

In addition, it probably takes more than genes to cause the disorder. Scientists think interactions between genes and the environment are necessary for schizophrenia to develop. Many environmental factors may be involved, such as exposure to viruses or malnutrition before birth, problems during birth, and other not yet known psychosocial factors.

Scientists are learning more about brain chemistry and its link to schizophrenia.

Different brain chemistry and structure. Scientists think that an imbalance in the complex, interrelated chemical reactions of the brain involving the neurotransmitters dopamine and glutamate, and possibly others, plays a role in schizophrenia. Neurotransmitters are substances that allow brain cells to communicate with each other. Scientists are learning more about brain chemistry and its link to schizophrenia.

Also, in small ways the brains of people with schizophrenia look different than those of healthy people. For example, fluid-filled cavities at the center of the brain, called ventricles, are larger in some people with schizophrenia. The brains of people with the illness also tend to have less gray matter, and some areas of the brain may have less or more activity.

Studies of brain tissue after death also have revealed differences in the brains of people with schizophrenia. Scientists found small changes in the distribution or characteristics of brain cells that likely occurred before birth.[3] Some experts think problems during brain development before birth may lead to faulty connections. The problem may not show up in a person until puberty. The brain undergoes major changes during puberty, and these changes could trigger psychotic symptoms. Scientists have learned a lot about schizophrenia, but more research is needed to help explain how it develops.

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APPENDIX B

PYROMANIA

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The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV and DSM-IV-TR) (American psychiatric Association, 1994)

Pyromania is defined as a pattern of deliberate setting of fires for pleasure or satisfaction derived from the relief of tension experienced before the fire-setting. The name of the disorder comes from two Greek words that mean "fire" and "loss of reason" or "madness." The clinician's handbook, the ***Diagnostic and Statistical Manual of Mental Disorders,*** also known as the DSM, classifies pyromania as a disorder of impulse control, meaning that a person diagnosed with pyromania fails to resist the impulsive desire to set fires—as opposed to the organized planning of an arsonist or terrorist. (Encyclopedia of Mental Disorders, 2010)

Diagnostic criteria for 312.33 Pyromania

1. Deliberate and purposeful firesetting on more than one occasion.

2. Tension or affective arousal before the act.

3. Fascination with, interest in, curiosity about, or attraction to fire and its situational contexts (e.g., paraphernalia, uses, consequences).

4. Pleasure, gratification or relief when setting fires or when witnessing or participating in their aftermath.

5. 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 a hallucination, or as a result of impaired judgment (e.g., in Dementia, Mental Retardation, Substance Intoxication).

The firesetting is not better accounted for by Conduct Disorder, a Manic Episode, or Antisocial Personality Disorder.

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APPENDIX C

RESEARCH ARTICLE

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The Interaction between Juvenile School Fire Setting and Bullying: An Exploratory Study

Amy Sharp, Dominique Roe-Sepowitz, and Janet Boberg

The aim of this study is to provide school social workers with an outline of the indicators common to school fire setters regarding their experiences of bullying and victimization by bullies. A sample of juvenile fire setters (N = 379) between the ages of five and seventeen years attending a fire-setter intervention program completed a modified Peer Relations Questionnaire. The purpose of this study was to determine if there are any differences regarding bully or bully victim characteristics between juvenile fire setters who set fires at school and those who set fires in other locations. Almost a third of the sample (32.7%, n =125) indicated that they had set a fire at school and reported a higher rate of having been bullied than non-school fire setters. Implications for school social work practices are discussed.

Keywords: *youth fire setters; bullying; school fire setters; juvenile arson; youth arson*

Juvenile bullying presents a significant threat to the health and safety of children in the United States (Espelage & Swearer, 2003). Bullying in schools is a phenomenon that occurs across many countries and cultures, although research on the prevalence and impact of bullying has

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primarily been conducted in Europe and Australia. Bullying research began in Norway when Dan Olweus (1995) conducted large-scale surveys within the schools and determined that 9 percent of students were victims of bullying. Somewhat higher percentages have been found in countries such as England (20%), Canada (20%), and Australia (10%) (Duncan, 1999). Research in the United States has shown that one in four children (25%) is bullied, and one in five children (20%) defines him- or herself as a bully (Whitted & Dupper, 2005).

Bullying has been difficult to define, and what constitutes the parameters of bullying and bully victimization varies in the literature. Bullying is often confused with roughhousing or teasing and is often not understood as a serious problem. Roughhousing and teasing, although unpleasant, are generally considered a normal part of growing up. According to Rigby (1999), bullying is defined as a repeated oppression, psychological or physical, of a less powerful person by a more powerful person or group of persons. It is important to note that bullying is somewhat different from aggression and violence due to the imbalance of power between the bully and victim (Rigby, 1999). This study explores the relationship between being a bully or being bullied and juveniles who set school fires.

The major problem of violence in schools, including mass school killings, has schools, school districts, communities, and the nation scrambling to come up with reasons and solutions to combat the issues of youths hurting and killing each other, school staff, and community members on school campuses during school hours (Osher, VanAcker, Morrison, Gable, Dwyer, & Quinn, 2004). Elam, Rose, and Gallup (1994) found that school-based crime and violence are currently ranked as the number one problem in public polls of people's attitudes toward schools. Ballantine (2001) reported that in many schools, many students face daily bullying, sexual harassment, and beatings, and some children are afraid to go to school or carry weapons to school for protection. The publicized school shootings of the last decade have caused school social workers, school district administrators, school principals, school psychologists, criminologists, fire and police departments, and the federal government to scramble in an effort to identify the root causes of school violence and devise prevention strategies in an effort to stop it (Osher et al., 2004).

Bullying has been identified as a main source of school violence. Bullying has been found to have a negative impact on both bullies and victims (Mishna, 2003; Nansel, Overpeck, Pilla, Ruan, Simons-Morton, & Scheidt, 2001; O'Connell, Pepler, & Craig, 1999; Olweus, 1994; Paetsch

& Bertrand, 1999). The distinction between bullies and victims of bullies can be confusing because some bullies are also victims. Bully/victims have been found to show different social characteristics than youths who just bully. In a study of young children, they showed more physical aggression than bullies, regardless of age, and were shown to be less cooperative and less sociable and had no playmates more frequently than children who were not bullied and bullies who were not victims (Perren & Alsaker, 2006).

The characteristics of bullies has been the topic of much research. Bullies have a positive view of aggression (Perry & Perry, 1974) and fail to feel negative about their aggression toward others (Perry & Bussey, 1977). The types of aggression have been shown to differ by the age of the bully. Younger children use more physical bullying, while older children use more verbal bullying (Perren & Alsaker, 2006). The type of aggression also differs by gender. Males are reported to use more physical and overt forms of bullying, while females use more covert forms, such as spreading rumors (Perry, Kusel, & Perry, 1988). Contrary to popular belief, bullies have been found to belong to strong social networks and to be the leaders of those social networks (Perren & Alsaker, 2006; Perry et al., 1988). Although bullies have been rated as somewhat popular by their peers, their popularity appears to decline with age (Olweus, 1994).

In the empirical literature on bullying, victims of bullying have been found to have a variety of long-term psychosocial problems. These include low self-esteem, depression (Whitted & Dupper, 2005), poor health, missing school, and relationship problems as adults (Fox & Boulton, 2003; Rigby, 1997; Slee, 1995). In 1988, Perry et al. assessed the degree to which students were bullied. They found that 10 percent of students surveyed ($N = 165$) were classified as extremely victimized. Victims often report being lonely and have few if any friends (Perren & Alsaker, 2006; Perry et al., 1988; Rigby, 2000). In some cases bullying is so severe that victims of bullying bring weapons to school for protection and revenge. Some victims have been tormented to the point that they have taken their own lives (Carney & Merrell, 2001). The connection between bullying and delinquency has also been explored by researchers. Bullies and bully/victims are involved in more delinquent behavior than non-bullies (Van der Wal, 2005). This is true for both males and females (Rigby & Cox, 1996), and bullies have been found to be more delinquent than bully/victims (Van der Wal, 2005).

There has been much research on bullying, bullies, and victims of bullies, and many school prevention programs have been designed to address bullying (Espelage & Swearer, 2003; Leff, Power, & Goldstein, 2003; Mihalic, Irwin, Elliot, Fagan, & Hansen, 2001; Rigby 1996, 1997). Yet

there has been limited research on how bullying affects students who demonstrate other types of delinquency, such as setting school fires.

Juvenile fire setting is costly and destructive. Researchers have explored the characteristics of juvenile fire setting and mental health disorders such as attention deficit disorder (Rea, 2000) and conduct disorder, physical abuse, neglect (Showers & Pickrell, 1987), parent pathology and family functioning (Kazdin & Kolko, 1986), social skill problems, and antisocial behaviors (Slavkin, 2002; Stickle & Blechman, 2002). Annually, more than 300 people die as a result of fires set by juveniles (Schwartzman, Stanbaugh, & Kimball, 1998; U.S. Fire Administration/National Fire Data Center, 2008).

In 2002, there were an estimated 14,300 fires in K–12 educational institutions in the United States, causing an estimated $103 million in property damage and 122 injuries (Federal Emergency Management Agency, 2004). There have been few deaths associated with school fires in the past fifty years, but fires at schools cause more injuries than other non-residential structure fires (Federal Emergency Management Agency, 2004). From 2002 to 2005 there were 6,560 reported fires on educational properties, $99 million in property damage, and ninety-five injuries (Flynn, 2007). Twenty-two percent of these school property fires were intentionally set (Flynn, 20007). It is believed that students are setting the majority of the fires, but this has been difficult to substantiate (Federal Emergency Management Agency, 2004).

In an exploratory study of school fire setters, Boberg (2006) found that school fire setters tend to set school fires for the following reasons: for entertainment purposes, out of boredom, because of internal or external peer group pressure, just because they had the idea, to see something burn, for no reason at all, they were mad at a teacher or parent, and to get warm. The school fire setters in Boberg's study who reported that they set a school fire because of external or internal peer group pressure stated that bullying was part of that peer group pressure. Two students reported that if they did not set a school fire, they would be beaten up after school. Another student reported that one of her classmates was calling her names because she refused to set a garbage can in the school bathroom on fire. After her repeated refusals to set the fire, her classmate began to physically push her toward the garbage can while taunting her and calling her names. Two other students reported that they set school fires because they wanted to be considered cool and fit in with their peers.

Few research studies have been conducted regarding the connection between juvenile school fire setters and bullying (Boberg, 2006; Lewis & Yarnell, 1951; Wooden & Berkey, 1984). Lewis and Yarnell (1951) found that students who set school fires were motivated by hatred, revenge, and

the desire to destroy the school building. Wooden and Berkey (1984) found the reasons students set school fires were revenge, spite, or a desire to disrupt classroom activities.

The goal of this article is to provide school professionals (social workers, school psychologists, teachers, and administrators) with details of the bullying-related experiences common to school fire setters. The research question of this study is: Do the bullying-related experiences of juvenile school fire setters differ from those of juveniles who set fires at non-school locations?

Methodology

Participants

The participants for this study were 379 children and adolescents from a fire-setter intervention program in a large city in the Southwest. The participants were referred to the intervention program by their parents, schools, law enforcement, fire service, or counselors. Parental permission and institutional review board approval were obtained for this study. All attendees of the intervention program who had set a fire were given the questionnaire, and most completed it independently in a pen-and-paper format. The very young participants were assisted by the third author, who administered all the questionnaires.

Data were collected over a one-year period at the twice-monthly fire-setter intervention program. The sample consisted of youths ranging in age from five to seventeen years (M =12.33, SD = 3.45) in first to twelfth grade (M = 6.98, SD = 2.04). Gender and race of the participants are displayed in table 1. Information on a single fire was available for each participant, and no participants attended the program more than once. There were two groups of participants: those who started a fire at school (32.7%, n = 125), and those who started a fire at a place other than school (66.5%, n = 254). See table 2 for gender and race of the participants for school fire setters compared to non-school fire setters.

Table 1. Participants' Demographics

Gender	
Male	326 (86%)
Female	53 (14%)
Race	
White	177 (46.7%)
Hispanic	104 (27.4%)
African American	22 (5.9%)
Mixed race/other	76 (20%)
Fire location	
School	125 (33%)
Not at school	254 (67%)

Table 2. Gender and Race of School and Non-school Fire Setters

	School fire setters (n = 125)	Non-school fire setters (n = 254)
Gender		
Male	104 (82.9%)	222 (87.2%)
Female	21 (17.1%)	32 (12.8%)
Race		
White	53 (42.4%)	124 (48.8%)
African American	3 (2.4%)	19 (7.5%)
Asian	5 (4%)	4 (1.6%)
Hispanic	41 (32.8%)	63 (24.8%)
Native American	2 (1.6%)	4 (1.6%)
Other	19 (15.2%)	38 (14.9%)
Mixed ethnicity	2 (1.6%)	2 (.8%)

Instrument

To assess participants' involvement in bullying at school, a modified Peer Relations Questionnaire (PRQ; Rigby & Slee, 1992) was used. The modified PRQ is a twenty-six-item measure of childhood peer relationships scored on a four-point scale. Each participant received a total score on scales consisting of items assessing the tendency to bully others or be a victim at school. Higher scores were assigned to responses that indicated greater frequencies of a bullying behavior or victimization. The PRQ was normed on more than 26,000 Australian primary and secondary students ranging in age from eight to eighteen years. These data were used to calculate the PRQ subscales' reliability estimates; strong Cronbach alpha reliability estimates were found for victim (.84), and moderate alpha reliability estimates for bully (.74) and bully/victim (.76).

Findings

To explore the differences between students who set fires at school and those who set fires in other places, chi-square analysis and t-tests were conducted. The differences between the two groups were significant, with the school fire setters reporting higher rates of victimization by bullies than non-school fire setters. Findings showed that juveniles who set

fires at school did not perceive themselves as getting good grades ($\chi^2(1, N = 379) = 8.03, p < .05$), whereas non-school fire setters more often saw themselves as getting good grades. School fire setters reported being picked on ($\chi^2(8, N = 279) = 23.07, p < .01$) and made fun of ($\chi^2(8, N = 379) = 130.93, p < .01$) more often than did non-school fire setters. School fire setters reported that they were called names by others ($\chi^2(8, N = 379) = 43.50, p < .01$), that they were left out of peer activities ($\chi^2(8, N = 379) = 42.89, p < .001$), and they stayed home from school because they were bullied ($\chi^2(4, N = 379) = 27.78, p < .001$), and they reported that they rarely helped people who were getting picked on ($\chi^2(10, N = 379) = 22.31, p < .05$). School fire setters reported that bullying was a big problem for them ($\chi^2(8, N = 379) = 55.28, p < .001$) more than non-school fire setters. School fire setters were found to be somewhat different from non-school fire setters in terms of age ($t(379) = 2.76, p = .006$): the average age of the school fire setters (12.7 years) was about half a year older than the non-school fire setters (12.1 years).

Discussion

Like all studies, this study has several limitations. First, the sample consisted of youths who had set a fire in a large metropolitan area in the Southwest and had attended a fire-setter intervention program. The results of this sample cannot be generalized to all fire setters or even those who were referred to the intervention program and did not attend. This study also did not look at the bullying and victimization of non–fire setters. Second, the self-report nature of the instrument, the PRQ, gave only the perspective of the youths and did not include collateral information from parents or teachers, which may have been helpful. Third, although the sample size was large, this only represents a small portion of the youths involved in fire setting each year. Finally, the questionnaire asked for only basic demographics and the location of the fire but did not ask respondents for details regarding motive, the extent of fire, how the fire was started, or the context of the fire.

Despite these limitations, the current study has the important advantage of examining a unique group. Most previous studies of juvenile bullying have explored the individual and family characteristics of the bullies and the victims, while most previous juvenile fire-setting research explored mental health and behavior problems. Our study explores the intersection between juvenile school fire setting and bullying.

In this decade of school violence, school fire setting is of great concern for school administrators, teachers, staff, parents, and students (Osher et al., 2004). The possibility that one lit match or the flick of a lighter could cause massive school destruction, injury, and loss of life is very real (Federal Emergency Management Agency, 2004). The finding that fire setters are often victimized by bullies contributes new information to the long-recognized connection between fire setting and mental health and behavior problems (Kazdin & Kolko, 1986; Lewis & Yarnell, 1951; Showers & Pickrell, 1987; Stickle & Blechman, 2002). The results of the current study suggest that students who set school fires are more often picked on and made fun of than students who do not set school fires, get called names by others, often feel left out of peer activities, and sometimes stay home from school because they are being bullied.

The results of this study are consistent with the results of Boberg's (2006) exploratory study that found that students set school fires for many reasons, including verbal and physical peer pressure from classmates. The juveniles in Boberg's study reported that they were either verbally or physically coerced into setting school fires rather than setting the school fires because they hated school, were troublemakers, or were mad at other students, teachers, or staff.

Some of the findings from this study, specifically that feeling left out and staying home from school are possible indicators of serious mental health problems including depression, anxiety, and possibly suicidal ideations, should be considered and assessed critically by school social workers to determine the etiology and possible coping strategies of these youths. Fire setting at school may be a reaction to bullying, as the majority of shootings at schools have been found to be (Leary, Kowalski, Smith, & Phillips, 2003). Leary et al. explored the relationship among social ostracism (including bullying and romantic rejection), mental health problems, interest in bombs and guns, and fascination with death/Satanism and school shootings. They found that thirteen of fifteen major school shooting incidents involved social ostracism. The link between social ostracism, specifically victimization by bullies, and juvenile fire setting should be further studied with the goal of preventing major fire incidents resulting in injury and death in educational communities.

Future training of school professionals to recognize the characteristics of juvenile fire setters may decrease the likelihood of a major school fire disaster and may allow school social workers to intervene before a fire is set. This study has implications for two areas of school social work: violence prevention and bullying prevention. School social workers have a unique viewpoint and the ability to work with the victims, the bullies, and their families to address the issues and possible outcomes of peer

victimization (Mishna, 2003). Evidence-based bullying prevention programs have been explored, resulting in a national blueprint program called the Olweus Bullying Prevention Program (Olweus, Limber, & Mihalic, 1998). Possible future research could support the addition of features regarding victimization by bullies and school fire-setting behavior to this blueprint program.

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APPENDIX D

ADD AND FIRESETTING: THE CONNECTION

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ADD and Firesetting: The Connection

by

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When children play with fire the results can be devastating, impacting their families and their communities as well as the children themselves. According to United States Fire Administration statistics, playing with fire is the leading cause of death for preschoolers and the second leading cause of accidental death for 5- to 14-year-old children in the United States.

In order to more effectively address this deadly problem, fire departments across the country have established juvenile firesetter intervention programs. Of the juveniles referred to these programs, higher percentages have ADD and other learning disabilities than are seen in the general population. Agencies in San Diego County, California are documenting that 20-40% of the juveniles who participate in their programs have been diagnosed with ADD or exceed the criteria described in DSM IV. Many interventionists suspect that the numbers are even higher. Why so many?

It appears that specific character traits common among kids with ADD and other learning disabilities can contribute to a child's interest in fire, including:

Impulsivity-- Children who are highly impulsive tend to be unable to consider the consequences of their actions as quickly as they are able to act. They discover the matches or lighter and start a fire without realizing what the outcome may be.

Risk taking-- Children who take risks crave that "adrenaline rush" and actively seek out activities and situations that can bring it on. Fire can offer the "ultimate" risk.

Hyperactivity-- Children who are excessively active are so driven to physically move that they have their hands on matches or lighters and are using them, almost in a single action. The drive to move overwhelms the opportunity to think.

High intelligence-- Children who are usually very bright and tremendously interested in the world around them often play with fire. Fire is fascinating and offers intellectual stimulation through experimentation.

Learning styles-- Children who "learn by doing" are curious about fire. Merely hearing that fire is dangerous does not mean as much to them as handling it and seeing what it can do in their own hands.

Difficulty retaining information-- Children who can be easily distracted and are very involved with multiple thoughts can forget previous experiences or lessons more easily. Memory problems can be inconsistent, depending on the situation and interest level.

Weak social skills-- Children who have trouble making and keeping friends often use poor judgment. Their impulsivity means saying hurtful things without thinking first. Difficulty focusing means that they miss important social clues. As a result, they desperately try to make friends, often with children who can be negative influences and they can be especially vulnerable to peer pressure in order to be accepted. Setting a fire may be another child's idea, but the child who is eager to please may agree to set a fire without considering the consequences to his own life.

Depression and other associated problems-- Being misunderstood by family, school teachers, and others, while not knowing themselves and why they do what they do, can lead to depression and anger in children. Learning disabilities and/or ADHD left undiagnosed can put success in the classroom even further out of reach. Low self-esteem and other emotional difficulties can be inevitable. Unable to express their feelings, the depression and anger can lead to self-and property-destructive behaviors. Also, the control they feel they have over fire seems to compensate for the lack of control they feel in their life.

What can a parent do for a child with ADD who plays with fire?

Acknowledge the problem-- While firesetting is serious, in fact, deadly serious, we often need to look at it as a symptom of other problems. Discovering that a child is playing with fire is no time to look the other way. It can be the opportunity to assess what is happening or not happening in the child's life.

If the parent has not done so already, **the local fire department should be contacted** and asked if they have a program for children who play with fire, staffed by persons who understand ADD and other learning disabilities. If not, a qualified mental health professional should be located.

Medical professionals should be consulted to rule out other health problems and for treatment options, making sure that the professional knows about the firesetting behavior.

All matches and lighters must be locked up. Smoke detectors should be installed in each bedroom and tested to make sure that they are working. Children with an interest in fire need constant, close supervision; necessary arrangements should be made to assure that it's available.

If he or she is mentally and physically capable, **the child can be allowed to use matches/lighters in appropriate situations**, like lighting candles or campfires, but only under close adult supervision. More importantly, the child's help should be enlisted to hunt for fire hazards around the home and act as a home "fire marshal" to heighten fire safety interest.

Children with ADD should be involved in other activities that they can enjoy to stay busy and fulfill the need for physical activity and risk taking. Sports, skateboarding, bicycle motocross racing and karate are just a few options.

Keep in mind that the best approach to ADD is often three-fold: behavior modification, counseling and medication.

- **Behavior modification:** Behavior modification requires a thorough understanding of how ADD works and what works most effectively for a specific child. It takes patience, consistency and structure in a loving atmosphere.

- **Counseling:** In addition to being depressed and angry, a child with ADD and/or other learning disabilities can have low self-esteem and difficulty expressing feelings. Children should be allowed the opportunity to meet regularly with a mental health professional who understands and can help a child cope with those feelings. Parents involved in the counseling process can be given the tools needed to better assist their children.

- **Medication:** Medication often has a bad reputation among those who do not understand how it works, and yet it is the most consistently effective way to help most children whose lives are impacted by their ADD. Dosage, unfortunately, may need to be adjusted several times to achieve the best possible effect. Ritalin is the most commonly prescribed medication and one of the safest drugs around, but if it proves unsuccessful, one of a variety of other medications is likely to work in its place. It's important to resolve that when impulsivity and other ADD characteristics are driving out-of-control fireplay and firesetting, medication should be seriously considered in order to protect the firesetter and his family.

If a child is not succeeding in school, testing should be requested in writing and, if indicated, an individualized education plan (IEP) initiated to determine what assistance can be provided. An effective IEP can be vital for assuring the school success that leads to improved self esteem. Within the scope of an IEP, a behavior intervention plan or mental health intervention as well as support for the family should be provided by the school if indicated.

Discipline as needed:

ADD and learning disabilities are not an excuse; even a child with special needs is still responsible for his actions and should be disciplined to discourage further fireplay. But discipline should be:

- **Immediate--** Waiting until Dad gets home or until there is time to take action means that the child is less likely to associate his misbehaving with the consequences. If too upset with the behavior and likely to overreact, however; time should be taken to withdraw and calm down or have someone else handle the situation.

- **Short term--** A child with learning disabilities or ADHD can forget the reason he's being punished if the consequences go on too long. Being put on restriction for several hours or for the weekend can be effective, but for a month or more is non-productive and can fuel an already frustrated child's anger.

- **Appropriate--** Being different because of learning disabilities and impulsivity problems causes enough shame for many children. Degrading the child further is not productive. Discipline should not be demeaning or humiliating, but educational and administered only in love.

Reward positive behavior:

- Parents and teachers should look for the positive things a child does, including any efforts toward changing a problem behavior.

- A child should be praised when he or she immediately hands matches/lighters to an adult or pursues other, non-fire related interests.

- Carefully limited opportunities should be provided to show responsibility and earn further praise

Unfortunately, there is no way to guarantee that any approach will end a child's firesetting behavior, but it is too important to give up on or ignore. A child who continues to play with fire needs the continuing support of his family, his school, and the community in order to re-direct his life.

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APPENDIX E

10 MOST VIOLENT GAMES NAMED

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10 MOST VIOLENT GAMES NAMED

Family Media Guide ranks the goriest games of the year; Resident Evil 4, GTA, 50 Cent make list.

Resident Evil 4. Grand Theft Auto: San Andreas. God of War. It might read like a list of Game of the Year nominees, but it's actually a sampling of games from Family Media Guide's recently released Top 10 Most Violent Video Games list.

Based on content assessments provided by sister company PSVratings, the parent watchdog group Family Media Guide released the list of titles on Thanksgiving, at the start of the holiday shopping season, stating that "this year, some of the most ultra violent video games ever created are being made available." While the 10 titles were all a cut (and probably a kick, and perhaps a stabbing) above the rest in terms of violent content, the group did not put their top 10 in any specific order of odiousness.

Not everyone agrees with the appropriateness of the titles on the list. For instance, Australia's Office of Film and Literature Classification refused to classify 50 Cent: Bulletproof, effectively banning the game in the country and suggesting it isn't appropriate for anyone. 50 Cent himself, on the other hand, went on the record last week saying that parents could use his game as a teaching tool for their children.

The 10 games named by Family Media Guide and the reasons given for their inclusions are as follows:

Resident Evil 4--"Player is a Special Forces agent sent to recover the President's kidnaped daughter. During the first minutes of play, it's possible to find the corpse of a woman pinned up on a wall--by a pitchfork through her face."

Grand Theft Auto: San Andreas--"Player is a young man working with gangs to gain respect. His mission includes murder, theft, and destruction on every imaginable level. Player recovers his health by visiting prostitutes then recovers funds by beating them to death and taking their money. Player can wreak as much havoc as he likes without progressing through the game's story line."

God of War--"Player becomes a ruthless warrior, seeking revenge against the gods who tricked him into murdering his own family. Prisoners are burned alive and player can use 'finishing moves' to kill opponents, like tearing a victim in half."

NARC--"Player can choose between two narcotics agents attempting to take a dangerous drug off the streets and shut down the KRAK cartel while being subject to temptations including drugs and money. To enhance abilities, player takes drugs including pot, Quaaludes, ecstasy, LSD, and 'Liquid Soul'--which provides the ability to kick enemies' heads off."

Killer 7--"Player takes control of seven assassins who must combine skills to defeat a band of suicidal, monstrous terrorists. The game eventually escalates into a global conflict between the US and Japan. Player collects the blood of fallen victims to heal himself and must slit his own wrists to spray blood to find hidden passages."

The Warriors--"Based on a '70s action flick that set new standards for 'artistic violence,' a street gang battles its way across NYC in an attempt to reach its home turf. Player issues several commands to his gang, including 'mayhem,' which causes the gang to smash everything in sight."

50 Cent: Bulletproof--"Game is loosely based on the gangster lifestyle of rapper Curtis '50 Cent' Jackson. Player engages in gangster shoot outs and loots the bodies of victims to buy new 50 Cent recordings and music videos."

Crime Life: Gang Wars--"Player is the leader of a ruthless street gang, spending time fighting, recruiting new gangsters, looting, and of course, more fighting. Player can roam the streets and fight or kill anyone in sight for no apparent reason."

Condemned: Criminal Origins--"Player is an FBI serial killer hunter in one of the first titles for the Xbox 360. Game emphasizes the use of melee weapons over firearms, allowing players to use virtually any part of their environment as a weapon. The next-generation graphics provide a new level of detail to various injuries, especially 'finishing moves'."

True Crime: New York City--"Player is a NYC cop looking for information regarding the mysterious death of a friend. Player can plant evidence on civilians and shake them down to earn extra money."

By Brendan Sinclair -- GameSpot

Posted Nov 28, 2005 3:27 PM PT

UNIT 3: IDENTIFICATION, INTAKE, SCREENING, DISPOSITION AND FOLLOW-UP

TERMINAL OBJECTIVE

The students will be able to:

3.1 Explain intervention options to mitigate youth firesetting behavior.

ENABLING OBJECTIVES

The students will be able to:

3.1 Determine sources to identify youth firesetters.

3.2 Identify necessary and effective intake procedures.

3.3 Describe the potential impact of cognitive, behavioral and learning disabilities.

3.4 Summarize the youth firesetting screening process.

3.5 Discuss the components of a screening tool.

3.6 Characterize the components of an effective screening environment.

3.7 Illustrate how to conduct a screening.

3.8 Define levels of firesetting risks.

3.9 Discuss potential intervention options for firesetters and families.

3.10 Given a screening form and case studies, determine firesetting risk levels and recommend appropriate intervention options.

3.11 Describe how to perform follow-up activities to assess impact of program services.

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UNIT 3: IDENTIFICATION, INTAKE, SCREENING, DISPOSITION AND FOLLOW-UP

Slide 3-1

ENABLING OBJECTIVES

- Determine sources to identify youth firesetters.
- Identify necessary and effective intake procedures.
- Describe the potential impact of cognitive, behavioral and learning disabilities.
- Summarize the youth firesetting screening process.

Slide 3-2

ENABLING OBJECTIVES (cont'd)

- Discuss the components of a screening tool.
- Characterize the components of an effective screening environment.
- Illustrate how to conduct a screening.
- Define levels of firesetting risks.
- Discuss potential intervention options for firesetters and families.

Slide 3-3

ENABLING OBJECTIVES (cont'd)

- Given a screening form and case studies, determine firesetting risk levels and recommend appropriate intervention options.
- Describe how to perform follow-up activities to assess impact of program services.

Slide 3-4

I. INTRODUCTION

INTRODUCTION

Five components of a Youth Firesetting Prevention and Intervention (YFPI) program:

- Identification.
- Intake process.
- Screening process.
- Intervention strategies.
- Follow-up.

Slide 3-5

A. When a child or youth is suspected of firesetting behavior, and/or a fire results from the actions of a child or youth, identification and intake procedures should be initiated.

B. Once juveniles and their families are identified, decisions are made regarding a course of action.

C. All youth firesetting intervention programs should be supported by an interdisciplinary team.

D. The interdisciplinary team is a broad-based multiagency partnership that works collaboratively to address youth firesetting cases and recommend/deliver appropriate intervention strategies.

E. There are five components of this process:

1. Identification.

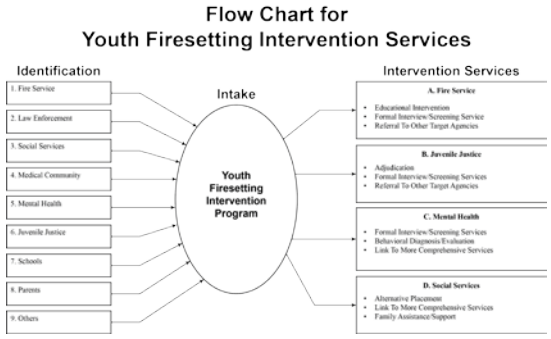
2. Intake.

3. Screening.

4. Intervention strategy(s).

5. Follow-up.

INTRODUCTION (cont'd)



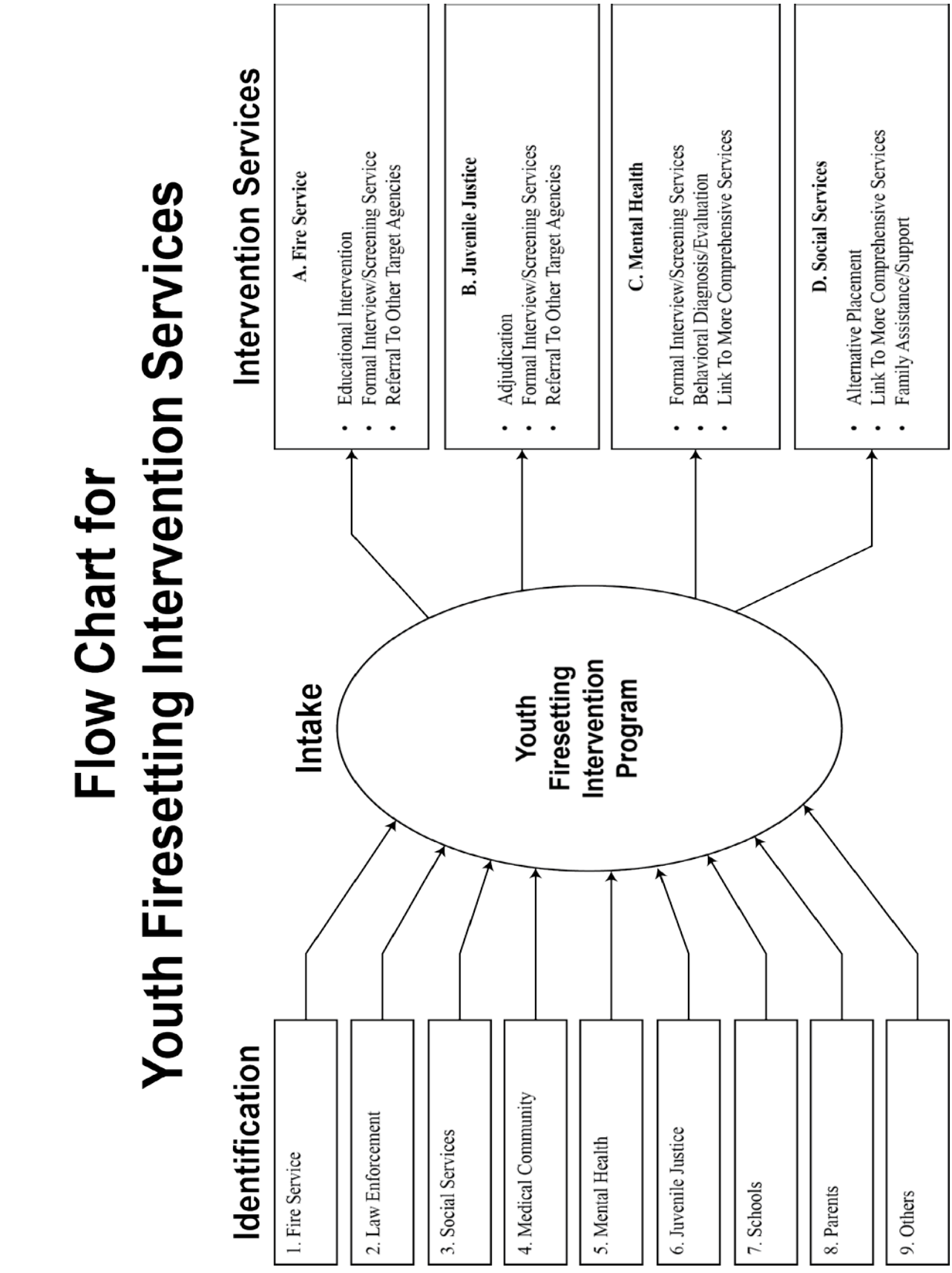
F. Once a youth firesetter has been identified:

1. Intake procedures should begin.

2. Shortly thereafter, a screening process is conducted.

3. This process is followed by disposition of which intervention strategy to initiate.

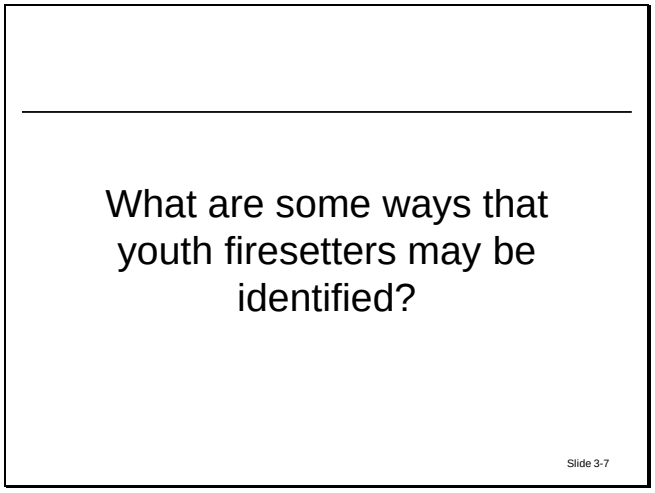
4. Once interventions have been conducted, follow-up to program services should occur.


Flow Chart for
Youth Firesetting Intervention Services
Identification
1. Fire Service
2. Law Enforcement
3. Social Services
4. Medical Community
5. Mental Health
6. Juvenile Justice
7. Schools
8. Parents
9. Others
Intake
Youth Firesetting Intervention Program
Intervention Services
A. Fire Service
Educational Intervention
Formal Interview/Screening Service
Referral To Other Target Agencies
B. Juvenile Justice
Adjudication
Formal Interview/Screening Services
Referral To Other Target Agencies
C. Mental Health
Formal Interview/Screening Services
Behavioral Diagnosis/Evaluation
Link To More Comprehensive Services
D. Social Services
Alternative Placement
Link To More Comprehensive Services
Family Assistance/Support

II. IDENTIFICATION OF YOUTH FIRESETTERS

A. Youth firesetters can be identified in a number of ways.

B. The earlier the identification is initiated, the better the chances of a successful intervention.



C. There are multiple ways children involved in fire incidents come to the attention of a youth firesetting program:

1. Parents/Caregivers.

   a. Adults may discover telltale signs such as burned items found in the youth's bedroom or in or around the home. These items may include toys, carpeting and furniture.

   b. Parents/Caregivers may call the local fire department for advice.

2. Schools.

   a. A school experiencing a series of trash can fires or other small fires identifies one or more youth involved in the incidents and contacts the fire service for assistance.

   b. Other resources to utilize within the school include the school resource officer (SRO) and/or guidance counselor.

3. Law enforcement, juvenile justice, courts and attorneys.

   a. A youth may be referred to the program by an agency in conjunction with (or in lieu of) formal adjudication proceedings.

b. Arson Hot Lines, Crime Stoppers, and other mediums may be used as well.

4. Mental health agencies.

   Clinical agencies and/or private practitioners may refer a client and his or her family after learning that firesetting behaviors have occurred.

5. Social and child protective services.

   Agencies that advocate for (or require) the well-being of youth may initiate (or require) a referral to the program.

6. Fire service.

   Fire service personnel during fire suppression and investigation procedures may identify youth firesetters.

   a. Immediately after suppression, most fire departments conduct an origin-and-cause investigation.

   b. The purpose of an origin-and-cause investigation is to determine the origin (i.e., where the fire started), cause (i.e., how the fire started), and more specifically, what event brought the heat, fuel and oxygen together to cause the incident.

   c. This information is gathered by:

      - Talking with firefighters at the fire scene.

      - Reviewing physical evidence at the fire.

      - Interviewing witnesses.

   d. Agencies frequently gather information using a witness-driven protocol. This protocol drives a successful investigation by gathering information such as:

      - Who was the last person in the area?

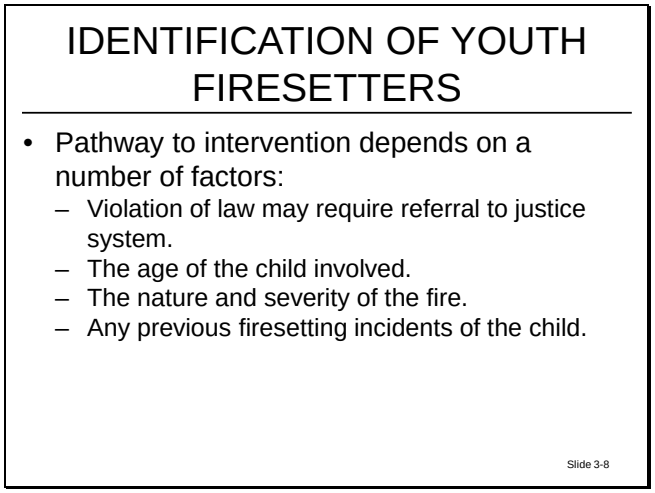
      - What did firefighters or police officers see when they arrived on the scene, etc.?

   e. A complete and thorough origin-and-cause investigation will reveal if a child or juvenile is involved in a fire.

f. Fire investigators often provide referrals to a Youth Firesetting Prevention and Intervention (YFPI) program.

g. A youth firesetter's fire-related activities may be made known through the investigator's report and/or the youth's own admission.

D. Factors to consider during the identification process.



Once a firesetter has been identified, the pathway to intervention depends on a number of factors:

1. If there is a violation of local, state or federal law, mandates may require immediate referral to the local justice system.

2. The age of the child or youth involved must be considered.

   a. Age of accountability is the minimum age at which state courts have ruled that a child is intellectually capable of understanding right from wrong and the consequences associated with inappropriate behavior (International Fire Service Training Association (IFSTA), 2010).

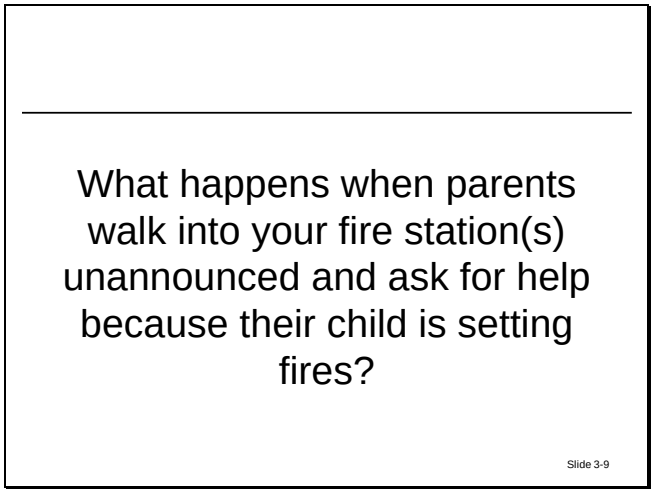
   b. Depending upon the state, the age of accountability may vary, but for most places this age is between seven and nine, though it can be as old as 12. It is the responsibility of program personnel to ensure that they are familiar with their state's age of accountability.

3. The nature and severity of the fire needs to be considered. Those firesetting acts that result in a large dollar loss and/or a loss of life may, by need or requirement, be referred to the juvenile justice system before any firesetting intervention takes place.

4. The firesetting history of the juvenile should be explored. Many YFPI programs have strict guidelines on disposition of first-time versus repeat firesetters.

5. It is essential that all personnel who have potential to interact with a youth firesetter and his or her family have basic understanding of the standard operating procedures (SOPs) or standard operating guidelines (SOGs) of the YFPI program.

   This is very important, especially when a parent or caregiver walks into a fire or police station asking for help with addressing a youth firesetting incident/situation.



6. Having a predetermined strategy will help ensure that rapid and reliable assistance is provided to all families in need of program services.

III. INTAKE PROCESS

A. Once a child or youth has been identified, whether through a parent/caregiver, community agency or fire department contact, there must be a mechanism in place to formally initiate the involvement and participation in the youth firesetting intervention program.

INTAKE PROCESS

- The intake process involves collecting initial information about the youth firesetter, his or her family, and the incident(s) that brought the youth to the program (National Fire Protection Association (NFPA), 2010).

Slide 3-10

B. Intake is defined as the process of collecting initial information about the youth firesetter, his or her family, and the incident(s) that brought the youth to the program (National Fire Protection Association (NFPA), 2010).

INTAKE PROCESS (cont'd)

- A firesetting intervention program must have a consistent and reliable intake process.
  - What to do when a parent/caregiver asks for help.
  - How to process a request for service from a partner agency.
  - How to contact and obtain information from a family after a fire incident has occurred.

Slide 3-11

C. A firesetting intervention program must have a consistent and reliable intake process. This includes protocol on the following:

1. What to do when a parent/caregiver asks for help.
2. How to process a request for service from a partner agency.
3. How to contact and obtain information from a family after a fire incident has occurred.

INTAKE PROCESS (cont'd)

- Intake forms should be used for each referral or complaint of youth firesetting behavior.
- Gather basic information about the youth, his or her family, and the fire event/situation that led to the program referral.

Slide 3-12

D. Intake forms should be used for each referral or complaint of youth firesetting behavior. The form should be standardized for the jurisdiction and designed to gather basic information about the youth, his or her family, and the fire event/ situation that led to the program referral.

E. All staff members who may perform intake duties must be provided with the training and tools to perform this important aspect of the program.

F. Depending on available resources and program protocol, the intake process may be handled by firefighters on a scene, a fire investigator, a receptionist/ administrative assistant or a member of the youth firesetting intervention program team.

INTAKE PROCESS (cont'd)

- Process must include:
  - Points of entry.
  - Reasonable response time.
  - Available contact person/people.
  - Intake forms.
  - Prioritization of cases.

Slide 3-13

G. A successful youth firesetting intervention program must have an intake process that includes the following five basic procedures:

1. Points of entry.

The mediums of how the youth enters the program.

a. Fire service can include suppression staff, investigators, public educators or on-duty station/administrative personnel.

b. Partner agencies can include juvenile justice, social services, mental health, schools or other groups.

c. All personnel from every agency must understand what to do if presented with a firesetting situation and how to initiate (or deliver) the intake component.

d. Some programs train partner agencies to conduct the intake process. Others direct all referrals to the lead agency. This process may vary based upon the lead agency for the interdisciplinary team.

2. Reasonable response time.

Once a firesetter has been identified, there is a significant but short window of opportunity to provide services for these at-risk youth.

a. The best window of opportunity to provide successful intervention is immediately after the fire.

b. The program should establish what contact window of time is appropriate.

c. Ideally, within 48 hours of initial contact, the youth firesetting program should make contact with the youth and his or her family. This may be either in person or by telephone.

- However, in the event of a significant fire that has displaced family, parents/caregivers may not be in the frame of mind to discuss their involvement in the program.

- Firefighters, investigators or program staff should ensure that a family's basic needs are being met. That includes shelter, food and clothing.

- Showing empathy toward a family that has suffered a loss often extends the window of opportunity to provide information about the program.

d. Caution, there must be a balance between compassion, care for the family, and persistence that action about the youth firesetting situation needs to occur in a timely manner.

e. Once a fire crisis has subsided, parents/caregivers may be reluctant to follow-through with fire intervention and education for their child.

According to data compiled from 1995-2005 by the Massachusetts Coalition for Youth Firesetting Intervention Program, only 1 out of 5 youth, who were voluntarily referred to a juvenile fire program, actually attended Day 1 of the program.

f. Depending upon the jurisdiction and the design of the program, it is up to the youth firesetting intervention program personnel to make contact with the family and encourage their participation.

3. Contact person/people.

Intake personnel and their availability must be identified.

a. Who in the program will be responsible for taking requests for service and/or contacting families?

b. Will there be more than one person available to initiate the contact?

c. There is a range of options; some programs have one contact person assigned per day, while others have one contact person available on a half-time basis or on call.

4. Intake forms.

Intake forms may be written or electronic and must be established for each case. A fire incident form should be attached to the intake form if it is available (if the referral is through an actual fire response).

5. Prioritization of cases.

Methods must be in place for responding to urgent cases that require a more rapid intervention.

ACTIVITY 3.1

Intake Instrument Review

Purpose

To review intake instruments presently in use and identify pertinent information needed by youth firesetting program personnel.

Directions

1. In your table groups, review the intake forms located in Appendix A, B and C (Firestoppers Intake Form, King County, Washington; Juvenile Firesetting Prevention Program Intake Form, State of Colorado; and Youth Firesetting Intervention Program Intake Forms, Glendale, Arizona).

2. After reviewing all three forms, each table group should identify pertinent information that should be included on an intake form. Ten minutes are allotted for the tasks listed above.

3. Once your groups have completed their discussions, you should be prepared to share with the class and justify your decision. Ten minutes are allotted for sharing.

Note: This activity is **not** intended to be a critique session on intake forms. It is simply an opportunity to review what is commonly found on a form and make suggestions on pertinent content that could be included.

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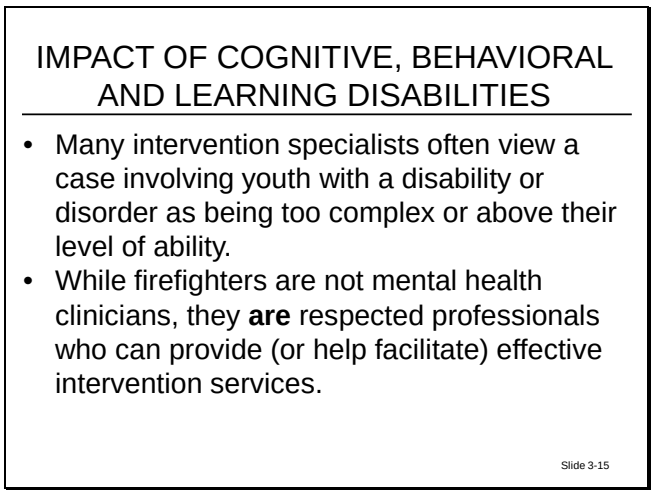
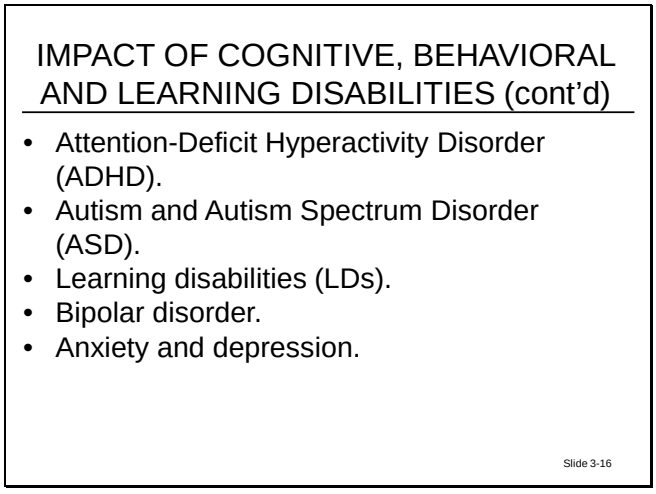
IV. UNDERSTANDING THE IMPACT OF COGNITIVE, BEHAVIORAL AND LEARNING DISABILITIES

A. Knowledge provides us with abilities to help others.



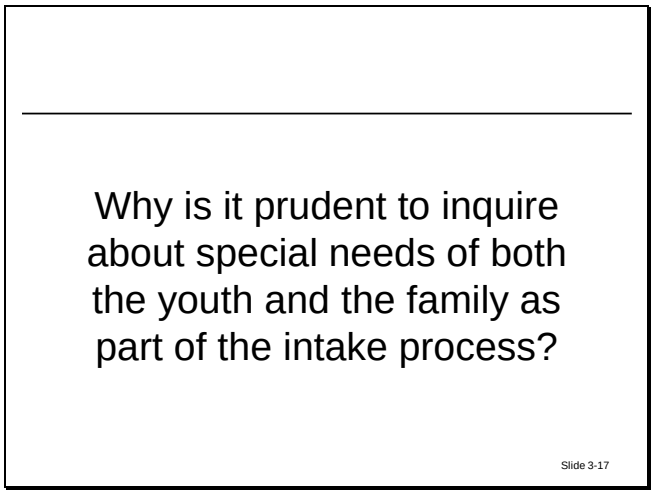
1. Many firesetting intervention specialists often view a case that involves a youth who is challenged by one or more cognitive, behavioral and/or learning disabilities or disorders as being too complex and above their level of ability to provide successful intervention.

2. While firefighters, investigators, police officers and public educators are not mental health clinicians, they are respected professionals who (with education) can provide effective intervention services that involve their respective domain of expertise.



3. Every intervention specialist should understand how cognitive, behavioral and/or learning disabilities can require them to modify service delivery strategies so a positive outcome is achieved.

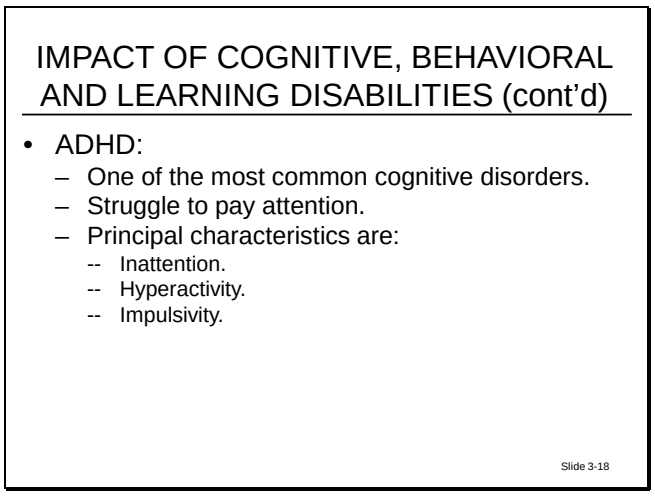
4. The culminating readings of Unit 2 presented an overview of several of the most common disorders that firesetting intervention specialists may encounter.



5. Understanding the nuances of a particular mental health disorder or learning disability (LD) will make the design and implementation of interventions more effective.

6. Program personnel need to understand how the disorder or disability may impact the youth/family and be able to speak knowledgeably about the implications of the diagnosis as it relates to firesetting behavior.

7. In addition, mental health practitioners may make referrals to the program. Having a basic understanding of the various common special needs enhances both communication ability and credibility of the firesetting intervention specialist.



B. Attention-Deficit Hyperactivity Disorder (ADHD).

1. ADHD is one of the most common cognitive disorders that develops in children.

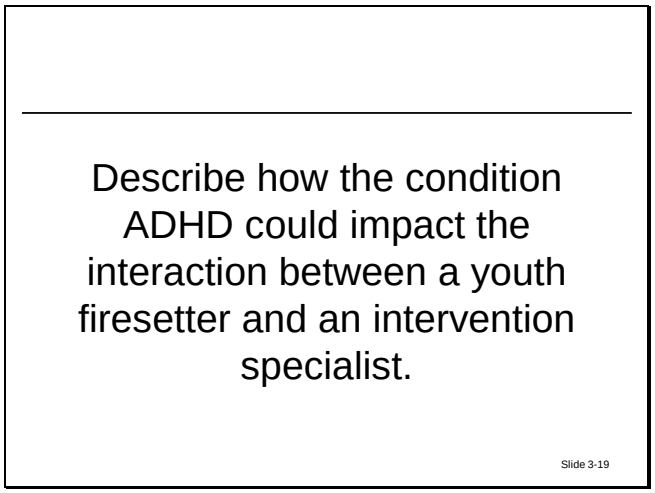
2. Children with ADHD often struggle to pay attention and/or control their behavior.

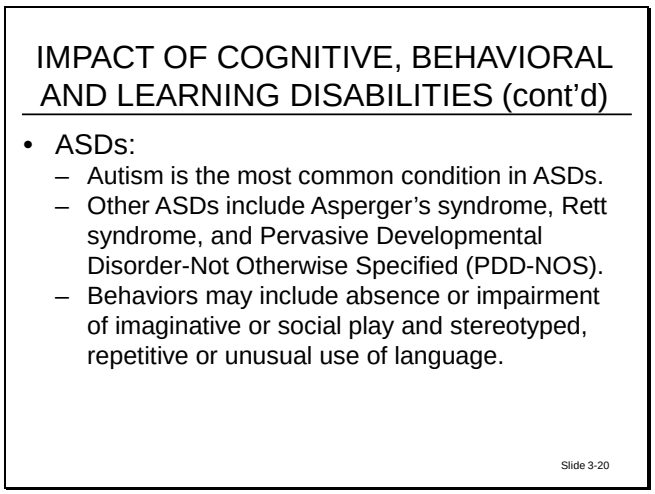
3. The principal characteristics of ADHD are inattention, hyperactivity and impulsivity.

    a. Children who are inattentive have a hard time keeping their minds on any one thing. They may get bored with a task after only a few minutes.

    b. Hyperactive children always seem to be "on the go" or constantly in motion. They may dash around touching or playing with whatever is in sight or talk incessantly.

    c. Impulsive children seem unable to curb their immediate reactions or think before they act. They will often blurt out inappropriate comments, display their emotions without restraint, and act without regard for the later consequences of their conduct.





C. Autism and Autism Spectrum Disorders (ASDs).

1. Autism is the most common condition in a group of developmental disorders known as ASDs.

2. Autism is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive, or severely limited activities and interests.

3. Other ASDs include Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (usually referred to as PDD-NOS).

4. Autism is a complex disorder. A comprehensive evaluation requires a multidisciplinary team including a psychologist, neurologist, psychiatrist, speech therapist, and other professionals who diagnose children with ASDs.

5. Doctors rely on a core group of behaviors to alert them to the possibility of a diagnosis of autism. These behaviors include:

   a. Impaired ability to initiate or sustain a conversation with others.

   b. Absence or impairment of imaginative and social play and stereotyped, repetitive or unusual use of language.

   c. Preoccupation with certain objects or subjects.

Describe the potential dangers associated with a youth firesetter who has an ASD and has "developed a focus" on fire.

Slide 3-21

IMPACT OF COGNITIVE, BEHAVIORAL AND LEARNING DISABILITIES (cont'd)

- LDs:
  - A mental health disorder and learning disability are not the same.
  - LD is a disorder that diminishes a person's capacity to interpret what he or she sees/hears.
  - Many children are **not** diagnosed unless the condition is severe.

Slide 3-22

D. LDs.

1. A mental health disorder and LD are **not** the same.

2. An LD is a disorder that diminishes a person's capacity to interpret what he or she sees and hears, and/or to link information from different parts of the brain.

3. If a person is unable to process information being presented, learning (or behavior change) will not occur.

4. In school age children, reading or spelling disabilities, writing, and arithmetic challenges may appear. A type of reading disorder, dyslexia, is quite widespread. Reading disabilities affect up to 8 percent of elementary school children.

5. An LD (now referred to as "a learning difference") is a learning problem in a school environment often regarding perception, comprehension and interpretation. (These vary with teaching styles and learning modalities.)

6. U.S. schools are basically two dimensional learning environments, where most children with "disabilities" are three dimensional learners.

7. If an LD is unrecognized and not addressed by providing education in a way the child can learn, the child can become discouraged and fail in school, and the lack of success and understanding can cause acting out and anti-social behavior.

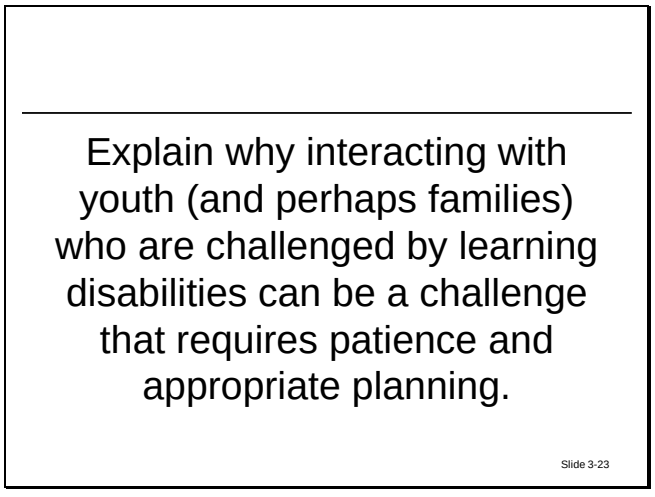
8. Many children who have learning differences are not diagnosed unless the condition is severe. The children may be thought to be "not very smart," "a behavior problem," anxious, depressed, etc.

9. These children and parents/caregivers try to cope with something they, themselves, cannot understand.

10. Children who attend public/private schools and are challenged by a cognitive, behavioral or LD or disorder will often have their own prescribed Individual Education Plan (IEP).

11. An IEP is a plan developed by a team of educational professionals to help the challenged student perform at a higher level. It often includes strategies of how to best address the student's disability or disorder.

12. Inquiring about the presence of such a plan can help the youth firesetting intervention specialist identify key partners within the local school environment who may be able to assist with intervention recommendations and perhaps offer supportive services.



IMPACT OF COGNITIVE, BEHAVIORAL AND LEARNING DISABILITIES (cont'd)

- Bipolar disorder:
  - Characterized by mood cycling between periods of intense highs and lows.
  - Youth with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes."
  - These mood episodes can result in damaged relationships, poor school performance, and even suicide.

Slide 3-24

E. Bipolar disorder.

1. In its classic form, bipolar disorder is characterized by mood cycling between periods of intense highs and lows.

2. In children, bipolar disorder often seems to be a rather chronic mood disregulation with a mixture of elation, depression and irritability.

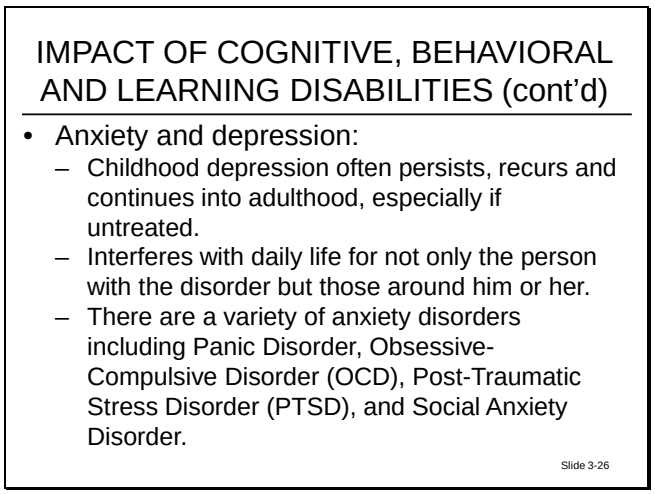
3. Youth with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes."

4. People with bipolar disorder also may be explosive and irritable during a mood episode.

5. These mood episodes are different from the normal ups and downs that everyone goes through from time to time. They can result in damaged relationships, poor school performance, and even suicide.

How might you interact with an adolescent male firesetter and his mother who are both challenged by bipolar disorders?

Slide 3-25



F. Anxiety and depression.

1. Doctors have begun to take seriously the risk of depression in children. Research has shown that childhood depression often persists, recurs and continues into adulthood, especially if it goes untreated.

2. Anxiety disorders commonly occur along with other mental or physical illnesses, including alcohol or substance abuse, which may mask anxiety symptoms or make them worse. In some cases, these other illnesses need to be treated before a person will respond to treatment for the anxiety disorder.

3. When a person has a depressive and/or anxiety disorder, it interferes with daily life, normal functioning, and it causes pain for both the person with the disorder and those who care about him or her.

4. There are a variety of anxiety disorders, including but not limited to:

   a. Panic Disorder.

   b. Obsessive-Compulsive Disorder (OCD).

   c. Post-Traumatic Stress Disorder (PTSD).

   d. Social Anxiety Disorder.

IMPACT OF COGNITIVE, BEHAVIORAL AND LEARNING DISABILITIES (cont'd)

– There are also multiple types of depression including Major Depressive Disorder, Dysthymic Disorder, Psychotic Depression, and Seasonal Affective Disorder.

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5. The same is true with depression. Types include:

   a. Major Depressive Disorder.

   b. Dysthymic Disorder.

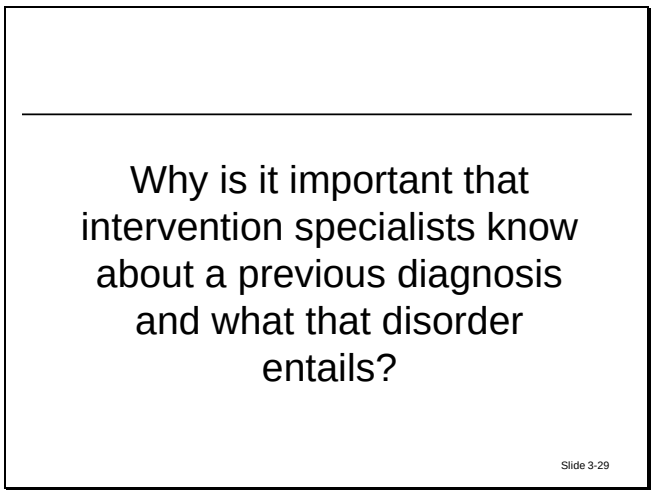
   c. Psychotic Depression.

   d. Seasonal Affective Disorder.

How might an anxiety disorder contribute to the occurrence of a youth firesetting situation?

What are the implications of these various disorders for intervention specialists?

Slide 3-28



G. Implications for intervention specialists.

1. Intervention specialists need to have knowledge about the various disorders that may affect a youth firesetter for the following reasons:

   a. Provide insight on how to best communicate with the firesetter and his or her family.

   b. Consider how the disorder may impact the risk of recidivism (future firesetting).

2. Program personnel must be able to relate the characteristics of the child and his or her disorder into the screening and intervention process.

3. Program personnel do not have to be experts on cognitive, behavioral and LDs.

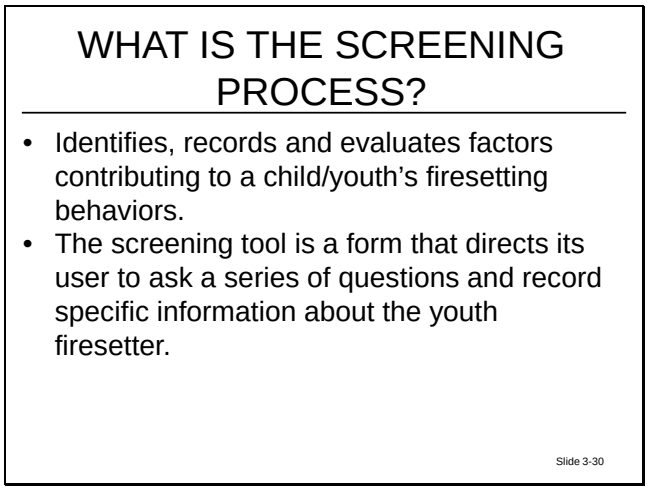
   However, having a basic understanding of these disabilities empowers the intervention specialist with knowledge to better communicate with those who request and are delivering program services.

4. If a potential participant in the firesetting intervention program has a disability or disorder, program personnel should consult the mental health representative for information concerning the implications for the screening and subsequent intervention process.

   This is why having representation from the mental health community on the youth firesetting program multidisciplinary team is essential.

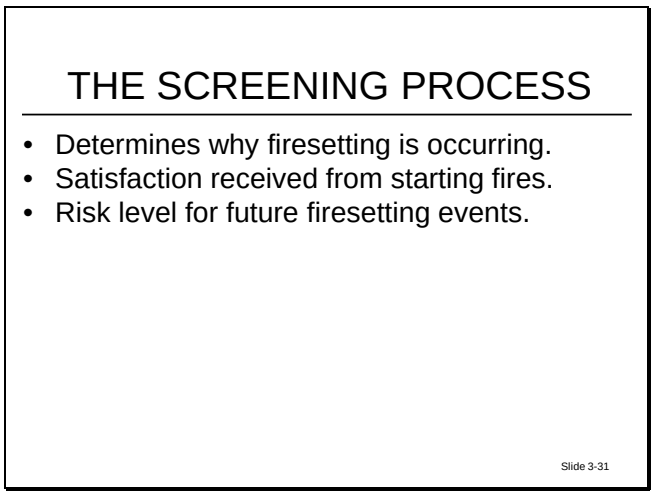
5. Of particular importance to the intervention specialist is the fact that many of these disorders are hereditary. This means that not only will program personnel be dealing with a child that has a particular disorder, but he or she will be working with a family where parents/caregivers or siblings have the same or similar disorder.

V. WHAT IS THE SCREENING PROCESS?

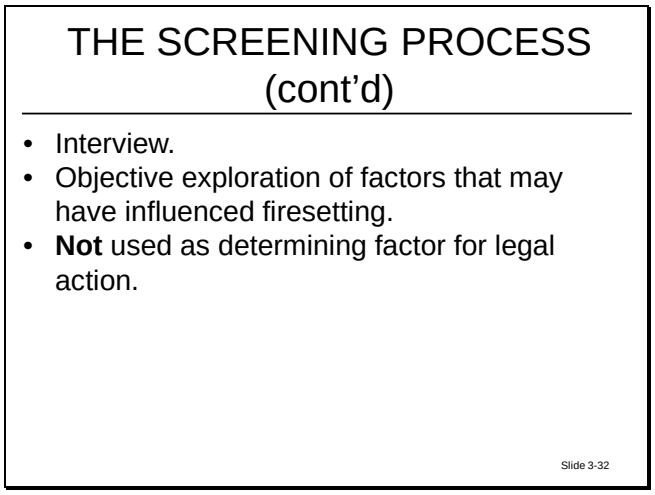


A. Once basic intake information about the youth firesetter, his or her family, and the fire incident(s) has been obtained, the next step is to perform a structured screening process.

1. A structured screening process that uses a valid screening instrument is a statistically reliable way to identify, record and evaluate factors contributing to a child/youth's firesetting behaviors.



2. The ultimate goal of the screening process is to determine why firesetting is occurring, what satisfaction the juvenile receives from starting fires, and the risk level for future firesetting events.



3. The screening process entails interviewing both the firesetter and his or her parents/caregiver(s).

4. The process allows for objective exploration of the factors that may have influenced the firesetting behaviors.

5. It also provides information about attitudes, behaviors, demographics and experiences of the youth/family that may present obstacles to the introduction of appropriate interventions.

6. Use of this process helps the interdisciplinary team understand why firesetting has occurred and what types of intervention to offer.

7. The screening process should occur in a timely manner according to the program protocol directive. Youth firesetting program personnel contact the parents/caregiver(s) to arrange for a screening interview of the firesetter and his or her family.

8. The screening process **should not** be used as a determining factor for legal action.

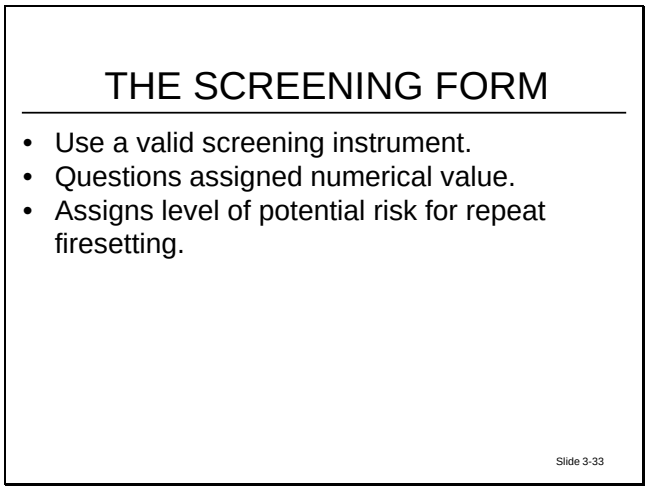
B. The screening tool is a form that directs its user to ask a series of questions and record specific information about the youth firesetter, his or her family, and the incident(s) that occurred.

1. Using an assessment tool, an intervention specialist's level of experience, and his or her education will help lead to a decision on possible intervention options.

2. Responses to the questions are assigned a numerical value and scored as indicated by the form.

3. Once scored, most screening tools assign the level of potential risk for repeat firesetting into one of three categories: some, definite and extreme.

VI. THE SCREENING FORM



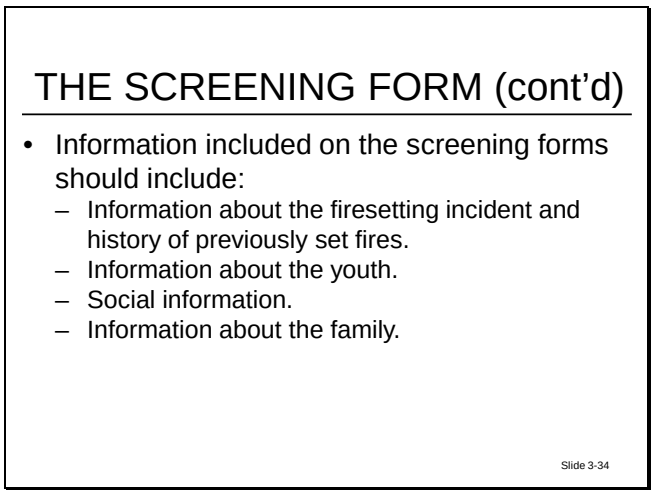
A. There are a variety of forms (screening tools) available that can provide the structure needed for an effective screening.

B. The decision of which form to use rests entirely with the youth firesetting intervention program and will depend on the program's service goals, available resources, and desired outcomes.

C. In order to provide a structured screening process, it is important that program personnel use approved screening forms — one for the child and one for the family.

D. An approved screening form is one that has been adopted and approved by the interdisciplinary team (youth firesetting task force) and the authority having jurisdiction (AHJ).

E. It is important that screening forms are considered to be reliable. While "less may look better," that is not always the case.



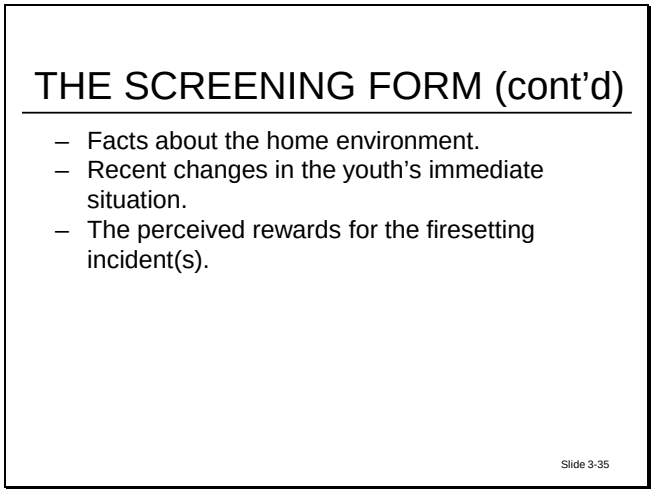
F. Information included on the screening forms should include:

1. Information about the firesetting incident and history of previously set fires.

2. Information about the youth to include medical/mental health history, interests, developmental level, etc.

3. Social information, including behavior of the youth at home, school, with friends, etc.

4. Information about the family to include activities, disciplinary practices, ability to relate with the youth, interest in the youth's welfare, concern for the youth, and supervision of the youth.



5. Facts about the home environment to include youth access to ignition materials, presence of life safety equipment, and knowledge/practice of fire safety.

6. Recent changes in the youth's immediate situation, such as a recent trauma, divorce in the family, death of family members or friend, crisis at school, etc.

7. The screening process may also identify the perceived rewards for the firesetting incident(s), such as peer attention, approval, money or gratification.

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ACTIVITY 3.2

The Screening Form

Purpose

To review a screening tool that is being used by the fire service to make an accurate determination of future risk for repeat firesetting behavior.

Directions

1. Individually, review the Oregon Office of State Fire Marshal Juvenile with Fire Screening Tool that is located in Appendix G. Ten minutes are allotted for Task 1.

2. Next, your instructor will walk you through each component of the screening tool.

Note: It is important to explore the scoring process of the form. Eliminating or changing any of the form's components may alter the scoring process and should be avoided.

Please also note the multiple components of the tool that can be utilized specifically with pertinent age groups. Ten minutes are allotted for Task 2.

3. Examples of other screening tools are located in Appendices D, E and F. You may review these forms after class.

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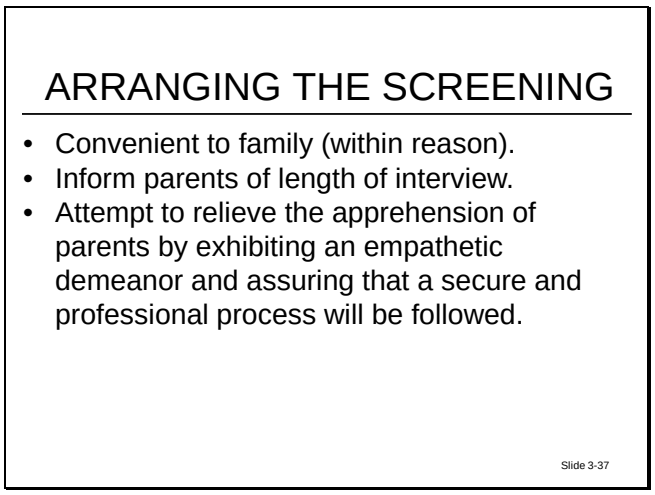
VII. ARRANGING THE SCREENING



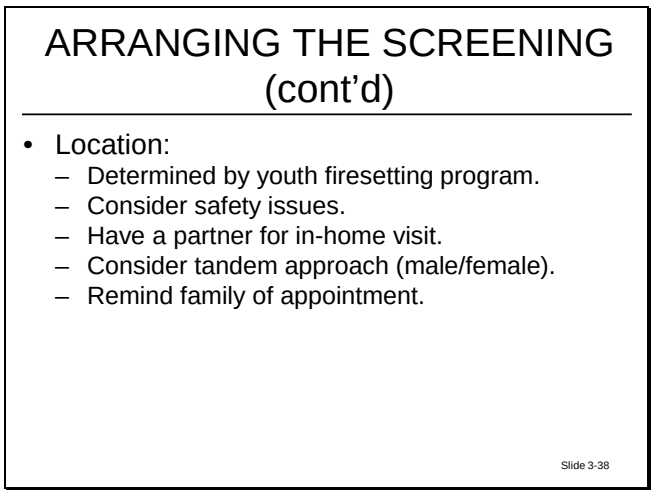
A. Once the intake information has been received (and reviewed) by youth firesetting program personnel, they should arrange for the screening meeting.

B. This meeting should be arranged to occur at a time and place that is convenient for the family and/or caregivers of the youth. Program personnel must recognize that this may have to be during evening or weekend hours depending upon the schedule of the family and the youth.

C. The youth and his or her parents/caregivers should be informed about the amount of time that the screening will encompass. Many may think that it will be a short visit when in fact it may take one to two hours depending on the structure of the screening process.

D. It is important that the screening involve the parents or caregivers of the firesetter, as well as the firesetter. Often parents/caregivers may be apprehensive about the screening process and involvement in the intervention program altogether. Because a firesetting situation is a family issue, parents/caregivers must be involved in the entire process.

E. The intervention specialist can help relieve this apprehension by exhibiting an empathetic demeanor and assuring that a secure and professional process will be followed.



F. Location of the screening.

1. The decision of where to conduct the screening should be in accordance with preapproved directives of the youth firesetting program.

2. Some agency's operating guidelines require interviews to be conducted at the office of the program personnel or at the fire station.

3. Some programs allow for the screening to take place in the home of the firesetter.

   If the agency allows for home visits, program personnel may find this to be very beneficial by observing the youth and/or his or her family in their own environment. It will also help the individuals being interviewed feel more comfortable and potentially provide more information.

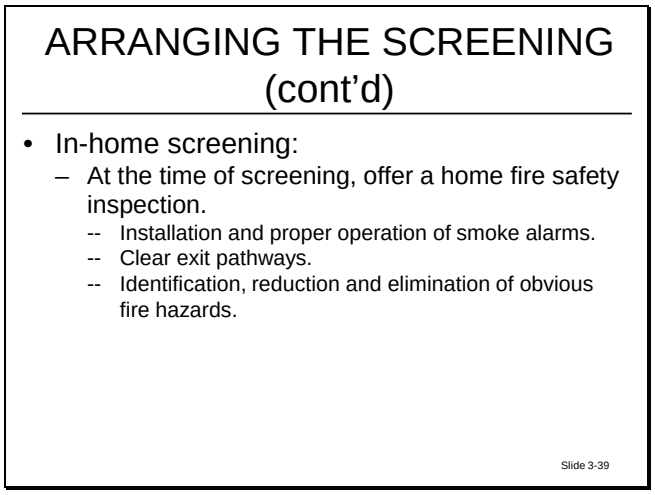
4. If a home visit is chosen, program personnel must consider their own personal safety. Program personnel should go in pairs. It may also be beneficial to have a male and female team.

5. If possible, program personnel should consult their local law enforcement agencies about the safety of the specific neighborhood and call history to the firesetter's home and who may reside there. This action should be taken before agreeing to perform a home visit.

6. Some programs allow fire department personnel to conduct the screenings. Others may call for a fire department representative and a representative from the interdisciplinary team (mental health practitioner, law enforcement representative, etc.).

G. If possible, place a reminder call to the family the day before the interview.

H. If the family fails to show up for the interview (or is not home) at the scheduled time, this should be documented and follow-up actions should be taken to find out why.



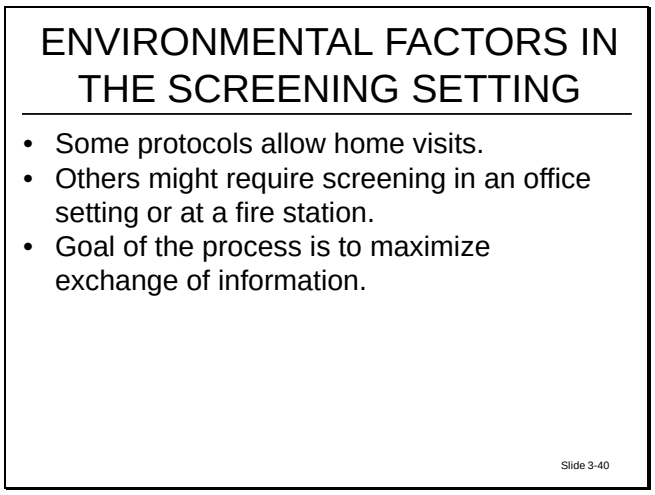
I. If the screening is conducted in the home, and the program personnel feel that it is appropriate, a home fire safety inspection may be conducted with the permission of the parents/caregivers. This is to assure a safe environment. Examples of items to review during a home fire safety inspection include:

1. Installation and proper operation of smoke alarms in each room of the home (except the bathroom and kitchen).

2. Clear exit pathways.

3. Identification, reduction and elimination of obvious fire hazards including properly securing matches and lighters.

VIII. ENVIRONMENTAL FACTORS IN THE SCREENING SETTING



A. Previous information in this unit discussed arranging the location for the screening.

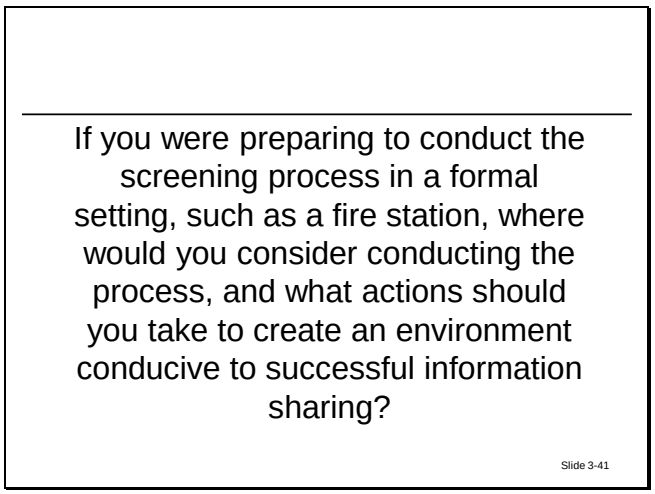
B. Some program protocols may allow home visits, while others might require the screening to take place in an office setting or at a fire station.

C. Regardless of the setting, the screening environment must include a balance between comfort and support for the firesetter and his or her family.

D. The goal of the process is to maximize the exchange of information between the interviewer and the youth/family.

E. In addition, there must be a balance between safety and the mandates established by the AHJ and/or program procedures.

F. The following section provides suggestions for facilitating an environment conducive to information sharing.



1. Formal setting (such as a fire station or office).

   a. Prepare the setting. Be sure that the room ensures privacy.

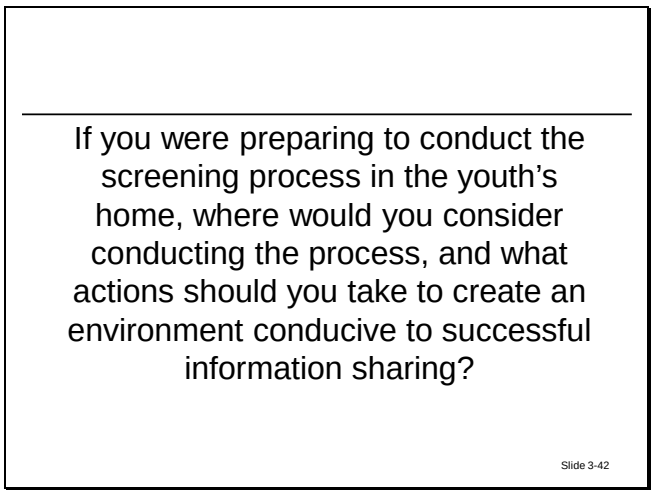
   b. Make sure there are enough chairs for everyone involved.

   c. Try to arrange a comfortable setting.

   d. Remove distractions. Turn off all electronic equipment, scanners, radios, pagers, etc.

   e. Be aware of physical barriers in the room. A semicircular pattern creates an open seating arrangement and facilitates communication.

   f. Since the parents/caregivers screening and the firesetter interviews should take place separately, it is beneficial to have an area where the child or youth can wait on the parents/caregivers. In the case of a small child, there will be the need for someone to stay with the child.



2. Informal setting (such as a family's home).

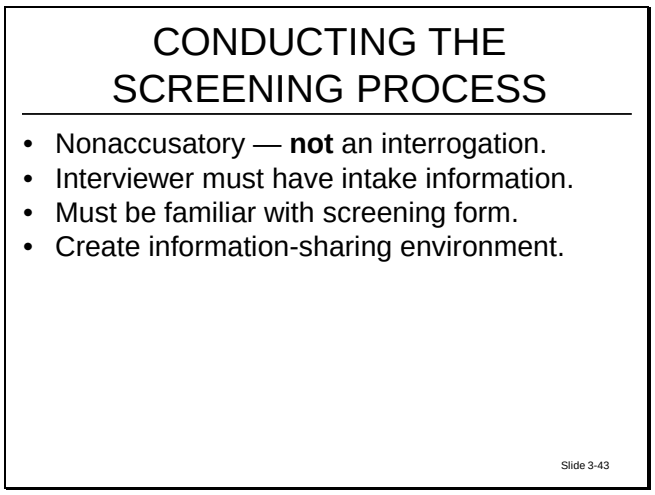
   a. Ask parents/caregivers if all electronic devices, such as televisions, computer, games, etc., can be turned off for the duration of the screening.

   b. Ask if there is an area where you can talk uninterrupted, such as a dining room, kitchen or office.

   c. If the family has other children, the screeners may wish to ask parents/caregivers in advance of the meeting to plan for some sort of childcare arrangement.

   d. While the screener has less control over the environment in the home, it is extremely beneficial to observe the family in their environment.

IX. CONDUCTING THE SCREENING PROCESS



A. Prepare for the process.

1. Each individual develops his or her own personal style in the screening process.

2. Techniques that are effective in screening some families may not be effective with others.

3. The screening process is nonaccusatory. It is designed to gather information. It is not an interrogation to ascertain guilt or innocence.

4. Prior to conducting the screening process, the intervention specialist must be fully familiar with the information obtained as part of the intake process. This includes the available information about the firesetter and his or her family and the details of the firesetting incident(s). If there are fire/police reports on the incident (and they are made available), review these as well.

5. The intervention specialist must be very familiar with the screening tool to be used and be practiced in its application.

6. He or she must create a safe environment that encourages the family and firesetter to participate and openly share information.

7. The intervention specialist must ensure and convey to the family that:

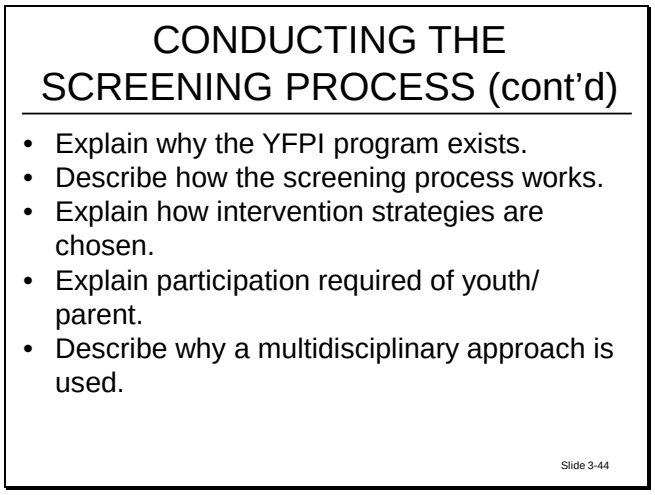
   a. He or she is there acting on behalf of the family.

   b. There is a true desire to uncover the root cause of the firesetting behavior.

c. The purpose is to see that the family receives the intervention needed to curb the firesetting behavior.

B. Describe the process to parents/caregivers.

1. While this may have already been a part of the initial contact with the family, the intervention specialist should provide an explanation of the intervention program to the family.



2. At minimum, the following information should be included:

a. Explanation of why the YFPI program exists.

b. Summary of the YFPI program history.

c. Explanation of how the screening process works.

d. Identification of the levels of intervention that are offered through the program.

e. Identification of how the intervention strategies are determined and by whom.

f. Summary of where intervention services are provided and by whom.

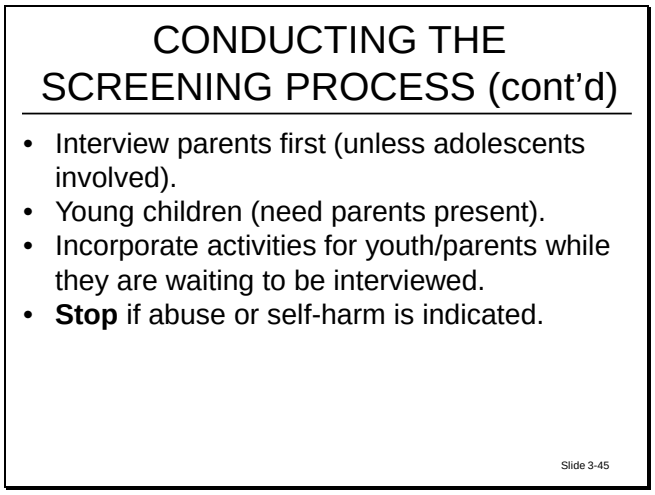
g. Identification of the level of participation required from the youth.

h. Clarification of what levels of support are expected from parents/caregivers.

i. Explain the multidisciplinary approach of the program and the involvement of other community agencies in the intervention process.

C. Perform the screening.

The following is a recommended sequence of events for conducting the screening process:



1. Conduct the screening with the parents/caregivers.

   a. This strategy permits the intervention specialist to obtain additional background information on both the firesetter and the firesetting situation.

   b. Assure parents/caregivers that all information documented during the intervention process is confidential and protected from viewing by unauthorized parties.

   c. Confirm signatures on all pertinent documents such as release forms, liability waivers, and confidentiality assurances.

   d. Follow the sequence of questions listed on the screening form.

   e. After completing the screening form, the intervention specialist should bring closure to the interview by asking parents/caregivers if they have questions or would like to offer any further information.

2. Conduct the screening with the firesetter.

a. If possible, the firesetter should be interviewed alone and not in the company of parents/caregivers.

   - This strategy permits validation of the fire-related events outlined by parents/caregivers.

   - It also creates an opportunity for the youth to disclose information that he or she may not be willing to share in the company of parents/caregivers.

b. When interviewing juveniles age eight and under, the intervention specialist may consider use of ancillary tools such as drawings, games, pictures or puppets to help the child recall/explain pertinent events related to the firesetting situation.

   Note: In cases involving young children, it may not be practical to interview the child without his or her parents/caregivers.

c. While interviewing the firesetter, the intervention specialist may have parents/caregivers complete a questionnaire about the program or view a video on firesetting intervention.

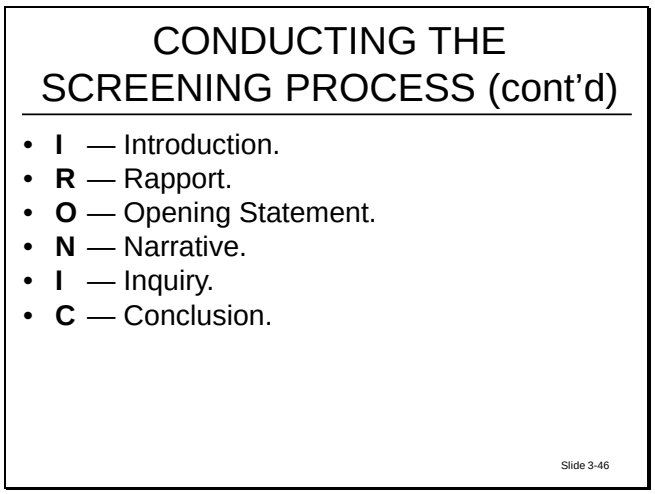
d. If possible, preteens and adolescents should be interviewed before parents/caregivers. This strategy builds rapport by validating their level of maturity and providing them the opportunity to offer a truthful account of the situation prior to parents/caregivers being interviewed.

e. When interviewing the parents/caregivers, it might be helpful to have a project for the firesetter to do.

   - For younger children, this may entail reading a book, coloring a picture, watching a video, etc.

   - In the case of older firesetters, consider asking them to write down their version of what happened or fill out an accompanying questionnaire.

f. If, at any time during the screening process, the intervention specialist has reason to believe that the child is a victim of child abuse or neglect, or intends to harm him or herself or others, the screening process should be stopped and the proper authorities notified.



D. **IRONIC** — A method of screening.

1. The following information was adopted from public domain information from Sergeant Paul Zipper, Ph.D., of the Massachusetts State Police. In 2004, Dr. Zipper was part of the team that developed and delivered a curriculum titled "The Investigation of Youth Set Fires" for the International Association of Arson Investigators (IAAI).

2. He has also co-authored an article with David K. Wilcox, Ed.D. titled "Juvenile Arson: The Importance of Early Intervention" for the FBI in their Law Enforcement Bulletin, which was published in April of 2005. Dr. Zipper and Dr. Wilcox stressed the importance of a structured interview process when working with youth firesetters.

3. The IRONIC method has been developed as an easy to remember method that identifies the procedures involved in conducting a screening and determining the facts of the event.

4. IRONIC stands for: Introduction, Rapport, Opening Statement, Narrative, Inquiry and Conclusion.

   a. **Introduction** — The person or people conducting the screening introduce themselves before the process begins. They can easily do this by showing credentials (photo identification, a fire or police department badge, or a business card).

   b. **Rapport** — This requires the interviewer to find some common ground that the youth enjoys discussing. Examples include sports, pets, travel, family or hobbies. This critical phase begins immediately on contact with the interviewee and continues throughout the interview.

c. **Opening Statement** — This step informs the youth the reason for the screening. For example, "I am here today because of the fire next door to your house."

d. **Narrative** — This step allows the youth the opportunity to provide a full account of what happened. Allowing the youth to describe the incident provides a wealth of information to the intervention specialist. He or she should closely analyze the youth's verbatim words. If possible, the narrative should be recorded and transcribed. This narrative of the event should not be contaminated with leading questions. Follow-up questions may be asked to determine the following:

- Who.
- What.
- When.
- Where.
- Why.
- How.

e. **Inquiry** — This step serves to document the answers to specific questions asked of the interviewee. Using an approved screening form, the intervention specialist should ask the questions listed on the form and document the answers.

f. **Conclusion** — This is the wrap-up of the screening. The intervention specialist should thank the youth and parents/ caregiver(s) for their time and ask if they will be available for a second screening, if necessary. They also should provide the family with information on how to maintain contact with the program.

CONDUCTING THE SCREENING PROCESS (cont'd)

- Building rapport:
  - Be on time. Dress appropriately.
  - Be prepared; do homework on case.
  - Avoid prejudices. Be respectful; it's their home.
  - Start with small talk.
  - Be aware of surroundings/fire safety issues.
  - Be comfortable with process.
  - Don't be surprised by anything.

Slide 3-47

E. Steps to building rapport with people.

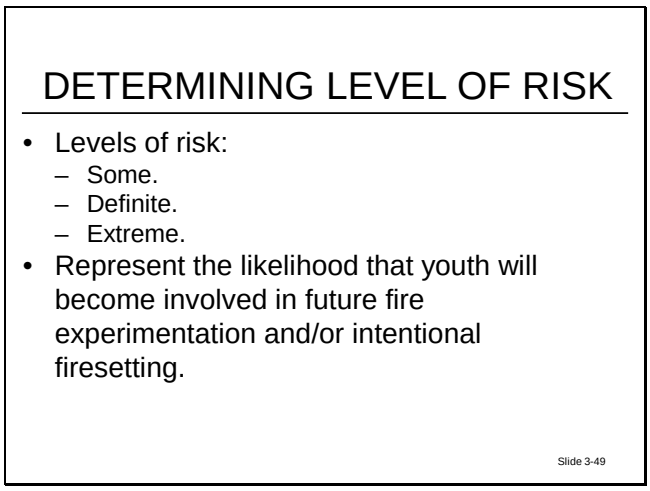
CONDUCTING THE SCREENING PROCESS (cont'd)

Slide 3-48

How to Build Rapport with a Youth and their Family

Be on time.	1. A structured interview requires that a specific amount of time be set aside by all parties involved. 2. Be respectful of the people you will be interviewing. Start and end the interview at the prearranged time.
Dress appropriately.	1. Each fire intervention program must develop its own policy regarding the attire of interviewers. 2. While some fire departments mandate the wearing of uniforms with a badge at all times, others may allow the interviewer to wear business casual attire. 3. Wearing a fire department uniform suggests that the interviewer is official and is recognized as a person of authority. However, in some cultures, those wearing a uniform or badge may represent that something negative is going to happen (i.e., a person is going to be arrested). 4. Some young children may be afraid of an adult in a uniform, and therefore it is important to get down to their level and wear clothing that is not intimidating. 5. Whatever attire is worn, it should be appropriate, respectful and representative of a professional.
Be prepared. Do your homework.	Be familiar with the details of the incident(s) **prior** to arriving at the screening. This demonstrates professionalism and shows empathy toward the family.
Avoid prejudices. Keep opinions to yourself.	
If knocking on a door, do so respectfully. You are representing a youth firesetting prevention and intervention team, **not** conducting a raid.	
Let the family seat you … it's their house.	
Break the ice with small talk. Start the conversation with questions not pertaining to the incident. This will help make the situation more comfortable for everyone involved.	
Be aware of your surroundings. In the home, look for lighters, matches, smoke alarms, clutter, etc.	
Be comfortable with the process. Gain experience by working with other seasoned people who conduct frequent interviews.	
Don't be surprised by anything!	

X. DETERMINING LEVEL OF RISK



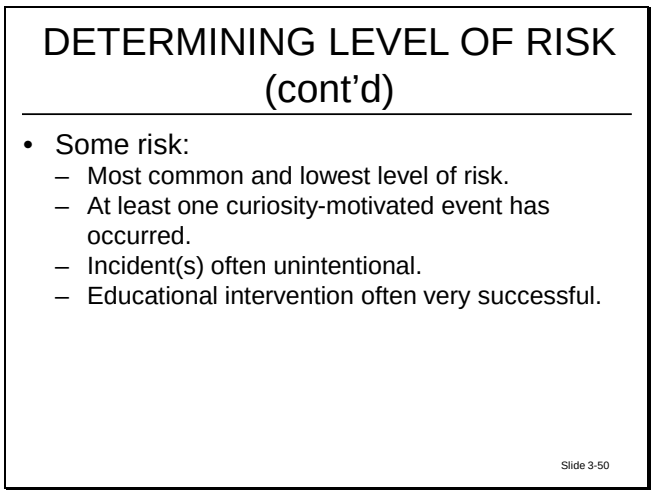
A. The purpose of the screening process is to determine the potential level of risk for repeat firesetting incidents.

B. By determining the level of risk, an appropriate intervention strategy can be developed.

C. There are three recognized levels of risk that ascend in the following order: some, definite, and extreme.

D. The levels have been identified and used in many professional firesetter publications, including the Juvenile Firesetter Intervention Handbook (U.S. Fire Administration (USFA), 2002) and the National Juvenile Firesetter/Arson Control and Prevention Program (USFA, 1994).

E. The risk levels represent the likelihood that youth will become involved in future fire experimentation and/or intentional firesetting.



F. Some risk.

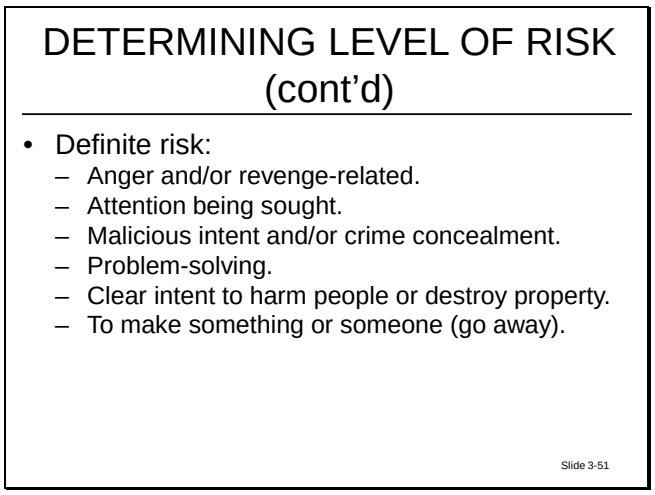
1. Most common and lowest of risk levels.

2. Youth has engaged in at least one unsupervised fire motivated by curiosity. Fires resulting from these incidents are often unintentional and are generally not a significant fire event. Young children will often attempt to put these fires out or go for help. Some may hide or run away.

3. Curiosity and experimentation with lighters and matches is the most common motive of children involved in unsupervised firesetting.

4. If these firesetters are identified and evaluated at an early age, and if they receive proper supervision and educational intervention, recidivism is unlikely.

5. However, some young children may exhibit more serious psychological problems or be exposed to stressful circumstances that increase their likelihood of inappropriately using fire repeatedly. These children may therefore require additional clinical assessment and intervention.



G. Definite risk.

1. Some youth go beyond experimentation and set fires for other motives.

2. Consider the influence of today's electronic age wherein youth are exposed to vast amounts of the negative aspects of fire.

3. Those aspects as seen on TV, in commercials, in the movies, and on the Internet can portray detrimental meanings that include power, control, revenge and rage, as well as inappropriate problem-solving.

4. Inappropriate fire use or acts of burning can provide a youth with feelings of satisfaction as well as a sense of power and control over their lives and others.

5. The misuse of fire may also be a form of communication where verbal skills are lacking. Firesetting could be an avenue to gain attention, express anger, and possibly even as a weapon for revenge.

6. When firesetters progress to repeated and intentional firesetting activity, underlying psychological or social problems and issues may be factors influencing it.

7. These types of fires are deliberate and may include the gathering of fuels and the possible selection of a target to be affected by the fire. The fires may be set for different reasons including:

    a. Anger.

    b. Revenge.

    c. Attention getting.

    d. Malicious mischief.

    e. Concealment of a crime.

    f. Problem-solving.

    g. The intent to harm people or destroy property.

    h. To make something or someone go away when they have no other solution.

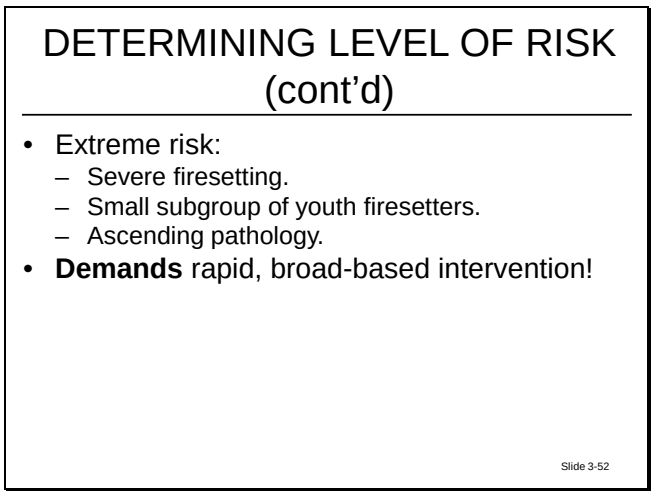
8. Youth engaged in this type of firesetting rarely attempt to put the fire out and will often retreat from the fire but may remain close enough to watch its effect.

9. This type of emotionally motivated firesetting is referred to as a crisis, troubled, cry-for-help typology.

10. Fire safety and primary prevention education may help the emotionally motivated firesetter.

11. However, he or she should also be referred to the appropriate mental health service for thorough screening and intervention.

12. With timely and broad-based support, there is a reasonably good chance that future recidivism can be prevented.



H. Extreme risk.

1. Firesetters in this category may reflect the same aspects as listed in the definite risk level.

2. Their behaviors usually involve more severe forms of firesetting influenced by psychological, social and environmental factors.

3. These youth generally reflect a small subgroup of firesetters, but they are often considered at-risk for engaging in future firesetting incidents.

4. Delinquent juveniles can exhibit certain patterns of aggressive, deviant and criminal behaviors that occur with greater frequency as the juvenile matures.

5. The longer the delinquent behavior continues, the harder it is to reverse; therefore, early identification and intervention from an interdisciplinary team of professionals is critical.

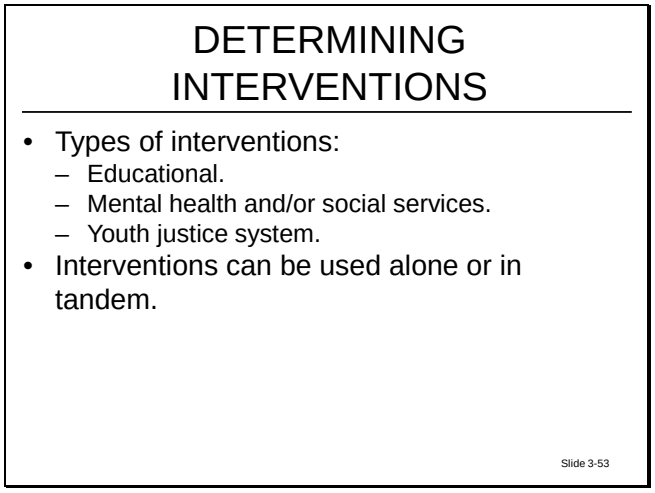
6. Fire safety education may positively impact but not always reverse this type of anti-social behavior.

7. Firesetters of extreme risk are often beyond the scope of immediate educational intervention services from a youth firesetting intervention program.

8. Youth included in the extreme-risk category demand a broad-based approach to solving their firesetting pathology. This includes a combination of justice system, educational, clinical and social service intervention.

9. Extreme-risk firesetters may pose a significant danger to themselves or others. The youth firesetting interdisciplinary team should be consulted immediately if a risk level of extreme is noted.

XI. DETERMINING INTERVENTIONS



A. Once the screening has been conducted and the level of risk determined, the proper intervention(s) can be recommended for the firesetter and his or her family.

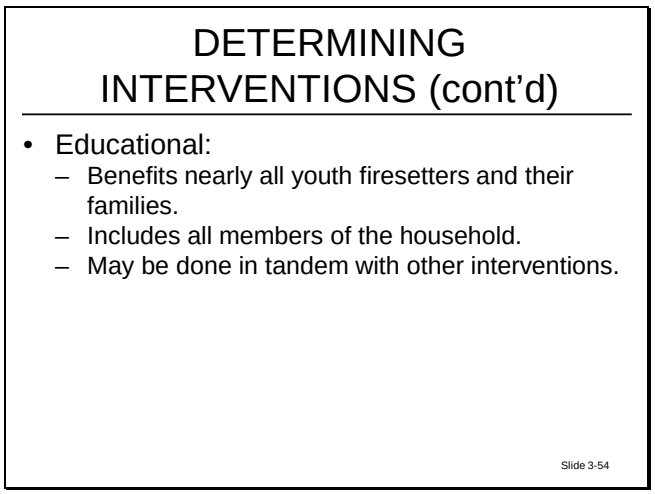
B. The involvement of the interdisciplinary team becomes crucial in final determination of the risk level and appropriate interventions.

C. There are several categories for interventions:

1. Educational intervention.

2. Mental health and/or social service referral.

3. Youth justice system referral.



D. Educational intervention.

1. Nearly all firesetters and families can benefit from fire safety and prevention education.

2. Educational intervention is particularly successful with the firesetters in the some-risk category.

3. If a simple (some risk) firesetting case is obvious, the intervention specialist may wish to score the assessment instruments on-site and schedule (or perform) fire safety education intervention immediately following the interview.

4. If educational intervention is the sole medium being recommended, the intervention specialist may choose to discuss options with the entire family as a group.

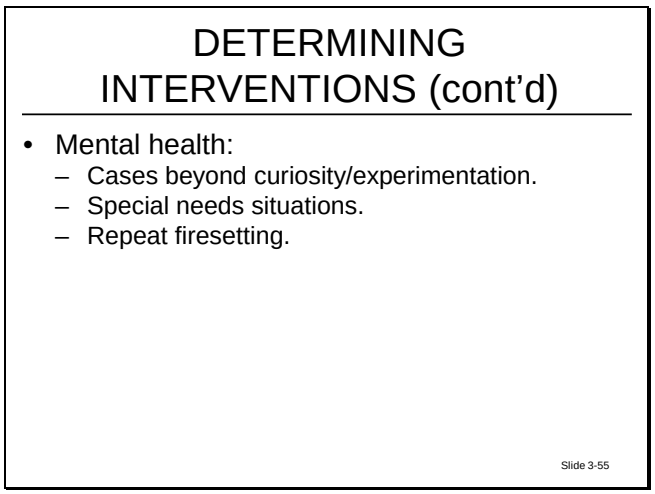
5. Educational interventions must include all members of the household.

6. However, if other intervention services are being recommended, the education component may need to wait for a more appropriate time.

7. YFPI program personnel should never assume that parents/caregivers (and youth) know the basics of fire safety and fire survival.

8. YFPI program personnel need to assess what the parents/caregivers and the youth know about fire prior to conducting educational intervention services.

9. Unit 4 is dedicated to education as a preventive intervention.



E. Mental health and/or social service referral.

1. When firesetting goes beyond curiosity or experimentation (or if there is repeat firesetting), it might be necessary to refer the family for mental health support.

2. The interdisciplinary team (youth firesetting task force) may need to be consulted before this referral is made to ensure that it is handled according to program protocol.

3. In complex situations, it may be wise to schedule a second meeting to discuss intervention options with parents/caregivers **after** scoring the assessment instrument privately and consulting with the interdisciplinary team.

4. A firesetter and his or her family may (or may not) be receiving service from a support agency.

5. YFPI program personnel need to be aware of the support services available in their community and any fees or costs associated with these services.

DETERMINING INTERVENTIONS (cont'd)

- Social services:
  - Can often provide families with voluntary training in parenting/caregiving skills, anger management, or dealing with a particular loss or change in lifestyle.
  - Can also mandate intervention services if child abuse or neglect is suspected.

Slide 3-56

6. Social service agencies can often provide families with training in parenting/caregiving skills, anger management, or dealing with a particular loss or change in lifestyle. Clinical staff may be able to help with referrals for these services.

7. Child Protective Services (Youth and Family Services) or whatever the unit is called that handles child abuse/neglect situations should be a partner that collaborates with youth firesetting cases.

8. Parents and careproviders will often respond rapidly to the offer of intervention services when an enforcement-related division of the social system becomes involved.

9. While supportive services are always suggested for definite and extreme-risk firesetting situations, they can also be helpful for families of some-risk firesetters as well.

DETERMINING INTERVENTIONS (cont'd)

- Youth justice system:
  - Helps ensure family participation.
  - Local authority having jurisdiction (AHJ) may mandate justice system involvement.
  - Follow YFPI program protocol.

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F. Youth justice system referral.

1. Invoking legal sanctions can help ensure that firesetters and their families participate in the YFPI program.

2. How this is accomplished will depend upon the laws and ordinances of the jurisdiction.

3. The decision to recommend legal sanctions may not be in the control of the YFPI program. The decision to take this action may depend upon:

   a. Violations of local or state laws.

   b. Deaths, injuries or property loss associated with the firesetting.

   c. Local operating procedures of the fire department.

   d. Age of accountability.

   e. Firesetting history of the youth.

4. Initiating a legal action for firesetting is a very serious matter. This decision is best made by an interdisciplinary team who can, in cooperation with the justice system, develop a protocol for action.

5. Once legal action is initiated, the defendant's civil rights must be recognized and honored. This means that the families must be informed of the decision, and juvenile Miranda rights must be read.

6. Again, it is important for each YFPI program to consult with the local district attorney regarding the protection of a juvenile's legal rights.

7. There are significant benefits of having a youth petitioned to the juvenile court for offenses relating to firesetting.

   a. The action helps ensure that parents/caregivers will participate and follow through with recommended program services.

   b. Parents/Caregivers of children with serious firesetting behavior problems are sometimes reluctant to pursue services when offered through a normal voluntary course of programming.

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ACTIVITY 3.3

Case Study Analysis

Purpose

Given a screening form, explore case studies to determine the level of risk for repeat firesetting behavior.

Directions

1. Each table group will be assigned three case studies.

2. Each group should again review the youth interview component of the Oregon screening tool.

3. Working in your table group, review/discuss each case and determine the following:

    a. The level of risk for repeat firesetting.

    b. An appropriate intervention strategy (consider all levels of intervention).

    Note: It is not necessary to perform a scoring process as there is not enough information in the case study to adequately do so. Simply use the youth interview component as a reference.

4. You will report to the class on your findings and recommendation for intervention.

    a. You will have 30 minutes for the case study review.

    b. You will have 30 minutes for all groups to make their presentations.

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ACTIVITY 3.3 (cont'd)

Firesetting Case Study 1

David Davis
Fire Incident 10-2321
Incident Location: Charles Middle School, 2002 Lewis Highway, Millton, Georgia

On March 20, 2010, you, the fire safety educator at Millton Fire Department, received a telephone call from a distraught mother, Mary Davis. Her 13-year-old son, David, had been expelled from Charles Middle School for conducting an "experiment" in the bathroom at the school. Ms. Davis wanted her son to learn about the dangers of fire, but she also wanted to get him back into school. The family was a middle-to-upper class family with both biological parents/caregivers present in the home. Ms. Davis did not work outside the home.

Ms. Davis said that her son has never been in trouble at school before. He is a good student, receiving A's and B's on his report cards. She reports no pertinent medical history. David lives at home with his parents/caregivers and his younger sister, Donna, age 8. To her knowledge, David has never used matches, lighters or other tools of ignition in this manner before. You schedule a convenient time for Ms. Davis to bring David for a screening.

They come to your office at the fire station (bypassing the apparatus bay) and arrive promptly for the interview. Ms. Davis seems a little harried, having to take this time to bring David for the screening. David presents as a neat, somewhat friendly 13-year-old but seems to act like a big deal is being made out of a simple incident. He also seems a bit embarrassed about coming to the fire department.

David enjoys sports, mainly basketball. He says that he doesn't really like school and that he finds it boring. He enjoys "hanging out" with his friends that live in his neighborhood. He says that he has never really been interested in fire or setting fires. He says that he has not started any fires previous to this one and that he really didn't consider this a fire. He stated, "After all, no damage was done, and if it hadn't been for the stupid janitor, I wouldn't be in trouble at all."

David tells you that he, along with two of his friends, wanted to see if gasoline would burn when it was in water. One of them had brought some gasoline to school in a drink bottle, and one had brought some matches. They gathered in the boy's bathroom, poured the gasoline on top of the water in the toilet, and then dropped a match in the water. There was a flash fire, but luckily none of the boys were injured. They were caught by the janitor at the school and were reported to the principal. The fire department was not notified nor was there any damage to the bathroom or the school. The school was not evacuated, and there was no interruption to the school day.

All three boys were subsequently expelled from school until a tribunal could be held before the school board (part of the school system's disciplinary process). David says his mom hopes that doing this (bringing him to the fire department) will get him back in school. He says that she is worried he won't get back in.

Ms. Davis says that David is just a natural 13-year-old, influenced heavily by his peers. She does seem more concerned about the effects of his act than the act itself. She does realize that he or his friends could have been injured or an actual fire could have started, causing damage to others and/or the school.

Firesetting Case Study 2

Tony Smith
Fire Incident 10-2321
Incident Location: 145 Serene Shores Drive, Lanier, Alabama

On a summer weekday afternoon, the Lanier Fire Department responded to a reported woods fire on Serene Shores Drive. The fire was located behind several houses in this quiet subdivision, Serene Shores. Upon arrival of Engine 8 personnel, they extinguished the extensive woods fire. The neighbors reported that it had been set by a young man who lived in a house directly in front of the woods where the fire started. The young man was 10 years old and lived in the house with his mother and younger brother.

The fire lieutenant, recognizing the seriousness of the problem, refers the family to the firesetter intervention program sponsored by the Lanier Fire Department. He contacts the intervention specialist, and he reports to the scene to conduct the screening.

Tony Smith appears angry about the incident but does show some remorse for what happened. He said that the fire only burned trees and grass and that it really didn't hurt anyone. He said that he helps his mom burn leaves behind their house all the time, and he was just trying to help her out. He had started this fire with the leaves he had gathered. According to Tony, the only reason the fire became out of control was because it was a windy day, and they had been experiencing dry weather during the summer. He said that he could have put the fire out if the neighbors hadn't called the fire department.

Tony goes to Jones Elementary School and will enter the fifth grade when school starts again. He likes school because he has friends there. There are no other children his age in the neighborhood to play with. He is an average student, earning B's and C's on his report card. He likes playing soccer. Tony denies setting other fires, stating that he had just graduated from the fire safety program at his school, and he has a certificate stating that he is a Junior Fire Marshal.

Tony's mother, Barbara Smith, works as a dietician at an elementary school in a neighboring county. She said that she and her husband, Tony's father, had recently separated. Since then she has noticed that Tony has been sad and somewhat angry, though he never acted in an aggressive manner. He has also been trying to act grown-up and help her around the house. She has been trying to pick up extra work since Tony's dad moved out, which means there is less time to spend with her children. Tony is often tasked with watching his younger brother, Charlie, who is 7. She says she tries not to leave them alone, but sometimes she has no choice. She was taking a nap when Tony started to burn the leaves and didn't know about the fire until she was awakened by the sirens.

She said that she has burned leaves before in the yard, and sometimes she leaves Tony "in charge" of the fire once it has died down. He has always been interested in the fires in the yard, but she did not believe that he had used ignition tools before. Once, he had placed the matches up high when his younger brother was trying to get them.

She said that Tony has no medical issues and has never given her any trouble. She said that she and her husband are trying to work on their issues, and she is hoping for reconciliation.

Firesetting Case Study 3

Brandon White
Fire Incident 08-4501
Incident Location: 1455 Barrett Road, White Sulphur, Georgia

Firefighters in the suburban community of White Sulphur were called to a residential structure fire at 1455 Barrett Road at approximately 1800 hours on a weekday. The fire caused approximately $100,000 in damage to a four-bedroom ranch style home. No one was at home at the time of the fire, and no injuries were reported. There was extensive fire damage to the garage, kitchen and dining room. The remainder of the house received substantial smoke and heat damage. Fire investigators determined that the fire started in the garage but were unable to determine an ignition source, and the fire cause was ruled undetermined.

Approximately three weeks after the fire, the department's fire marshal (lead fire investigator) received a call from the principal at Sweetbriar Elementary School. She asked if a fire had occurred on Barrett Road in the last few weeks. He stated yes, and she continued to say that a bus driver had reported to her that he had overheard a conversation between two boys on the bus. One boy (Brandon White) was telling his friend about the fire on Barrett Road and that he thought he had caused it. He was scared that he was going to go to jail, and he hadn't told anyone.

The fire marshal and the intervention specialist went to the school to meet with Brandon. The school's counselor had contacted Brandon's mother, Susan, to be there as well.

Brandon is a polite 10-year-old boy. He is in the fourth grade because he was held back a year due to poor grades. He says that school is okay, but it is hard. His grades are adequate, though he does get math tutoring one day a week at school. He doesn't really enjoy playing sports, but he does like to ride his bicycle.

Brandon lives with his mother, Susan, and his grandmother (Susan's mother). According to him, he doesn't have a dad. He has no siblings. His mom works at the local Dollar General store and isn't home when he gets off the bus. He is supposed to stay at the house with his grandmother, but he doesn't always do that because she is sick a lot.

When asked about the fire, he said that he didn't mean to burn the house down and felt really bad. He said that he didn't want to go to jail. Brandon said he was riding his bike down the street and went up the driveway to the residence. He said he knew that an Asian family lived there, and they always waved and said hello. He said they were always cooking on a "fancy grill" in their garage and that their food was different. He saw no cars in the garage, and he wanted to check out their "fancy grill." He said that he found a lighter, which was like a gun, so he picked it up and started playing with it. He said that he lit some papers on fire but thought he had put the fire out. He realized that his mom would be home soon, so he left.

Once informed about the situation, Susan White showed her distress. She didn't want her son to get in trouble nor did she want social services called. She also didn't have any money to pay restitution to the family that lost their home, and she felt very bad by what he had done. She said that "he was going to be grounded forever."

Susan is a struggling single mom. When she got pregnant, she was 16 years old and unmarried. She lives with her mom, who receives disability as her only form of income. Susan works for minimum wage, and she tries to pick up overtime whenever possible. She said that Brandon has never really had many friends and that he seems okay to play alone. She says she wishes she had more time to spend with him but that just isn't possible. She said that Brandon has had trouble with his grades in school, and she helps him with his homework whenever she can. She said that he is a sweet boy and takes good care of his grandmother. She said that she has never seen him set other fires nor show any interest in fire. She said that she has met the Asian family and that Brandon has always talked about their grill and the different foods that they eat.

She does want to know how much of her time this is going to take because she doesn't get paid when she is not at work. She wants to help Brandon, but the financial stresses are really getting to be too much for her.

Firesetting Case Study 4

B.J. Nicholas
Fire Incident 09-23867
Incident Location: 18646 Lagrange Highway, Mount Pleasant, NC

The Mount Pleasant Fire Department received a call from Katie Williams, mother of B.J. Nicholas. She stated that her son, B.J., had been setting fires and he had recently set some items on fire in his bedroom. She was scared and didn't know what to do. An appointment was scheduled for them to come for a screening.

Mr. and Mrs. Williams arrived promptly with B.J. and his sister Andrea. B.J. is 6 years old, and his sister is 10. B.J. is a typical 6-year-old child.

Mr. and Mrs. Williams stated that they had been married for approximately three years. She said that she and Mr. Nicholas, the children's father, divorced when B.J. was about a year old. Mr. Nicholas lives in the area and sees the children every other weekend. Mr. and Mrs. Williams said that the children love their stepfather, and Mr. Williams said that he treats them as he would his own biological children. Both parents/caregivers work, and the children participate in the afterschool program at Callaway Elementary School where B.J. is in the first grade and Andrea is in fifth grade. B.J. is a good student, earning average grades. He gets in trouble occasionally for talking in class or not staying in his seat. Katie Williams said that B.J. is in good health and seems to be a happy child.

Mrs. Williams stated that recently she has found evidence of burning around the house. She found some papers on the floor of B.J.'s closet, and he had also tried to ignite the back steps to the house. The most recent incident caused damage to B.J.'s bedspread. The damage was minimal, and the fire department was not called. She put the fire out with some water from the bathroom.

Both she and her husband smoke and have tried to "do better" with their lighters and matches. She doesn't understand the interest that B.J. is showing in fire. She said that Andrea never showed any kind of interest like this.

B.J. says that he likes school okay, but he doesn't like getting in trouble when he talks in class. He said that he enjoys helping his stepdad work in the garage on cars and other stuff like that. When asked about his firesetting, he says that he only starts small fires. He sees his parents/ caregivers' lighters, and he thinks it is cool to use them. Sometimes he tries to be like his parents/caregivers because they both smoke cigarettes. He denies trying to damage the house, himself or others with the fires.

He said they live in the country, and there aren't really any other children around to play with. He said that he likes his sister, except sometimes he gets mad because she "tattles on him."

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Firesetting Case Study 5

Jim Jacobs
Fire Incident 11-56745
Incident Location: Smith Middle School, Madison School District, Anytown, New York

On April 15, 2011, at 0930 hours, you were contacted by Principal Abrahmson of Smith Middle School located at 555 W. Oak St., Anytown, New York, in regard to a school bathroom fire. The fire occurred today at 0830 hours in the eighth grade boy's bathroom. The principal said that the fire alarms began to ring at 0830 hours, and the school evacuated to the playground. He said that the janitors were checking the school when they saw smoke coming from the eighth grade boy's bathroom. Custodian Smith immediately called 911. The Anytown Fire Department arrived and found the soap dispenser and toilet paper rolls on fire in the bathroom. The fire department extinguished the fire before it spread out of the bathroom. Principal Abrahmson said that the fire investigator had reviewed the hall video camera tapes and found that the only student seen going in and out of the bathroom right before the fire was an eighth grade student named Jim Jacobs. Principal Abrahmson said that the fire investigator, Mike Blaire, was currently interviewing Jim Jacobs and his mother Mary Jacobs in the assistant principal's office.

On April 15, 2011, at 1130 hours you contact Fire Investigator (FI) Mike Blaire who provides you with the following information: Today at about 0830 hours, Jim Jacobs (a 14-year-old white male) walked into the eighth grade boy's bathroom and lit the soap dispenser and six toilet paper rolls on fire using a lighter he stole from the neighborhood convenience store after receiving an "F" on his math test. FI Blaire stated that Jim told him that if he brought home an "F" on his math test, he would be grounded for a month by his mother and not be able to go on his family's vacation to Florida. Jim also said that if the school burned down, his mother would not find out how poorly he was doing in school because all of the papers would burn up and he wouldn't have to go to school anymore. He also told FI Blaire that he was glad he set the fire and closed the school for the day and didn't think the fire was that big a deal because the building didn't burn down.

FI Blaire stated that due to Jim's age and admission to setting the fire, he would be charging Jim with arson of a school and submitting the charging documents to the district attorney. The total fire damage estimate is $21,000.

On May 18, 2011, you receive a telephone call from Mary Jacobs, Jim Jacob's mother. She states that as part of Jim's court requirements he is required to attend a youth firesetter intervention program and that you should be receiving a referral document from Probation Officer Julie Johnson. Mary went on to say that she doesn't know what to do with Jim. He has an older brother Jeff (16 years old) who is a high school honor student and on the lacrosse team and who loves school and has never been in trouble. And, then there is Jim, who has been suspended from school, fights with other kids in the neighborhood, has been arrested for shoplifting, and hates school. She says that she does not understand where Jim's anger comes from because they have a great home life. She said that they even had Jim tested by a psychiatrist for depression, ADD/ADHD, and bipolar disorder, and the doctor said that Jim is a very healthy 14-year-old with no disabilities. When asked about Jim's firesetting history, she said that to her knowledge,

he has never experimented with fire, they have never had a house fire, the family has been practicing their home escape plan three times a year since Jim and Jeff were in elementary school, Jim is responsible for testing the 10 smoke alarms in their home once a month, and no one in the home smokes. Mary states that she is very perplexed by Jim's behavior.

You schedule a date and time to interview Jim and his mother at their residence located at 115 Harbor Drive, Anytown, New York, telephone number 000-123-4567.

Firesetting Case Study 6

Mark Keppler
Fire Incident 10-6756
Incident Location: 1246 Temple St., Madison, Montana, Telephone 901-555-4321

On July 4, 2010, at approximately 1608 hours, the Madison Fire Department responded to a fence fire located at 1246 Temple St., Madison, Montana. Upon arrival, the fire captain, Mark Valenzuela, contacted resident owner Kathy Phillips. Kathy stated that she was in the house when her 12-year-old son Mark Keppler ran inside the residence to tell her that the wooden fence caught on fire. Kathy stated that she looked outside and saw the fire and then called 911. Kathy stated that she asked Mark how the fire started, and he stated that he did not know. After extinguishing the fire, Captain Valenzuela observed a burned towel and melted lighter on the ground near where the fire started. He informed Kathy of this, and she again asked Mark how the fire started, and he said that he did not know. Captain Valenzuela stated that someone had to light the lighter and the towel for the fire to have started. Captain Valenzuela wrote down Mark and Kathy's information and referred the family to the youth firesetter intervention program.

On July 5, 2010, Youth Firesetter Intervention Specialist Angela Wong received Captain Valenzuela's fire report and contacted Kathy by telephone in reference to the fence fire. Kathy stated that she did not know how the fire started but thought that Mark may know more than he is telling. She related that she had Mark since he was 2 months old. She said his mother (Maggie Keppler, a Native American) was a drug addict, and after Mark was born, she gave him to Kathy because she could not take care of him. Kathy related that she has had guardianship of Mark since he was given to her. She stated that he is very healthy and very intelligent. She related that he gets A's and B's in school, has many friends at school and in the neighborhood, and has few if any behavior problems. She said that if Mark set the fire, it was his first fire. She said that the family is very fire safety conscious, has smoke alarms, and has drawn a home escape plan. She did state that her boyfriend and Mark do not get along, so there is some stress in the household. She also stated that when Mark gets home from school, he is not allowed inside the house until he takes care of the 12 dogs that they own and breed. He is responsible for feeding, watering, exercising, washing and grooming all of the dogs. After receiving this information, Angela scheduled the family for a youth firesetting intervention class including a family interview. Kathy was not very receptive to the class and said that the family would probably not attend because the fire department could not prove that Mark set the fire.

On Aug. 10, 2010, Mark, Kathy's boyfriend Scott, and her 5-year-old son Calvin attended the youth firesetter intervention interview and class. During the interview, Mark admitted that he had set the fence fire but refused to tell why he did it. After the interview, Mark attended the youth firesetting intervention class with eight other youth firesetters. When the adults left for the parents/caregiver group, Mark related that the reason he set the fire might be for revenge but refused to say anything else. At the end of the class, the counselor facilitator for the parents/caregiver group sat down with Mark and asked him about the fence fire. He related that the neighbor behind them squirts water on the dogs, cusses at the dogs, and throws things at the dogs. He stated that he has asked her to stop numerous times but she just ignores him. He stated that he got so angry with her that he lit a towel on fire with a lighter and tried to throw the towel

over the fence but the towel got caught on the fence and started the fence fire. Mark said that he was sorry but that the neighbor just got him very angry. Mark stated that this was his first and only fire and that he would never do it again. He also told the counselor that he might like to attend counseling to work on his anger issue and his relationship with Scott so that they could be a real family.

Firesetting Case Study 7

Jose Sanchez
Fire Incident 11-200234
Incident Location: 11234 Palmer St., Everytown, Alaska, Telephone 011-543-2100

On Feb. 5, 2011, at approximately 0801 hours, Everytown Fire Department Dispatch received a report of a house fire at 11234 Palmer St. Upon arrival, the residence was found to be engulfed in flames on the northeast side. After the fire was extinguished, Fire Investigator (FI) Scott Miller began his investigation.

FI Miller found that the area of fire origin was the guest bathroom and the 12-year-old resident's bedroom. He also located multiple pour patterns of a flammable liquid throughout the residence that had not been ignited. He found the flammable liquid to be "Jim Beam" whiskey. He also located the empty bottle of Jim Beam lying on the living room floor. During his examination of the fire scene, he was advised by Everytown Police Detective Joe Morse that the only person at home at the time of the fire was 12-year-old Jose Sanchez and his dog Bomber. Jose is the son of the homeowners, Alma and Jorge Sanchez. Upon completing his fire scene examination, Investigator Miller interviewed Jose Sanchez about the fire.

Jose is a 12-year-old Hispanic male who attends sixth grade at Alhambra Middle School and is an A student. Jose is very small for his age. He states that he has only one friend, and the rest of his class picks on him because of his size and intelligence. Jose states that he lives with his mother and father and that his older sister Maria, who is 16 years old, sometimes lives with them but mostly lives with her natural father. Jose states that he suffers from asthma but does not take medicine and has no other medical conditions. He also states that he has never been in trouble at school or with the law.

When asked about what happened this morning, in reference to the house fire, Jose related the following story. On Feb. 5, 2011, at about 0745 hours, his mother left for work, and he was getting ready to walk to school. He stated that a man wearing a "Scream" style mask, black-hooded robe, and white tube socks with red stripes pulled over police-type black boots broke into his residence through the back sliding glass door. He stated the unidentified man went through the kitchen drawers until he found matches and lighters and then went to his parents/caregiver's liquor cabinet and took out a bottle of "Jim Beam" whiskey and dumped it all over the house. He stated that the man then came into his bedroom and grabbed a pocket knife from Jose's dresser and cut Jose on the underside of his left forearm, causing a scratch. Jose stated that during the assault, he was able to get away from the man. He got his dog Bomber and Bomber's collar and leash and left the house. He ran down the street to his friend's house where he called 911. FI Miller asked Jose if he was upset by the fire and the fact that his property had burned, and Jose responded that he could always get new stuff and it was "no big deal."

An investigation of the scene showed no forced entry into the residence from the rear sliding glass door. There were no footprints found in the muddy backyard. Two of the local power company's service workers were in the alley behind the house from approximately 0730 hours on and did not see anyone in the rear yard of this residence or in the alley. The service workers also related that they were working directly behind this residence the whole time and saw no movement in the backyard or heard any noise from the backyard. The knife that Jose stated the intruder used to cut him was found on the dresser of Jose's burned room, and a lighter was found on Jose's bedroom floor. It also should be noted that the only two rooms in the house that were burned were Jose's bedroom and bathroom.

When Jose was interviewed again, with the lack of evidentiary information regarding his story, he still would not admit to setting the fire; however, he did agree to go to any type of class or do any type of community service that was asked of him.

FI Miller interviewed Jose's mother, Alma Sanchez, who related that Jose is a very well-behaved boy and does excellent at school. She stated that he rarely gets into any trouble. She stated that he does not have many friends and recently got into a fight with his only friend from down the street. When she was told about the story Jose had told about an intruder and then given the information about the lack of evidence that would verify his story, she stated that she believed that he did start the fire but does not have any idea why he would do it. Mrs. Sanchez went on to say that, to the best of her knowledge, Jose has never set fires inside or outside the house because he always talks about the firemen coming to his school to teach his class about fire safety. He reminds his father that smoking is unhealthy. She said that he is even in charge of testing their smoke alarms every month. Alma could provide no further information. FI Miller was just about to leave the Sanchez residence when Mr. Sanchez arrived home and immediately began to yell at Jose telling Jose that he was a "good-for-nothing spoiled brat." Mrs. Sanchez had to calm him down before he could talk with FI Miller.

FI Miller referred Jose and his family to the youth firesetting intervention program.

Firesetting Case Study 8

Charles Spellman
Fire Incident 10-44689
Incident Location: 634 Concho Way, Hertown, Oklahoma

On Sept. 12, 2010, at about 0300 hours, the Hertown Fire and Rescue were dispatched to a garage fire located at 634 Concho Way. An individual with burn injuries was involved. Upon arrival, it was found that the homeowner had attempted to extinguish the fire with a garden hose, but the fire spread to the neighbor's garage. Fire Captain George Hooks contacted homeowner Dory Spellman who told him that her 14-year-old son Charlie had awakened her and told her that the garage was on fire. She stated that she and her boyfriend Alvin immediately went to the rear yard and grabbed a garden hose to extinguish the fire, but the fire was too big and had spread to the neighbor's garage. She stated that Charlie had received second- and third-degree burns on his legs and that no one else was injured. She said that the paramedics transported Charlie to the Hertown Burn Unit and that her boyfriend Alvin (Charlie's father) was on the way to the hospital. She stated that Charlie told her that he and his friend Roger found the garage fire. Captain Hooks contacted Fire Investigator (FI) James Newman and requested that he respond to the fire.

FI Newman examined the area of the fire and found a can of WD-40 lying under a bush behind the garage along with a "BBQ" igniter. After FI Newman investigated the fire scene, he went to the burn unit to interview Charlie.

Charlie stated that he had been igniting WD-40 with a "BBQ clicker" and accidentally lit a plastic bottle containing gasoline (that had been lying near the garage) on fire. The "BBQ clicker" was an igniter switch from a BBQ grill that sparked when squeezed. He stated that he went to pick up the plastic bottle and move it away from the garage. He dropped it, burning his legs and catching a pile of rags on fire that caught the garage on fire. He stated that he went to get the garden hose and tried to put the fire out but couldn't, so he awakened his mom and told her about the fire. When asked what role Roger had in the fire, Charlie stated that Roger just watched but did not play with any fire. He also stated that Roger told him not to play with fire because he could get hurt. Charlie then stated, "I lied to you. Roger was never there. I told my mom that so I wouldn't get into trouble."

The burns on Charlie's legs were second and third degree, and he would be in the hospital about one month for treatment.

Charlie is a 14-year-old white male who attends Sunbeam Middle School. He has a "C" grade point average and states that school is "OK." The most fun part is being with his friends. He lives with his mother, her boyfriend (his father), and a 6-year-old sister named Heather. Charlie has no known medical problems and has no criminal history. Charlie states that he has experimented with fire on numerous occasions but has never been caught, and the fire has never spread. He thought he could control all fire and that only stupid people get burned. He stated that he was making a torch at 0300 hours because he was bored and could not sleep. He states that he likes to build fires when he is anxious because it calms him down and makes him feel good. He set this fire because he thought it would calm him down and help him sleep.

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Firesetting Case Study 9

Nathan Adams
Fire Incident 09-8795012
Incident Location: 1534 W. Tether Trail, Truetown, Illinois

On March 10, 2009, at approximately 1343 hours, Officer Coker responded to 1534 W. Tether Trail in reference to an incorrigible juvenile call. The complainant stated that a young juvenile male had been starting fires under the carport of his residence. Upon arrival, Officer Coker was contacted by Fire Captain Adam Ellis who stated that 12-year-old Nathan Adams had been burning a cardboard box in the carport area of his residence. Captain Ellis also stated that he and the fire company had gone into the residence and found it to be very unsanitary — old food lying in the kitchen, on the counters and floors, and trash, along with clothing and shoes, strewn throughout the residence. The conditions were so severe that rats had run over the boots of two of the firefighters who responded to the residence.

Officer Coker then made contact with Nathan Adams, a 12-year-old Asian male. Nathan had shaved his head and applied some type of red makeup in a flame pattern on his head, placed black makeup around his eyes, and painted his fingernails black. Nathan stated that he was cooking eggs on the stove when the box caught fire, and he took the box outside and watched it burn. Officer Coker asked if this was really true and Nathan said no, he just wanted to see fire, so he burned the box using a lighter.

When asked if this was his first fire, Nathan stated that he sets fires in the wash behind his house all of the time but is always able to put them out with a water hose. Nathan was also asked about the conditions of his residence, and he stated that his mom is always drunk and knocks things on the floor and never picks them up. He also stated that his mother blows marijuana smoke and cigarette smoke in his face and tells him that someday he will be a smoker. He stated that the house always looks like this because his mom is always drunk and never cleans, does laundry, takes out the trash, or picks things up off of the floor. Nathan also related that he has to cook his own food and wash his clothes. Sometimes his mother is gone for days at a time, and there is nobody to watch him. (Nathan is an only child.)

Nathan told Officer Coker that he adores Marilyn Manson and that is why he dresses like he does. When asked why he was not in school, he stated that he hates school, dropped out, and his mother does not make him go anymore. During the conversation with Nathan, his mother arrived at the residence. She smelled of alcohol and was slurring her words when contacted by Officer Coker. Mrs. Adams became very belligerent and refused to answer any questions after she was told why the police and fire personnel were at her residence.

Officer Coker took custody of Nathan and transported him to the police station so the fire investigators (FIs) could interview him about the fire. Social Services was contacted and responded to the scene to offer their assistance to Mrs. Adams. Upon the social workers contacting Mrs. Adams, she promptly spit in their faces and slammed the door on them.

FI Trenton responded to the police station to interview Nathan about his alleged firesetting activities. During the interview, Nathan told FI Trenton that he had been arrested seven times for setting fires to dumpsters, shopping carts and playground equipment. Nathan said that fire is his best friend. He hates people; people are mean to him. He said that he sets fires every day but doesn't get caught very often. He said that he hasn't been to school for two years and that he has been expelled from three school districts because of beating up teachers and students. He said that he suffers from ADHD but his mother never buys him his medicine because she uses the money to buy her drugs instead. FI Trenton found during the interview that Nathan was on intensive probation for the sexual assault of a 10-year-old neighbor girl. Upon completion of his interview, Nathan was turned over to custody Officer Coker. Nathan was arrested for his probation violation and taken to the county juvenile detention facility for processing.

Based on the living conditions of his residence, Nathan was placed in the custody of Child Social Services without the consent of his mother who refused to sign the Custody Notice.

Firesetting Case Study 10

Melanie Bridges
Fire Incident 11-23589
Incident Location: 543 Elm St., No. 60, Yourtown, Michigan

On Jan. 5, 2011, at approximately 0835 hours, the Yourtown Fire Department responded to an apartment fire at 543 Elm St., No. 60. Upon arrival, they found a bedroom fire in apartment No. 60 with smoke alarm and sprinkler activation. When Fire Captain Randy Rodriguez found out that an 8-year-old girl had started this fire, he immediately contacted Fire Investigator (FI) Marcy Johnson and requested that she respond to the fire scene. FI Johnson made contact with apartment resident Courtney Bridges who related the following fire history: On Dec. 23, 2010, between 0820 and 0828 hours, Melanie Bridges used a cigarette lighter she stole from her mother's bedroom and set fire to the bedding and/or mattress of her 9-year-old brother Ben because she was mad at him for looking at her. She then returned to her own bedroom and hid under the covers without making any attempt to extinguish the fire. Ben discovered the fire as he left the bathroom. Upon discovering the fire, Ben attempted to get Melanie to leave her room because of the fire, but she would not respond or get out from under her covers. When he pulled her from her bed and out into the hallway, she pushed him down into the doorway of the burning bedroom. She then returned to her bedroom. He escaped down the stairs alerting his mother, who was sleeping on the couch. Ben exited the apartment, and Courtney ran upstairs to Ben's bedroom. She attempted to put the fire out by dousing it with water but was unsuccessful. She then attempted to get Melanie to leave her room; however, Melanie refused to leave her bed until her mother screamed and cursed at her. Courtney then went downstairs, retrieved a fire extinguisher, and attempted to put out the fire. Ben contacted 911 from the residence next door, and the Yourtown Fire Department responded and extinguished the fire. Courtney went on to say that on Dec. 28, 2010, between 0800 and 0830 hours, Melanie had been the only person on the second floor of the apartment upon being seen walking down the steps. A few minutes later, Ben walked upstairs. He found papers he had put on his bedroom door in flames. He yelled for Courtney, and when she arrived, the fire had burned itself out. It was then discovered that a folding pocketknife had been stabbed into the wall of Ben's room with a handwritten note attached that read "YOU WILL DIE." The cumulative damage for the two fires was $1,500. However, Melanie was never referred to a youth firesetting intervention program.

On Jan. 5, 2011, at approximately 0930 hours, FI Johnson conducted a taped interview with Melanie regarding the three fires. FI Johnson advised Melanie of her Juvenile Miranda Warnings, and she waived her rights and agreed to talk with FI Johnson. Melanie admitted to three incidents of firesetting, the two previously mentioned fires that had damaged her brother's bedroom and another fire. She stated that she set these fires because she was angry with Ben and wanted to scare and kill him. She also admitted to writing and stabbing the death threat note into his bedroom wall. Melanie also stated that she didn't have any friends at school or at home because she likes to beat them up and set their hair on fire with lighters she steals from her mother's bedroom. Melanie also told FI Johnson that she likes to see people hurt and "fire is the best way to hurt someone really bad."

Melanie is an 8-year-old white female and is reported to be in good health. She is an excellent student receiving straight A's in her second grade class at Campus Elementary School. She lives with her mother Courtney and her brother Ben. She is currently under psychiatric care regarding issues of alleged prior sexual abuse and molestation by a stepfather. She is currently taking Zoloft and Depakote for her psychiatric condition. Melanie was referred to the Yourtown Firesetter Program in January of 2009 for lighting matches and dropping them on her brother's bedroom floor. She and her mother and brother attended the program in February of 2009. At that time, she was already in counseling through a nonprofit counseling agency. Melanie has had numerous behavioral problems to such an extent that her mother has placed an alarm on her bedroom door and video cameras throughout the apartment to monitor Melanie's activities.

Upon consultation with Melanie's psychiatrist, Melanie was referred to a 23-hour locked mental health facility for evaluation of her behavior. On Jan. 6, 2011, the attending psychiatrist contacted Courtney to tell her that Melanie had been evaluated and was determined not to be a danger to herself or others, and she could be picked up from the mental health facility.

Firesetting Case Study 11

Michael Capman
Fire Incident 09-56678
Incident Location: Carson Junior High School, Histown, Indiana

On Nov. 15, 2009, Carson Junior High School Psychologist Karen Smoot contacted the Histown Fire Department about one of her students, 15-year-old Michael Capman. She stated that she found Michael's notebook covered with drawings of people on fire and the following saying, "Life sucks, then you burn." She stated that when she found this, she contacted Michael's mother, Jeri. Jeri told Karen that she had found burned school papers, school books, and other items in Michael's bedroom closet. She also stated that she found 15 lighters and a long PVC pipe tube under Michael's mattress. She stated that when she asked Michael about the burned items, lighters and PVC pipe, he told her to, "f--- off." Jeri went on to say that Michael was sneaking out of the house in the middle of the night dressed in black, carrying a black backpack. She didn't know what she should do because every time she confronted him he punched her in the face. Karen also stated that after speaking to Michael's mother, she contacted the Histown Police Department to report the possible bomb and abuse.

Karen related that Michael has been having problems in school for the past six months. She stated that his grades have dropped from A's and B's to D's and F's. She also stated that he has been skipping classes or walking in halfway through a class. He has stopped turning in homework assignments and has begun to disrespect his teachers. A urine test was requested by the school and when done showed no signs of drugs or alcohol in his system. She went on to say that Michael has become very distant and appears to be very depressed. She stated that he no longer talks to his friends and does not "hang out" with anyone from the school. He also failed to try out for the track team this year even though he got first in the 6.2 mile run last year at the state meet. Michael has no known medical problems and has never been a behavior problem in school up until six months ago. She stated that no one knows why he is acting like this. Per his mother, nothing in his life has changed over the past three years: no deaths, no moves, no family problems, and no known problems with friends. It is a mystery as to why he has changed so dramatically.

Karen stated that she contacted the fire department at the request of the bomb squad detective.

Contact was then made with Michael's mom, Jeri Capman. Jeri stated that the bomb squad just left her residence located at 1615 State St. with three PVC tubes. The bomb squad detective Mark Morris had advised her that these PVC tubes were actual explosive devices, that the police were out looking for Michael, and that he would be arrested for bomb making. Jeri went on to say that she has no idea what has happened to Michael. Up until about six months ago, Michael was involved in sports, school clubs, Boy Scouts and church. Then one day he just changed. He started to wear black clothes, painted his fingernails black, and started listening to heavy metal music. She said that he began to build things that blew up in the backyard, put burn marks on his arms, yell and scream at her and his father Matt, and push and hit both of them. He also started to steal money from his 17-year-old sister Valerie. She said that he even threatened to kill them if they called the police. Jeri stated that she and her husband are willing to do anything to help their son, including having him locked up.

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Firesetting Case Study 12

Robert Welsh
Fire Incident 10-67543
Incident Location: 7810 E. Ribbon Lane, Stocktown, Mississippi

On June 5, 2010, at approximately 0800 hours, the Stocktown Fire Dispatch Center received a frantic 911 telephone call from Barbara Welsh. Barbara was heard screaming that her residence was on fire and that she and her two children, Robert 5-years-old and Natalie 2-years-old, were trapped in the bedroom by fire and could not get out. The dispatcher could hear smoke alarms ringing in the background along with Barbara screaming. The dispatch center immediately dispatched the Stocktown Fire and Rescue Service while staying on the telephone with Barbara to give her instructions. The fire department was on scene within four minutes; however, during that time, telephone contact had been lost with Barbara. Fire crews found Barbara, Natalie and Robert unconscious in the bedroom and removed them from the home. Barbara died at the scene, Natalie died at the Stocktown Hospital Emergency Room, and Robert was in critical condition at Stocktown Hospital's Burn Unit with third-degree burns over 40 percent of his body.

Fire Investigator (FI) John Peters responded to the scene and was in charge of the investigation. During his investigation, friends of the family told him that Robert had been caught setting fires during the week prior to the fatal house fire. He had set fires in the family room, to a pile of clothes near the washer and dryer, and outside on the deck. His firesetting had begun after his mother's boyfriend was arrested for molesting him. Robert is a 5-year-old white male who resides with his mother, sister, mother's girlfriend and her children. He attends Stocktown Headstart and is an average student. He suffers from no known medical or psychological illnesses and has not been reported to have any behavioral problems. FI Peters contacted Robert's grandmother Nellie at the scene, and Nellie told FI Peters that under no circumstances did Robert start the fire and that Barbara's ex-boyfriend must have started the fire even though he lives 50 miles away and has no means of transportation.

FI Peters' investigation revealed that the fire started in the middle of the family room floor, and the ignition point was not near any electrical outlets or appliances. He also found a burned pack of matches under the remains of the burned sofa, near the point of origin, and numerous burn marks near the washer and dryer and on the family room floor. Throughout his investigation, FI Peters found that the family was what he considered "very dysfunctional." Robert's mother was divorced from Robert's father because her best friend had run away with Robert's father. After a year, the best friend "dumped" Robert's father and started dating Robert's mother. Robert's mother Barbara was recently diagnosed with severe depression and would sleep up to 18 hours a day. Because of this, Robert and Natalie were left unsupervised up to 18 hours per day.

Robert was released from the burn center approximately five months after the fire. FI Peters was finally able to interview Robert. Robert stated that he was sorry that he burned up the house but that fire made him feel better and was pretty to look at. When asked if he set fires before the house caught on fire, he stated that he has set "lots of them. I like fire." When asked what he knew about fire, he said that it was pretty, warm and colorful. When asked if he would play with fire again, he said "yes."

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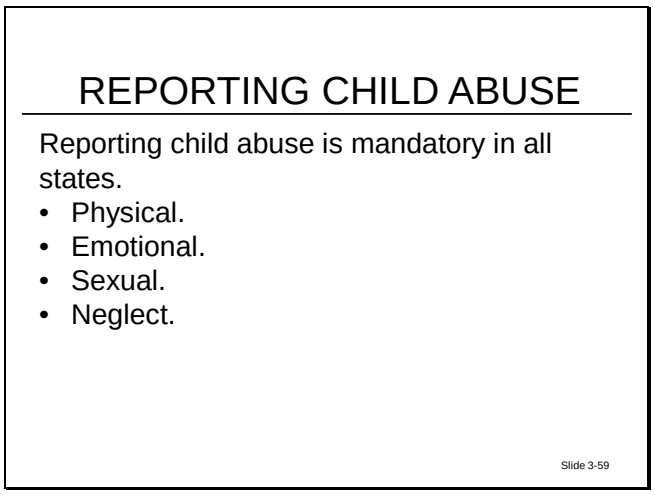
XII. MANDATED REPORTING AND CONFIDENTIALITY



A. Reporting child abuse.

1. All 50 states, the District of Columbia, and the U.S. Territories have statutes specifying procedures that a mandated reporter must follow when making a report of child abuse or neglect.

2. Mandated reporters are individuals who are required by law to report cases of suspected child abuse or neglect. Members of a YFPI program would be classified as mandated reporters.

3. Most states require mandated reporters to make a report immediately upon gaining knowledge or suspicion of abusive or neglectful situations.

Signs of Child Abuse

Physical Abuse:	Unexplained burns, cuts, bruises, welts Bite marks Anti-social behavior Problems in school Fear of adults
Emotional Abuse:	Apathy Hostility or stress Lack of concentration Eating disorders
Sexual Abuse:	Inappropriate interest or knowledge of sexual acts Nightmares and bed-wetting Drastic changes in appetite Overcompliance or excessive aggression Fear of a particular person or family member
Neglect:	Unsuitable clothing for weather Dirty or unbathed Extreme hunger Parent/Caregiver lack of supervision
Source of Information (Childhelp USA, Scottsdale, Arizona) www.childhelpusa.org	

OTHER LEGAL ISSUES

- Confidentiality of information.
- Release of liability.
- Release of information.

Slide 3-60

B. Confidentiality of information.

1. Program personnel need to assure parents/caregivers that information obtained through the screening process will be kept confidential.

2. Referrals may be made, such as to mental health and/or counseling agencies, and information should be released appropriate to those professions only if the referral is made and/or it is relevant to their care and treatment of the child and/or family.

3. If information is obtained from the youth that indicates he or she is being harmed, or intends to harm him or herself and/or the family, this information must be released to the proper authorities.

4. Parents/Caregivers and/or guardians should be informed that they will be required to sign a release of liability before the youth can be interviewed by program personnel. This is for the protection of the program personnel and the agencies involved in the firesetter program.

C. Release of liability.

1. Liability refers to the potential for firesetter intervention programs to be at risk for legal action because of the behavior of the firesetter and his or her family.

2. It is important that programs protect themselves from being held liable for the actions of firesetters.

3. Liability waivers that release the intervention program from being responsible for the actions of juveniles should be developed and implemented. Parents/Caregivers of children or youth participating in the program must sign this form prior to the screening process.

4. This release of liability should be written with advice from the AHJ's legal counsel and the local district attorney.

D. Release of information.

1. When working with children and/or youth and their families, confidentiality of information is an important aspect to protect.

2. When a juvenile is referred to an intervention program, it is essential to obtain a signed "Release of Information" form from the parents/caregivers.

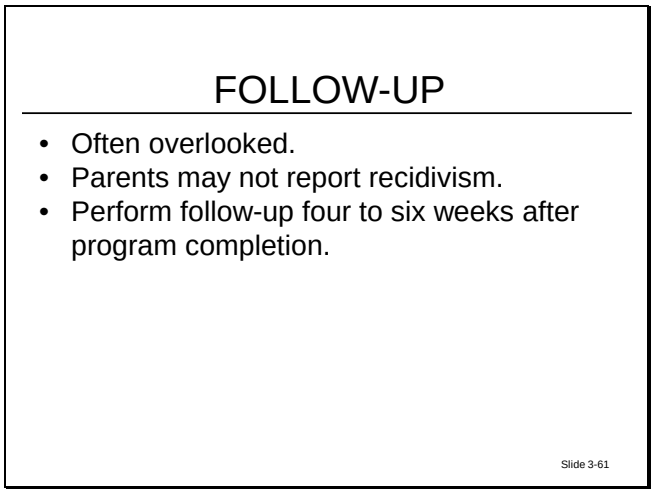
3. The "Release of Information" form provides the program officials the right to release information received to those persons and/or agencies necessary for intervention.

4. Without an official release of information, no information may exchange hands, thereby preventing any intervention from taking place and thus wasting the time and energy of the program.

5. Jurisdictions have specific procedures for the proper release of information. The legal counsel for the AHJ and the local district attorney should be consulted.

6. Examples of Release of Information forms can be found in the appendix of this unit.

XIII. FOLLOW-UP



A. It is important that follow-up contact be made with each family that participates in a youth firesetting intervention program.

B. Unfortunately, follow-up is a program component that is often overlooked.

C. Parents/Caregivers may not always report a repeat incidence of firesetting for the following reasons:

1. Embarrassment.

2. Fear of legal sanction.

3. Uncertainty of actions to take.

D. For all youth firesetting cases, a primary follow-up is recommended four to six weeks after completion of the program. A secondary follow-up can take place between six to 12 months after close-out of the file.

E. Follow-up can be conducted in a number of different ways to include:

1. Telephone calls, which are the most cost-effective and least time-consuming.

2. Written contacts, including postcards, letters, surveys and electronic communication.

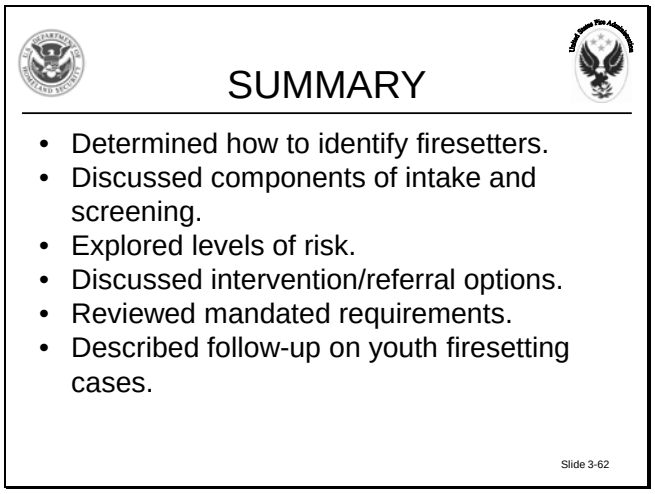
3. Home visits require the most resources but allow for a direct reassessment of the firesetting situation problem.

F. Challenges with follow-up include the transient nature of today's society. More frequent contact may be necessary just to ensure the location of the family.

G. While follow-up takes time and effort, it helps reinforce program information and demonstrates that the youth firesetting team is truly interested in the well-being of the youth and his or her family.

H. Follow-up is an essential component of program evaluation that must be performed to prove the youth firesetting program is working.

XIV. SUMMARY



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APPENDIX A

FIRE STOPPERS INTAKE FORM, KING COUNTY, WASHINGTON

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FIRE STOPPERS INCIDENT REFERRAL FORM

Incident Number _____ Incident Date _____

Referring Officer: _____ Employee number __ __ __

Incident Address: _____

City _____ State _____ Zip _____

Fire Investigator: _____ Investigator's Incident # _____

Youth Information

Name: _____ Sex: M (__) F (__) DOB _____

Address: _____

City_____State_____Zip_____

School currently attending: _____ Grade _____

Mother/Guardian: _____

Wk phone (_ _ _) __ __ __-__ __ __ __Home phone: (_ _ _) __ __ __-__ __ __ __

Father/Guardian:_____

Wk phone (_ _ _) __ __ __-__ __ __ __Home phone: (_ _ _) __ __ __-__ __ __ __

Where did the incident/fire occur? _____

Items ignited: _____

Source of ignition: matches (__) lighter (__) other (__)

Others involved in incident?

Yes (__) *list names on reverse side of this form*

No (__)

When applicable

Were smoke alarms present?

Did they activate? Yes (__) No (__) (if no, why) _____

(When appropriate, test all smoke alarms and provide a new detector/battery.) Done_____

If matches and lighters are accessible to children, please ask parents/caregivers to remove them immediately. You will want to explain some about our program and that the parents/caregivers can expect a call from the Prevention Division to extend these services and explain the intervention program in greater detail.

Comments:

_____

_____

APPENDIX B

JUVENILE FIRESETTER PREVENTION PROGRAM INTAKE FORM, STATE OF COLORADO

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COLORADO JUVENILE FIRESETTER PREVENTION PROGRAM CONTACT FORM

_____DEPT. NAME _____Inc. Census Tract _____County

INCIDENT DATE: _____ NO. _____ TIME _____ CR NO. _____
INCIDENT ADDRESS: _____ Street _____ City _____ Zip

Multiple Juveniles ☐ Y ☐ N #___
Ignition Source: ☐ Match ☐ Lighter ☐ Other ☐ Flammable Liquid/Accelerant Used

Loss: $_____ Intentional: ☐ Y ☐ N Injuries: ☐ Y ☐ N #_____ Deaths: ☐ Y ☐ N #_____
Hospitalizations: ☐ Y ☐ N #_____ Describe Injuries/Deaths_____
_____
Location of Fire: Outside-Location of Origin _____ ☐ Inside / ☐ Inside Occupied
Room of Origin _____

Referral Source Name:_____ Agency/Address:_____Phone:_____
☐ Caregiver ☐ School ☐ Law Enforcement ☐ Mental Health ☐ Fire Service ☐ Juvenile Justice
☐ Parent ☐ Other/Describe_____

Caregiver/Parent Smokes ☐ Y ☐ N Did the home meet community standards for health/welfare of the child? ☐ Y ☐ N
Was the child supervised by a person 12 years of age or older at the time of the incident? ☐ Y ☐ N

Description of the Incident and Pertinent Information:
_____
_____
_____

Report by: _____ _____
Printed Name Signature

Juvenile Information:

Last Name:_____First Name:_____M.I._____ DOB___/___/___
Sex ☐ M ☐ F Race: ☐ White ☐ Asian ☐ African Am. ☐ Native Am. ☐ Hispanic ☐ Other
Age: _____ Grade in School _____ School Currently Attending _____
Soc. Sec. #: _____-_____-_____

Home Address: _____ Phone:_____

Adult No. 1 Residing With The Child

Name: _____

Address: _____

Phone: H _____ W_____
Employed: ☐ Y ☐ N
Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Remarried ☐ Widowed
Relation to Juvenile: ☐ Natural ☐ Step
☐ Adoptive ☐ Foster ☐ Grandparent
☐ Other_____

Adult No. 2 Residing With The Child

Name: _____

Address: _____

Phone: H_____ W_____
Employed: ☐ Y ☐ N
Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Remarried ☐ Widowed
Relation to Juvenile: ☐ Natural ☐ Step
☐ Adoptive ☐ Foster ☐ Grandparent
☐ Other_____

Others Residing With The Child

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

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APPENDIX C

YOUTH FIRESETTER INTERVENTION PROGRAM INTAKE FORMS, GLENDALE, ARIZONA

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Glendale Fire Department

Youth Firesetter Referral Form

Parents/Caregiver/Guardian Interview: Intake

Officer:_____ Date:_____ Time: _____
Referring person/agency/telephone and fax numbers:
_____
Child's Name:(Last) _____ (First)_____
DOB: _____ Age: _____ Sex: _____ Race: _____
School: _____ School District: _____ Grade: _____

Who lives in home/siblings names and ages?_____
_____
_____

Parents/Caregiver: _____ Relationship: _____

Address _____
City _____ State _____ Zip _____
Home phone: (_ _ _) __ __ __-__ __ __ __ Work phone: (_ _ _) __ __ __-__ __ __
Message/Cellular phone: (_ _ _) __ __ __-__ __ __ __
Has there been a recent stressful event in the family? _____Yes _____No
If so, what? _____
Is child ADD/ADHD/Other diagnosis? _____Yes _____No
Is child in Counseling? _____Yes _____No
How did you hear about the YFS Program? _____

INCIDENT INFORMATION

Did the fire department respond? _____Yes _____No
Incident #: _____
Date _____ Time _____ Fire Co/Inv. _____
Ignition source _____ Location of incident _____
Was child alone or with others in the fire incident? _____Alone _____Others
Does child have a history of playing with matches or lighters? _____Yes _____No
(If Yes) How long? _____
Has child set previous fires? _____Yes _____No
(If Yes) How many?_____ When? _____
Has child attended a previous YFS class? _____Yes _____No
(If Yes) When _____ Where_____
Does the residence have a working smoke alarm? _____Yes _____No _____Unknown
Is there a smoker in the residence? _____Yes _____No _____Unknown
Synopsis of incident:

_____
_____
_____
_____

SCHOOL REFERRAL FORM

Fax Completed Form to Glendale Fire Department 623-847-5313

Date: _____
Referring School: _____ School District: _____
Contact Person: _____ Phone # _____ Fax # _____
Child's Name: _____
DOB: _____ Age: _____ Sex: _____ Grade in School: _____
Parents/Caregiver/Guardian: _____
Relationship: _____
Mailing Address: _____ City: _____ Zip: _____
Phone (H): _____ (W): _____ (Message): _____
Does Child Have A.D.D.or A.D.H.D. or other mental health issue? _____
Was Parents/Caregiver/Guardian Notified? _____ By Whom? _____
When? _____
Was The School Counselor/Intervention Specialist Notified? _____ When? _____
Was the School Resource Officer (SRO) Notified? _____ Is There a SRO? _____
What Type of School Discipline Will the Child Receive? _____
Is Mandatory Attendance at a Firesetter Class Part of That Discipline? _____

Fire Incident Information

What Was Used To Start the Fire? (Matches, Lighter, etc.) _____
How Did the Child Obtain These Items? _____
Location of Incident: _____ Date _____ Incident# _____
Was Child Alone or With Others in Fire Incident? _____
Names of Others Involved: _____
Were The Others Referred to the Firesetter Program? _____
How Was the Incident Brought To Attention of School? _____
Signature of School Official Making Referral: _____
I am the Parents/Caregiver/Guardian of _____ and I Give Permission For _____ School to Release This Information to the Phoenix Fire Department, for enrolling my child in the Firesetter Educational program.
(Parents/Caregiver's Signature) _____
Date _____
Synopsis of Incident
_____
_____
_____
_____

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APPENDIX D

WASHINGTON FIRE STOPPERS SCREENING TOOL

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FIRE Stoppers
Children's Fire Prevention Network
Of Washington

INTERVIEW FORM GUIDELINES

The Child and Parent Interview forms were designed by Fire Stoppers Children's Fire Prevention Program of Washington. The forms were created in response to interventionists needing a high quality, yet, easy to use tool to help assist them in the intervention process. The goal of the forms is to give the non-clinical (fire service) user a broad picture as to the level of functioning of the youth referred for firesetting. These forms will help the user to determine if referrals for further services are advisable.

Each form is simple to use. Start by asking the questions and checking off the answers given. You will notice that the "answer key" includes answers that are a circle as opposed to a square. If any circle answer is given then you check the large circle score in the left hand margin. Note that some questions have more then one possible circle answer, however, you only check the large circle score once.

When finished you add the number of large circle scores (from the left hand column) together. You will then have both a Parent/Child Interview score. You then add the two scores together to arrive at a composite score.

If the composite score is greater then 12, then referrals for further services are recommended. Referrals should also be made if the interventionist has a compelling belief that youth would benefit from further services even if the score were less then 12. The tool is there to help give you guidance, but understand that it is a non-clinical tool with no psychometric studies to substantiate its use. The cut score of 12 is based upon a sample of 200 subjects and represents one standard deviation above the mean for the composite scores. The majority of the youth you interview will score less then 12. They represent the classical construct of Little Concern/Curiosity fire setting.

Finish by completing the Interviewer Observation section of the interview tool. Your comments here could be helpful to someone receiving your referral.

FIRE Stoppers
Children's Fire Prevention Network
Of Washington

CHILD INTERVIEW FORM

NAME: _____

1. Where do you go to school? What do you like about it?

_____

❍ 2. After school, who watches you? (negative response ❍)

_____

3. What do you like to do with your friends?

_____

FIRE HISTORY QUESTIONS

❍ 4. Have you ever talked to any fire department people about setting fires or playing with M/L?

❍ Yes ❑ No When?_____

5. What did you use to start this fire?

❑ Matches ❑ Lighter ❑ Both Other: _____

❍ 6. Where did you get these lighters/matches?

A. ❑ Home ❑ School ❑ Store ❑ Friend ❑ Other:_____

B. ❑ Found it ❍ Went out of way to acquire

❍ 7. What did you set on fire?

❑ Nothing ❑ Paper product ❑ Grass/leaves ❑ Trash ❍ Flammable liquids

❍ Someone else's property Other:_____

❍ 8. What did you do after you used the matches/lighters or the fire started?

❍ Denied or lied about involvement ❍ Hid ❍ Did nothing

❑ Extinguished the fire ❑ Sought help ❑ Other: _____

9. How many others were involved in this incident?

A: ❑ None B. Who were they?

Name/Relationship Name/Relationship

1._____ 2._____

10. Tell me the reason you decided to light the fire or play with the matches/lighters.

❍ Another child told me to ❍ To see it burn ❑ To see what would happen

❍ To destroy something ❍ To hurt someone Other: _____

11. How did you feel when you started this fire or played with the M/L.

❍ Happy ❑ Sad ❍ Excited ❑ Scared ❑ Nervous

❑ Normal ❍ Angry Other: _____

12. Has anything happened lately that really bothers you?

❑ Nothing ❍ Being angry at a brother/sister ❍ Parents split up ❍ Death ❍ Moved

❍ Argument with parent ❍ Family fight ❍ Problem at school

Other: _____

13. How many fires have you set or how many times have you played with matches/lighters?

❑ None ❑ One ❑ Two ❍ Three or more

Explain: _____

14. What have you set on fire in the past?

❑ Nothing ❑ Paper product ❑ Grass ❍ Flammable liquids

❑ Trash ❍ Others belongings Other: _____

15. Have you ever been with your friends when they have set fires?

❑ Yes ❑ No Explain: _____

16. What are two things that could happen when children play with fire?

A. _____ B. _____

17. Do you have any M/L hidden anywhere or know where some are?

❍ Yes ❑ No Where: _____

18. Do you think that you will continue to light more fires?

❍ Yes ❑ No How come: _____

19. Is there anything else about fires that you want to tell me? _____

_____

SOCIAL HISTORY QUESTIONS

❍ 20. How do you get along with parents, caregivers, siblings? (❍ for negative response)

(The following sample questions are to help generate dialogue.)

Do you spend as much time with them (parent/caregiver) as you would like?

How do you feel about this? _____

What are things that you and your family do together? _____

Tell me about them,(parent/caregiver/siblings) what are they like? _____

_____

❍ 21. How often do you fight, argue or disagree with your parent(s)?

❑ Never ❑ Rarely ❑ Sometimes ❍ Often ❍ All the time

What is it usually about? _____

❍ 22. How are you punished when you have done something wrong?

❑ Don't get punished ❑ Time-out ❑ Ground or take away privileges

❑ Yell ❑ Spank ❍ Hit/Beat Other:_____

❍ 23. When you get punished do you think the punishment is fair?

❍ Never ❍ Rarely ❑ Sometimes ❑ Mostly ❑ Always

Comments: _____

❍ 24. Does anyone else in your family argue a lot?

❍ Yes ❑ No ❑ Sometimes

Who and what about: _____

❍ 25. Is there anything else that you want to tell me about you? (❍ for negative response) _____

(These are some optional questions that may be used to generate dialogue regarding abuse issues.)

Has anyone done mean things to you that hurt you?

❍ Yes ❑ No Explain: _____

Is/has there anyone that touches you in a way that makes you feel uncomfortable?

❍ Yes ❑ No Explain: _____

For Official Use Only

Interviewer's Observations (compared to other interviews)

During your interview it is important to recognize some important signs the child may be giving to you. Your observations relating to behavior, mannerisms, mood and way of thinking are important to note. If a referral is necessary, counselors or therapists may get some insights based on your notes and observations.

Child's behavior: _____
(e.g. fidgety, nervous, stubborn, eye contact, shy, open, hyper, polite)

Child's mood: _____
(e.g. angry, sad, defiant, happy, depressed, excited, afraid)

Child's way of thinking: _____
(e.g. rational, age appropriate, scattered, illogical)

Overall	**Within Normal Limits?**	**Yes**	**No**
Child's behavior:		❑	❑
Child's mood:		❑	
Child's cognitive process:		❑	❑

If you visited the home, what was the appearance? _____
(e.g. orderly, messy, unsafe)

Do the caregivers appear indifferent towards the child?	❑	❑
Do the caregivers appear hostile towards the child?	❑	❑
Does the child appear neglected/abused?	❑	❑

Does mother ❑, father ❑, caregiver ❑, appear to be developmentally disabled?

Does mother ❑, father ❑, caregiver ❑, show signs of substance abuse?

Total ❍ Score = _____ (parent+child forms)

Additional Comments:

_____

_____

_____

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FIRE Stoppers
Children's Fire Prevention Network
Of Washington

PARENT INTERVIEW FORM

CAREGIVER INFORMATION

Child's name: _____
Last First Date of Birth

Female caregiver name: _____
Last First

Date of Birth: _____ Relationship to child: _____

Male caregiver name: _____
Last First

Date of Birth: _____ Relationship to child: _____

Phone: Home (____) _____-_____(male/female) Work (____) _____-_____ (male/female)

Address: _____

_____ Zip Code_____

FAMILY INFORMATION

1. Biological parent's present marital status:
   ❑ Never married ❑ Married ❑ Divorced ❑ Separated
2. Who is the custodial parent and/or primary caregiver?
   ❑ Mother ❑ Father ❑ Both ❑ Other_____
3. Has/is your child been in counseling? ❍ Yes ❑ No
   If yes, when and with whom _____
4. Does anyone in your home smoke? ❍ Yes ❑ No How many?_____
5. Has your family ever experienced a serious fire or burn injury? ❑ Yes ❑ No
6. Where are matches/lighters generally kept in your home?_____
7. How did your child get the materials used in this incident?
   ❑ Found it easily ❍ Went out of the way to acquire

❍ 8. Do you believe this fireplay/firesetting was intentional?

❍ Yes ❑ No If yes, explain_____

Do you believe your child was attempting to do harm or destroy property?

❍ Yes ❑ No

❍ 9. Has your child expressed an interest/fascination in fire?

❍ Yes ❑ No If yes, explain_____

❍ 10. Do you believe your child was pressured or coerced into fireplay/firesetting by peers?

❍ Yes ❑ No If yes, explain_____

❍ 11. Within the last 6 months has there been an event in your child's life that could have contributed to this behavior? ❍ Yes ❑ No *If yes, check those that apply:*

❍ Family problems ❍ Parent/child conflict ❍ Family moved ❍ Death

❍ Problem at school ❍ Angry at self or another ❍ Trauma

❍ Other (❍ if negative response)_____

❍ 12. What was your child's behavior after this fireplay/firesetting incident?

❍ Denied or lied about involvement ❍ Hid ❍ Did nothing ❑ Extinguished the fire

❑ Sought help ❑ Other_____

❍ 13. Does the fireplay/firesetting appear to be an attempt to get attention by your child?

❍ Yes ❑ No ❑ Not sure

❍ 14. Please check any of the behaviors that apply or are demonstrated by this child:

❍ Jealousy ❍ Stealing ❍ Bedwetting ❍ Destructive ❍ Compulsive behaviors

❍ Moody ❍ Nightmares ❍ Impulse ❍ Cruel to animals

Comments:_____

❍ 15. Please check if any of the following apply to this child:

❍ Physical abuse ❍ Sexual abuse ❍ Emotional abuse ❍ Neglected abuse

❑ Other/explain: _____

APPENDIX E

COMPREHENSIVE FIRERISK EVALUATION (LONG FORM)

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INSTRUCTIONS FOR USING THE COMPREHENSIVE FIRERISK FAMILY AND CHILD EVALUATION

Kenneth R. Fineman, Ph.D.

General Instructions

The Comprehensive FireRisk Evaluation was developed to help you acquire the information you need to determine risk; specifically, the determination of little risk, definite risk, or extreme-risk, relative to the prediction of future firesetting, and especially dangerous firesetting. To accomplish this you must have a child or family member answer your questions honestly and completely.

The parent questionnaire and the child and family interview forms are constructed so you can score most responses as C-1, C-2, C-3, P-1, P-2, or P-3. A C-2 or -3, or a P-2 or -3 response suggests that the child or parent answered in a way consistent with those who are pathological firesetters or recidivist firesetters. C-2 or -3, or P-2 or -3 responses may also suggest the presence of emotional or behavioral dysfunction. Positioning a C or P response in column 2 of a 3 column matrix indicates definite risk for further and dangerous firesetting. Positioning a C or P in column 3 suggests extreme risk (due either to the child's focus on fire, the likelihood of emotional or behavioral dysfunction, or both).

When a child is given a C-1 or a parent is given a P-1, this indicates that the child or parent is engaging in a behavior that is quite normal or a behavior that is indicative of curiosity firesetting and is not correlated with recidivistic firesetting. It is important that a C-1 or P-1 not be assigned without good reason; since doing so signifies the normalcy of a response. If a response is not normal and it is assigned a C-1 or P-1, the statistics upon which prediction of risk is based becomes distorted.

Some questions are for general information only and are not scored. Some are geared toward setting the groundwork for the questions to follow that are scored. Sometimes there will be many responses that are correct. When this happens mark all that are accurate. However, when it comes time to score the response on the profile sheet, only score (i.e., give credit for) the most severe response. When narrative information is required and you run out of room, use the back of the form.

For some questions you are offered the option of a C-1, C-2, or C-3, and/or a P-1, P-2, or P-3 response. When offered only C responses to choose from, only one C response is required. (In other words, it's either a C-1, a C-2, or a C-3.) When offered only P responses, only one P response is required (P-1, P-2, or P-3). However, when given an option such as C-1/-2/-3 and/or P-1/-2/-3, you are given the opportunity to choose two responses, one from each category. You may also choose only one response, from either the C category or the P category. It is only appropriate to choose two responses, one from each category, if the answer to an item suggests some degree of concern for both the child (C) and the parent (P) or family (P).

Fineman, K. (1996). Comprehensive Fire Risk Assessment Instructions

When Opposite Responses Can Both Get a C-1 or P-1

It is important to think of a C-1 or P-1 response as signifying appropriateness, and C-2 or -3 and P-2 or -3 responses as signifying inappropriateness. By this we mean that the choice of one response over the other must be thought of in terms of the overall context in which the child lives and functions.

As an example, spending what appears to be enough time with a child, while usually being scored a P-1 may actually require a P-2 if the child is being ill-treated by the parent. A child staying to watch a fire, or choosing to run away (seemingly opposite responses) can both generate a C-1 if you judge that those behaviors are appropriate responses under the circumstances that you uncover.

Clarifying Your Choices

As an interviewer, you have the option to obtain more information on any question when you feel it is necessary to help you make you C-1/-2/-3 and/or P-1/-2/-3 decision. Within the limits of the time, you can allow for an interview; the more information you get the better. Also, when you choose to give a C or P based on a parent or child's "other" response, please elaborate on what "other" means for greater clarification in the future. When you are unsure if a response falls more into a column 1 vs. 2, or a column 2 vs. 3, have the interviewee explain his answer.

If a child is being home schooled, answer only questions 1, 3, and 4 on the child interview and evaluation form, in the school section.

When you answer questions that deal with whether a structure was or was not occupied at the time of the fire, answer the question in terms of what was actually set on fire as opposed to what the juvenile says he intended. As an example, an occupied structure is one that had people in it at the time of the firestart, an unoccupied structure is unoccupied if it had no one in it at the time of the firestart, even if it usually does. A vacant structure is one that not only did not have occupation at the time of the fire, but is generally believed not to, such as a structure in the process of being built.

When answering questions concerning where a child got his firesetting material, consider the most appropriate answer, not the most obvious. Thus, determine the sequence of how the child got his matches before deciding on the response to circle.

Clarifying the Child or Family's Choices

If after you have asked the question exactly as it is written, you feel that the child or parent does not understand a question, either because of the way it is phrased or because they don't understand a word, you have the option to change the way the question is stated to make it clear to the child or parent. You also have the option to substitute a word to be understood.

In order that the questionnaires be applicable to all ages it has been necessary to insert optional language. As an example, you might want to talk to a younger child about his teacher, but to an

older child about his classes or subjects. Thus a question may give you a choice of words such as teacher/subject and it is up to you to use the correct word or phrase depending upon the age of the child.

The Format of the Interview Forms and the Parent Questionnaire

Both the original assessment tools in the FEMA manuals as well as the present updated tools are based on the dynamic-behavior theory of firesetting (Fineman, 1980, 1995). The original forms were less structured and less complex. The present forms have greater structure and, at the same time, provide wider latitude for the fire evaluator to explore the factors that lead to higher risk for future firesetting. The dynamic-behavioral model suggests that past history of dysfunctional behavior coupled with poor supervision and training in fire safety generates an at-risk child. Add to this a traumatic event to lessen the child's inhibitions and increase his impulsiveness, and we are poised for a firestart.

The model further suggests that certain thoughts and feelings that occur before, during, and after the fire should be investigated, as that information will help us understand the motivation for the firesetting and provide very specific information for the referral source who will provide the therapy for those assessed as definite and extreme risk. The present instruments are set up in such a manner as to allow the evaluator to more clearly understand the sequence of thoughts, feelings, and behavior that lead to and maintain firesetting.

You may use the number of column 2 or 3 responses on each of the three instruments, or their additive value as represented on the structure category profile sheet, to understand the sequence as well as to assess risk. Probably the easiest method will be to calculate the percentages on the forms, as discussed below.

On some occasions you may not be able to interview the family, as only the child will be available for the interview. In those situations, use the first sheet of the family interview form with the child in order to get as much information about the family and living arrangements as possible.

The Child Evaluation

This interview form is divided into eight content sections plus demographics. As you interview, circle C or P responses and write in narrative information that you want to remember. When the interview is completed, count up all C-1 responses and enter that number in the appropriate square on the small summary box that is included at the end of each of the eight sections. Repeat this process for C-2 through P-3. When complete, transfer that information to the large summary box at the end of the interview form. Then total each column and record that sum in the appropriate square. Once you have all totals recorded, use the total score for each of the columns to calculate the percentage of risk for child, family, and total risk according to the following formula.

Child Risk $\frac{C2+C3}{C1+C2+C3}$ = _____ %

Family Risk $\frac{P2+P3}{P1+P2+P3}$ = _____ %

Total Risk $\frac{C2+P2+C3+P3}{C1+P1+C2+P2+C3+P3}$ = _____ %

Does a child see fire as having special, miraculous, or spiritual powers? If so, how do we know if it's a C-2 or C-3 response? The evaluation that you are conducting, though yielding an eventual numerical result, is still very much of a qualitative assessment. Thus, we must take all aspects of a child or parent's response into consideration. When you believe that a child's belief system concerning fire deviates considerably from the typical, it should be rated C-3.

The Family Interview Form

This interview form is divided into nine content sections plus demographics. When the interview is completed, count up all C-1 responses and enter that number in the appropriate square on the Family Fire Risk Summary Sheet. Repeat this process for C-2 through P-3. When complete, total each column and record that sum in the appropriate square. Once you have all totals recorded, use the total score for each of the columns to calculate the percentage of risk for child, family, and total risk according to the above formula.

The observation section of the questionnaire is filled out when you observe the family at their home. It is possible that you will choose not to interview at the home. If this is the case, skip the observation section.

It is sometimes difficult to determine when a question should receive a C-3 as opposed to a C-2 score. As an example, how long does a child have to stay and watch a fire before the behavior goes from C-2 to C-3? The answer is a function of the context. It is up to you to judge the level of dysfunction, based on your years of experience. When the length of time watching (i.e., extensive), the facial expression (i.e., transfixed), the behavior manifested (i.e., taking pictures), and general attitude suggest a "very" atypical response, you are generally warranted in giving a C-3 score.

The Parent Questionnaire

This questionnaire form is divided into eight sections. When the interview is completed, using the transparency scoring sheet, count up all C-1 responses and enter that number in the appropriate square on the Parent Questionnaire Summary Sheet. Repeat this process for C-2 through P-3. When complete, total each column and record that sum in the appropriate square. Once you have all totals recorded, use the total score for each of the columns to calculate the percentage of risk for child, family, and total risk according to the above formula.

A parent may ask for clarification on certain questions. When a parent assesses the appropriateness of a child's reaction to fire, the overall context is examined. Thus, watching the fire, running away, panicking or not, may all be C-1 responses, i.e., those responses that provide for the safety of the child as well as for others, within the child's developmental ability to provide for the safety of others. When evaluating eye contact, consider whether that behavior is appropriate to the child's culture. Severe behavior difficulties refer to extraordinary problems that a parent admits are beyond his or her ability to control. Chewing odd things has to do with those children who put things in their mouth to suck on or chew that are inappropriate considering the age of the child. Phobias refer to specific and severe fears such as heights, spiders, closed places, and snakes. General fears refer to non-specific fears.

A parent may ask you what an excessive parental absence means. This is a subjective judgment and depends on what is normal, not so much in one family, but on what is accepted in society in general. Thus, asking whether the parent is absent from their children more than other parents in the neighborhood might be helpful.

The Structured Category Profile Sheet

At the conclusion of the interviews, transfer all individual and total scores from the Parent Questionnaire and the two evaluation forms to the Category Profile Sheet. The total scores from the summary sheets are placed in the respective subtotal columns on the structured category profile sheet. When complete, add all the columns and place the result in the total column at the bottom of the page. Next, transfer the total numeric score to compute percentages from the formula for the Child Risk, Family Risk, and Total Risk. Follow the numeric format for computing percentages from the formula. From the computation of these percentages, the child and family can be classified into risk levels.

The following criteria are used to classify the juvenile and family into risk level.

Little Risk	**Total Risk Score is equal to or less than 20%.**
Definite Risk	**Total Risk Score is between 21% - 66%.**
Extreme Risk	**Total Risk Score is equal to or greater than 67%.**

The above criteria also can be used to classify the child and family individually into their respective risk levels, however it is suggested that the Total Risk Score be used for the overall classification and recommendation for intervention and referral.

References

Fineman, K. R. (1995). A model for the qualitative analysis of child and adult fire deviant behavior. American Journal of Forensic Psychology, 13, 31-60.

Fineman, K. R. (1980). Firesetting in children and adolescents. In B. J. Blinder (Ed.), Psychiatric Clinics of North America Vol. 3. Child Psychiatry: Contributions to diagnosis, treatment, and research (pp. 483-500). Philadelphia/London/Toronto: W. B. Saunders.

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PARTICIPATION RELEASE

The _____utilizes the youth firesetting screening program developed by the Federal Emergency Management Agency and the United States Fire Administration to evaluate the child that has been involved in a fire incident or has been referred to the city by a parent or another entity or agency.

Based on the results of the evaluation, your child's tendencies will place him/her in one of the following areas of concern:

Little Risk - needs educational intervention

Definite Risk - needs referral for evaluation to a mental health agency or to a licensed psychologist or psychiatrist and education intervention

Extreme Risk - needs immediate referral for evaluation by a licensed psychologist or psychiatrist

If educational intervention is indicated, the _____ program will offer further educational activity for your child.

Depending on the circumstances regarding an individual case, other agencies such as the school your child attends, local law enforcement, social services departments, etc. may become involved.

The questions asked in this evaluation may be viewed prior to signing this release upon request.

I, _____, have read the previous statement and do hereby grant permission for my child, _____, to participate in the _____ Intervention Program and hereby authorize to release information regarding my child to such other governmental entities and agencies as it may deem appropriate.

_____ _____

Parent/Guardian Date/Time

_____ _____

Juvenile Witness

COMPREHENSIVE FAMILY FIRE RISK INTERVIEW FORM

(Questions to be asked of parents of children 3 to 18 years of age)

CONTACT FORM _____ **DEPT. NAME** _____ **Inc. Census Tract**____ **County**

INCIDENT-DATE_____ NO. _____ TIME_____ CR. NO_____
INCIDENT ADDRESS:_____Street _____City _____ZIP

Multiple Juveniles ☐ Y ☐ N #____ Ignition Source: ☐ Match ☐ Lighter ☐ Other ☐ Flammable Liquid/Accelerant Used

Est. Loss: $_____ Intentional: ☐ Y ☐ N Injuries: ☐ Y ☐ N #____ Death: ☐ Y ☐ N #_____
Hospitalizations: ☐ Y ☐ N #_____ Describe Injuries/Deaths _____

Location of Fire: Outside-Location of Origin _____ ☐ Inside/☐ Inside-Occupied Room of Origin_____

Referral Source Name:_____ Agency/Address: _____ Phone: _____
☐ Caregiver ☐ School ☐ Law Enforcement ☐ Mental Health ☐ Fire Service ☐ Juvenile Justice
☐ Parent ☐ Other/Describe _____

Caregiver/Parent Smokes ☐ Y ☐ N Did the home meet community standards for health/welfare of the child? ☐ Y☐ N

Was the child supervised by a person 12 years of age or older at the time of the incident? ☐ Y ☐ N

Description of Incident and Pertinent Information:

_____

_____

Report by: _____ _____
Printed Name Signature

Juvenile Information

Last Name: _____ First Name: _____ M.I. _____ DOB _____/_____/_____
Sex ☐ M ☐ F Race: ☐ White ☐ Asian ☐ African Am. ☐ Native Am. ☐ Hispanic ☐ Other
Age: _____ Grade in School_____ School Currently Attending _____
Soc. Sec. #: _____-_____-_____

Home Address: _____ Phone: _____

Adult No. 1 Residing With The Child

Name:_____

Address: _____

Phone: H _____ W _____
Employed: ☐ Y ☐ N
Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Remarried ☐ Widowed

Relation to Juvenile: ☐ Natural ☐ Step

Adult No. 2 Residing With The Child

Name:_____

Address: _____

Phone: H _____ W _____
Employed: ☐ Y ☐ N
Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Remarried ☐ Widowed

Relation to Juvenile: ☐ Natural ☐ Step

Others Residing With The Child

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Fineman, K, (1996). *Comprehensive FireRisk Assessment.* Published in Poage, Doctor, Day, Rester, Velasquez, Moynihan, Flesher, Cooke, and Marshburn, (1997). Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. 1, Denver, CO, Colorado Division of Firesafety.

SCORE ALL ANSWERS BELOW THAT APPLY

	C-1	C-2	C-3	P-1	P-2	P-3
HEALTH HISTORY						
1. What medical or physical problems does your child have? _____ Professionally diagnosed No Yes By whom _____						
2. Has your child taken any medication in the past 3 months? If so, what? _____						
3. Has your child been diagnosed with any impulse control conditions, such as ADHD/ADD (hyperactivity)? Diagnosis _____Yes No						
4. Is your child currently in counseling or has he or she been seen by a counselor before? For what _____ Yes (C-2) No (C-1) With whom _____						
5. Is any other family member currently in counseling or have they been seen before? By whom _____Yes (P-2) No (P-1) For what reason _____						
6. Are there smokers in your home? Yes (P-2) No (P-1)						
Health History Subtotal						
COMMENTS:						
FAMILY STRUCTURE/ISSUES						
7. How long have you rented or owned at present location? _____ If less than 1 year score (P-2); if more that 5 years score (P-1)						
8. Do you think that you or your spouse/partner may be overprotective of the child? always (P-3) usually (P-2) sometimes (P-1) rarely (P-1) never (P-3)						
9. Is mother/female caregiver available to the child as much as the child needs her? always (P-1) usually (P-1) sometimes (P-2) rarely (P-2) never (P-3)						
10. Is father/male caregiver available to the child as much as the child needs him? always (P-1) usually (P-1) sometimes (P-2) rarely (P-2) never (P-3)						
11. Do you feel you spend enough time with your child? always (P-1) usually (P-1) sometimes (P-2) rarely (P-2) never (P-3)						
12. Are there significant conflicts between this child and other members of the family? always (P-3) usually (P-2) sometimes (P-2) rarely (P-1) never (P-1)						
13. Do you believe that you have adequate influence and control over your child? always (P-1) usually (P-1) sometimes (P-2) rarely (P-2) never (P-3)						
14. What do you discipline your child for? _____ How often? _____						
15. How do you normally discipline your child? _____						
16. Is there a history of emotional abuse in the family? Yes (P-2) or (P-3) or (C-2) or (C-3) No (P-1) Who? _____ Relationship? _____ Currently in the home? _____						
17. Is there a history of physical abuse the family? Yes (P-2) or (P-3) or (C-2) or (C-3) No (P-1) Who? _____ Relationship? _____ Currently in the home? _____						
18. Is there a history of sexual abuse in the family? Yes (P-2) or (P-3) or (C-2) or (C-3) No (P-1) Who? _____ Relationship? _____ Currently in the home? _____						
Family Structure/Issues Subtotal						
COMMENTS:						

Fineman, K, (1996). *Comprehensive FireRisk Assessment.* Published in Poage, Doctor, Day, Rester, Velasquez, Moynihan, Flesher, Cooke, and Marshburn, (1997). Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. 1, Denver, CO, Colorado Division of Firesafety. Comprehensive Family FireRisk Interview Page 2 of 7

	C-1	C-2	C-3	P-1	P-2	P-3
PEER ISSUES						
19. Does your child interact normally with peers? Yes (C-1) No (C-2)						
20. Does your child get into fights frequently? Yes (C-2) No (C-1)						
21. Does your child frequently get picked on by other children? Yes (C-2) No (C-1)						
22. Does your child frequently play/stay alone rather than with other children? Yes (C-2) No (C-1)						
23. Do you think his friends are a bad influence? Yes (C-2) No (C-1)						
Peer Issues Subtotal						
COMMENTS:						
SCHOOL ISSUES						
24. Is your child in the age appropriate grade? Yes No If no….. [Is your child ahead (C-1) or behind (C-2)]						
25. How does your child perform academically? Well (C-1) Average (C-1) Poorly or below expectation (C-2)						
26. Have there been any recent negative changes in your child's academic performance? Yes (C-2) No (C-1)						
27. Does your child have any special educational (special ed.) learning needs? Yes [learning disabled, mentally retarded, or developmentally disabled] (C-2) No (C-1)						
28. Have there been any discipline problems at school within the last year? Yes (C-2) No (C-1)						
School Issues Subtotal						
COMMENTS:						
BEHAVIOR ISSUES						
29. Has your child been in trouble outside of school for non-fire-related behaviors? What? _____ Yes (C-2) No (C-1)						
30. Does your child frequently say no when he or she is asked to do something? Yes (C-2) No (C-1)						
31. Has your child ever stolen or shoplifted? Yes (C-2) No (C-1)						
32. Has your child ever lied excessively? Yes (C-2) No (C-1)						
33. Has your child ever used drugs/alcohol/inhalants? Yes (C-2) No (C-1)						
34. Has your child ever beat up or hurt others? Yes (C-2) or (C-3) No (C-1)						
Behavior Issues Subtotal						
COMMENTS:						

	C-1	C-2	C-3	P-1	P-2	P-3
FIRE HISTORY						
35. What were you doing when the fire occurred? appropriate supervision (P-1) not home, asleep, or other indication of inappropriate supervision, score (P-2)						
36. Are matches or lighters readily available to the child in the home? Yes (P-2) No (P-1)						
37. How did you teach your child about fire? appropriate supervision (P-1) inappropriate (P-2) e.g., has the parent directed and demonstrated proper use of fire?						
38. Have any other members of the family engaged in inappropriate fire behavior? Who? _____ Yes (P-2) No (P-1)						
39. If you had to describe your child's curiosity about fire, would you say it was: absent (C-1) mild (C-1) moderate (C-2) extreme (C-3)						
40. How many times has your child used fire inappropriately? No other times (Assess no score, skip question #41.) 1 time (C-1) 2-4 times (C-2) more than 4 times (C-3)						
Fire History Subtotal						
41. Tell me what you know about all the fires that he or she started before this one. [Use a common time frame, i.e., Christmas, school starting, etc. to help parent describe when fires were started or fireplay initiated] **INFORMATION ONLY**						

What Set	Date Set	Where Set	With Whom	Ignition Source	Accelerant Used
1.					
2.					
3.					
4.					
5.					
Others.					

COMMENTS:

	C-1	C-2	C-3	P-1	P-2	P-3
CRISIS OR TRAUMA						
42. Has anything bad happened in the family or in your child's life within the last year? What? _____ Yes (C-2) or (P-2) No (C-1)						
43. Has there been an ongoing (chronic) crisis/problem in your child's life or in the family? Yes (C-2) or (P-2) No (C-1)						
44. Did the fire/fireplay occur after: No crisis (No score) family fight (C-2) being angry at sibling (C-2) being angry at boss (C-2) being angry at school authority (C-2) recent move (P-2) being angry with another (C-2) other crisis (C-2) or (C-3) or (P-2) or (P-3)						
Crises or Trauma Subtotal						

COMMENTS:

Fineman, K, (1996). *Comprehensive FireRisk Assessment.* Published in Poage, Doctor, Day, Rester, Velasquez, Moynihan, Flesher, Cooke, and Marshburn, (1997). Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. 1, Denver, CO, Colorado Division of Firesafety. Comprehensive Family FireRisk Interview Page 4 of 7

	C-1	C-2	C-3	P-1	P-2	P-3
CHARACTERISTICS OF FIRESTART OR FIREPLAY ***[circle all that apply but only score the most severe response for each question]***						
45. Materials used to set the fire or fireplay: matches lighter flammable liquid/aerosol fireworks other (butane torch, flare, stove, pilot light) What? _____						
46. How did the child get material to start fire or engage in fireplay? found it (C-1) went out of his way to acquire it (C-2) from his hidden/saved incendiary supplies (C-2) readily available at home (P-2) or (C-1) another child had material (C-1)						
47. Where was the fire set or where did the fireplay occur? home-*occupied at the time* (C-3) other residence-*occupied at the time* (C-3) school-*occupied at the time* (C-3) other structure-*occupied at the time* (C-3) home-*unoccupied at time* (C-2) school-*unoccupied at time* (C-2) other structure-*unoccupied at time* (C-2) other residence-*unoccupied at time* (C-2) dumpster (C-2) vacant structure (C-2) outside (C-2) wildland (C-2) or (C-3) vehicle (C-2)						
48. What was set on fire? *(e.g., if the object of value was intentionally set on fire, score a C-3.)* object of little of no value (C-1) or (C-2) object of value to child (C-2) or (C-3) object of value to others (C-2) or (C-3) part of a building (C-2) people, animals, self (C-3) flammable liquids/aerosols (C-3) wildland-*unintentional* (C-2) or *intentional* (C-3) fireworks (C-2) or (P-2) paper, tissue, cardboard, twigs (C-1) or (C-2) bedding/bed-child's own (C-2) bedding/bed-someone else's (C-2) clothing-child's own (C-2) clothing - someone else's (C-2) toys (C-2) furniture (C-2) trash, leaves, grass (C-2) animals (C-3) insects (C-2) matches only (C-2) or (P-2) lighter only (C-2) or (P-2)						
49. What did he or she do after the fire started? (*If the response is appropriate based on the circumstances, score a C-1; if not, score a C-2 or C-3.)* put it out (C-1) or (C-2) called for help (C-1) ran away [if appropriate] (C-1) if not (C-2) stayed and watched (C-2) or (C-3) panicked (C-1) tried to extinguish (C-1) or (C-2) didn't try to extinguish (C-1) or (C-2) other (C-1) or (PC-2) or (C-3)						
50. Did child lie about involvement? total denial, minimizing (C-2) denial at first and then confess (C-1)						
51. Did child act alone? Yes (C-2) No (C-2) List names _____						
52. Was child pressured or coerced into firesetting or fireplay behavior by his or her peers? Yes (C-2) No (C-2) Child was instigator (C-3)						
53. Did the child respond to the fire or fireplay as if it were a positive or humorous experience? Yes (C-2) or as a negative (remorseful) experience (C-1)						
54. Does the child believe that fire has spiritual qualities or extraordinary powers? Yes (C-2) or (C-3) No (C-1)						
55. Is there an impulsive quality to the child's firesetting/fireplay? Yes (C-2) or (C-3) No (C-1)						
56. Did your child set the fire or play with fire intentionally? Yes (C-2) No (C-1)						
57. What did you do to the child in response to the fire or fireplay? grounded/restricted (P-1) physical punishment (P-1) or (P-2) nothing (P-1) or (P-2) talked/lectured (P-1) or (P-2) sought outside help (P-1) yelled (P-1) or (P-2) abused (P-2) or (P-3) other (P-1) or (P-2) Explain _____						
Characteristics of Firestart Subtotal						
COMMENTS:						

	C-1	C-2	C-3	P-1	P-2	P-3
OBSERVATIONS- KEEP SEPARATE - NOT FOR PARENTAL REVIEW!						
58. How does the mother act towards the child? appropriately concerned (P-1) inappropriately concerned (P-2) hostile or indifferent (P-3)						
59. How does the father act towards the child? appropriately concerned (P-1) inappropriately concerned (P-2) hostile or indifferent (P-3)						
60. Does the mother show appropriate self-care? Yes (P-1) No (P-2)						
61. Does the father show appropriate self-care? Yes (P-1) No (P-2)						
Observations Subtotal						

COMMENTS:

COMPREHENSIVE FAMILY FIRERISK INTERVIEW SCORE SHEET

Transfer the information from the Subtotal Boxes into the table below; then total each column for the Total at the bottom.

SECTION SUBTOTALS	C-1	C-2	C-3	P-1	P-2	P-3
Health History						
Family Structure/Issues						
Peer Issues						
School Issues						
Behavior Issues						
Fire History						
Crisis or Trauma						
Characteristics of Firestart						
Observations						
TOTAL						

These totals will be used to compute the Total Risk after all interviews are complete.

COMPREHENSIVE CHILD FIRERISK INTERVIEW FORM

(Questions to be asked of children 3 to 18 years of age)

AGENCY _____ COUNTY _____

INTERVIEWER _____ DATE _____

JUVENILE'S NAME _____

SEX _____ DOB _____ ETHNICITY/RACE _____

ADDRESS _____ PHONE _____

SCHOOL _____ GRADE _____

DEVELOPMENT OF RAPPORT

The purpose of this section is to make the child comfortable with you. The more at ease you can make him, the greater the likelihood that he will answer all of your questions. If the following questions aren't enough, add your own. Questions or language can be modified throughout this form to accommodate the age of the child or adolescent.

A. [Introduce yourself] I'm _____ What's your name?_____

B. How old are you? _____

C. What school do you go to? _____ What grade are you in? _____

D. Do you like your school?_____ Are there nice/okay teachers at your school?___

E. What classes/subjects do you like/not like? _____

F. What do you do for fun? Do you have hobbies? _____

G. Who's you best friend? _____

H. What do you like to play/do with your friend? _____

I. What do you watch on TV and/or what videos do you watch? _____

J. What is your favorite person/show on TV? _____

K. What is your favorite video/computer game? _____

L. What do you like about that game? [Is there extreme interest in violence or fire?] _____

[When rapport is established, determine level of understanding if the child is under 7 or appears to have problems communicating.]

DETERMINE LEVEL OF UNDERSTANDING

It is often difficult to determine if a young child really understands you. (These instructions may be skipped if you are interviewing an older child.) There may be an age barrier, a language barrier, a learning problem, or sub-normal intelligence. It is fruitless to go through an entire interview unless you are first assured that the child has enough understanding to complete the interview. There are several ways to gauge whether you are on the same "wave length" as the child. The following are suggested ways to do so:

a. Obtain information from the rapport section above:
   By paying close attention to the manner in which a young child responds to the 11 questions above, you can estimate whether he can understand and respond to the other questions in this instrument.
b. Using crayons/paper as a tool:
   You can ask the child to draw pictures of common objects, his favorite toys, houses, trees, and people. Then ask him to describe what he has drawn. Clear explanations of his drawings and the action taking place in some of those drawings will tell you something about the child's vocabulary and his ability to understand.
c. Using toys and games:
   Have toys of the appropriate developmental level of the child available. Engage the child in a game with the toys or allow the child free play with the toys. After a while ask the child about the toys and the game he or she is playing. Inquire about the rules, the purpose, etc. Estimate the child's vocabulary in terms of his or her ability to complete the interview.
d. Using puppets:
   Have hand puppets available. Allow the child to set the interaction, with the child playing all parts or with you playing some of the parts. Quiet children can become quite verbal with this approach. Focus on the child's ability to understand your questions during the puppet play and determine if this level of communication is sufficient for continued interviewing.

If you are satisfied that the child has adequate understanding, proceed with the interview.

SCORE ALL ANSWERS BELOW THAT APPLY

			C-1	C-2	C-3	P-1	P-2	P-3
SCHOOL ISSUES (If home schooled, skip question #2)								
1. Do you like school/learning?	Yes (C-1)	No (C-2)						
2. Do you listen to your teacher(s) most of the time:	Yes (C-1)	No (C-2)						
3. Have there been any recent problems with your school performance within the last year?	Yes (C-2)	No (C-1)						
4. Have you gotten in trouble at school?	Yes (C-2)	No (C-1)						
	School Issues Subtotal							
COMMENTS:								
PEER ISSUES								
5. Do you get along with most of your friends?	Yes (C-1)	No (C-2)						
6. Do you get picked on?	Yes (C-2)	No (C-1)						
7. Do you have as many friends as you want?	Yes (C-1)	No (C-2)						
8. Do you want to be alone or with other kids?	Alone (C-2)	Kids (C-1)						
9. Do you think your friends are a bad influence on you?	Yes (C-2)	No (C-1)						
	Peer Issues Subtotal							
COMMENTS:								

	C-1	C-2	C-3	P-1	P-2	P-3
BEHAVIOR ISSUES						
10. Do you get in trouble frequently at school? Yes (C-2) No (C-1)						
11. Do you usually not do things that you are asked to do? Yes (C-2) No (C1)						
12. Have you ever stolen or shoplifted? Yes (C-2) No C-1)						
13. Have you ever frequently lied? Yes (C-2) No (C-1)						
14. Have you ever used drugs, alcohol, or inhalants? Yes (C-2) No (C-1)						
15. Have you ever beat up or hurt others? Yes (C-2) or (C-3) No (C-1)						
Behavior Issues Subtotal						
COMMENTS:						
FAMILY ISSUES						
16. Do you like going home? Yes No Why?_____						
17. How well do you get along with your mother (female caregiver)? always get along (P-1) usually get along (P-1) sometimes get along (P-2) don't get along very often (P-2) never get along (P-3)						
18. Do you fight or argue with your mother? always (P-3) usually (P-2) sometimes (P-1) rarely (P-1) never (P-1)						
19. Are you afraid of your mother? always (P-3) usually (P-2) sometimes (P-2) rarely (P-1) never (P-1)						
20. How well do you get along with your father (male caregiver)? always get along (P-1) usually get along (P-1) sometimes get along (P-2) don't get along very often (P-2) never get along (P-3)						
21. Do you fight or argue with your father? always (P-3) usually (P-2) sometimes (P-1) rarely (P-1) never (P-1)						
22. Are you afraid of your father? always (P-3) usually (P-2) sometimes (P-2) rarely (P-1) never (P-1)						
23. Do your mother and father fight? [If the parents fight, have the child elaborate on the fights] always (P-3) usually (P-2) sometimes (P-1) rarely (P-1) never (P-1)						
24. Tell me about your brothers and/or sisters. How well do you get along with them? *(If there is variability in the relationship among siblings, rate the most serious.)* always get along (P-1) usually get along (P-1) sometimes get along (P-2) don't get along very often (P-2) never get along (P-3)						
25. Do you see your mom as much as you'd like? Yes (P-1) No (P-2)						
26. Do you see your dad as much as you'd like? Yes (P-1) No (P-2)						
27. What do you do that gets you into trouble at home? _____						
28. What happens at home when you get in trouble? grounded him/her (P-1) physical punishment (P-1) or (P-2) nothing (P-2) talked/lectured (P-1) or (P-2) sought outside help (P-1) yelled (P-1) or (P-2) abused (P-2) or (P-3) other (P-1) or (P-2) Explain_____						
29. Do you get spanked/punished too much? Yes (P-2) No (P-1) If so, by whom_____						
Family Issues Subtotals						
COMMENTS:						

	C-1	C-2	C-3	P-1	P-2	P-3
CRISIS OR TRAUMA (Probe for severity)						
30. Within the last year has anything bad happened in your life? Yes (C-2) or (P-2) No (C-1) What?_____						
31. Has there been an ongoing (chronic) crisis/problem in your life or in the family? Yes (C-2) or (P-2) No (C-1) What?_____						
32. Was the fire set after: No crisis (no score) family fight (C-2) being angry at sibling (C-2) being angry with boss (C-2) being angry with school authority (C-2) being angry with another (C-2) recent move (P-2) other crises, such as stress, death, depression (C-2) or (C-3) or (P-2) or (P-3) What?_____						
Crisis or Trauma Subtotal						
COMMENTS:						
FIRE HISTORY						
33. Do you like to look at fire for long periods of time? Yes (C-2) or (C-3) No (C-1)						
34. Do you dream about fires at night? Yes (C-2) or (C-3) No (C-1)						
35. Do you think about or daydream about fires in the day? Yes (C-2) or (C-3) No (C-1)						
36. Number of past (inappropriate) fires or fireplay incidents No other times (Assess no score, skip question #37.) 1 time (C-1) 2-4 times (C-2) more than 4 times (C-3)						
37. Tell me about all the fires that you started or your fireplay before this one. [Use a common time frame, i.e., Christmas, school starting, etc. to help child describe when fires were started or fireplay occurred] **INFORMATION ONLY**						

What Set	Date Set	Where Set	With Whom	Ignition Source	Accelerant if used
1.					
2.					
3.					
4.					
5.					
Others.					

38. *If there is more than one fire ask questions #38 and #39.* Do you feel the need to set fires over and over again? Yes (C-2) or (C-3) No (C-1)						
39. Do you always set your fires in exactly the same way? Yes (C-2) or (C-3) No (C-1)						
Fire History Subtotals						
COMMENTS:						

	C-1	C-2	C-3	P-1	P-2	P-3
CHARACTERISTICS OF FIRESTART OR FIREPLAY **[circle all that apply but only score the most severe response for each question]**						
40. Tell me about how you think the fire/fireplay started? admits/confesses (C-1) denies or minimizes (C-2) denial then truth (C-1)						
41. What do you think made you want to start the fire or the fireplay/what happened? to express anger (C-2) or (P-2) to see it burn (C-2) bored (C-2) to show power or control (C-2) or (C-3) didn't want to (accident or curiosity) (C-1) reaction to stress (C-2) or (P-2) from peer pressure (C-2) to destroy something (C-2) or (C-3) or (P-2) to hurt self (C-3) or (P-2) to hurt others (C-2) or (P-2) to get attention (C-2) or (P-2) don't know (C-2) rebellion - was told not to do so (C-2) or (P-2)						
42. What did you use to set the fire or start the fireplay? matches lighter flammable liquid/aerosol fireworks flarestove pilot light other_____						
43. How did you get the (above igniter) to start the fire or the fireplay? went out of way to acquire (C-2) found it (C-1) hidden stockpile (C-2) readily available at home (P-2) or (C-1) another child had material (C-1)						
44. What was set on fire? *(e.g., if the object of value was incidental to the fire score a C-2; or if purposely set on fire score a C-3.)* object of little or no value (C-1) or (C-2) object of value to child (C-2) or (C-3) object of value to others (C-2) or (C-3) part of a building (C-2) people, animals, self (C-3) flammable liquids/aerosols (C-3) wildland *intentional* (C-2) or *intentional* (C-3) fireworks (C-2) or (P-2) paper, tissue, cardboard, twigs (C-1) or (C-2) bedding/bed-child's own (C-2) bedding/bed-someone else's (C-2) clothing-child's own (C-2) clothing-someone else's (C-2) toys (C-2) furniture (C-2) trash, leaves, grass (C-2) animals (C-3) insects (C-2) matches only (C-2) or (P-2) lighter only (C-2) or (P-2)						
45. Where was the fire set or where did the fireplay occur? home-*occupied at the time* (C-3) other residence-*occupied at the time* (C-3) school-*occupied at the time* (C-3) other structure-*occupied at the time* (C-3) home-*unoccupied at time* (C-2) school-*unoccupied at time* (C-2) other structure-*unoccupied at time* (C-2) other residence-*unoccupied at time* (C-2) dumpster (C-2) vacant structure (C-2) outside (C-2) wildland (C-2) or (C-3) vehicle (C-2)						
46. Did you intend to set the fire? Yes (C-2) No (C-1)						
47. Did you drink or take any drugs before, during, or after the fire/fireplay Yes (C-2) No (C-1)						
48. What did you do after the fire started? *(If the response is appropriate based on the circumstances, score a C-1; if not, score a C-2 or C-3.)* put it out (C-1) or (C-2) called for help (C-1) ran away [if appropriate] (C-1) if not (C-2) stayed and watched (C-2) or (C-3) panicked (C-1) tried to extinguish (C-1) or (C-2) didn't try to extinguish (C-1) or (C-2) other (C-1) or (PC-2) or (C-3)						
49. How do your parents punish you? grounded/restricted (P-1) physical punishment (P-1) or (P-2) nothing (P-1) or (P-2) talked/lectured (P-1) or (P-2) sought outside help (P-1) yelled (P-1) or (P-2) abused (P-2) or (P-3) other (P-1) or (P-2) Explain _____						

	C-1	C-2	C-3	P-1	P-2	P-3
50. Did the fire(s) or fireplay you started make you happy or make you laugh? Yes (C-3) No (C-1)						
51. Can fire do magical, special, or miraculous things? Yes (C-2) or (C-3) No (C-1) Explain _____						
52. After the fire how did you feel? happy (C-2) nervous (C-1) sad (C-1) powerful (C-3) angry (C-2) hateful (C-2) vengeful (C-2) scared (C-1) remorseful (C-1) elated (C-3) guilty (C-1) ashamed (C-1) excited (C-3) curious (C-1) or (C-3) aroused sexually (C-3) aroused sensually (C-3)						
Characteristics of Firestart Subtotal						
COMMENTS**:**						
<u>OBSERVATIONS-</u> KEEP SEPARATE - NOT FOR PARENTAL REVIEW!						
53. Are child's behaviors and mannerisms: normal (C-1) troubled (C-2) very troubled (C-3)						
54. Is the child's mood: normal (C-1) troubled (C-2) very troubled (C-3)						
55. Is the child's way of thinking: normal (C-1) troubled (C-2) very troubled (C-3)						
56. Are there signs of abuse? Yes (P-2) or (P-3) No (P-1) Explain_____						
57. Are there signs of neglect? Yes (P-2) or (P-3) No (P-1) Explain_____						
Observations Subtotal						
COMMENTS:						

Comprehensive Juvenile FireRisk Interview Form Score Sheet

Transfer the information from the Subtotal Boxes into the table below; then total each column for the Total at the bottom.

SECTION SUBTOTALS	C-1	C-2	C-3	P-1	P-2	P-3
School Issues						
Peer Issues						
Behavior Issues						
Family Issues						
Crisis or Trauma						
Fire History						
Characteristics of Firestart						
Observations						
TOTAL						

These totals will be used to compute the Total Risk after all interviews are complete.

COMPREHENSIVE PARENT FIRERISK QUESTIONNAIRE

for the child 3 to 18 years of age

Respondent _____ **Agency** _____ **County** _____ **Date** _____

PARENTS: Please complete this form. Mark the answer under "rarely to never," "sometimes," or "frequently" that best describes your child for each question. When marking the form, consider all parts of the child's life (at home, at school, etc.) where the events below might occur. If an item does not apply, leave it blank. If you do not understand a term or question, make a mark next to it in the left margin and ask the interviewer for clarification.

ITEM	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Hyperactivity at school			
Lack of concentration			
Learning problems at school			
Behavior problems at school			
Impulsive (acts before he or she thinks)			
Impatient			
Fantasizes (daydreaming)			
Likes school			
Listens to teacher(s)/school authorities			
Shows age appropriate interest in future school/jobs/career			
Truant/school runaway			
Convulsions, seizures, "spells"			
Need for excessive security			
Need for affection			
Loss of appetite			
Excessive weight loss			
Excessively overweight			
Knows what is moral			
Feels good about self			
Comfortable with own body			
Likes overall looks			
Stuttering			
Wets during the day (after age 3)			
Night time bed wetting (after age 3)			
Soiling (after age 3)			
Participates in sports			

ITEM	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Injury prone			
Shyness			
Tries to please everyone			
Relationships are socially appropriate			
Physically fights with peers			
Withdraws from peers/group			
Destroys toys/property of others			
A poor loser			
Shows off for peers			
Easily led by peers			
Plays with other children			
Shows appropriate peer affection			
Plays alone (not even with adults)			
Picked on by peers			
Has many friends			
Is good at sports			
Is a loner (few friends)			
Lies			
Excessive and uncontrolled verbal anger			
Physically violent			
Steals			
Cruel to animals			
Cruel to children			
Is/was in a gang			
Expresses anger by damaging the property of others			
Destroys own toys/possessions (if child is age 3-6)			
Destroys own toys/possessions (if child is age 7-18)			
Disobeys			
Severe behavior difficulties (past or present)			
Expresses anger by hurting others' things			
Has been in trouble with police			

ITEM	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Uses drugs or alcohol			
Jealous of peers/siblings			
Temper tantrums			
Unacceptable showing off			
Sexual activity with others			
Stomach aches			
Nightmares			
Sleeps too deep or has problem waking up			
Anxiety (nervousness)			
Has twitches (eyes, face, etc.)			
Cries			
Bites nails			
Vomits			
Aches and pains			
Chews odd/unusual things			
Extreme mood swings			
Depressed mood or withdrawal			
Constipation			
Diarrhea			
Self-imposed unnecessary or excessive diets			
Sleepwalking			
Phobias			
General fears			
Curiosity about fire			
Plays with matches/lighters			
Plays with fire (singeing, burning)			
Was concerned when fire got out of control			
Was proud or boastful regarding fireplay or firestart			
Stares at fire for long periods (fire fascination)			
Unusual look on child's face when he or she stares at fire(s)			
Daydreams or talks about fires			

ITEM	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Fear of fire			
Other(s) in family set fire(s) (past or present)			
Set occupied structure on fire			
Appropriate reaction to fire(s) he or she set			
Extensive absences by father			
Extensive absences by mother			
Family has moved			
Runs away from home			
Has seen a counselor/therapist			
Other family member has seen a counselor/therapist			
Makes attempts at age appropriate independence from parents			
In trouble at home			
Parent or sibling with serious health problem			
Marriage is unhappy			
Mother's discipline is effective			
Father's discipline is effective			
Fighting with siblings			
Conflicts in family			
Unusual fantasies			
Strange thought patterns			
Bizarre, illogical, or irrational speech			
Out of touch with reality			
Strange quality about child			
Expresses anger by hurting self or something he or she likes			
Destroys own property			
Was/is in a cult			
Severe depression or withdrawal			
Poor or no eye contact			

PARENT QUESTIONNAIRE SCORE SHEET

Transfer the information you obtained above to the table below; then total each column for the Total at the bottom.

	C-1	C-2	C-3	P-1	P-2	P-3
School						
Health/Developmental						
Peers						
Antisocial Behavior (BEHAVIOR)						
Symptoms of Anxiety or Depression (ANXIETY)						
Fire History						
Family Issues (FAMILY)						
Severe Dysfunction (OTHER)						
TOTAL						

These totals will be used to compute the Total Risk after all interviews are complete.

COMPREHENSIVE PARENT FIRERISK QUESTIONNAIRE

for the child 3 to 18 years of age

VISUAL KEY

	RARELY TO NEVER	SOMETIMES	FREQUENTLY
SCHOOL			
Hyperactivity at school			C-2
Lack of concentration	C-1	C-1	C-2
Learning problems at school		C-2	C-2
Behavior problems at school	C-1	C-2	C-2
Impulsive (acts before he or she thinks)	C-1	C-1	C-2
Impatient	C-1	C-1	C-2
Fantasizes (daydreaming)			C-2
Likes school	C-2	C-1	C-1
Listens to teacher(s)/school authorities	C-2		C-1
Shows age appropriate interest in future school/jobs/career	C-2	C-1	C-1
Truant/school runaway		C-2	C-3
HEALTH/DEVELOPMENTAL			
Convulsions, seizures, “spells”		C-2	C-2
Need for excessive security	C-2	C-1	C-2
Need for affection	C-2	C-1	C-2
Loss of appetite			C-2
Excessive weight loss		C-2	C-2
Excessively overweight			C-2
Knows what is moral	C-2		C-1
Feels good about self	C-2		C-1
Comfortable with own body	C-2		C-1
Likes overall looks	C-2		C-1
Stuttering		C-2	C-2
Wets during the day (after age 3)	C-1	C-2	C-2
Night time bed wetting (after age 3)	C-1	C-2	C-2
Soiling (after age 3)		C-2	C-2
Participates in sports	C-2		C-1

	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Injury prone	C-1		C-2
Shyness	C-1		C-2
Tries to please everyone			C-2
Relationships are socially appropriate	C-2		C-1
PEERS			
Physically fights with peers	C-1		C-2
Withdraws from peers/group	C-1		C-2
Destroys toys/property of others	C-1	C-2	C-2
A poor loser	C-1		C-2
Shows off for peers			C-2
Easily led by peers	C-1	C-2	C-3
Plays with other children	C-2		C-1
Shows appropriate peer affection	C-2		C-1
Plays alone (not even with adults)	C-1		C-2
Picked on by peers	C-1		C-2
Has many friends	C-2	C-1	C-1
Is good at sports	C-2		C-1
Is a loner (few friends)	C-1	C-2	C-3
BEHAVIOR			
Lies	C-1		C-2
Excessive and uncontrolled verbal anger	C-1	C-2	C-3
Physically violent	C-1	C-2	C-3
Steals	C-1	C-2	C-3
Cruel to animals		C-2	C-3
Cruel to children		C-2	C-3
Is/was in a gang		C-2	C-3
Expresses anger by damaging the property of others			C-2
Destroys own toys/possessions (if child is age 3-6)			C-2
Destroys own toys/possessions (if child is age 7-18)		C-2	C-3
Disobeys	C-1		C-2
Severe behavior difficulties (past or present)		C-2	C-3
Expresses anger by hurting others' things		C-2	C-3
Has been in trouble with police		C-2	C-3

	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Uses drugs or alcohol		C-2	C-3
Jealous of peers/siblings	C-1		C-2
Temper tantrums	C-1		C-2
Unacceptable showing off	C-1		C-2
Sexual activity with others		C-3	C-3
ANXIETY			
Stomach aches			C-2
Nightmares	C-1		C-2
Sleeps too deep or has problem waking up		C-2	C-2
Anxiety (nervousness)	C-1		C-2
Has twitches (eyes, face, etc.)		C-2	C-2
Cries			C-2
Bites nails			C-2
Vomits			C-2
Aches and pains			C-2
Chews odd/unusual things			C-2
Extreme mood swings		C-2	C-2
Depressed mood or withdrawal		C-2	C-3
Constipation			C-2
Diarrhea			C-2
Self-imposed unnecessary or excessive diets			C-2
Sleepwalking		C-2	C-2
Phobias		C-2	C-3
General fears	C-1		C-2
FIRE HISTORY			
Curiosity about fire	C-1		C-2
Plays with matches/lighters	C-1	C-2	C-3
Plays with fire (singeing, burning)	C-1	C-2	C-3
Was concerned when fire got out of control	C-3	C-2	C-1
Was proud or boastful regarding fireplay or firestart		C-3	C-3
Stares at fire for long periods (fire fascination)		C-2	C-3
Unusual look on child's face when he or she stares at fire(s)		C-2	C-3
Daydreams or talks about fires		C-2	C-3

	RARELY TO NEVER	SOMETIMES	FREQUENTLY
Fear of fire	C-2		C-1
Other(s) in family set fire(s) (past or present)		P-2	P-3
Set occupied structure on fire		C-3	C-3
Appropriate reaction to fire(s) he or she set	C-3	C-2	C-1
FAMILY			
Extensive absences by father	P-1	P-2	P-2
Extensive absences by mother	P-1	P-2	P-2
Family has moved			P-2
Runs away from home	C-1	C-2	C-2
Has seen a counselor/therapist		C-2	C-2
Other family member has seen a counselor/ therapist		P-2	P-2
Makes attempts at age appropriate independence from parents	C-2	C-1	C-1
In trouble at home	C-1		C-2
Parent or sibling with serious health problem		P-2	P-2
Marriage is unhappy	P-1		P-2
Mother's discipline is effective	P-2		P-1
Father's discipline is effective	P-2		P-1
Fighting with siblings	C-1		C-2
Conflicts in family	P-1		P-2
OTHER			
Unusual fantasies		C-2	C-3
Strange thought patterns		C-2	C-3
Bizarre, illogical, or irrational speech		C-3	C-3
Out of touch with reality		C-3	C-3
Strange quality about child		C-2	C-3
Expresses anger by hurting self or something he or she likes		C-3	C-3
Destroys own property			C-2
Was/is in a cult		C-2	C-3
Severe depression or withdrawal		C-3	C-3
Poor or no eye contact		C-2	C-2

THE STRUCTURED CATEGORY PROFILE SHEET

COMPREHENSIVE FIRERISK ANALYSIS

Transfer the values from the "TOTAL" line for the family interview, parent questionnaire, and the child interview to the table below; add the columns for a "GRAND TOTAL." Use these totals to compute the percentages according to the formula below the table.

	C-1	C-2	C-3	P-1	P-2	P-3
Family Interview TOTAL						
Parent Questionnaire TOTAL						
Child Interview TOTAL						
GRAND TOTAL						

Child Risk (Use the values from the Grand Total Line.)

$$\frac{C-2+C-3}{C-1+C-2+C-3} = \text{\_\_\_\_\_}\%$$

Family Risk (Use the values from the Grand Total Line.)

$$\frac{P-2+P-3}{P-1+P-2+P-3} = \text{\_\_\_\_\_}\%$$

Total Risk (Use the values from the Grand Total Line.)

$$\frac{C-2+P-2+C-3+P-3}{C-1+P-1+C-2+P-2+C-3+P-3} = \text{\_\_\_\_\_}\%$$

Fineman, K., (1996). *Comprehensive Fire Risk Assessment.* Published in Poage, Doctor, Day, Rester, Velasquez, Moynihan, Flesher, Cooke, and Marshburn, (1997). Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. 1. Denver, CO, Colorado Division of Firesafety Comprehensive FireRisk Analysis
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Niño que comenzó un incendio - edad de 3 a 18 años

Dr. Kenneth R. Fineman– USFA-FEMA
Profesional de Servicios Causados por Incendios - Versión 3.0

FORMULARIO DE PREGUNTAS PARA LOS PADRES

(Para los padres de niños y adolecentes de 3 a 18 años de edad)

PADRES: Favor de completar esta forma. Marque la repuesta en "raramente o nunca," "a veces" o "frecuentemente" que mejor describa a su niño por cada pregunta. Cuando marque la forma, considere todas las partes en referencia a la vida del niño (en la casa, en la escuela, etc.) donde los eventos que se muestran abajo pudieran ocurrir. Si un artículo no aplica, déjelo en blanco. Si no entiende un término o pregunta, ponga una marca al lado del margen izquierdo y pida al entrevistador que le aclare su duda.

ARTÍCULO	RARAMENTE O NUNCA	A VECES	FRECUENTEMENTE
Hiperactividad en la escuela	☐	☐	☐
Falta de concentración	☐	☐	☐
Problemas de aprendizaje en la escuela	☐	☐	☐
Problemas de conducta en escuela	☐	☐	☐
Impulsivo (actúa antes de pensar)	☐	☐	☐
Impaciente	☐	☐	☐
Fantasea (sueña despierto)	☐	☐	☐
Le gusta la escuela	☐	☐	☐
Escucha a al maestro(s)/autoridades escolares	☐	☐	☐
Muestra el interés apropiado para su edad sobre futuras escuelas, trabajos, o carrera	☐	☐	☐
Falta a la escuela/se escapa de la escuela	☐	☐	☐
Padece convulsiones, ataques, "periodos o etapas"	☐	☐	☐
Necesidad de seguridad excesiva	☐	☐	☐
Necesidad de afecto	☐	☐	☐
Pérdida de apetito	☐	☐	☐
Pérdida de peso excesiva	☐	☐	☐
Sobrepeso excesivo	☐	☐	☐
Sabe lo que es la moral	☐	☐	☐
Se siente bien de si mismo	☐	☐	☐
Cómodo con su propio cuerpo	☐	☐	☐
Acepta miradas en general de parte de otras personas.	☐	☐	☐
Tartamudea	☐	☐	☐
Se orina durante el día (después de la edad de 3 años)	☐	☐	☐
Se orina en la noche mientras duerme (después de la edad de 3 años)	☐	☐	☐
Se ensucia (después de la edad de 3 años)	☐	☐	☐
Participa en deportes	☐	☐	☐
Es propenso(a) a lesiones	☐	☐	☐
Es tímido(a)	☐	☐	☐
Trata de agradar a toda la gente	☐	☐	☐
Sus relaciones son socialmente apropiadas	☐	☐	☐

ARTÍCULO	RARAMENTE O NUNCA	A VECES	FRECUENTEMENTE
Lucha físicamente con sus compañeros	☐	☐	☐
Se retira de sus compañeros/grupo	☐	☐	☐
Destruye juguetes/propiedad de otros	☐	☐	☐
Es un mal perdedor	☐	☐	☐
Le gusta llamar la atención de sus compañeros	☐	☐	☐
Fácilmente guiado por sus compañeros	☐	☐	☐
Juega con otros niños	☐	☐	☐
Muestra el afecto apropiado a sus compañeros	☐	☐	☐
Juega solo (tampoco con adultos)	☐	☐	☐
Es hostigado(a) por sus compañeros	☐	☐	☐
Tiene muchos amigos	☐	☐	☐
Participa en deportes	☐	☐	☐
Es un solitario(a) (pocos amigos)	☐	☐	☐
Miente	☐	☐	☐
Enojo verbal en exceso y sin control	☐	☐	☐
Es violento(a) físicamente	☐	☐	☐
Roba	☐	☐	☐
Es cruel con los animales	☐	☐	☐
Es cruel con los niños	☐	☐	☐
Está/estaba en una pandilla	☐	☐	☐
Expresa su enojo dañando la propiedad de otros	☐	☐	☐
Destruye sus propios juguetes / pertenencias (si el/la niño(a) tiene de 3-6 años de edad)	☐	☐	☐
Destruye sus propios juguetes / pertenencias (si el/la niño(a) tiene de 7-18 de edad)	☐	☐	☐
Desobedece	☐	☐	☐
Tiene dificultades severas de conducta (pasadas o presentes)	☐	☐	☐
Expresa su enojo destruyendo las cosas de los demás	☐	☐	☐
Ha estado en problema con la policía	☐	☐	☐
Usa drogas o alcohol	☐	☐	☐
Está celoso de sus compañeros/hermanos	☐	☐	☐
Berrinches de enojo	☐	☐	☐
Exhibición inaceptable	☐	☐	☐
Tiene actividad sexual con otros	☐	☐	☐

ARTÍCULO	RARAMENTE O NUNCA	A VECES	FRECUENTEMENTE
Dolores del estómago	☐	☐	☐
Pesadillas	☐	☐	☐
Duerme demasiado profundo o tiene problemas para despertar	☐	☐	☐
Ansiedad (nerviosismo)	☐	☐	☐
Parpadea o gestea (ojos, cara, etc.)	☐	☐	☐
Llora	☐	☐	☐
Se muerde las uñas	☐	☐	☐
Vomita	☐	☐	☐
Sufre de dolores	☐	☐	☐
Mastica cosas raras	☐	☐	☐
Sufre de cambios extremos de humor	☐	☐	☐
Sufre de depresión o se retira	☐	☐	☐
Estreñimiento	☐	☐	☐
Diarrea	☐	☐	☐
Se impone dietas innecesarias o excesivas	☐	☐	☐
Sonámbulo	☐	☐	☐
Fobias	☐	☐	☐
Miedos en general	☐	☐	☐
Tiene curiosidad por el fuego	☐	☐	☐
Juega con fósforos/encendedores	☐	☐	☐
Juega con fuego (chamusco, ardiente)	☐	☐	☐
Se preocupó cuando el fuego perdió el control.	☐	☐	☐
Estaba orgulloso(a) o jactancioso(a) con respecto al fuego	☐	☐	☐
Mira fijamente al fuego por largos periodos de tiempo (fascinación por el fuego)	☐	☐	☐
Semblante inusual en la cara cuando él/ella fija la mirada en el fuego	☐	☐	☐
Sueña despierto o habla acerca de fuegos	☐	☐	☐
Le tiene miedo al fuego	☐	☐	☐
Otro(s) en la familia han comenzado un incendio (en el pasado o en el presente)	☐	☐	☐
Estructura fija ocupada en el fuego	☐	☐	☐
Reacción apropiada acerca del fuego que el/ella enciende	☐	☐	☐

ARTÍCULO	RARAMENTE O NUNCA	A VECES	FRECUENTEMENTE
Ausencias extensivas del padre	☐	☐	☐
Ausencias extensivas de la madre	☐	☐	☐
La familia se ha mudado	☐	☐	☐
Huye del hogar	☐	☐	☐
Ha visto a un consejero/terapeuta	☐	☐	☐
Otro miembro familiar ha visto a un consejero/terapeuta	☐	☐	☐
Hace intentos de acuerdo a su edad para ser independiente de sus padres	☐	☐	☐
Tiene problemas en casa	☐	☐	☐
Tiene padres o hermanos con problemas serios de salud	☐	☐	☐
El matrimonio no es feliz	☐	☐	☐
La disciplina de la madre es efectiva	☐	☐	☐
La disciplina del padre es efectiva	☐	☐	☐
Pelea con sus hermanos	☐	☐	☐
Tiene conflictos en familia	☐	☐	☐
Fantasías raras	☐	☐	☐
Tiene pensamientos extraños	☐	☐	☐
El lenguaje es raro, ilógico, o irracional	☐	☐	☐
Fuera de contacto con la realidad	☐	☐	☐
Calidad extraña acerca del niño	☐	☐	☐
Expresa su enojo lastimándose a si mismo	☐	☐	☐
Destruye sus propias cosas o lo que le gusta	☐	☐	☐
Estaba/asiste a un culto	☐	☐	☐
Depresión severa o retiro	☐	☐	☐
Deficiencia o ausencia de contacto visual	☐	☐	☐

Niño que comenzó un incendio - edad de 3 a 18 años

Dr. Kenneth R. Fineman– USFA-FEMA
Profesional de Servicios Causados por Incendios - Versión 3.0

FORMULARIO DE PREGUNTAS PARA LOS PADRES

(Para los padres de niños y adolecentes de 3 a 18 años de edad)

PADRES: Favor de completar esta forma. Marque la repuesta en "raramente o nunca," "a veces" o "frecuentemente" que mejor describa a su niño por cada pregunta. Cuando marque la forma, considere todas las partes en referencia a la vida del niño (en la casa, en la escuela, etc.) donde los eventos que se muestran abajo pudieran ocurrir. Si un artículo no aplica, déjelo en blanco. Si no entiende un término o pregunta, ponga una marca al lado del margen izquierdo y pida al entrevistador que le aclare su duda.

ARTÍCULO	RARAMENTE O NUNCA		A VECES		FRECUENTEMENTE	
Hiperactividad en la escuela	☐		☐		☐	
Falta de concentración	☐	C1	☐		☐	C2
Problemas de aprendizaje en la escuela	☐	C1	☐		☐	C2
Problemas de conducta en escuela	☐	C1	☐	C2	☐	C2
Impulsivo (actúa antes de pensar)	☐	C1	☐		☐	C2
Impaciente	☐	C1	☐		☐	C2
Fantasea (sueña despierto)	☐		☐		☐	C2
Le gusta la escuela	☐	C2	☐	C1	☐	C1
Escucha a al maestro(s)/autoridades escolares	☐	C2	☐		☐	C1
Muestra el interés apropiado para su edad sobre futuras escuelas, trabajos, o carrera	☐	C2	☐	C1	☐	C1
Falta a la escuela/se escapa de la escuela	☐		☐	C2	☐	C2
Padece convulsiones, ataques, "periodos o etapas"	☐		☐	C2	☐	C2
Necesidad de seguridad excesiva	☐		☐		☐	C2
Necesidad de afecto	☐	C2	☐	C1	☐	C2
Pérdida de apetito	☐		☐		☐	C2
Pérdida de peso excesiva	☐		☐	C2	☐	C2
Sobrepeso excesivo	☐		☐	C2	☐	C2
Sabe lo que es la moral	☐	C2	☐		☐	C1
Se siente bien de si mismo	☐	C2	☐		☐	C1
Cómodo con su propio cuerpo	☐	C2	☐		☐	C1
Acepta miradas en general de parte de otras personas.	☐	C2	☐		☐	C1
Tartamudea	☐		☐	C2	☐	C2
Se orina durante el día (después de la edad de 3 años)	☐	C1	☐	C2	☐	C2
Se orina en la noche mientras duerme (después de la edad de 3 años)	☐	C1	☐	C2	☐	C2
Se ensucia (después de la edad de 3 años)	☐		☐	C2	☐	C2
Participa en deportes	☐	C2	☐		☐	C1
Es propenso(a) a lesiones	☐	C1	☐		☐	C2
Es tímido(a)	☐	C1	☐		☐	C2
Trata de agradar a toda la gente	☐		☐		☐	C2
Sus relaciones son socialmente apropiadas	☐	C2	☐		☐	C1

ARTÍCULO	RARAMENTE O NUNCA	A VECES	FRECUENTEMENTE
Lucha físicamente con sus compañeros	☐ C1	☐	☐ C2
Se retira de sus compañeros/grupo	☐ C1	☐	☐ C2
Destruye juguetes/propiedad de otros	☐ C1	☐ C2	☐ C2
Es un mal perdedor	☐ C1	☐	☐ C2
Le gusta llamar la atención de sus compañeros	☐	☐	☐ C2
Fácilmente guiado por sus compañeros	☐ C1	☐ C2	☐ C3
Juega con otros niños	☐ C2	☐	☐ C1
Muestra el afecto apropiado a sus compañeros	☐ C2	☐	☐ C1
Juega solo (tampoco con adultos)	☐ C1	☐	☐ C2
Es hostigado(a) por sus compañeros	☐ C1	☐	☐ C2
Tiene muchos amigos	☐ C2	☐ C1	☐ C1
Participa en deportes	☐ C2	☐	☐ C1
Es un solitario(a) (pocos amigos)	☐ C1	☐ C2	☐ C2
Miente	☐ C1	☐	☐ C2
Enojo verbal en exceso y sin control	☐ C1	☐ C2	☐ C3
Es violento(a) físicamente	☐ C1	☐ C2	☐ C3
Roba	☐	☐ C2	☐ C3
Es cruel con los animales	☐	☐ C2	☐ C3
Es cruel con los niños	☐	☐ C2	☐ C3
Está/estaba en una pandilla	☐	☐ C2	☐ C3
Expresa su enojo dañando la propiedad de otros	☐	☐ C2	☐ C3
Destruye sus propios juguetes / pertenencias (si el/la niño(a) tiene de 3-6 años de edad)	☐	☐	☐ C2
Destruye sus propios juguetes / pertenencias (si el/la niño(a) tiene de 7-18 de edad)	☐	☐ C2	☐ C3
Desobedece	☐ C1	☐	☐ C2
Tiene dificultades severas de conducta (pasadas o presentes)	☐	☐ C2	☐ C3
Expresa su enojo destruyendo las cosas de los demás	☐	☐ C2	☐ C3
Ha estado en problema con la policía	☐	☐ C2	☐ C3
Usa drogas o alcohol	☐	☐ C2	☐ C3
Está celoso de sus compañeros/hermanos	☐ C1	☐	☐ C2
Berrinches de enojo	☐ C1	☐	☐ C2
Exhibición inaceptable	☐	☐ C2	☐ C2
Tiene actividad sexual con otros	☐	☐ C3	☐ C3

ARTÍCULO	RARAMENTE O NUNCA		A VECES		FRECUENTEMENTE	
Dolores del estómago	☐		☐		☐	C2
Pesadillas	☐	C1	☐		☐	C2
Duerme demasiado profundo o tiene problemas para despertar	☐		☐	C2	☐	C2
Ansiedad (nerviosismo)	☐	C1	☐		☐	C2
Parpadea o gestea (ojos, cara, etc.)	☐		☐	C2	☐	C2
Llora	☐		☐		☐	C2
Se muerde las uñas	☐		☐		☐	C2
Vomita	☐		☐		☐	C2
Sufre de dolores	☐		☐		☐	C2
Mastica cosas raras	☐		☐		☐	C2
Sufre de cambios extremos de humor	☐		☐	C2	☐	C2
Sufre de depresión o se retira	☐		☐	C2	☐	C3
Estreñimiento	☐		☐		☐	C2
Diarrea	☐		☐		☐	C2
Se impone dietas innecesarias o excesivas	☐		☐	C2	☐	C2
Sonámbulo	☐		☐	C2	☐	C2
Fobias	☐		☐	C2	☐	C2
Miedos en general	☐	C1	☐		☐	C2
Tiene curiosidad por el fuego	☐	C1	☐		☐	C2
Juega con fósforos/encendedores	☐	C1	☐	C2	☐	C3
Juega con fuego (chamusco, ardiente)	☐	C1	☐	C2	☐	C3
Se preocupó cuando el fuego perdió el control.	☐	C3	☐	C2	☐	C1
Estaba orgulloso(a) o jactancioso(a) con respecto al fuego	☐		☐	C3	☐	C3
Mira fijamente al fuego por largos periodos de tiempo (fascinación por el fuego)	☐		☐	C2	☐	C3
Semblante inusual en la cara cuando él/ella fija la mirada en el fuego	☐		☐	C2	☐	C3
Sueña despierto o habla acerca de fuegos	☐		☐	C2	☐	C3
Le tiene miedo al fuego	☐	C2	☐		☐	C1
Otro(s) en la familia han comenzado un incendio (en el pasado o en el presente)	☐		☐	P2	☐	P3
Estructura fija ocupada en el fuego	☐		☐	C3	☐	C3
Reacción apropiada acerca del fuego que el/ella enciende	☐	C3	☐	C2	☐	C1

ARTÍCULO	RARAMENTE O NUNCA		A VECES		FRECUENTEMENTE	
Ausencias extensivas del padre	☐	P1	☐	P2	☐	P2
Ausencias extensivas de la madre	☐	P1	☐	P2	☐	P2
La familia se ha mudado	☐	P1	☐		☐	P2
Huye del hogar	☐		☐	C2	☐	C2
Ha visto a un consejero/terapeuta	☐		☐	C2	☐	C2
Otro miembro familiar ha visto a un consejero/terapeuta	☐		☐	P2	☐	P2
Hace intentos de acuerdo a su edad para ser independiente de sus padres	☐	C2	☐	C1	☐	C1
Tiene problemas en casa	☐	C1	☐		☐	C2
Tiene padres o hermanos con problemas serios de salud	☐		☐	P2	☐	P2
El matrimonio no es feliz	☐	P1	☐	P2	☐	P2
La disciplina de la madre es efectiva	☐	P2	☐		☐	P1
La disciplina del padre es efectiva	☐	P2	☐		☐	P1
Pelea con sus hermanos	☐	C1	☐		☐	C2
Tiene conflictos en familia	☐	P1	☐		☐	P2
Fantasías raras	☐		☐	C2	☐	C3
Tiene pensamientos extraños	☐		☐	C2	☐	C3
El lenguaje es raro, ilógico, o irracional	☐		☐	C3	☐	C3
Fuera de contacto con la realidad	☐		☐	C3	☐	C3
Calidad extraña acerca del niño	☐		☐	C2	☐	C3
Expresa su enojo lastimándose a si mismo	☐		☐	C3	☐	C3
Destruye sus propias cosas o lo que le gusta	☐		☐	C2	☐	C2
Estaba/asiste a un culto	☐		☐	C2	☐	C3
Depresión severa o retiro	☐		☐	C3	☐	C3
Deficiencia o ausencia de contacto visual	☐		☐	C2	☐	C2

RELEASE OF LIABILITY

I do hereby release, indemnify, and hold harmless the _____ Juvenile Firesetter Intervention Program, all its employees and volunteers against all claims, suits, or actions of any kind and nature whatsoever which are brought or which may be brought against the _____ Juvenile Firesetter Intervention Program for, or as a result of any injuries from, participation in this program.

_____	_____
Parent/Guardian	Date/Time
_____	_____
Juvenile	Witness

RELEASE OF CONFIDENTIAL INFORMATION

Juvenile's Name _____ D.O.B. _____

Release to/Exchange with:

Name _____

Address _____

_____

Phone _____

Information Requested _____

_____

I consent to a release of information to and/or and exchange of information with the _____ Youth Firesetting Intervention Program. I understand that this consent may include disclosure of material that is protected by state law and/or federal regulations applicable to either mental health or drug/alcohol abuse or both.

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law for drug/alcohol abuse records or by State Law for mental health records, federal requirements prohibit further disclosure without the specific written consent of the patient. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of drug/alcohol abuse or mental health information.

A copy of this Release shall be as valid as the original.

_____ _____

Parent/Guardian Date/Time

_____ _____

Juvenile Witness

RISK ADVISEMENT

I have been informed that the FEMA/USFA Youth Firesetting Evaluation indicates that my child, _____ has a serious risk of continued involvement with firesetting activity.

I have also been informed by the _____ Youth Firesetting Intervention Program of the serious risk of injury and property damage that may continue to exist until the problem is resolved.

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APPENDIX F

CHILD AND FAMILY RISK SURVEYS (SHORT FORM)

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Child and Family Risk Surveys
Description and Instructions
Colorado Juvenile Firesetter Prevention Program

Survey Development

In September 1995, the Colorado Department of Public Safety/Division of Fire Safety was awarded a grant to design and test the applicability and effectiveness of the Juvenile Firesetter/Arson Control and Prevention Program model for statewide dissemination. Funding for this program was provided by the Federal Emergency Management Agency, U.S. Fire Administration (EMW-95-S-4780), under P.L. 103-254, the Federal Arson Prevention Act of 1994. Also, the Adam and Dorothy Miller Lifesafety Center, Inc. (dba Miller Safety Center) was awarded a grant in 1991 to develop a pilot program based upon the model produced by the Institute for Social Analysis for the Bureau of Justice, Office of Juvenile Justice and Delinquency Prevention and the U.S. Fire Administration under Cooperative Agreement #JN-CX-K002, "The National Juvenile Justice Firesetter/Arson Control and Prevention Program."

The Miller Safety Center determined that the fire service needed a risk assessment tool that was accurate for predicting future risk of firesetting in juveniles, yet offered a reduction in the length of time needed to conduct the evaluation. The Colorado Project's primary objective was to develop a juvenile fire risk survey for the fire service. Kenneth Fineman, Ph.D., the primary author of the U.S. Fire Administration's juvenile firesetter evaluation which was first published in the 1970's and updated throughout the 1980's, offered his most current, unpublished version of this instrument as the basis for the Colorado Project. In the fall of 1995, Fineman and members of the Colorado Project (Marion Doctor, LCSW; Joe B. Day; Larry Marshburn; Kenneth Rester, Jr.; Cheryl Poage; Paul Cooke; Carmen Velasquez; Michael Moynihan, Ph.D., and Elise Flesher, Ph.D. candidate), met to revise the juvenile firesetter evaluation so that it could be used for research purposes. The result was the Comprehensive FireRisk Assessment, published in the Colorado Juvenile Firesetter Prevention Program. Training Seminar. Volume 1.

In 1998, using the Comprehensive FireRisk Assessment, Moynihan and Flesher conducted a study to develop the Child and Family Risk Surveys. The method and results of this study are reported in detail in their research paper (1998) cited in the reference list. From the Comprehensive FireRisk Assessment, Moynihan and Flesher identified a subset of statistically valid questions to comprise the Risk Surveys. Hence, the questions on the Risk Surveys are derived directly from the questions on the Comprehensive FireRisk Assessment. The Risk Surveys represent a shortened version of the Comprehensive FireRisk Assessment.

Survey Use

The Child and Family Risk Surveys offer an accurate means to assess the risk of future firesetting in juveniles. They are comprised of two sections, the Child Risk Survey (for the juvenile) and the Family Risk Survey (for the parent). The Risk Surveys take about thirty minutes to administer. It is recommended that the Risk Surveys be conducted in an interview format with the juvenile and at least one parent. The Risk Surveys do not release the fire service from the need to properly conduct cause and origin investigations, case documentation, obtain proper parental releases to interview a child, network community referral resources, and provide intervention education when appropriate.

When using the Risk Surveys, the following procedures are recommended:

- **Develop rapport with the family.**
- **Explain to the juvenile and parents the purpose of the interview.**
- **Obtain written permission from the parent or legal guardian to conduct the Child Survey.**
- **Complete all the demographic information.**
- **First conduct the Family Survey without the child present.**

- **If possible, conduct the Child Survey without the parents present in the same room.**
- **Begin the Child Survey with the Development of Rapport section.**
- **Ask all the questions exactly as they are written, to conform to the validated protocol.**

It is also recommended that both the Family and Child Surveys be conducted. The highest degree of accuracy will be achieved if both surveys are used. The Family Survey can be conducted over the phone with the child's parent; however, the Child Survey must be conducted in person and only after the proper parental release has been signed. It is also recommended that a fire or police incident report be placed in the file whenever possible.

While the questions on the Child and Family Surveys must be asked as they are written, there may be circumstances in individual cases where additional information is obtained. Please be sure to write notes in the case file regarding any information that is offered during the interview, even if the information is not scored.

Survey Scoring

Total the numerical weights assigned to the answers received during the interview. The following table shows how the total scores on the Child and Family Surveys correspond to the levels of firesetting risk and related methods of intervention.

Risk Level	Source	Score	Intervention
Little	Family Survey	<429	Education
Little	Child Survey	<511	Education
Definite	Family Survey	429<457	Referral and Education
Definite	Child Survey	511<540	Referral and Education

If the Child Risk Score is equal to or greater than 511, but less than 540, and/or the Family Risk Score is equal to or greater than 429, but less than 457 consider conducting the Comprehensive FireRisk Evaluation both the child and the parents or refer to a mental health professional.

Extreme	Family Survey	>457	Referral
Extreme	Child Survey	>540	Referral

There are discretionary areas where it may be advisable to conduct the Comprehensive FireRisk Evaluation initially. The Comprehensive FireRisk Evaluation is recommended for cases which may involve the following factors:

- **When the family is referred by social services, mental health, probation, or in some cases, juvenile diversion.**
- **When a resistant or uncooperative child or parent has been encountered.**

References

Moynihan, M. and Flesher, E. Locating a Risk Cut-Off Level Based on Key Variables in the Regression Equation. Child Interview. Parent Interview. Boulder, CO: Department of Psychology, University of Colorado, 1998.

Poage, C., Doctor, M., Day, J.B., Rester, K., Velasquez, C., Moynihan, M., Flesher, E., Cooke, P., Marshburn, L. (1997). Colorado Juvenile Firesetter Prevention Program: Training Seminar. Vol. 1. Denver, CO: Colorado Division of Firesafety.

PARTICIPATION RELEASE

The _____ utilizes the screening program developed by the Federal Emergency Management Agency and the United States Fire Administration to evaluate the child that has been involved in a fire incident or has been referred to the city by a parent or another entity or agency.

The evaluation tries to assess the risk of involvement in future firesetting behavior. To do this, six areas describing individual characteristics are evaluated (demographic, physical, cognitive, emotional, motivation, and psychiatric).

Based on the results of the evaluation, your child's tendencies will place him/her in one of the following areas of concern:

Little Risk	-	needs educational intervention
Definite Risk	-	needs referral for evaluation to a mental health agency or to a licensed psychologist or psychiatrist and educational intervention
Extreme Risk	-	needs immediate referral for evaluation by a licensed psychologist or psychiatrist

If educational intervention is indicated, the _____ program will offer further educational activity for your child.

Depending on the circumstances regarding an individual case, other agencies such as the school your child attends, local law enforcement, social services departments, etc. may become involved.

The questions asked in this evaluation may be viewed prior to signing this release upon request.

I, _____, have read the previous statement and do hereby grant permission for my child, _____, to participate in the _____ Intervention Program and hereby authorize to release information regarding my child to such other governmental entities and agencies as it may deem appropriate.

_____ _____

Parent/Guardian Date/Time

_____ _____

Juvenile Witness

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COMPREHENSIVE FAMILY FIRERISK INTERVIEW FORM

(Questions to be asked of parents of children 3 to 18 years of age)

CONTACT FORM _____ DEPT. NAME _____ Inc. Census Tract____ County

INCIDENT-DATE_____ NO. _____ TIME_____ CR. NO_____
INCIDENT ADDRESS:_____Street _____City _____ZIP

Multiple Juveniles ☐ Y ☐ N #_____ Ignition Source: ☐ Match ☐ Lighter ☐ Other ☐ Flammable Liquid/Accelerant

Est. Loss: $_____ Intentional: ☐ Y ☐ N Injuries: ☐ Y ☐ N #____ Death: ☐ Y ☐ N #_____
Hospitalizations: ☐Y ☐N #_____ Describe Injuries/Deaths _____

Location of Fire: Outside-Location of Origin _____ ☐ Inside/☐ Inside-Occupied Room of Origin_____

Referral Source Name:_____ Agency/Address: _____ Phone: _____
☐ Caregiver ☐ School ☐ Law Enforcement ☐ Mental Health ☐ Fire Service ☐ Juvenile Justice
☐ Parent ☐ Other/Describe _____

Caregiver/Parent Smokes ☐ Y ☐ N Did the home meet community standards for health/welfare of the child? ☐ Y ☐ N

Was the child supervised by a person 12 years of age or older at the time of the incident? ☐ Y ☐ N

Description of Incident and Pertinent Information:

_____

_____

Report by: _____ _____
Printed Name Signature

Juvenile Information

Last Name: _____ First Name: _____ M.I. _____ DOB _____/_____/_____
Sex ☐ M ☐ F Race: ☐ White ☐ Asian ☐ African Am. ☐ Native Am. ☐ Hispanic ☐ Other
Age: _____ Grade in School_____ School Currently Attending _____
Soc. Sec. #: _____-_____-_____

Home Address: _____ Phone: _____

Adult No. 1 Residing With The Child

Name:_____

Address: _____

Phone: H _____ W _____
Employed: ☐ Y ☐ N
Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Remarried ☐ Widowed

Relation to Juvenile: ☐ Natural ☐ Step

Adult No. 2 Residing With The Child

Name:_____

Address: _____

Phone: H _____ W _____
Employed: ☐ Y ☐ N
Marital Status: ☐ Married ☐ Separated
☐ Divorced ☐ Remarried ☐ Widowed

Relation to Juvenile: ☐ Natural ☐ Step

Others Residing With The Child

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

Moynihan, Flesher, and Colorado Juvenile Firesetter Prevention Program Staff 06/29/98 Family Risk Survey

FAMILY RISK SURVEY **Date Survey Conducted:** _____

This Family Risk Survey is designed to be given to parents who have concerns about their child's fire-play or firesetting behavior or whose child has set a fire which has come to the attention of a fire department, police agency or other community agencies. The Family Risk Survey is intended for use only as a preliminary screening tool and should be used with the Child Risk Survey to assess the child's suitability for fire intervention education or mental health referral.

The Family Risk Survey may be administered to parents over the phone or in person. The Child Risk Survey should be administered to the child in person and separate from their parents only after the parents or guardians have provided written informed consent for the child's participation in the survey.

Prior to administering the Family Risk Survey, please provide the following incident and demographic information.

I. Incident #: _____ Incident Date: ____/ ____/ ____ Incident Location: _____ CR #: _____

Incident Description: _____

_____

_____

_____

II. Child's Last Name: _____ First Name: _____ M.I. _____ D.O.B. ___/___/___

Child's Address: _____ Home Phone: _____

School Child Attends: _____ Grade: _____

III. Name of Parent/Guardian providing information: _____

Address (if different from child's): _____ Work Phone: _____

IV. Referral Source if **not** a fire call (Name/Agency): _____

Agency's Address: _____ Phone: _____

V. Interviewer's Name: _____ Phone: _____

Interviewer's Affiliation: _____

Interviewer's notes and/or comments: _____

_____

_____

_____

_____

Moynihan, Flesher, and Colorado Juvenile Firesetter Prevention Program Staff 06/29/98 Family Risk Survey
*Original questions appear in Fineman, *(1996), Comprehensive Fire Risk Assessment*, Published in the Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. I, (1997).

FAMILY RISK SURVEY

Date Survey Conducted: _____

To administer: Ask the question as written, check the response, place the appropriate constant weight in the score column, and add the scores to determine the Total Family Risk Score. Please substitute the child's name in questions 1-5.

Questions*		**Constant**	**Score**
1. If you had to describe (child's name) curiosity about fire, would you say it was absent, mild, moderate, or extreme?			
absent	_____	0	_____
mild	_____	99	_____
moderate	_____	198	_____
extreme	_____	297	_____
2. Has (child's name) been diagnosed with any impulse control conditions, such as Attention Deficit Disorder (ADD) or Attention Deficit Disorder with Hyperactivity (ADHD)?			
yes	_____ _____(Diagnosis)	28	_____
no	_____	0	_____
3. Has (child's name) been in trouble outside of school for non-fire-related behavior?			
yes	_____ _____(What?)	90	_____
no	_____	0	_____
4. Has (child's name) ever stolen or shoplifted?			
yes	_____	14	_____
no	_____	0	_____
dk/na	_____	0	_____
5. Has (child's name) ever beat up or hurt others?			
yes	_____	14	_____
no	_____	0	_____
dk/na	_____	0	_____
6. Besides this fireplay or firesetting incident, how many other times has your child played with fire, including matches or lighters, or set something on fire?			
1 (current)	_____	84	_____
2 (current + 1)	_____	168	_____
4 (current + 2-4)	_____	336	_____
6 (current + 5)	_____	504	_____
7. Is there an impulsive (sudden urge) quality to your child's firesetting or fire play?			
yes	_____	71	_____
no	_____	0	_____
dk/na	_____	0	_____
		TOTAL FAMILY RISK SCORE	_____

Question (8) is for informational purposes and does not score.

8. *Is there a history of emotional, physical, or sexual abuse in the family?* *Yes* _____ *No* _____
Who _____ *Relationship* _____ *Currently in the home* _____
If there are indications of abuse or neglect, consult with social services or law enforcement immediately.

A. **The Cut Off Score For Mental Health Referral For the Family Risk Survey Is 457 or Above.** If either the Family Risk Survey is equal to or greater than 457 and/or the Child Risk Survey is equal to or greater than 540, the child should be referred to a mental health professional.

B. If either the Family Risk Score is equal to or greater than 429, but less than 457 and/or the Child Risk Score is equal to or greater 511, but less than 540 consider conducting the comprehensive firesetter risk assessments for both the child and the parents or refer to a mental health professional.

C. **AN INTERVENTION EDUCATION PROGRAM** is appropriate if the Family Risk Score is less than 429 and/or the Child Risk Score is less than 511.

Moynihan, Flesher, and Colorado Juvenile Firesetter Prevention Program Staff 06/29/98 Family Risk Survey
*Original questions appear in Fineman, *(1996), Comprehensive Fire Risk Assessment*, Published in the Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. I, (1997).

CHILD RISK SURVEY **Date Survey Conducted:** _____

This Child Risk Survey is designed to be given to children (with their parent's written informed consent) who have played with fire or who have set a fire which has come to the attention of a fire department, police agency or other community agencies. The Child Risk Survey is intended for use only as a preliminary screening tool and should be used with the Family Risk Survey to assess the child's suitability for fire intervention education or mental health referral.

The Family Risk Survey may be administered to parents over the phone or in person. The Child Risk Survey should be administered to the child, in person, and separate from their parents only after the parents or guardians have provided written informed consent for the child's participation in the survey.

Prior to administering the Child Risk Survey, please provide the following incident and demographic information if it has not already been provided in the Family Risk Survey section.

I. Incident #: _____ Incident Date: ____/ ____/ ____ Incident Location: _____ CR #: _____

Incident Description: _____

_____

_____

_____

II. Child's Last Name:_____ First Name: _____ M.I. _____ D.O.B. ___/___/___

Child's Address: _____ Home Phone: _____

School Child Attends: _____ Grade: _____

III. Name of Parent/Guardian providing information: _____

Address (if different from child's): _____ Work Phone: _____

IV. Referral Source if **not** a fire call (Name/Agency): _____

Agency's Address: _____ Phone: _____

V. Surveyor's Name: _____ Phone: _____

Surveyor's Affiliation: _____

Surveyor's notes and/or comments: _____

_____

_____

_____

CHILD RISK SURVEY **Date Survey Conducted:** _____

INFORMATIONAL ACTIVITY FOR THE CHILD

Have the child draw a picture of the fire or fireplay incident and/or write a paragraph describing why they are in your office today while you are conducting the Family Survey with the parents.

DEVELOPMENT OF RAPPORT

The purpose of this section is to make the child comfortable with you. The more at ease you can make him, the greater the likelihood that he will answer all of your questions. If the following questions aren't enough, add your own. Questions or language can be modified in the Development of Rapport section only, **all other questions should be asked as written.** This section was developed by Kenneth R. Fineman Ph.D., and is reprinted from Comprehensive Fire Risk Assessment as published in the Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. I.

1. [Introduce yourself] I'm _____ What's your name? _____
2. How old are you? _____
3. What school do you go to? _____ What grade are you in? _____

   Do you like your school? _____ Are there nice/okay teachers at your school? _____
4. What classes/subjects do you like/not like? _____
5. What do you do for fun? Do you have hobbies? _____
6. Who's your best friend? _____
7. What do you like to play/do with your friend? _____
8. What do you watch on TV and/or what videos do you watch? _____
9. What is your favorite person/show on TV? _____
10. What is your favorite video/computer game? _____
11. What do you like about that game? [Is there extreme interest in violence or fire?] _____

[When rapport is established, determine level of understanding if the child is under 7 or appears to have problems communicating.]

COMPARISON OF THE ORIGINAL AND REVERSE ORDER VERSIONS OF THE INCIDENT

For children age nine and older, consider asking the following prior to proceeding:

Have the child describe their involvement in the incident from some point in time prior to some point in time after the incident. At the end of the interview ask the child to repeat this description in reverse order.

The average child whom is at least nine years old should be able to relate incident details in reverse order if the original version of his or her account of the incident was truthful.

CHILD RISK SURVEY **Date Survey Conducted:**_____

DETERMINE LEVEL OF UNDERSTANDING (Under 7)

This section was developed by Kenneth R. Fineman, Ph.D., and is reprinted from the Comprehensive Fire Risk Assessment as published in the Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. I.

It is often difficult to determine if a young child really understands you. (This section may be skipped if you are interviewing an older child). There may be an age barrier, a language barrier, a learning problem, or sub-normal intelligence. It is fruitless to go through an entire interview unless you are first assured that the child has enough understanding to complete the interview. There are several ways to gauge whether you are on the same "wave length" as the child. The following are suggested ways to do so:

a. Obtain information from rapport section above:
   By paying close attention to the manner in which a young child responds to the 11 questions above, you can estimate whether he can understand and respond to the other questions in this instrument.

b. Using crayons/paper as a tool:
   You can ask the child to draw pictures of common objects, his favorite toys, houses, trees, and people. Then ask him to describe what he has drawn. Clear explanations of his drawings and the action taking place in some of those drawings will tell you something about the child's vocabulary and his ability to understand.

c. Using toys and games:
   Have toys of the appropriate developmental level of the child available. Engage the child in a game with the toys or allow the child free play with the toys. After a while ask the child about the toys and the game he is playing. Inquire about the rules, the purpose, etc. Estimate the child's vocabulary in terms of his ability to complete the interview.

d. Using puppets:
   Have hand puppets available. Allow the child to set the interaction, with the child playing all parts or with you playing some of the parts. Quiet children can become quite verbal with this approach. Focus on the child's ability to understand your questions during the puppet play and determine if this level of communication is sufficient for continued interviewing.

If you are satisfied that the child has adequate understanding, proceed with the interview.

CHILD RISK SURVEY **Date Survey Conducted** _____

To administer: Ask the question as written, check the response, place the appropriate constant weight in the score column, and add the scores to determine the Total Child Risk Score.

Questions*			**Constant**	**Score**
1. Do you have any brothers or sisters?				
	yes _____		0	
	no _____	**(If no, skip to Q. 3)**	0	
2. How well do you get along with them?				
	always get along	_____	28	
Score only one	usually get along	_____	56	
response, using	sometimes get along	_____	84	
the one with the	don't get along very often	_____	112	
highest risk value.	never get along	_____	140	
3. How well do you get along with your mother?				
	always get along	_____	10.5	
	usually get along	_____	21	
	sometimes get along	_____	31.5	
	don't get along very often	_____	42	
	never get along	_____	52.5	
4. Do you fight or argue with your mother?				
	never	_____	10.5	
	rarely	_____	21	
	sometimes	_____	31.5	
	usually	_____	42	
	always	_____	52.5	
5. Do you see your father as much as you'd like?				
	yes	_____	0	
	no	_____	60	
	too much	_____	60	
6. When you are asked to do something, do you usually do it?				
	yes	_____	0	
	no	_____	17.5	
7. Do you lie a lot?				
	yes	_____	17.5	
	no	_____	0	
8. What happens at home when you get in trouble?				
grounded _____	physical punishment	_____	0.0	
talked/lectured _____	sought outside help	_____	0.0	
abused** _____	other/nothing	_____	0.0	
	yelled at	_____	32	
9. Has there been an ongoing (chronic) crisis or problem in your life or in your family?				
yes _____	_____ (What?)		62	
no _____			0	

Moynihan, Flesher, and Colorado Juvenile Firesetter Prevention Program Staff 06/29/98 Child Risk Survey
*Original questions appear in Fineman, *(1996), Comprehensive Fire Risk Assessment*, Published in the Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. 1, (1997).

CHILD RISK SURVEY **Date Survey Conducted** _____

10. Besides this fireplay or firesetting incident, how many other times have you played with fire, including matches or lighters, or set something on fire?

1 (current)		32	
2 (current +1)		64	
4 (current +2-4)		128	
6 (current +5)		192	

11. What did you do after the fire started?

put it out		called for help		0,0	
ran away		didn't try to run		0,0	
panicked		tried to extinguish		0,0	
other		didn't try to extinguish		0,0	
		stayed and watched		40	

12. Did you intend to play with fire or set the fire, that is, did you play with or set the fire on purpose?

yes		187	
no		0	

If the surveyor has evidence of intent, the surveyor may override the youth's denial

13. Where did you set the fire?

_____

(If any type of structure was involved as a target or a location, score:)	47	
	0	

other _____

14. Do you like to look at fire for long periods of time?

yes		250	
no		0	

TOTAL CHILD RISK SCORE _____

Question (15) is for informational purposes and does not score.

15. How did you get the ignition source (match/light/other) used in the fire/fireplay?

_____

** *If there are indications of abuse or neglect consult with social services or law enforcement immediately.*

If the child is at least nine years old, ask the child to repeat, in reverse order, the description of the incident.
How does this compare to the original description?

A. The Cut Off Score For Mental Health Referral For The Child Risk Survey Is 540 or Above. If either the Child Risk Survey is equal to or greater than 540 and/or the Family Risk Survey is equal to or greater than 457, the child should be referred to a mental health professional.

B. If the Child Risk Score is equal to or greater than 511, but less than 540, and/or the Family Risk Score is equal to or greater 429, but less than 457 consider conducting the comprehensive firesetter risk assessments for both the child and the parents or refer to a mental health professional.

C. AN INTERVENTION EDUCATION PROGRAM is appropriate if the Child Risk Score is less than 511 and/or the Family Risk Score is less than 429.

Moynihan, Flesher, and Colorado Juvenile Firesetter Prevention Program Staff 06/29/98 Child Risk Survey
*Original questions appear in Fineman, *(1996), Comprehensive Fire Risk Assessment,* Published in the Colorado Juvenile Firesetter Prevention Program: Training Seminar Vol. 1, (1997).

RELEASE OF LIABILITY

I do hereby release, indemnify, and hold harmless the _____ Youth Firesetting Intervention Program, all its employees and volunteers against all claims, suits, or actions of any kind and nature whatsoever which are brought or which may be brought against the _____ Youth Firesetting Intervention Program for, or as a result of any injuries from, participation in this program.

_____ _____

Parent/Guardian Date/Time

_____ _____

Juvenile Witness

RELEASE OF CONFIDENTIAL INFORMATION

Juvenile's Name _____ D.O.B. _____

Release to/Exchange with:

Name _____

Address _____

_____

Phone _____

Information Requested _____

_____

I consent to a release of information to and/or an exchange of information with the _____ Youth Firesetting Intervention Program. I understand that this consent may include disclosure of material that is protected by state law and/or federal regulations applicable to either mental health or drug/alcohol abuse or both.

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by Federal Law for drug/alcohol abuse records or by State Law for mental health records, federal requirements prohibit further disclosure without the specific written consent of the patient. A general authorization for release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of drug/alcohol abuse or mental health information.

A copy of this Release shall be as valid as the original.

_____ _____

Parent/Guardian Date/Time

_____ _____

Juvenile Witness

RISK ADVISEMENT

I have been informed that the FEMA/USFA Youth Firesetting Evaluation indicates that my child, _____ has a serious risk of continued involvement with firesetting activity.

I have also been informed by the _____ Youth Firesetting Intervention Program of the serious risk of injury and property damage that may continue to exist until the problem is resolved.

I have been advised to seek an evaluation by a licensed psychotherapist or psychiatrist.

_____ _____

Parent/Guardian Date/Time

_____

Witness

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APPENDIX G

OREGON OFFICE OF STATE FIRE MARSHAL JUVENILE WITH FIRE SCREENING TOOL

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JUVENILE WITH FIRE

Screening Tool

Distributed by Oregon Office of State Fire Marshal
Oregon Department of State Police
Juvenile Firesetter Intervention Unit
4760 Portland Road NE,
Salem, Oregon 97305-1760
(503) 373-1540, ext. 230

November 2003

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Introduction

The Juvenile Firesetter Screening Tool is designed for use by fire service personnel to screen youth referred to them for a fire-related incident. This is a basic screening tool. It is used to decide if a youth needs fire education intervention or needs to be referred to other community agencies. The screening tool is only the first step in the evaluation process for a youth who is using fire. It is not a risk inventory nor does it attempt to predict recidivism.

The tool is based on the statistical analysis of 130 juvenile firesetter assessments. The assessment form used in the research was developed by Kenneth Fineman, Ph.D. The analysis, done by Paul Yavonoff, Ph.D. and Michael Bullis, Ph.D. of the Institute on Violence and Destructive Behavior, was based on Item Response Theory (IRT). The National Arson Prevention Initiative provided the funding for this research effort.

The present document reflects the work of many fire and mental health professionals in Oregon. However, the format of the interview is based on the work of Laurie Birchill, LCSW. Ms. Birchill developed a screening tool for youth applying for entrance into residential treatment in 1989. Ms. Birchill's instrument proved to be user-friendly and stood the test of time. Ms. Birchill made a significant contribution to this project by refining many of her original questions. We are indeed grateful for her expertise.

The Oregon fire service participated in the research which formed the basis for this inventory. They recognized the need for a screening instrument based on empirical data. During the course of the project, interventionists from over twenty fire departments participated in the development of this tool. We are grateful for the dedication of the many men and women from the Oregon fire service who worked so hard to make this screening tool a reality.

Additional funding and facilitation for this project was provided by the Oregon Office of State Fire Marshal, Juvenile Firesetter Intervention Unit.

The Oregon ***Juvenile with Fire*** screening tool was designed to give the fire service professional or community partner a "broad brush" approach to understanding the firesetting behavior of a youth. In Oregon, this screening tool represents only the first step in an evaluation process. The next step includes a mental status evaluation, psychosocial history, firesetter history, diagnosis and treatment recommendations. This step is completed by a qualified mental health professional in the community. A more comprehensive evaluation may also include a battery of psychological testing given by a state licensed clinical psychologist.

The J***uvenile with Fire*** screening tool was designed to meet the needs of both a paid and volunteer fire service. The tool is easy to administer, can be completed in a relatively short period of time, is flexible and focuses mainly on the fire incident. It is not a psychometric risk inventory and therefore does not assign levels of risk. Rather, the fire service in Oregon believes that any fire started by a youth has the potential to cause property loss, injury, and even death and is, therefore, a serious risk-taking behavior.

The screening booklet has several parts:

Steps for Conducting a Screening Interview: Self explanatory

Personal Information: Serves as a basic intake form or the face sheet on a file

Youth Interview: Since the focus of the screening tool is on the fire incident, eleven questions in the youth interview are fire-related. Only three of the fourteen questions in the youth interview are non-fire related. The three questions ask about school, peer group and recent family crisis. Under each of the fourteen primary questions is a list of "suggested" questions. You may ask one of them, all of them, or even probe the topic area with your own questions. You want to ask as many questions as you need until you feel comfortable enough to be able to score the question. Each question is scored on a range of 1-3 with 1 being the most normative behavior. It is recommended that you score the questions after you complete the entire interview. The Comment section is for your notes.

Parent Checklist: This is a self-report checklist. It is included in the referral package. Fire personnel do not need to ask any follow-up questions on this checklist. Many of the items on the checklist were determined to be red-flag behaviors requiring the services of community partners working with at-risk youths.

Parent Interview: The parents are asked ten questions. These questions deal with past firesetting behavior, parents' perceptions of their child's behavior and what fire safety is practiced in the home. The parent interview gives fire professionals an indication of the level of fire education the family needs.

Scoring and Referral Procedure: See Scoring and Referral Procedure Page

Report: This is a sample format to use when writing up a referral.

Authorization for Release of Information: This form is used in Oregon. Other jurisdictions may have their own form.

Child-Parent Contract: This form outlines safety precautions for the child and family. It is recommended that you select one or more items for the family to complete. Have the family sign the form, make a copy for them and put a copy in your files. While one cannot predict a child's future firesetting behavior, the fire service can make sure that the family was given fire safety and fire survival information at the time of the interview.

Good Fire, Bad Fire: This is an activity sheet for the younger age child. There are many activity sheets available for younger age youth. You may have your own preference.

Fire and Life Safety Questionnaire: This activity sheet was designed for the middle school aged youth. It can assist the interviewer in assessing the educational level of the youth, which can be helpful in assigning reading or writing homework assignments.

Form 10J: Submit to the Oregon Office of State Fire Marshal for data collection. (Your state or department may have their own data collection point.)

Steps for Conducting a Screening Interview

Step 1: A request for a screening interview is received. This request may come from several sources: a parent/caregiver, fire personnel, or other agency (i.e. juvenile, school, mental health)

Step 2: When the person calls for a screening interview, complete as much as possible of the **Incident Information** form.

Step 3. Schedule screening interview. Inform the family that the interview will take about an hour.

Step 4. At the time of the interview, introduce yourself, explain the purpose and format of the meeting. *Example:* "We are here today to gather information that will help determine what educational intervention is needed to stop your child from playing with or setting fires. There are many reasons why kids are interested in fire. We are concerned about your child's safety and the safety of your family. We know only too well how fast fire can get out of control and we want to make sure that it doesn't happen to you. So, we are going to ask you and your child a series of questions about the fire incident. I will also be asking you to complete a checklist. This information will direct us on how to best help your child.

Step 5. Give the parent the **Parent Checklist** and place them in a separate room to fill it out. Time permitting, you might also want them to view a safety video. We recommend *Plan to Get out Alive* or *Fire Power*.

Step 6. Interview the youth. Complete the **Youth Interview** form. Take time to establish rapport with the youth before beginning your questions about the fire.

Step 7. After the parent has completed the **Parent Checklist** and you have finished interviewing the child, bring the parent and child back together to complete the **Parent Interview** form. Depending on your situation, you may want to interview the parent alone.
(Optional: If interviewing the parent first, give the youth an assignment to complete such as a work sheet*, a fire safety questionnaire*, or ask them to draw a picture of their fire.)

Step 8. Score the **Youth Interview** form and the **Parent Interview** form. Depending on the results of the scoring, the interviewer will recommend intervention strategies. There are basically two:
1) Fire Education for the youth and family
2) Referral to another agency for a more comprehensive assessment, accountability program, and fire education for the youth and family

When is a release of information form* needed? If the interviewer is recommending a referral to another agency, have the parent/caregiver complete a release of information form. This release allows the fire department personnel to discuss the case with other providers. We recommend that you list the county juvenile firesetter network on the release form.

*Sample provided at back of book.

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Juvenile Firesetter Incident Information

Personal Information

Date Received _____ Agency/Department _____ Initial Contact Person _____

Person/Agency Requesting Service _____ Phone# _____

Youth's Name _____

Address _____ City _____

Age _____ DOB _____ Male ____ Female ____

Parents/Caregivers

Father _____ Work# _____ Home# _____

Mother _____ Work# _____ Home# _____

Other adults in the home

Name	Relationship
_____	_____
_____	_____
_____	_____

Brothers/Sisters

Name	Age
_____	_____
_____	_____
_____	_____

School _____ Grade _____

Incident Information

Did the fire dept. respond? (Yes ____) (No ____) Incident # _____ Date _____

Where did the incident take place? _____

What was set on fire? _____

What was the ignition source? _____

Have there been any other firesets? _____

Action Taken

Screening Interview Date _____ Time _____

Name of Interviewer _____

Results: Fire Education _____ Referral to _____

Describe educational intervention provided: (Use back.) _____

Comments:

Youth Interview

Name _____ Date_____

Interviewer's name _____ Total score _____

Instructions: Place a check mark next to the scoring level that best describes the situation for this youth. Expand the questions as you feel necessary to complete the interview with confidence. Use the comment line for anything that seems out of the ordinary or supports your impressions.

A. Is the youth experiencing any school problems?
Suggested Questions: ***How's school? What do you like about school? What don't you like? Do you get in trouble at school? Do you have lots of friends at school? Who is your best friend?***

Scoring:

_1 The youth likes school and has minimal problems.
_2 The youth has some trouble in school either socially or academically.
_3 The youth has frequently been in trouble at school, hates the teachers, doesn't like the classes, etc.

Comments:

_____

_____

B. How does the youth get along with the others in the neighborhood?
Suggested Questions: ***Do you have any friends in the neighborhood that you hang out with? Do you like them? Do they like you? Do you ever get picked on by the kids in the neighborhood?***

Scoring:

_1 The youth has friends in the neighborhood.
_2 The youth gets into fights frequently in the neighborhood or has few friends. The youth may get picked on by others.
_3 The youth is involved in a gang or is "hanging out" with other youths involved in delinquent or criminal activity.

Comments:

_____

_____

C. What was set on fire? _____ Was there anything significant about the object ?
Suggested Questions: ***Tell me about what was burned? Tell me about the fire. I wonder why you wanted to burn _____? Have you ever burned _____before? What other types of things have your burned? Whose stuff did you burn?***

Scoring:

_1 The object that was burned had little emotional significance for the youth. (i.e. toilet paper, leaves or trash)
_2 The object that was burned had some emotional significance for the youth (i.e. plastic army figures, other person's possessions)
_2 For an adolescent, the object may not have any significance but may be an act of vandalism.
_3 The object that was burned had emotional significance for the youth or someone else (i.e. sibling's crib or favorite toy, a parent's or caregiver's possession)

Comments:

_____

_____

D. Where was the fire set? Was there any particular significance to the location of the fire?
Suggested Questions: ***Where did the fire start? If at home, what room were you in, or were you outside? If not at home, do you go to this place often? Do you like being there?***

Scoring:

_1 The fire was started in a place where the youth plays such as his/her bedroom, a closet, a fort, a hiding place.
_2 The fire was started in a place with community significance i.e. church, a school, a park, in the forest.
_3* The fire was set in a building occupied with people with the intent to place people at-risk.

Comments:

_____

_____

E. How much planning was done prior to the fire?
Suggested Questions: ***Tell me what you were you doing right before the fire? Did you think about how you were going to start the fire? Where did you get the things that were burned? What was used to light the fire? Where did it come from?***

Scoring:

_1 The fire was started using available materials; the act of firesetting was spontaneous and done without planning. Matches and lighters were readily available.
_2 There was some pre-planning for the fire and some gathering of materials; however, the fire was not especially thought out.
_3 There was definite planning for the fire, materials were sought out, and matches and lighters were stashed and/or hidden at the site beforehand. Accelerants may have been used.

Comments:

_____

_____

F. Who was with the youth at the time of fire?
Suggested Questions: ***Was anyone with you when the fire started? If yes, who? What did they say about the fire? Did the person with you do anything as the fire started burning?***

Scoring:

_1 The youth was with many peers/siblings when the fire was set.
_2 The youth was with other peers/siblings and this youth might have instigated the fire.
_3 The youth was alone when the fire was set.

Comments:

_____

_____

G. What was the youth's response to the fire?
Suggested Questions: ***What was the first thing you did when the fire started to burn? What was the next thing? Did you tell someone (an adult) about the fire? If so, who was it: When was it?***

Scoring:

_1 The youth tried to extinguish the fire and called for help.
_1 The youth engaged in match or lighter play.
_2 The youth may have made some attempts to extinguish the fire, but called for help only after others discovered the fire.
_3 The youth ignored the fire, did not call for help, may have stayed to watch, or may have left the fire scene.

Comments:

_____

_____

H. How did the youth feel after the fire?

Suggested Questions: ***What did your (parents/caregivers/principal/dad/mom) say to you about the fire? Was anyone angry with you about the fire? Do you care about what others think of you for having started a fire? Did you feel like you had done something bad or did the fire scare you? Did you think you would be in trouble?***

Scoring:

_1 The youth showed remorse for the fire.
_2 The youth showed interest in how others reacted.
_3 The youth is unconcerned about others' reactions or is pleased with the fire.

Comments:

I (A). Was the youth supervised when the fire occurred at home?

Suggested Questions: ***When you were playing around with the matches and lighters, where was mom or dad? Was anybody at home at the time? Who was taking care of you?***

Scoring:

_1 Parents or caregivers were home at the time of the fire incident.
_2 Parents or caregivers were home but unavailable (i.e. sleeping, watching TV, not being attentive)
_3 Youth was left alone or with younger children.

or ...

I (B). Was the youth supervised when the fire occurred outside of the home?

Scoring:

_1 The youth was under appropriate adult supervision (i.e. school, church, neighbor's home, babysitter).
_2 The youth was NOT directly supervised at the time of the fire (i.e. at recess, in bathroom, at the park).
_3 Youth was left alone or with younger children.

Comments:

J. How knowledgeable is the youth about fire? How much does the youth understand about the dangers of fire? Does the youth use fire for power or control?

Suggested Questions: ***Did you think that the fire could get out of control and get really big? Do you feel you can control a fire that you start? Can you determine how big the fire will get? How? What did you want to have happen when you started the fire?***

Scoring:

_1 The youth is knowledgeable about some aspects of fire survival but is unaware of the destructiveness or speed of fire.
_2 The youth may indicate some concern about the dangers and risk of firesetting but thinks they can control it.
_3* The youth does have an understanding of fire and uses it to defy authority, to gain status or attention, to express anger or for revenge.

Comments:

K. Has the family experienced any kind of crisis in the past six months?
Suggested Questions: ***Tell me about home. Do you like being at home? Is there anything about home that you don't like? Has anything happened at home in the last six months that upset you? Is there anything different at home lately?***

Scoring:

_1 There has been no major crisis in the family in the last six months.
_2 There have been some changes in the family structure in the last six months, ie. divorce, death, moving, death of a pet, etc.
_3 The family is in a state of crisis or chaos.

Comments:

_____

_____

L. Does the youth have a fire history?
Suggested Questions: ***Tell me the other times you have burned things? What was the smallest fire? What was the largest fire? What are some of the other things you have burned? If you started other fires, how did you start them? Have you ever used an accelerant like gasoline or lighter fluid? How about fireworks? Have you ever altered fireworks?***

Scoring:

_1 This is the first known incidence of fireplay or firesetting.
_2 The youth admitted to setting from 2-5 fires or played with matches/lighters.
_3* The youth has started more than 5 unsupervised or inappropriate fires. One or more of the fires has resulted in property loss or injury.

Comments:

_____

_____

M. How concerned was the youth for accepting responsibility for the fire?
Suggested Questions: ***Now the fire is out and you have had a chance to think about what has happened, would you do it again? Tell me your reasons or why this fire occurred?***

Scoring:

_1 The youth acknowledges the seriousness of the firesetting and accepts help appropriately.
_2 The youth acknowledges the seriousness of the firesetting but seeks to blame others and denies his/her own responsibility.
_3 The youth denies the seriousness of the firesetting and his/her own responsibility for it or takes full responsibility for it because he/she intended to cause destruction or injury.

Comments:

_____

_____

N. Has the youth ever been burned?
Suggested questions. ***Have you ever been hurt by fire? Tell me what happened? Where did it happen? Who was involved?***

Scoring:

_1 The youth has never been burned.
_2 The youth has been burned unintentionally.
_3 The youth has been burned by another person, may have scars from this burn.

Comments:

_____

_____

Comments:

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Parent Checklist

(Please print)
Name of youth: _____ Date of birth: ____/____/____

Name of person filling out this questionnaire: _____

Relationship to child _____ Are there smokers in the home? Y m N m

My son or daughter takes medicine for a behavior problem. Y m N m

Please check if any of the following statements are true for your son or daughter.

Yes	No	Some-times	
___	___	___	My son or daughter has set more than one fire or has played with matches more than one time.
___	___	___	My son or daughter has set fires outside of the home before.
___	___	___	Other people in the home have set fires.
___	___	___	My son or daughter is fascinated with fire (for example, often stares at flames).
___	___	___	My son or daughter has misused or altered fireworks.
___	___	___	My son or daughter has easy access to matches and/or lighters.
___	___	___	There is a fireplace, wood stove, and/or candles or incense frequently in use in our home.
___	___	___	My son or daughter fights with brothers and sisters.
___	___	___	My son or daughter argues with parents/caregivers.
___	___	___	My son or daughter has witnessed parents arguing.
___	___	___	My son or daughter spends as much time as he/she would like with father/male caregiver.
___	___	___	My son or daughter spends as much time as he/she would like with mother/female caregiver.
___	___	___	There has been a traumatic experience in my child's life or family in the last year.
___	___	___	There has been physical or sexual abuse in the family.
___	___	___	The family has moved frequently.
___	___	___	My son or daughter has special education needs.
___	___	___	My son or daughter has been suspended/expelled from school.
___	___	___	My son or daughter has few friends.
___	___	___	My son or daughter is often picked on by others.
___	___	___	My son or daughter has friends who are a bad influence.
___	___	___	My son or daughter has a history of lying.
___	___	___	My son or daughter has stolen/shoplifted.
___	___	___	My son or daughter destroys his/her own possessions.
___	___	___	My son or daughter has been or is in counseling.
___	___	___	My son or daughter is physically aggressive or hurts others.
___	___	___	My son or daughter has intentionally harmed or injured an animal.
___	___	___	I feel like I have no control over my son or daughter.

Use back for additional comments.

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Parent Interview

Name_____ **Date**_____

Total score_____

Instructions: Place a check mark next to the scoring level that best describes the situation for this youth. Expand the questions as you feel necessary to complete the interview with confidence. Use the comment line for anything that seems out of the ordinary or supports your impressions.

A. What was the parent's or caregiver's response to the fire?
Suggested Questions: ***Mom, Dad, what was your reaction to the fire?***

Scoring:

_1 The reaction of the parents to the fire was an immediate and appropriate response, with concern for any victims.
_2 The reaction of the parents to the fire was one that appears too lax or too punitive.
_3 The reaction of the parents to the fire was either nonexistent or was an immediate and overly punitive response (such as burning of the youth's hands).

Comments: _____

_____

B. Is there a family history with fire?
Suggested Questions: ***Did anybody else in the family ever play with fire or get burned from a fire that got out of control? Have you ever had a house fire?***

Scoring:

_1 There is no traceable history of fire in the family. There are no parents, siblings or close relatives who are/were firefighters, who were burned in a fire, lost their home in a fire or were firesetters.
_2 There is some fire history in the family that the youth has or may have heard about.
_3 There is a fire history about which the youth has direct knowledge.

Comments: _____

_____

C. Does the youth have a history of fireplay or firesetting?
Suggested Questions: ***How many other times has your child lit matches, played with a lighter or burned things of little or no value? Do you know if he has ever threatened anybody with fire or if he/she has been hurt by fire himself/herself?***

Scoring:

_1 This is the first known incidence of fireplay for the youth.
_2 The youth has a sporadic history of fireplay. There was little or no damage from previous fireplay.
_3 The youth has a history of chronic fireplay and/or has set at least one fire with serious consequences.

Comments: _____

_____

D. What kind of modeling is going on in the home? How did the parents/caregivers teach their youth about fire? What kinds of fire safety practices occur in the home? Are there any cultural or traditional ways the family uses fire?
Suggested Questions: ***How did you teach your child about fire? Do you have a working smoke detector? Do you have candles or a woodstove? How do you store matches and lighters? How does your family use fire? Are there smokers in the home?***

Scoring:

_1 Appropriate fire safety is observed in the home. Smoke detectors work, woodstoves are safely installed. Parents, siblings or other family members avoid modeling fire play.
_2 There is modeling of fire play at home and fire safety is only moderately observed by parents and siblings.
_3 Family members have used fire inappropriately. The youth's home is not firesafe.

Comments: _____

_____

E. How is the youth supervised?
Suggested Questions: ***When you are not at home, who takes care of the child?***

Scoring:
_1 The youth has good, continual parental and/or caregiver supervision.
_2 The youth has some supervision, but the supervision is often sporadic.
_3 The youth has minimal supervision.
Comments: _____

_____

F. Does the youth have any problems in school?
Suggested Questions: ***Is the youth having any problems in school? Does your child have any learning problems, ie. school referral for problem behaviors, trouble paying attention or being impulsive? Is he or she in a special classroom of any kind?***

Scoring:
_1 The youth has minimal problems in school.
_2 The youth gets some school referrals.
_2 The youth receives special education services.
_3 The youth has been suspended or expelled from school.
Comments: _____

_____

G. Has the youth ever been in counseling?
Suggested Questions: ***Has your child ever seen the school counselor or other mental health provider for problems?***

Scoring:
_1 The youth has never been in counseling.
_2 The youth has been in counseling in the past.
_3 The youth is currently in counseling or has been referred for counseling.
Comments: _____

_____

H. How would you describe your youth's friends?
Suggested Questions: ***Do you like your kid's friends? Are they a positive influence on …? Who is his best friend?***

Scoring:
_1 The youth has a healthy, supportive peer group.
_2 The youth has some peer support, but his/her behavior is influenced by peers (bad friends).
_3 The youth has little or no peer support, is shunned by peers and is isolated and withdrawn.
Comments: _____

_____

I. ***Has any kind of crisis or traumatic event happened within your family? Please describe.***

Scoring:
_1 There has not been a traumatic family experience in the past year.
_2 There has been a major traumatic family experience in the past year.
_3 There has been a major traumatic family event in the past that may be influencing the youth's behavior.
Comments: _____

_____

J. ***Would you be willing to seek additional help for your child such as taking him/her to counseling?***

Scoring:
_1 The youth's family acknowledges the seriousness of the firesetting and seeks help appropriately.
_2 The family protects the child, seeks to blame others and denies their own and the child's responsibility for the fire.
_3 The family doesn't seem to take the behavior seriously and simply wants the fire department to "fix" the youth and/or doesn't see the need for other services. They may even refuse services.
Comments: _____

_____

Scoring and Referral Procedure

Add the face value of the checked responses for both the youth and the parent interview. Enter the total on the lines provided below:

Total Score: (Youth Interview) _____ (Parent Interview)_____

If the total number for the **youth interview** is from 14-19 then:

The fire behavior appears to be basically experimental in nature and set out of curiosity This youth does not have a history of fire behavior. The intervention for a youth motivated primarily out of curiosity is fire education for the youth and the family. There are numerous fire education intervention curricula available to use with this child. The family should set clear rules about fire use in the home and practice home fire safety. Fire departments should emphasize the importance of working smoke alarms and home escape planning for these families. With education, curiosity firesetters usually do not continue their fire behavior. However, because curiosity firesetters do not understand the consequences of their actions, it is important that parents/caregivers increase their knowledge of fire safe practices.

If the total number for the **youth interview** is 20-42 then:

The youth has a sporadic history of firesetting and needs to be referred to other community agencies that serve children and their families. These agencies include community mental health centers, teen courts, youth service teams, multi-disciplinary teams, or juvenile departments. Many of these youths will require a more comprehensive mental health evaluation to determine the motives for his/her behavior. Youth who score in this range are setting fires as a cry for attention, as a response to a crisis event, to express anger or to defy authority. Many youth use fire because they are seeking power and control. The firesetting in this case is often a symptom of other family, school or peer group problems. Mental health professionals are positioned to evaluate all the dynamics affecting this youth's firesetting behavior.

In addition to referring the family for further evaluation, fire departments need to provide fire safety education. As with the curiosity firesetter, families often do not understand the power of fire and need to increase their knowledge of home fire safety practices. Again, emphasizing the importance of working smoke alarms and practicing home escape planning. After a mental health evaluation or court referral, fire departments may be asked to provide additional educational intervention. Helping educate the youth about how their firesetting behavior affected the community and the risk involved is another way fire departments can provide a service to the youth and their family and hold youth accountable for their behavior. Curricula for educating adolescent firesetters are available.

If question D, J and/or L is answered with a 3 response, consider referring this youth for a crisis evaluation.

If the total number for the **parent interview** is from 10-15 provide fire safety education to the youth and family.

If the number for the **parent interview** is between 16-30
provide fire safety education to the family and recommend to the family that they seek the services of other community agencies to further evaluate the youth's firesetting behavior.

Referral should consist of:

1) a cover letter which includes-
   - a statement of the fire incident
   - observations of the interviewer
   - recommendations
2) copies of the parent checklist and both screening interviews
3) copy of the fire report
4) a brief summary of the education provided
5) release of information form

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Juvenile Firesetter Screening Report

Name _____ Address _____

Telephone _____ DOB _____ Age _____

Presenting Problem (Includes date of interview, name of child and accompanying adult, location of interview and presenting fire problem.)

Fire History (Includes a list of the fires reported by the child and/or accompanying adult/s.)

Results of the Screening (Gives an explanation of the screening instrument, how it is being used by the fire service. Indicate that it is a basic screening tool used to determine if a child needs to be referred for a more comprehensive assessment. Do NOT assign a risk level.)

Observations (Includes only statements of facts, i.e. family was late for interview, child refused to answer all questions.)

Recommendations (Given the child's scoring, suggest fire safety education or a referral for a needs assessment or more extensive mental health assessment/treatment, and conditions for a fire safety plan for the family.)

Signature _____ Date _____

Fire Department _____ Telephone _____

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Child/Parent Responsibility Contract

This contract outlines several steps both children and their parents/caregivers can take to prevent firesetting behavior in the home. While increasing safety in the home, they may not eliminate all fire risks and are not a substitute for parent/caregiver supervision.

THE YOUTH (initial on line)

___ Shall not possess any incendiary devices of any kind. This includes but is not limited to matches, lighters, lit cigarettes, lighter fluid, fireworks, aerosol cans and other flammable liquids.

___ Shall submit to searches of his/her person and property by his/her parent/caregiver. This includes the youth's personal property and immediate area where the youth is located (car, room, school locker, back-pack, etc.).

___ Shall complete a fire-escape plan for their family and practice it with his/her parent/caregiver.

___ Shall tell an adult if they find matches or lighters.

___ Shall not play with friends who engage in any form of fire activity.

___ Other_____

Youth_____ **Date**_____

THE PARENT

___ Shall install and maintain working smoke alarms in every room of the home, including garages and sheds. A working class (2A-10BC) fire extinguisher shall be accessible to every level of the home and garage.

___ Shall secure all combustibles and all matches, lighters, flammable liquids, fireworks, and other sources of ignition in an area where the youth does not have access, preferably a locked cabinet.

___ Shall use only a child resistant lighter if a smoker and kept on their person at all times.

___ Shall conduct routine searches of the youth's room and possessions for matches or lighters.

___ Shall monitor the youth's access to the Internet for information that can assist them in modifying fire-works or manufacturing destructive devices.

___ Shall give permission to other children in the home to tell on someone who misuses fire.

___ Shall increase supervision of youth. Youth should not be left alone or unsupervised in other youth's homes where ignition material may be easily available.

___ Shall set firm rules that any child in the house should not touch matches, lighters, the stove, barbecue lighters, flares, fireworks or any other object that could potentially set a fire.

___ Inform children of the fire safety rules and the consequences of breaking them. Discuss the rules and consequences with your child to check for understanding.

___ Shall not display any candles, incense lamps or other fire related items in the home regardless of their use.

___ Shall complete a home fire safety checklist obtained from the local fire department.

___ Shall forbid youth to watch shows or videos with provocative fire themes.

___ Shall lock up all flammable chemicals such as turpentine, gasoline, lighter fluid or charcoal starter for barbecues.

___ Shall remove closets doors to avoid a hiding place.

___Other_____

Parent or Guardian_____ Date_____

Removing the risk today prevents the fires of tomorrow.

Provided by the Office of State Fire Marshal, June, 2001

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Fire and Life Safety Questionnaire

Name _____

1. Describe the fire. Tell what happened. Who was involved? What methods were used to start the fire?

2. On a scale from 1 to 10, how much responsibility for the firesetting is yours?
1 (no responsibility) - 10 (full responsibility)

3. List four things you could have done to stop yourself from starting the fire.

1) _____
_____
2) _____
_____
3) _____
_____
4) _____
_____

4. Who was harmed by your firesetting behavior?

5. How much time do you and your family have to safely escape a fire in your home?

6. Name the elements of a fire that are life-threatening.

7. When is it OK for you to use matches or lighters?

8. List the ways your family can make your home firesafe.

9. What do you know about fire?

10. Have you ever been burned?

APPENDIX H

CONSENT, RELEASE, REFUSAL AND PAYMENT ARRANGEMENT FORMS

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JUVENILE FIRE INTERVENTION PROGRAM

Consent for Screening Interview Waiver of Rights and Acknowledgement of Non-Confidentiality

I, _____ and _____
Child's name and D.O.B. parent/guardian

Both agree to the following:

We give our consent to the _____ Juvenile Fire Intervention Program to be screened for suitability for this program, for which we authorize _____ to conduct a screening interview of this child and his family to collect information and records pertaining to this child.

_____We understand that authorizing the screening of our child for the JFIP does not guarantee acceptance in the JFIP, nor can the JFIP guarantee that any specific services it may recommend will be provided.

_____We agree to hold the JFIP, its agents and volunteers harmless from any liability or damage that may arise from the screening or participation in the JFIP. We understand that completion of the educational class does not necessarily prevent our child from future firesetting. We understand that fire education is sometimes just a portion of a child's treatment.

_____We understand that the burning of property may be a criminal offense. We hereby understand that the program representatives may report to the appropriate authorities, including but not limited to, the District Attorney's Office, the State Fire Marshal, local fire and police departments, and DSS, any information they receive regarding the setting of fires by_____ or anyone else.

_____We understand that the _____ JFIP representatives are mandated by the state law to report to DSS any situations where a child is at risk, including neglect and/or any form of abuse.

_____We understand that by participating in this program we hereby waive our child's rights of confidentiality regarding evaluation and treatment. We understand that whatever is told an interviewer who is part of my treatment program is neither privileged nor private. If any such rights of confidentiality exist by statute or rule of law, we hereby waive any and all such rights on behalf of our child.

_____ _____
signature of child signature of parent/guardian

_____
signature of RVJFIP person/witness

RELEASE OF LIABILITY

I do hereby release, indemnify, and hold harmless the _____ Juvenile Fire Intervention Program, all its employees and volunteers against all claims, suits, or actions of any kind and nature whatsoever which are brought or which may be brought against the (name of) Juvenile Fire Intervention Program for, or as a result of any injuries from, participation in this program.

_____	_____
Parent/Guardian	Date/Time
_____	_____
Juvenile	Witness

_____ **Juvenile Fire Intervention Program**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

(In the case of a minor child) I, _____ (parent/guardian) hereby authorize representatives of the _____ Juvenile Fire Intervention Program to obtain records of:
Child's name: _____ D.O.B. _____
Address: _____
Phone: _____ Contact person: _____
I authorize the following individual or agency: (include name and phone number)

_____
_____
_____
_____

Including records of:

☐ yes ☐ no family history

☐ yes ☐ no educational reports

☐ yes ☐ no alcohol/drug treatment

☐ yes ☐ no mental health services

☐ yes ☐ no medical/psychiatric treatment

☐ yes ☐ no other: _____

I understand that this release allows the _____ Juvenile Fire Intervention Program to discuss this child's case with the "**triage team**" before, during, and at the conclusion of the program in order to determine the best form of treatment and follow-up care. I understand the "triage team" consists of members of the _____ JFIP Task Force, including mental health clinicians, firefighters, and probation officers, trained to help children with their firesetting behaviors. I understand that the "triage team" will maintain confidentiality at all times, and not discuss this child's case with anyone outside of the _____ JFIP.

> ***NOTICE:*** *I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If not previously revoked, this consent will expire automatically ninety (90) days from the date signed, or will terminate thirty (30) days after completion of the _____ JFIP program.*
> *I understand that my records are protected by state and local law and cannot be disclosed without my written consent except as otherwise specifically provided by law. Furthermore, I understand that if my records involve alcohol or drug abuse, they are also protected under Federal Regulation (42 CFR Part 2), Confidentiality of Alcohol and Drug Abuse.*

The reason for disclosure of information is to facilitate adequate treatment for stated child due to firesetting incident(s). I have read carefully, understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information to those persons/agencies named above.

Signature of Parent/Guardian	**Date**
Signature of Witness	**Date**

AGENCY NAME _____
JUVENILE FIRE INTERVENTION PROGRAM REFUSAL FORM

I acknowledge that the program offered by the _____ Juvenile Fire Intervention Program was explained to me, and I was given an outline of the program.

I understand the _____ JFIP has been established to help educate children who have played with fire, and this program educates children about the "dangers of fire and fire safety."

I acknowledge that the Fire Intervention Program was offered to me and at this time, I ***do not*** want my child to participate in the program.

I will not hold any member of the _____ JFIP liable or responsible for any further actions of my child, in regards to playing with, or setting fires.

_____

Signature of parent or guardian Date _____

_____

Witness Date_____
City/Town

JUVENILE FIRE INTERVENTION PROGRAM
PAYMENT CONTRACT

I, _____ parent/guardian
of _____ (participant), agree to pay
the _____ Juvenile Fire Intervention Program the sum of $275.00 for
attending the education classes. Please make check payable to: _____.
I agree to the following:

_____ _____

Signature parent Signature witness

_____

Date

UNIT 4: YOUTH FIRESETTING EDUCTIONAL INTERVENTION

TERMINAL OBJECTIVE

The students will be able to:

4.1 Present an educational intervention for a Youth Firesetting Prevention and Intervention (YFPI) program.

ENABLING OBJECTIVES

The students will be able to:

4.1 Describe types and levels of prevention.

4.2 Illustrate how education can be utilized as an effective intervention strategy.

4.3 Categorize the stages of cognitive development and how they apply to the delivery of an educational intervention.

4.4 Describe how to deliver age-appropriate educational interventions.

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UNIT 4: YOUTH FIRESETTING EDUCATIONAL INTERVENTION

Slide 4-1

ENABLING OBJECTIVES

- Describe types and levels of prevention.
- Illustrate how education can be utilized as an effective intervention strategy.
- Categorize the stages of cognitive development and how they apply to the delivery of an educational intervention.
- Describe how to deliver age-appropriate educational interventions.

Slide 4-2

I. INTRODUCTION

INTRODUCTION

- The purpose of the screening process is to determine a firesetter's level of risk for repeat firesetting behavior and consider appropriate interventions.
- Intervention is defined as the act of intervening, interfering or interceding with the intent of modifying the outcome.

Slide 4-3

A. As was discussed in earlier units, the purpose of the screening process is to determine a firesetter's level of risk for repeat firesetting behavior and consider appropriate interventions.

1. Regardless of the typology of firesetting being addressed, education is an appropriate prevention intervention to employ.

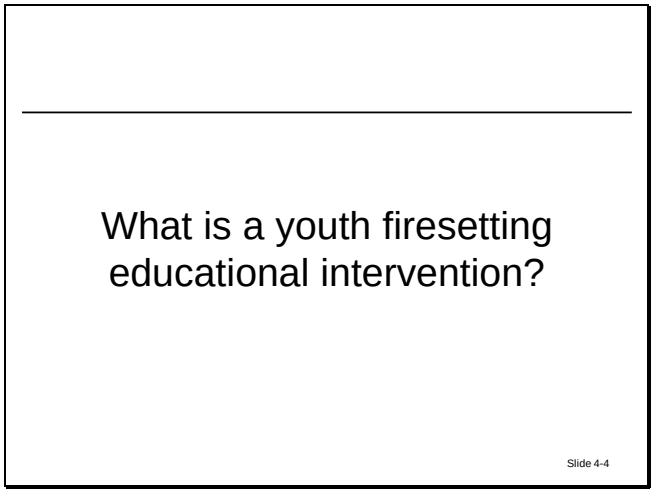
2. While education may not be the first level of intervention, such as when mental health assistance or law enforcement involvement may be indicated or required early on, it definitely serves a vital purpose in the process of preventing recidivism.

3. It is up to each jurisdiction to determine the circumstances and setting for the delivery of the educational intervention.

4. Most Youth Firesetting Prevention and Intervention (YFPI) programs rely on the fire service to provide educational intervention to firesetters and their families.

B. Intervention is defined as the act of intervening, interfering or interceding with the intent of modifying the outcome.

In medicine, an intervention is usually undertaken to help treat or cure a condition. For example, early intervention may help children with autism to speak.



INTRODUCTION (cont'd)

- A youth firesetting educational intervention is a strategy used to provide educational information to youth firesetters and their families.
- Should include education on:
  - Fire science.
  - Fire safety.
  - Decision-making skills.
  - Consequences of inappropriate decisions.
  - Cause and effect relationship of fire.
  - Legal ramifications for firesetting.

Slide 4-5

C. A youth firesetting educational intervention is a strategy used to provide educational information to youth firesetters and their families. The content of an intervention should include education on:

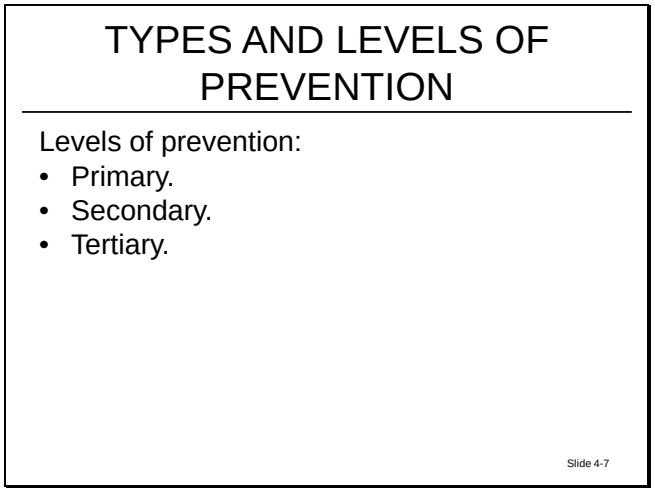
1. Fire science.
2. Fire safety.
3. Decision-making skills.
4. Consequences of inappropriate decisions.
5. Cause and effect relationship of fire.
6. Legal ramifications for firesetting.

What is the goal of a youth firesetting educational intervention?

Slide 4-6

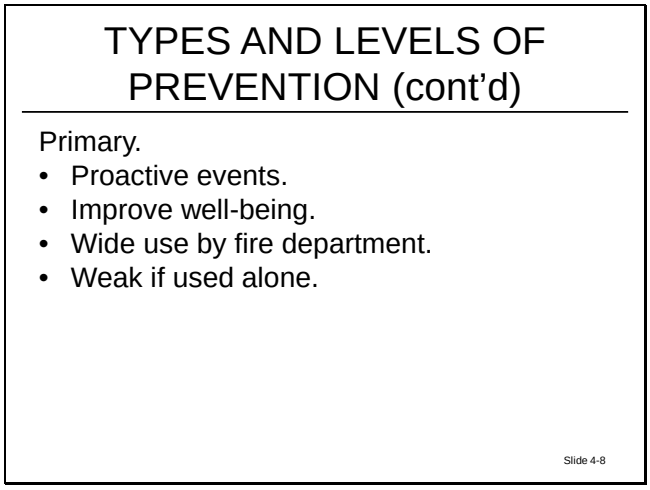
D. The goal of the youth firesetter intervention is to empower youth (and their families) to make better decisions regarding fire and prevent future firesetting through dissemination of accurate educational information.

II. TYPES AND LEVELS OF PREVENTION



A. Levels of prevention.

There are three levels of prevention: primary, secondary and tertiary.



1. **Primary prevention** is all of the activities designed to prevent an event from happening.

   a. Primary prevention is designed to teach individuals what to do so that an event that could cause property damage, injury or death does not happen at all.

   b. Examples of primary prevention are community-based education, school prevention programs, injury-prevention programs, etc.

TYPES AND LEVELS OF PREVENTION (cont'd)

Secondary.
- Response to trouble.
- Targets high-risk groups.
- Screening for risk.

Slide 4-9

2. **Secondary prevention** seeks to change or modify events and/or behaviors that reduce the severity of the event.

   a. Examples would include the activation of a smoke alarm, the use of a home escape plan, the use of a fire extinguisher to extinguish a fire, or the use of child restraint seats in vehicles.

   b. Secondary prevention also targets groups that have demonstrated behaviors that place them at risk from harm. Youth firesetting certainly ranks in this category.

TYPES AND LEVELS OF PREVENTION (cont'd)

Tertiary.
- Reduce negative impact of event.
- Rehabilitation to functional condition.

Slide 4-10

3. **Tertiary prevention** seeks to reduce a negative impact of an event over the long term.

   Its goal is to prevent complications and/or work with case management/ rehabilitation regarding an event. The following are some examples:

   a. Long-term community-based services after a disaster.

b. Prompt medical care at a burn facility for those individuals that have been burned.

c. Youth firesetters detained at a long-term treatment center.

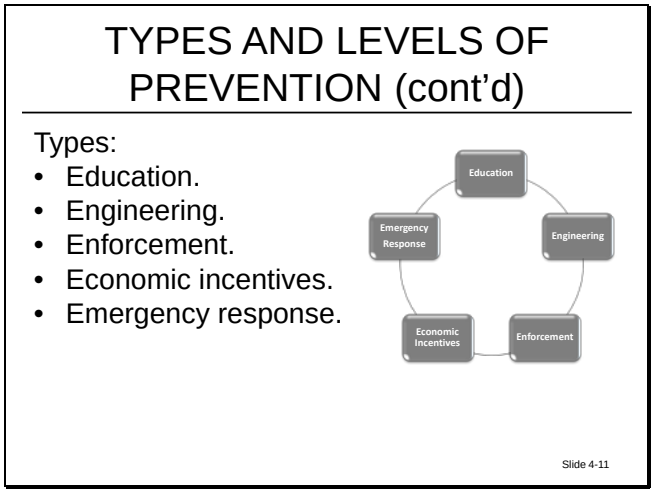
4. Relating levels of prevention to youth firesetting:

a. Many times, youth firesetting intervention is a culmination of all three levels.

b. When school-based and/or community-based prevention programs are conducted on a regular basis, this serves as a primary prevention measure to prevent a firesetting incident before it occurs.

c. When a firesetter has been identified because of a firesetting incident, secondary interventions such as attending a YFPI program are applied.

d. If a pathology of firesetting develops, admittance to a tertiary treatment center may be required.



B. Types of prevention interventions: the five E's.

1. The five E's of prevention are: Education, Engineering, Enforcement, Economic incentives and Emergency response.

2. It takes all five working in tandem to effectively prevent deaths, injuries and property loss as a result of fire.

3. It also takes all five to effectively work with a youth firesetter and his or her family.

TYPES AND LEVELS OF PREVENTION (cont'd)

- Education:
  - Goal of education is to provide awareness, change behavior and eliminate risky behavior.
  - Every youth firesetting program needs an educational component.
- Why do educational interventions often produce a limited impact when used independently of other interventions?

Slide 4-12

4. Education.

   a. The goal of education is to provide awareness, change behavior and eliminate risky behavior.

   b. Every youth firesetting intervention program must have an educational component.

TYPES AND LEVELS OF PREVENTION (cont'd)

- Engineering:
  - Modifying of an environment to enhance safety.
  - Includes use of technology.

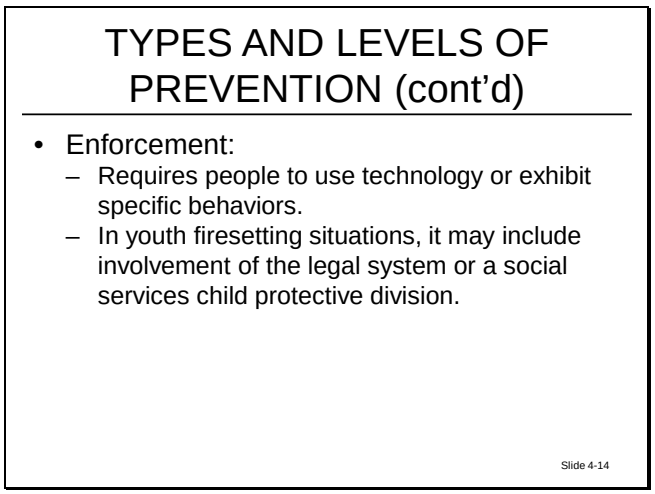
Slide 4-13

5. Engineering.

   a. Engineering efforts include modification of an environment to enhance safety.

   b. Examples: fire-resistive building designs, sprinklers, etc.

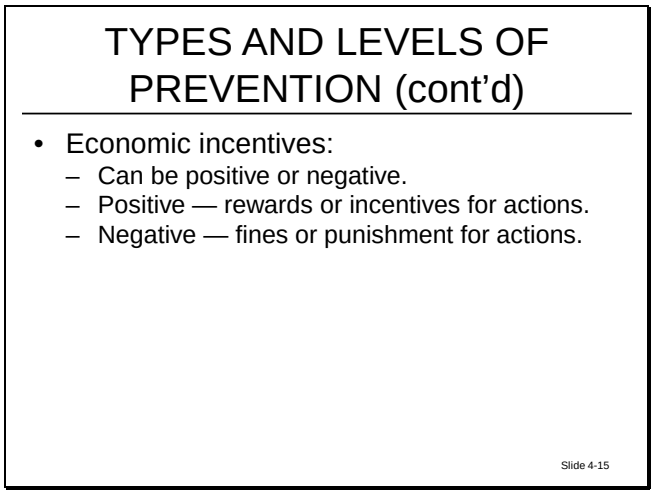
   c. Firesetting intervention programs must ensure that the homes of firesetters are equipped with working smoke alarms and child-resistant lighters are used as needed.



6. Enforcement.

   a. Enforce or obtain compliance with fire laws and codes.

   b. For firesetting situations, this means involvement of the legal system or action from a social services child protective division.

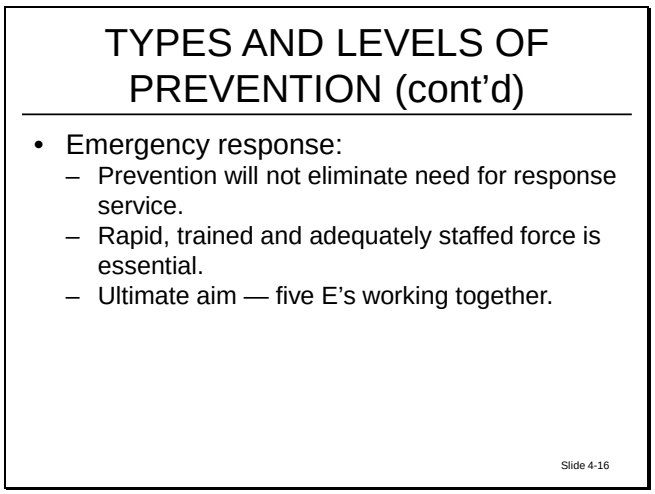


7. Economic incentives.

   a. Enhancing safety measures through monetary incentives.

   b. One example would be providing economic incentives to builders who install sprinkler systems.

   c. Another type of economic incentive may be in the form of a negative incentive, such as the payment of fines, fees and/or restitution.



8. Emergency response.

   a. This refers to an adequately staffed, equipped and trained cadre of responders to mitigate emergency incidents when they occur.

   b. Emergency response is pertinent to the youth firesetting situations. Available resources respond to an incident and refer the youth and his or her family for intervention.

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ACTIVITY 4.1

Education as a Primary Prevention Intervention

Purpose

To explore the primary prevention programs that your organization offers to prevent or mitigate youth firesetting behaviors.

Directions

1. Please identify the programs that your organization currently offers that are designed (or include content) to **prevent or mitigate** youth firesetting behaviors.

2. Think about the level of impact these programs have on youth firesetting and if you believe any of the **delivery strategies** may be in need of improvement.

3. If there are areas that may be in need of improvement, please identify what they are. Information on **how** to facilitate improvements will be presented later in this unit. There are 10 minutes allotted for these tasks.

4. In your table group, please share with peers the programs that you feel need improvement and why you believe action needs to be taken. There are 10 minutes allotted for these tasks.

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III. EDUCATION AS AN INTERVENTION STRATEGY

EDUCATION AS AN INTERVENTION STRATEGY

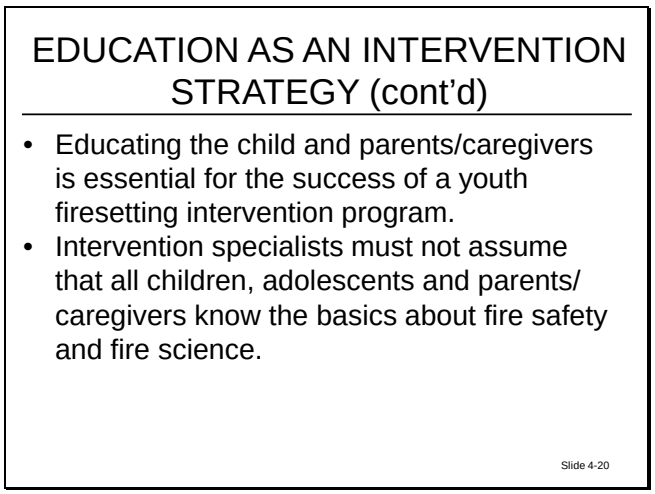
The goal of youth firesetting educational interventions are to empower the child, adolescent or teen with knowledge to make better decisions and abstain from firesetting and other types of fire-related experimentation.

Slide 4-18

A. The goal of fire safety education (a youth firesetting educational intervention) is to empower the child, adolescent or teen to make the right decisions regarding abstinence from firesetting and other types of fire-related experimentation.

Why do intervention specialists need good baseline knowledge of fire safety and fire science before they begin working with youth firesetters and their families?

Slide 4-19



1. Educating the child and parents/caregivers is essential for the success of a youth firesetting intervention program.

2. Youth firesetting intervention specialists must not assume that all children, adolescents and parents/caregivers know the basics about fire safety and fire science.

   a. Children may or may not have had a fire safety or fire science class in school.

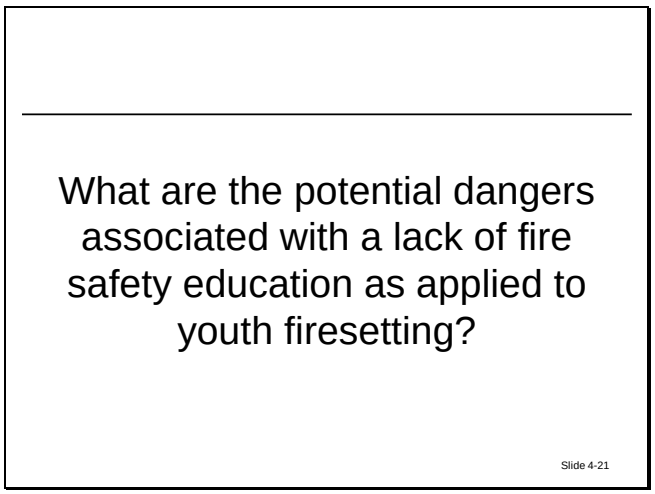
   b. The parents or caregivers may or may not have had a fire safety or fire science class at some point in their lives.

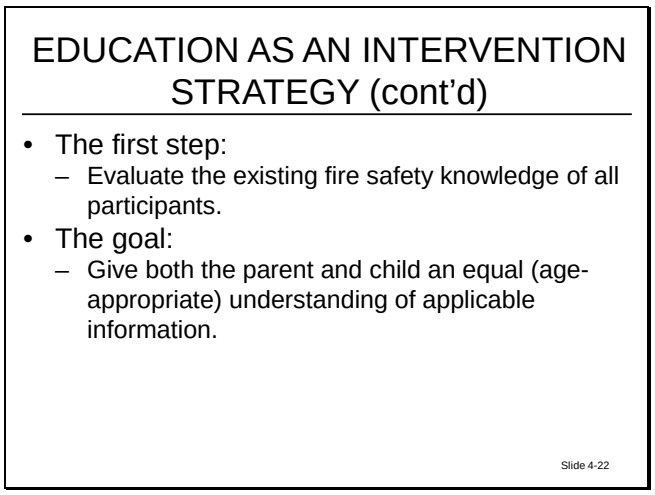
   c. Children, adolescents and adults may be uneducated or misinformed about proper fire safety practices.

3. All three populations can be educated to make good decisions through structured, age-appropriate processes. Similarly, all groups need to feel empowered to make the right decisions.

4. Children have to rely on the experience and education of adults to understand the danger of fire.

5. If parents or caregivers do not have this knowledge or experience, the likelihood of passing on information regarding fire safety and fire science is compromised.





B. When a youth firesetter and his or her family have been referred to a youth firesetting program, the first step is to evaluate the fire safety knowledge of all participants.

1. The goal is to give the parents/caregivers and child an equal (age-appropriate) understanding of applicable information.

2. An age-appropriate fire safety pretest can provide the intervention specialist with knowledge of what the child and parents/caregivers already know about fire safety and fire science.

EDUCATION AS AN INTERVENTION STRATEGY (cont'd)

- Fire safety pretest:
  - Obtains baseline knowledge of participant's understanding of fire safety (includes youth **and** parents).

Slide 4-23

3. Conducting a pretest is the most reliable way to obtain a baseline understanding of a participant's existing knowledge level.

Why are parents/caregivers often the most important target audience of a youth firesetting educational program?

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EDUCATION AS AN INTERVENTION STRATEGY (cont'd)

- Parents/Caregivers are important students:
  - May not realize dangers of fire.
  - May lack insight into what children can (or cannot) understand.
  - May have deficits and challenges similar to their children.

Slide 4-25

C. Parents/Caregivers are important students.

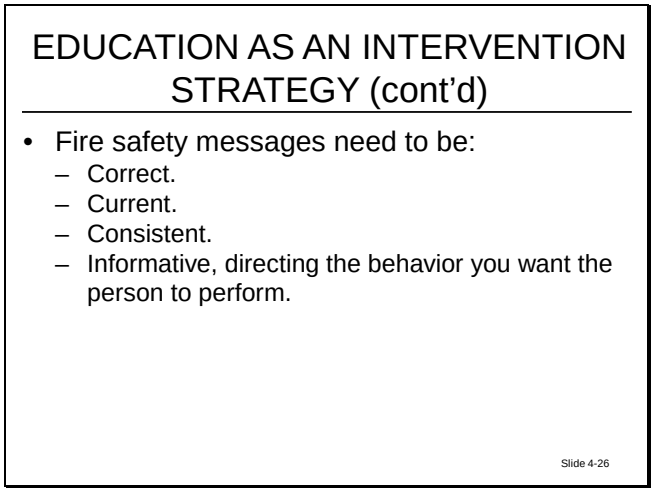
1. Parents/Caregivers may not consider fire to be a dangerous tool.

2. Parents/Caregivers may minimize the danger associated with firesetting because they lack insight into what their children can (or often cannot) understand.

3. It should be suggested that parents/caregivers set the same kind of rules for fire that they have for guns, sharp knives, chain saws, etc.

4. Parents/Caregivers also may suffer the same experience deficits and neurological compromises as their children.

5. Parents/Caregivers may have some of the same difficulties recognizing true hazards and making appropriate choices.



D. Fire safety messages need to be:

1. Correct, current and consistent regardless of the target population.

2. Many of our messages offer an increase in awareness. But increased awareness doesn't necessarily educate a person or change their behavior.

"Be Safe with Fire" on a pencil reminds us that fire safety is important; however, the message is not specific.

3. Messages should provide information about the behavior you want the person to perform, not about what you don't want them to do. Messages should be positive.

Example: "Don't play with matches and lighters" doesn't tell a child what to do if he or she encounters matches and lighters. It only mystifies these tools and makes the child wonder why he or she shouldn't handle them.

4. Offer direction as to the desired behavior expected.

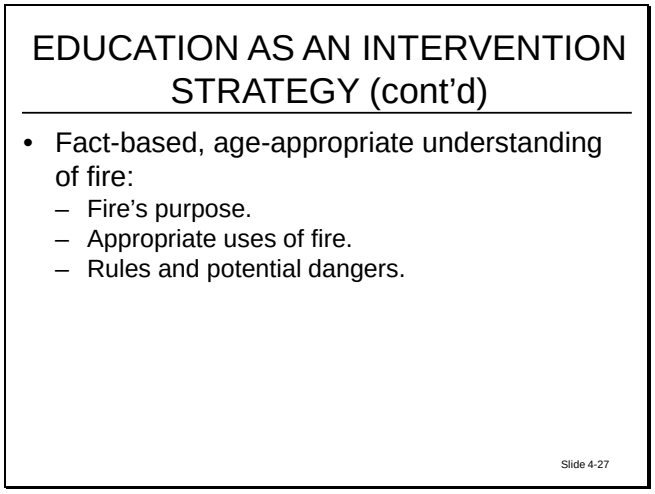
   Example: "Go tell a grown-up if you find matches and lighters."

5. Scare tactics don't work, especially for the children we work with in the firesetting venue.

   Youth have been so desensitized by TV and video games that it just doesn't work!

E. Children are conditioned to seek information about the world around them.

1. If fire is available, children may often try to explore its nature.



2. All children need a fact-based, age-appropriate understanding of fire, to include:

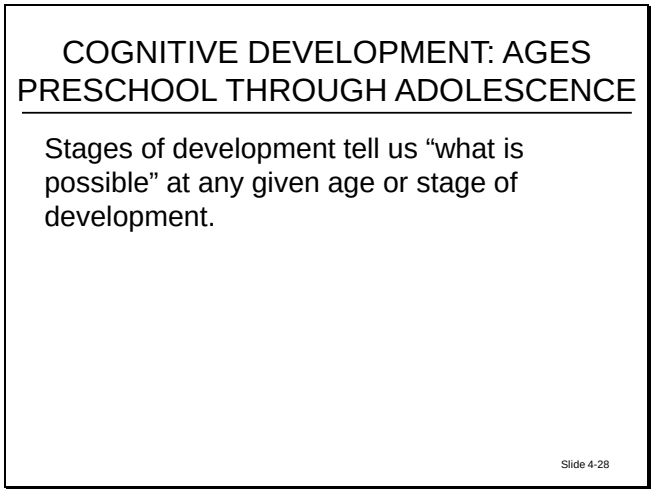
   a. Fire's purpose.

   b. Appropriate uses of fire.

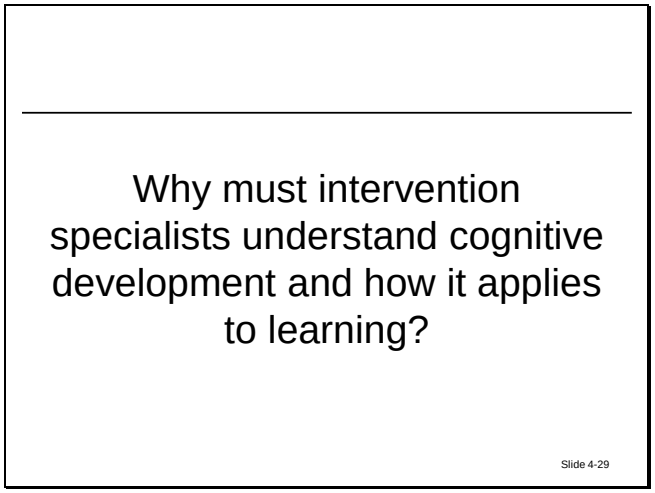
   c. Rules and potential dangers.

3. Prior to delivering an educational strategy, it is important to remember that an individual's stage of development has a lot to do with what he or she is able to understand.

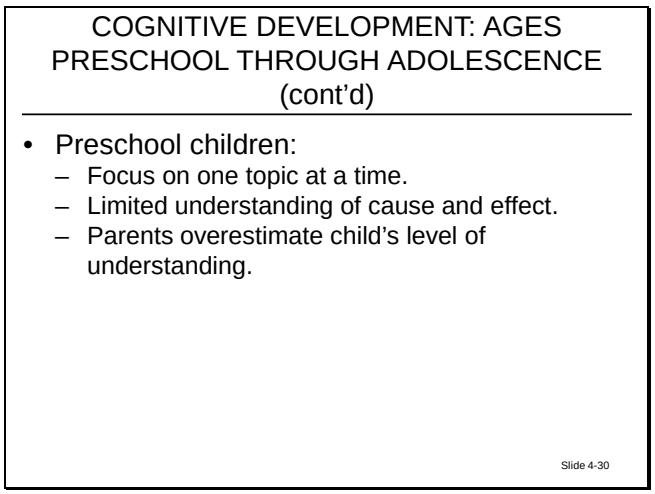
IV. COGNITIVE DEVELOPMENT: AGES PRESCHOOL THROUGH ADOLESCENCE



A. Stages of development tell us "what is possible" at any given age or stage of development.



B. This information should be applied to the delivery of educational interventions. Knowledge of cognitive development will help determine the appropriateness of materials and methods to be used and the content to be presented.



C. Preschool children.

1. Younger children (ages 4 to 6) can only focus on one feature of an object at a time.

   a. A single match is small.

   b. A house fire is large.

   c. How one becomes the other is a mystery.

   d. Even if we show them how it happens, they really don't understand.

2. Preschool children have only a limited understanding of cause and effect.

   a. Those children who do have some notion of cause/effect are easily confused by too much or distracting information, i.e., if you do "this," then "that" will happen.

   b. Until a child can understand cause and effect, he or she can't recognize unsafe conditions or figure out how to correct or avoid them.

3. Many parents/caregivers are unaware of or overestimate their child's level of understanding.

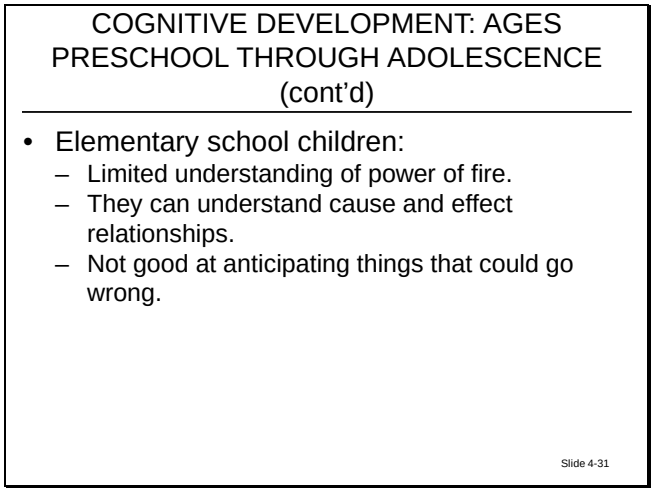
   a. Parents/Caregivers may confuse their children's language ability with the child's actual understanding of cause and effect.

   b. Many 3- and 4-year-olds have remarkable language skills.

c. Since parents/caregivers overestimate their children's ability to understand, they focus on teaching safety principles long before the children can benefit from them, rather than simply eliminating the hazards and closely supervising the children.

d. Young children do not understand the concept or the finality of death.

e. Many parents/caregivers believe that just because a child can mimic their words about the concept of death, it means the child understands the reality.



D. Elementary school children.

1. Most elementary school children have a better (but limited) appreciation of the power of small flames.

2. Elementary school children understand the transformations that fire can make, and they understand cause and effect.

a. Although they have these abilities, sometimes they don't use them.

b. Children at this age rely heavily on their own experience and can't anticipate events that they haven't experienced.

c. If they haven't seen the progression of a fire out of control, they can't visualize it.

d. Elementary school children are very good at following directions. If they are shown how to do something, most often they can do it and do it correctly time and again.

e. What they are not good at is anticipating what might go wrong and how to respond if something does.

PAPPY'S HOUSE

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COGNITIVE DEVELOPMENT: AGES PRESCHOOL THROUGH ADOLESCENCE (cont'd)

- Adolescents:
  - Impulsiveness, questionable decision-making skills, attention problems, and the frustrating lack of initiative seem to be tied to brain development.

Slide 4-33

E. Adolescents — a complex target population.

1. Brain development in adolescents is becoming more understandable!

2. Impulsiveness, questionable decision-making skills, attention problems, and the frustrating lack of initiative seem to be tied to brain development.

3. Research is showing that the brain continues to develop (to include executive functions) well beyond age 25!

4. During adolescence, the parts of the brain that helps adolescents exercise judgment are still under construction.

a. This situation often leads to a world of fast cars, early driving, drug and alcohol accessibility, etc., and it puts a teen at high risk of preventable injury.

b. According to Dahl (2004), adolescence in almost every measurable domain "is a developmental period of strength and resilience."

c. Adolescent death and disability is often related to difficulties in controlling behavior and emotion.

SETTING HAIR ON FIRE

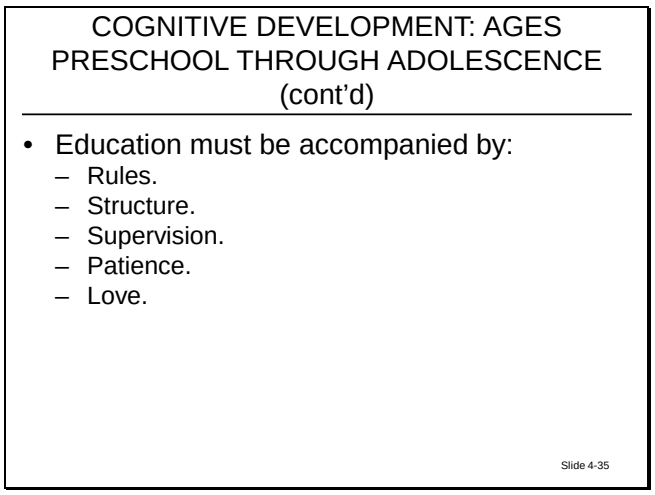
Slide 4-34

5. Taking healthy risks can help adolescents develop more complex thinking and increase confidence.

   Examples of healthy risks are supervised sports, training, and use of tools and guided safety practices for those activities.

6. Science helps us understand why teens are susceptible to impulsive risk-taking behavior.

   a. It also gives us a clue that, although education about fire is critical for teens, it has to be complemented with other critical components.



b. Since teens have increased difficulty making mature decisions and understanding the consequences of their actions, education must be accompanied by:

- Rules.
- Structure.
- Supervision.
- Patience.
- Love.

c. When working with a youth firesetter and his or her family, our job isn't complete if we don't teach about risk as well as fire.

d. The intervention specialist must be ready to teach families how to structure opportunities for independence.

COGNITIVE DEVELOPMENT: AGES PRESCHOOL THROUGH ADOLESCENCE (cont'd)

- Parents/Caregivers:
  - Youth and adults need education about consequences of risky behavior.
  - Parents may be former (or current) risk-takers.
  - Many youth are being raised in nontraditional family environments.

Slide 4-36

F. Parents/Caregivers' ideas of risk-taking are influenced by their own experiences.

1. For example, parents/caregivers who experimented with fire as youth may believe there's no danger because they never got hurt or caught.

2. Also consider that the youth may be raised by someone other than his or her natural parents.

3. Many youth are being raised by grandparents, aunts, uncles, older siblings or someone outside the family.

4. This means that the caregiver may not understand adolescents or adolescent brain development.

5. The intervention program must educate them regarding the importance of boundaries, rules, supervision and love.

V. DELIVERING EDUCATIONAL INTERVENTIONS

DELIVERING EDUCATIONAL INTERVENTIONS

- Nearly all firesetters and their families will benefit from a structured, age-appropriate fire safety program.

Slide 4-37

A. The majority of the cases identified by a youth firesetting intervention program will be classified as "some-risk."

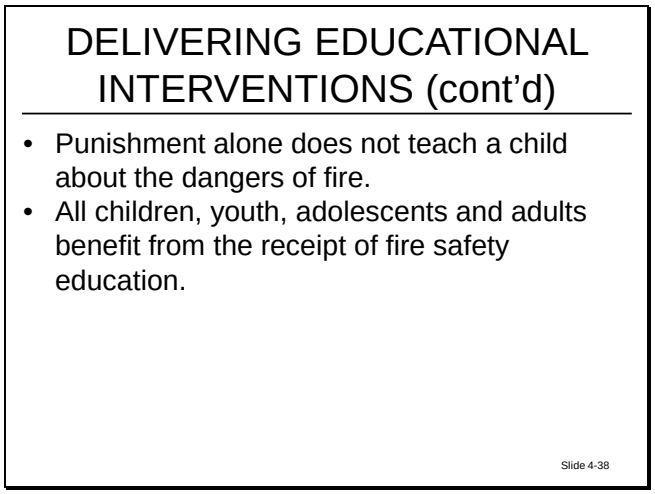
1. Curiosity or experimentation is the prime motive for firesetting as defined in the "some-risk" category.

2. The recommended intervention strategy for these cases is education.

B. "Definite and extreme-risk" firesetting situations also require educational intervention. However, sometimes the education will follow a referral for other types of intervention such as clinical support or youth justice system actions.

C. Regardless of the assessed level of risk, education should be used as an intervention component. Its delivery will depend upon the specific situation and level of risk assessed.

D. Educational interventions for the youth firesetter and his or her family should be based upon the following concepts:



1. Punishment alone does not teach a child about the dangers of fire.

2. All children, youth, adolescents and adults benefit from the receipt of fire safety education.

DELIVERING EDUCATIONAL INTERVENTIONS (cont'd)

- Common factors that influence firesetting:
  - Access to ignition materials.
  - Lack of supervision.
  - Lack of fire safety in home.
  - Easy access to information.

Slide 4-39

3. Remember to consider the four common factors that influence firesetting behavior:

   a. Easy access to ignition materials.

   b. Lack of adequate supervision.

   c. Lack of practice of fire safety in the home.

   d. Easy access to information on firesetting and explosives construction on the Internet.

DELIVERING EDUCATIONAL INTERVENTIONS (cont'd)

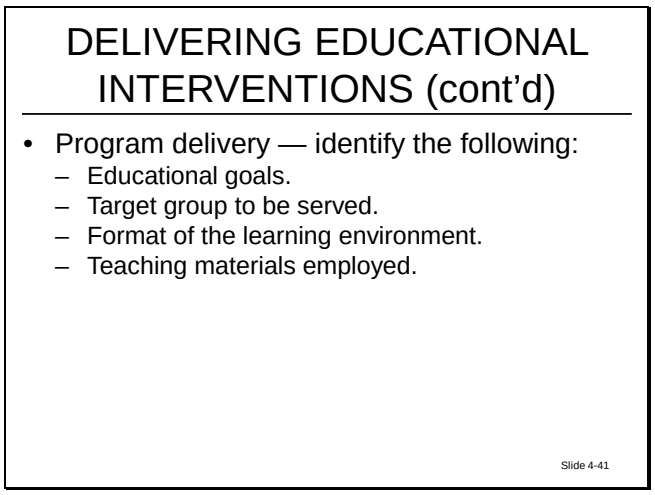
- Messages, methods and materials should be broad-based and age-appropriate.
- Education may be delivered in various ways (groups by age, one-on-one, etc.).
- Parents/Caregivers need to follow up with home intervention practice.

Slide 4-40

4. Messages, methods and materials should be broad-based (without bias, educationally sound, etc.) and age-appropriate.

5. Education may be delivered in various ways (groups by age, one-on-one, etc.) depending upon the resources available in the jurisdiction providing the intervention.

6. Parents/Caregivers need to follow up with home intervention practice.



E. To deliver an education component, a youth firesetting intervention program must consider four important factors:

1. Educational goals.

2. Target group to be served.

3. Format of the learning environment.

4. Teaching materials employed.

F. Educational goals.

1. The goal of a youth firesetting educational intervention is to empower students of all ages to make the right choices so that recidivism is prevented.

2. Remember, setting fires oftentimes indicates that youth are seeking attention. By providing appropriate education about fire science, safety and the consequences of firesetting behavior, youth firesetters will be able to make better choices regarding their own behavior, especially with fire.

G. Target group to be served.

1. A youth firesetting intervention program must deliver the appropriate means of education intervention for each specified target group. This delivery is usually based upon age and/or developmental ability of the youth.

DELIVERING EDUCATIONAL INTERVENTIONS (cont'd)

- Considerations:
  - Age and abilities of the youth(s).
  - Abilities of the parents/caregivers.
  - Potential communication challenges.
  - Culture of the family environment.

Slide 4-42

2. Considerations:

   a. The developmental level or ability of the youth to understand and learn fire-safety education.

   b. The age of the youth.

   c. The ability of the parents/caregivers/guardians to understand the educational intervention.

   d. The language spoken and understood by the youth firesetter and the parents/guardians/caregivers.

   e. The culture of the youth firesetter and parents/caregivers/ guardians.

DELIVERING EDUCATIONAL INTERVENTIONS (cont'd)

- Formats for program:
  - One-on-one with youth and parent(s).
  - One-on-one with youth without adult present.
  - Group setting of youth and adults together.
  - Two groups — youth in one, adults in other.
    -- If at all possible, have a separate adult group.

Slide 4-43

H. Format of the learning environment.

1. There are a number of different formats for teaching the educational component of a youth firesetting intervention program.

2. The delivery of a youth firesetting educational intervention component depends on the type and amount of resources available to your program.

3. There are a wide range of options for educational intervention:

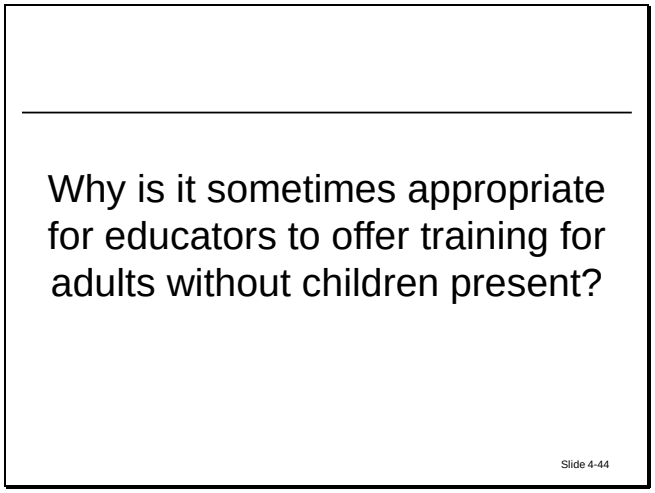
   a. A one-on-one intervention with the youth firesetter and his or her parents/caregivers.

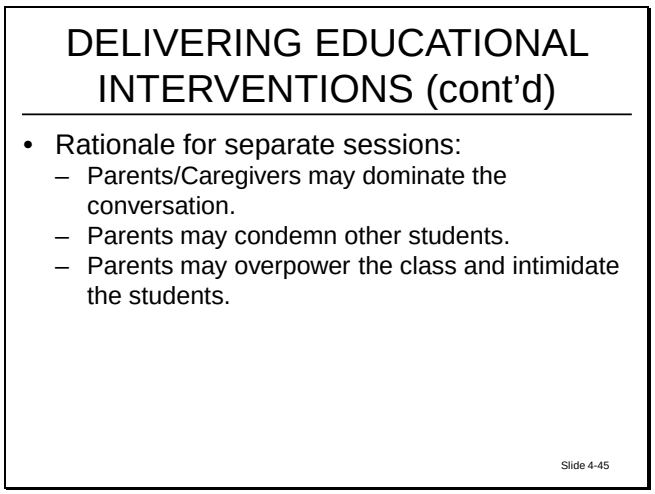
   b. A one-on-one intervention with the youth firesetter separate from a one-on-one session with the parents/caregivers/guardians.

   c. Group sessions with multiple youth firesetters of similar ages and/or cognitive abilities and their parents/caregivers/guardians.

   d. Separate group sessions with multiple youth firesetters of similar ages and/or cognitive abilities and a separate group for parents/caregivers/guardians.

   e. If at all possible, it is recommended to separate the parents/ caregivers from the firesetters.





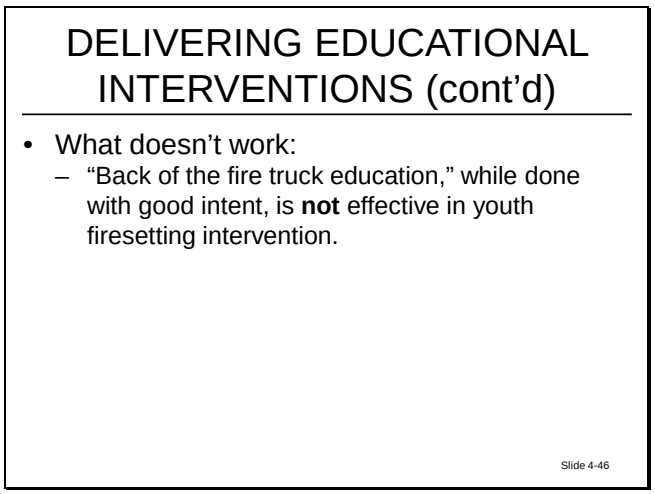
f. Reasons for having separate educational sessions include:

- Parents/Caregivers may dominate the conversation.
- Parents/Caregivers may condemn other students when interacting with them in a group setting.
- Parents/Caregivers may overpower the class and intimidate the students.
- Youth should feel at ease to learn without the influence of the parents/caregivers.

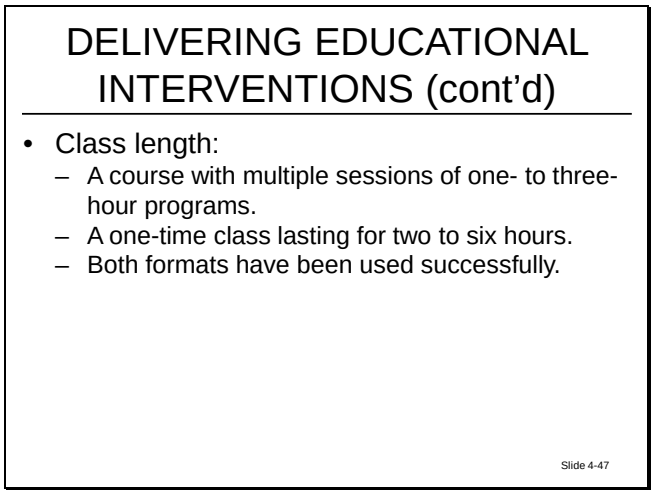
g. How the intervention specialist structures a class is based upon available resources.

h. There is no set type of program that has been deemed better than others. The effectiveness of a program often depends on the interest, education and experience of the intervention specialist and how the YFPI program is structured/delivered.

i. When choosing a group format, give consideration to class size limits. Class size is ultimately the decision of the educator and YFPI program protocol.



j. One format does not work: "back of the fire truck" education.



4. Class length.

The length of time for a youth firesetting intervention also varies depending upon available resources:

a. The intervention could be a course with multiple sessions of one- to three-hour programs, or it could be a one-time class lasting for two to six hours.

b. Youth firesetting intervention specialists have used both formats with great success depending upon the resources they have available.

c. Determining factors will be the resources available to the intervention specialist, as well as the availability of the parents or caregivers.

DELIVERING EDUCATIONAL INTERVENTIONS (cont'd)

- Class schedule:
  - One-time program.
  - Weekly meeting.
  - Monthly program.
  - Individualized services.

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5. Class schedule.

   a. There are several different ways that educational interventions are scheduled:

      - Monthly basis on a set day and time.

      - As needed when the intervention specialist receives a youth firesetting referral.

      - Some programs have multiple sessions scheduled on a specific day and time weekly, biweekly or monthly.

      - Some classes are scheduled on the availability of the youth firesetter and his or her family.

      - Individualized services for younger children and their families are often offered due to the age of the child.

DELIVERING EDUCATIONAL INTERVENTIONS (cont'd)

- The sooner that services are provided, the greater the likelihood of success.
- Program needs to be convenient to parents (within reason).
- Always use a medium to remind parents about the class.

Slide 4-49

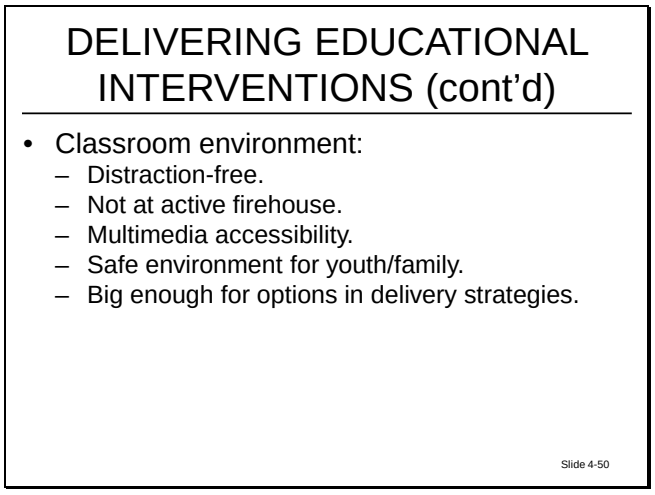
b. The sooner that a youth firesetter and his or her family receive services, the greater the likelihood of successful intervention.

c. If an extended period of time exists between the firesetting incident and intervention (and there is no repeat firesetting), then parents, caregivers or guardians may feel that the child has learned his or her lesson and doesn't need to attend the program.

d. The more convenient it is for the youth firesetter and family to obtain services, the more likely they are to attend the program.

e. There are several ways of notifying and reminding parents/ caregivers of the youth firesetting intervention class:

- Telephone call the night before the class.
- A letter sent the week before the class to remind the parents/caregivers of the date, time and location.
- An email reminding the parents/caregivers of the scheduled class.
- Whatever medium is utilized, it is very important to remind the family of the scheduled class.



6. Classroom environment.

The classroom environment of a youth firesetting intervention must be conducive to learning. The following are suggested strategies for creating such conditions:

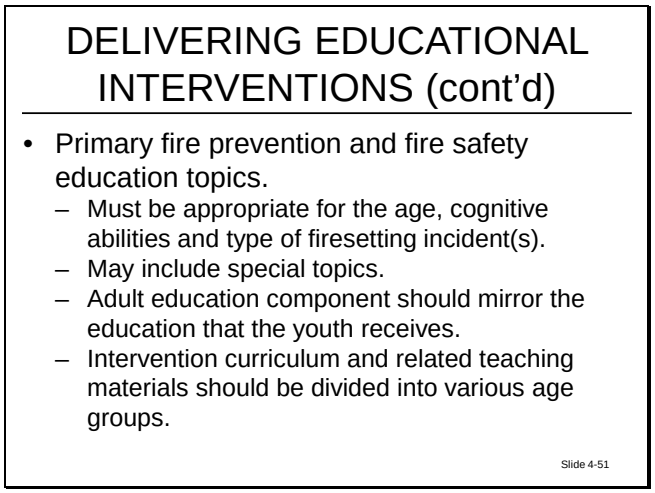
a. A classroom that is free of distractions such as people coming in and out to use equipment, phones, computers, etc.

b. The classroom should not be connected to an active fire station. If children walk through a fire station with on-duty firefighters and fire trucks, they may feel that they are being rewarded for their firesetting by going to a fire station.

c. The classroom should be a comfortable environment that will allow both the firesetter and his or her family to relax and learn.

d. A classroom that has multimedia is helpful for videos, PowerPoint presentations, etc.

I. Teaching materials employed.



1. There is nothing magical about educational interventions for firesetters. Primary fire prevention and fire safety education are appropriate topics for youth firesetter educational interventions.

2. When providing educational interventions for the firesetter, the method of presentation may vary, and there may need to be more emphasis on the consequences of firesetting and the importance of making good choices. There may also be the need to focus on the "tool of choice" for a particular firesetter (fireworks, lighters, candles).

3. Taking the time needed to appropriately screen the youth will help facilitate understanding of the youth, what he or she did, and why he or she did it.

4. Having this baseline knowledge will allow the educator to provide a more effective educational intervention.

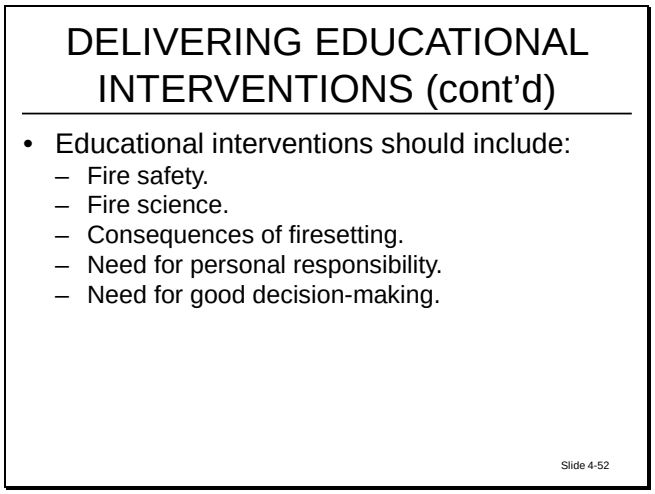
5. The youth firesetting intervention curriculum must be appropriate for the age, cognitive abilities and type of firesetting incident(s).

6. The intervention may include special topics related to the firesetter(s) attending the education intervention.

7. The adult education component should mirror the education that the youth receives and encourage parents/caregivers to practice it with their child.

8. The intervention curriculum and related teaching materials should be divided into various age groups. This means that, while the topics may be the same, the methodologies for the education intervention will be different for the young child and the older youth.

9. When performing the educational intervention, it is important that firesetters of different ages receive a different method of instruction and related activities. Therefore, a 6-year-old firesetter should not be in the same class as a 14-year-old firesetter.



10. Educational interventions should include the following topics:

    a. Fire safety.

    b. Fire science.

    c. Consequences of firesetting.

    d. Need for personal responsibility.

    e. Need for good decision-making.

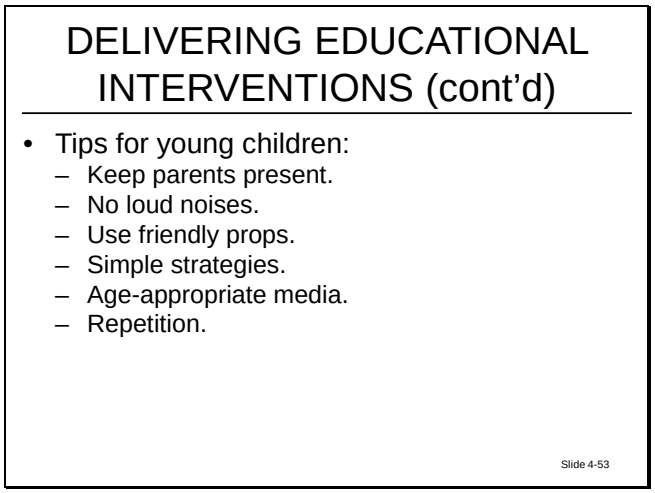
11. Educational intervention should use current age and developmentally appropriate instructional methodologies.

12. Many programs include video and/or other interactive media.

13. Every intervention curriculum should include extension activities/ homework or a family activity to reinforce program lessons.

14. It is appropriate to include an "oath" or contract, depending on age, at the end of the educational session regarding the youth's use of fire in order to reinforce the interventions.

15. Some curricula for older youth may require the firesetter to write an apology letter to the fire chief or to the individuals who were the victim(s) of the fire.



16. Tips for working with young children.

    a. Younger children often do not feel comfortable when separated from their parents/caregivers. It may be necessary to conduct the intervention with parents/caregivers present.

    b. Since younger children may be fearful of loud noises or scary situations, avoid use of props that make loud noises. Avoid graphic presentations that may scare children.

    c. Consider using puppets, toys, or other props that children are familiar with to tell a story about fire safety and explain good and bad fire.

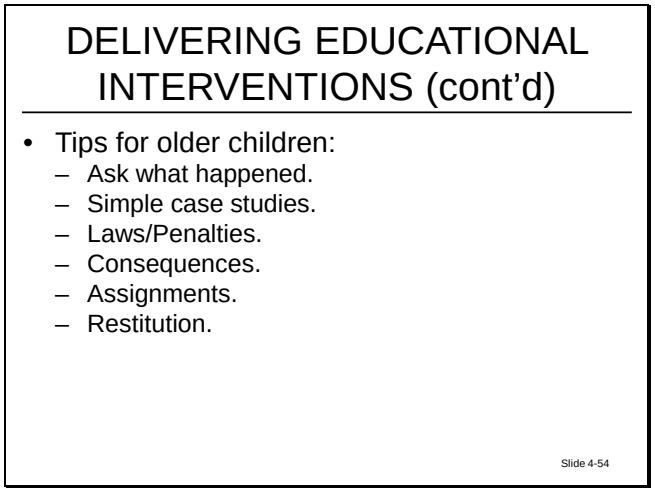
    d. Present simple fire safety messages and rules.

e. Ask the child to explain the fire and why it was bad.

f. Use age-appropriate media.

g. Keep presentations within the attention span of the young child, and make them interactive and varied.

h. With younger children, the parents/caregivers' education component is especially important.



17. Tips for working with older children.

a. Ask the firesetters why they are participating in the program. Discuss fire and its use.

b. Use simple case studies or current real-life fire-related events. Introduce props such as burned objects, pictures or firefighting tools. Note: Pictures of fire victims are never appropriate.

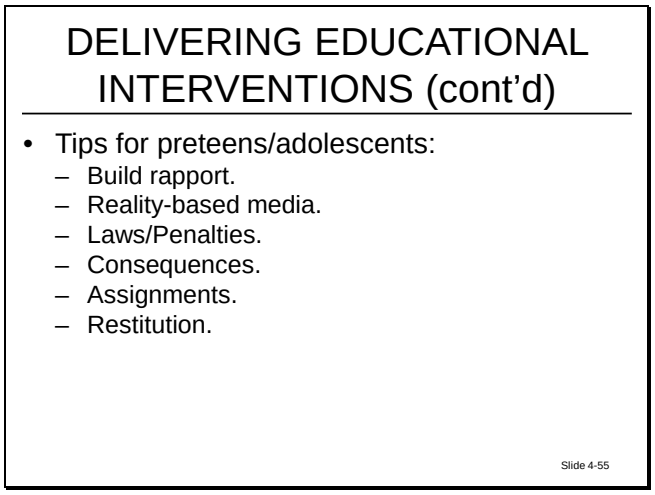
c. In an age-appropriate manner, discuss local laws and penalties. Ask them how they would feel if their home was destroyed (or how they felt if it was).

d. Consider use of a case study that overviews a juvenile firesetting situation.

e. Assign extension activities like writing letters to parents, firefighters and victims.

f. Extension activities should be assigned in conjunction with parents/caregivers.

g. A form of restitution may be included, such as home chores, neighborhood services or doing safety checks in homes of family and trusted friends.



18. Tips for working with preteens and adolescents.

a. Conduct an introduction activity to build rapport with the children.

b. Use reality-based media, such as news clips, news articles and digital media.

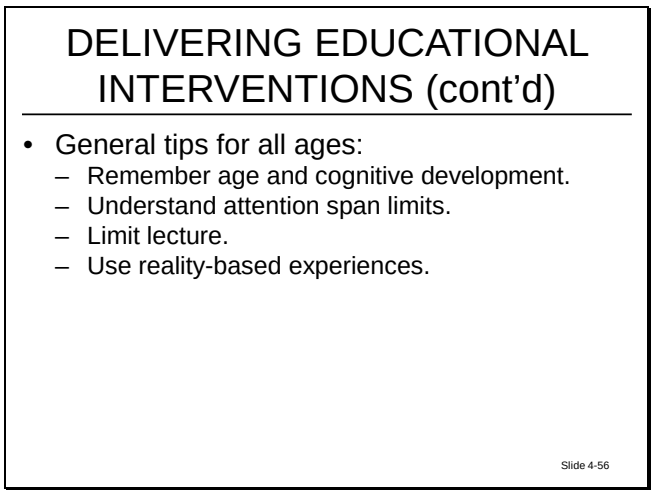
c. Use peer testimonials, case studies and problem-solving activities.

d. Reality-based experiences, such as a tour of a burned home, media presentations, and/or mock court exercises may work well.

e. Adolescents need to have a clear understanding of local fire laws and penalties.

f. Writing assignments such as a summary of what has been learned as a result of the firesetting experience may work well with this age group.

g. Restitution may be appropriate, whether monetary or community service. This may depend upon sanctions that have been enacted if the firesetter has had involvement with the legal system.



19. General tips for presenting education programs.

    a. Be aware of the group's age and cognitive development level.

    b. Understand and honor attention span limits.

    c. Limit the use of lecture-based instruction.

    d. Intersperse the lecture with interactive and reality-based experiences.

ACTIVITY 4.2

Stages of Development and Program Delivery

Purpose

To explore and apply the stages of development to the delivery of fire safety educational programs.

Directions

1. You will be divided into six groups of three to four students.

2. One of the following age groups will be assigned to each new student group:

   a. 3- to 6-year-olds.

   b. 7- to 11-year-olds.

   c. 12- to 15-year-olds.

   d. 16- to 18-year-olds.

   e. Adults.

   f. Senior adults.

3. Using information from the chart attached to this activity and personal experience, each group will become subject-matter experts (SMEs) on the developmental abilities of your assigned age group. Specifically, you will illustrate how educational interventions should be delivered to the specific age group that you have been assigned.

4. Include the following information in your summary:

   a. Developmental abilities of your assigned age group.

   b. Recommended methods of instruction.

   c. Types of learning activities appropriate for the assigned age group.

   d. Characteristics of a presentation environment that is conducive to learning.

5. Each group should choose a representative. Information should be posted on easel pads.

    a. There are 20 minutes allotted for preparation time.

    b. There are five minutes allotted for each group to present to the class at large (total is 30 minutes).

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
3 YEARS	High-level activity — jumps; is able to ride a tricycle. Helps to dress himself/herself. Emerges outside of home to peer group.	Development of imaginary fears (e.g., of the dark, scary things, etc.). Fears loud, harsh tones and gruff voices.	Intellectual: Piaget's Preoperational period (2 to 7 years) classifies by single salient feature. Language: Short sentences combining relational words and object words, e.g., "More cookie." What they see and hear may not be in agreement.	Active and sensory involvement, simple classification, repetitive jingles, action stories, directed learning in short segments, likes puppets and imaginative situations and characters. Opportunity to identify with program.	Sensory learning applications: • Hearing warnings and sounds such as smoke detectors. • Repetition. • Sightseeing danger. • Smell — good and bad smells can introduce something burning. • Touch — hot and burn. • Movement — Get Low and Go — exiting. • Meeting place call for help — 911 or Zero (Operator).

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
4 YEARS	Dresses himself/ herself. Increasing large muscle control and some small muscle control. Eye-hand coordination developing. Brushes teeth.	Loving but also quarrelsome and argumentative. Learning how to control own anger. Fears separation from parents and injury to self. Strong "mine" feelings. Uses senses.	Intellectual: Piaget's sub phase of the Preoperational period: the intuitive (discerning meanings in terms of class, relationship, etc.) Language: Engages in word games and silly humor. Asks many questions. Tries long sentences.	Active and sensory involvement, simple classification, repetitive jingles, action stories, directed learning in short segments, likes puppets and imaginative situations and characters. Opportunity to identify with program.	Sensory learning applications: • Hearing warnings and sounds such as smoke detectors. • Repetition. • Sightseeing danger. • Smell — good and bad smells can introduce something burning. • Touch — hot and burn. • Movement — Get Low and Go — exiting. • Meeting place call for help — 911 or Zero (Operator).

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
5 YEARS	Mature motor control with increasing developments in small muscle movements.	Strong affection for home, persons and objects associated with it. Fears of unreal events are lessened, but fear of mother leaving remains high.	Language: The child has mastered the basic grammar of his/her culture. Likes repetitive activity. Learns through modeling.	Active and sensory involvement, simple classification, repetitive jingles, action stories, directed learning in short segments, likes puppets and imaginative situations and characters. Opportunity to identify with program.	Sensory learning applications: • Hearing warnings and sounds such as smoke detectors. • Repetition. • Sightseeing danger. • Smell — good and bad smells can introduce something burning. • Touch — hot and burn. • Movement — Get Low and Go — exiting. • Meeting place call for help — 911 or Zero (Operator).

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
6 YEARS	Very active physically, but still clumsy; apt to get injured. Works hard in sports but tires easily.	Extremes in mood — loving and hating things. Temper tantrums. Rudeness may be common. Favorite activities and programs followed religiously. Basic emotions established but continue to develop subtlety in how, when and where to express them.	Vocabulary expanding rapidly. Likes memorization and alliterative sounds and rhyming; very active; needs practice time.	They like to do favorite activity over and over. Can process simple (if/than) situations. They like stories both real and imaginary.	• Build upon previous activities. • Sees smoke and understands danger. • Meeting place concepts.

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
7-11 YEARS	More integrated and coordinated motor activity. High expenditure of energy and experimentation with new skills. Shows poise.	Have definite likes and dislikes, but not as strong when expressing them. Have worries (of school work, being liked, etc.). Often in good mood. There is increasing sensitivity about sex and nudity.	Piaget's period of concrete operations (7 to 11 years) where the person is able to use some logical operations like true classification, ordering, etc. Curiosity about all things. Vocabulary gains.	Likes to be in charge; masters simple reading and more than one step directions. Likes ordering and stepping activities. Questioning: likes to know how to do it right. Mastery of language and symbols. Understands danger and potential dangers. Enjoys logic.	• Classifying dangers in our environment. • Exit drills as a learning experience. • Burn prevention. • Cause and effect activities. • Responsible behavior and decision-making. • Intervention activities.

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
12-15 YEARS	Uneven development (e.g., hands and feet reach mature size before arms and legs). There is awkwardness until physical changes and control functions are coordinated. High performance in puberty, but lacks experimental judgment and discretion.	Variable swings of emotion reflecting concerns over appearance, new skills and achievement, or pace of physical growth. Hero worship may be present. Affection and respect for parents and other role models. Not dependent on them. Affection for peers, but also opposite sex friends. Increased concern about one's body.	Piaget's period of formal operations (12 to 15 years) where the development of abstract thinking and hypothesis testing occurs. Performance on standardized tests peaks. Beginning explorations with abstract social ideas.	Abstract thinking. Makes applications to self (personal situations) and can work well independently. Actively involved in the learning process. Does not respond well to lecture. Can master hypothesis testing and reasoning. More difficult to get their attention and keep it. Interested in self.	• Know two ways out. • Creating a safe environment. • Common sense fire/ injury prevention. • Getting help. • Burn prevention. • Appropriate action when burn occurs. • Making and prioritizing choices.

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
16-18 YEARS	Continues high level of motor performance with practice adding to the experiential judgment (as in driving a car).	Strong feelings of affection and anger (especially over issues of independence). Favorable attitude about one's body and performance.	Peak of biologically based intellectual potential, which then decreases as the experientially based intelligence begins to increase.	Very capable of responsibility for self and others. Logical thinkers. Great at cause and effect problems. Good planners. Need high interest-level activities. Capable of recognizing insincerity, lack of confidence, trust or capability. Need to earn their respect, not given easily, once gained are loyal.	• All prevention and protection messages. • General safety practices. • Being responsible for creating a safe environment for self and others — especially the very young.

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
19-21 YEARS	Continues high level of motor performance, but overconfidence may become a problem.	Favorable attitude about one's body and high level of performance. Emergence of adult affection.	The college years for a large number of persons. Trade and technical schools are popular with this age group. Young parents and/or teen parents.	Teach, don't preach. Treat as adult learners. Recognize learning styles. Make programs relevant. Explain consequences and cost relationships. Respectful of dangers or potential dangers when explained. Personal application (i.e., cost, insurance, etc.) proves helpful when asking for behavior change.	• General information regarding program. • Kitchen fires — prevention and intervention. • Working smoke alarms. • Careless handling of matches and lighters. • Alcohol/smoking — share data, encourage safe practices. • Role of supervision and security of fire tools in firesetter invention.

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
22-40 YEARS	Continues high level of motor performance with increased judgment. Motor performance does not necessarily decrease even with physical changes, if one exercises routinely.	Emergence of psychological and social maturity. Also, social stresses appear in occupational area, family and social life. Favorable attitude toward one's body, even with changes in agility, etc., some culturally bound negative feelings about being "over 30."	A period of major creative contributions for persons in some fields — mathematics, physics. Creativity reaches its highest output on the average; different occupations, such as law, manifest major contributions at later ages.	Treat with respect, recognize any special needs, teach with adult materials that have relevancy to this audience. Build on good parenting techniques.	• General. • Kitchen fires. • Family exit drills. • Maintain a safe environment (i.e., careless handling of fire tools). • Checking environments for family members (both younger and older, such as parents) to encourage safe practices — caring enough to model practices.

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
41-60 YEARS	Some of the senses are not as keen.	Fears of aging may emerge. Concerns about discrepancy between career aspirations and realities; changes in one's body are becoming noticeable.	Vocabulary and information peak around forties. Comprehension skills declining slightly, and arithmetic and other subjects begin to show decline in middle age.	Recognize experience, be respectful of lifestyle, teach with adult materials that have relevancy for this audience. Good advocacy possibilities. Can be informed about dangers and potential dangers and be effective in creating safe environments for their aging parents and grandchildren.	• General — with consideration for limitations of living arrangement changes. • Review general practices and upgrade with current information.

ACTIVITY 4.2 (cont'd)

STAGES OF HUMAN DEVELOPMENT WITH APPLICATIONS FOR EDUCATION

Provided by Joan Williams from Pan Education Institute

AGE	MOTOR	AFFECTIVE	INTELLECTUAL	RECOMMENDED STRATEGIES	CHARACTERISTICS FOR EFFECTIVE FIRE AND LIFE SAFETY EDUCATION
61+ YEARS	Performance may be at same levels as earlier, but experience rather than agility helps to attain goals.	Grief concerning widowhood. Depending on personality and social environment, some are satisfied with retirement's disengagement while others are frustrated by inactivity forced on them.	Vocabulary and information begin to decline as other cognitive functions have done earlier. But the decline in overall "verbal" intelligence is very gradual.	Be sensitive to emerging physical limitations, use adaptive techniques toward fire and life safety behaviors. Treat as responsible adults in non-condescending manner. Can be tremendous supporters.	• General safety practices and prevention with special consideration for limited mobility.

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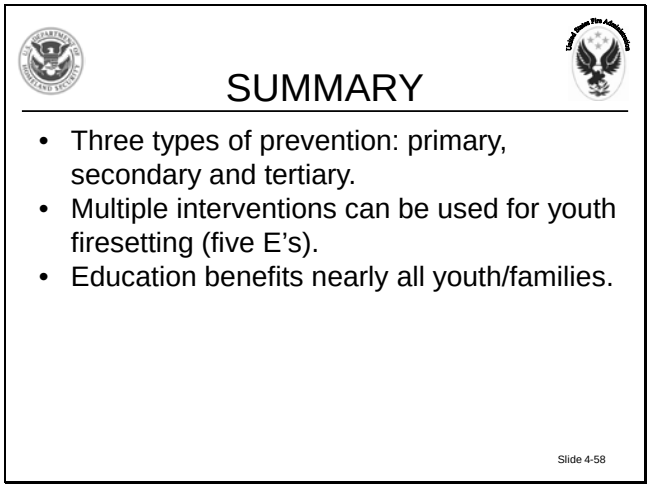
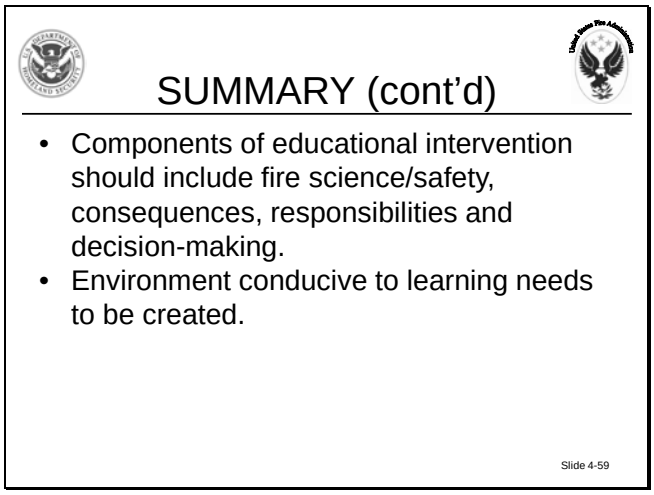
VI. SUMMARY


SUMMARY
• Three types of prevention: primary, secondary and tertiary.
• Multiple interventions can be used for youth firesetting (five E's).
• Education benefits nearly all youth/families.
Slide 4-58


SUMMARY (cont'd)
• Components of educational intervention should include fire science/safety, consequences, responsibilities and decision-making.
• Environment conducive to learning needs to be created.
Slide 4-59

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APPENDIX A

PRETESTS

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Youth Firesetting Intervention Program — Pre and Post Test

Elementary Age Level

Part I

Please fill in the box with the correct answer: (pick answer from word bank)

1. What is the name of the safety tool that smells for smoke?

2. During a fire, where do the smoke and heat go?

3. If a person's clothes are on fire, what must he or she do?

4. What should you do if you find a lighter?

WORD BANK

Stop, Drop and Roll	Seat Belt	Down
Whistle	Crawl	Up
Bike Helmet	Tell an Adult	Smoke Alarm

Part 2

Please answer true or false. Draw a circle around the correct answer.

1. Most fires happen because adults are not careful with tools that make heat.

   True or False

2. Smoke alarms only need to be tested once a year.

   True or False

3. During a fire, it is very hot near the floor.

   True or False

4. Using a window is the safest and fastest way to escape from a fire.

   True or False

5. Laws are important rules that everyone must obey.

   True or False

6. If you start a fire on purpose, you can be taken to jail.

   True or False

7. If you find a lighter, you should pick it up and take it to an adult.

   True or False

8. A lighter is a tool for adult use only.

   True or False

Part 3

Multiple choice questions. Please circle the letter next to the correct answer.

1. Fire is a powerful
    a. Toy
    b. Tool
    c. Game
    d. Weapon
2. 911 is used to
    a. Find out what time it is
    b. Get directions
    c. Get help during an emergency
    d. Find a friend’s telephone number
3. When adults are cooking food, they should
    a. Watch television
    b. Watch the stove
    c. Talk on the telephone
    d. Lie down to rest
4. If smoke is near, a person should
    a. Stop, drop, and roll
    b. Stand up and run
    c. Look for a fire
    d. Get low and go

5. People who get hurt are most often those who are

   a. Following safety rules and laws

   b. Listening to people they trust

   c. Not taking risks and dares

   d. Not following safety rules and laws

APPENDIX B

ADOLESCENT BRAIN DEVELOPMENT: A PERIOD OF VULNERABILITIES AND OPPORTUNITIES

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Adolescent Brain Development: A Period of Vulnerabilities and Opportunities

Keynote Address

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ABSTRACT: This article introduces and summarizes the goals of the symposium. It also provides an overview of a conceptual framework for understanding adolescence, which emphasizes how the very nature of this developmental transition requires an interdisciplinary approach—one that focuses on brain/behavior/social-context *interactions* during this important maturational period. More specifically it describes a set of neurobehavioral changes that appear to be linked to pubertal development, which appear to have a significant effect on motivation and emotion, and considers these puberty-specific changes in affect in relation to a much larger set of developmental changes in adolescence. This framework is used to argue for the need for a transdisciplinary dialogue that brings together work in several areas of neuroscience (including animal models) and normal development with clinical and social policy research aimed at early intervention and prevention strategies.

KEYWORDS: adolescence; puberty; neuroplasticity; high-risk behavior; interdiciplinary studies

INTRODUCTION AND GOALS

One of my first goals in this opening address is to try to convey some of the excitement that has been generated among the organizers of this conference—Linda Spear, Ann Kelley, Dick Clayton, Rashid Shaikh, and myself—in the months of planning that led up to this meeting. In part, this enthusiasm emerged directly from the prospects of hearing about and discussing the many rapid advances that will allow us to gain greater understanding of the development of the adolsecent brain. Even further, we were excited at the prospect of bringing together investigators from a wide range of backgrounds and scientific disciplines in order to *create a broader interdisciplinary dialogue*.

This, we believe, is one of the key issues for the field: stronger scientific bridges need to be built across disciplines that will allow previously separate bodies of knowledge to be linked and more effectively applied to the large-scale problems af-

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fecting youth. It is essential, we believe, not only to deepen our understanding of specific neurobiological changes during adolescent development, but also to broaden our knowledge of how behavioral, familial, and social influences *interact,* in multifaceted ways, with the development of the biological systems of interest.

The stakes are high: the problems affecting adolescents in our society are both enormous and complex. On one hand, there are reasons to be optimistic about the prospects of contributions from current and future scientific advances in these areas: We are entering a period of rapid progress in research aimed at many aspects of adolescent development, including several areas of basic and clinical research. These studies are beginning to provide new insights about adolescence as a unique developmental period. These include normal developmental studies of cognitive, emotional, and social maturation in adolescence; clinical research focusing on the development of a broad range of behavioral, emotional, and substance abuse problems in adolescence; and advances in using animal models to understand both neural and behavioral aspects of development during puberty and adolescence. In addition, many conceptual and methodological advances have been made in studies of adults—including rapid progress in cognitive and affective neuroscience as well as the use of structural and functional neuroimaging tools and molecular and genetic methods—that can now be applied to questions about adolescent maturation. Several of these areas of investigation are creating invaluable contributions that have direct relevance to understanding a variety of dimensions of adolescent development. There is every reason to predict that the rapid growth in many of these fields will continue to accelerate.

On the other hand, rapid growth along several different lines of investigation introduces new challenges as well as opportunities. A key part of the difficulty in this field is the tendency toward fragmentation—insularity within disciplines working on related and somewhat overlapping areas of investigation. There is often a shortage of effective bridges between disciplines: Stronger links need to be forged between animal and human investigations of adolescence, and developmental and clinical approaches need to be better integrated, as do biological and social frameworks, for understanding adolescent development. More generally, we need to promote *trans*disciplinary dialogues as well as better conceptual integration of many of the separate lines of investigation.

This is, in many ways, the *primary goal* of this conference (and a key goal for this *Annals* volume as well as its eBriefing on the Academy's web site <http://www.nyas.org/ebriefreps/main.asp?intSectionID=189>). We seek to establish connections—scientifically, conceptually, and through personal relationships—that will help counteract the tendency towards insularity within disciplines.

This emphasis on integrating a diversity of scientific backgrounds began at the level of the organizing committee for the conference, which included individuals from basic and behavioral neuroscience, clinical research in pediatrics and child psychiatry, and the social sciences and prevention research. We have attempted to organize this symposium in ways that are consistent with this trans-disciplinary goal, as will be seen in the eight sessions reported here. The format for each section includes an introduction by the organizer who selected each presenter for that session, followed by two or three papers that juxtapose basic research with other more clinical or social approaches, followed by a discussant who provides some integration of the different papers or points to particular lines of research needed to advance future understanding.

We believe that promoting such trans-disciplinary dialogue represents a crucial step toward the long-term goal of achieving a deeper understanding of adolescence as a unique period of development. In this opening address I want to sketch a conceptual framework for adolescence that emphasizes how the very nature of this developmental transition requires an interdisciplinary approach. I wish to underscore how a set of neurobehavioral changes at puberty represents *part* of a much larger set of maturational changes in adolescence, and how these require an approach that focuses on brain/behavior/social-context *interactions* during this important maturational period.

FRAMING THE BIG QUESTIONS: THE HEALTH PARADOX OF ADOLESCENCE

Adolescence presents a striking paradox with respect to overall health statistics. This developmental period is marked by rapid increases in physical and mental capabilities. By adolescence, individuals have matured beyond the frailties of childhood, but have not yet begun any of the declines of adult aging. Compared to young children, adolescents are stronger, bigger, and faster, and are achieving maturational improvements in reaction time, reasoning abilities, immune function, and the capacity to withstand cold, heat, injury, and physical stress. In almost every measurable domain, this is *a developmental period of strength and resilience*.

Yet, despite these robust maturational improvements in several domains, overall morbidity and mortality rates *increase* 200% over the same interval of time. This doubling in rates of death and disability from the period of early school age into late adolescence and early adulthood is not the result of cancer, heart disease, or mysterious infections. Rather, the major sources of death and disability in adolescence are related to *difficulties in the control of behavior and emotion*. It is the high rates of accidents, suicide, homicide, depression, alcohol and substance abuse, violence, reckless behaviors, eating disorders, and health problems related to risky sexual behaviors that are killing many youth in our society. These problems are documented as frequently in the popular media as they are in the medical or epidemiologic literature. Adolescence is strongly associated with an increase in risk-taking, sensation-seeking, and reckless behavior—all of which which lead, far too often, to actions with dire health consequences.

These high rates of "reckless" behavior in adolescence also highlight a second level of paradox: In most measurable ways, adolescents have developed *better* reasoning capabilities and decision-making skills than children. Older teenagers can perform at (or very near to) adult levels in their abilities to understand, cognitively, the consequences of risky behavior. Adolescents are much better than children at the mental processes that underpin making logical and responsible choices. Yet, despite these cognitive improvements, adolescents appear to be more prone to erratic—and, as I will argue, *emotionally influenced*—behavior, which can lead to periodic disregard for the risks and consequences.

These striking paradoxes—high rates of morbidity and mortality despite robust physical health, and increasing rates of reckless behavior despite improved capacities for decision making—provide part of the framework regarding the importance of research into the neurobehavioral underpinnings of these developmental changes.

Compelling scientific questions lurk within these mysteries and seeming contradictions. Achieving a deeper understanding of adolescent neurobehavioral development can, in the long run, contribute to the pragmatic goals of early intervention to address these large-scale problems.

ACKNOWLEDGING THE COMPLEXITY OF THE PROBLEMS

On one hand, there are compelling reasons to believe that neuroscientific research can ultimately help to delineate underlying developmental processes in ways that can inform more effective early interventions and social policies to promote healthier adolescence. On the other hand, there are equally compelling reasons to believe that complex behavioral and social factors are so intertwined with biological development as to make simplistic or reductionist goals untenable.

Examining neurobehavioral contributions in the developmental pathways leading toward these problems does *not* equate to a reductionistic approach; the goal is not to try to reduce those complex problems to the level of brain mechanisms or biological interventions. Investigators working in basic research in these areas must collaborate closely with their colleagues in clinical and social sciences. And for their part, the clinical and social scientists must seek collaboration with basic scientists without fearing that a mechanistic understanding of some aspects of these problems implies any diminished role for the social, cultural, and familial influences on these developing biological systems. Rather, it is important to emphasize how a mechanistic understanding of biological processes can actually *enhance* the importance of behavioral or social policy interventions.

To provide a simple example of this principle of collaboration between both ends of the scientific spectrum, consider the effect of scientific progress in understanding the biologic mechanisms contributing to genetic vulnerability to skin cancer. This set of insights about biological processes has not led to "blaming" the problem on the genes *or* ignoring the role of behavior and context (i.e., the role of excessive sun exposure and sunburn leading to skin cancer). Instead, mechanistic understanding of how fair-skinned children are at high risk for ultra-violet skin damage has *promoted* adaptive behavior: parents of fair-skinned children are now more highly motivated to use sunscreen and protective clothing for these children to prevent the biological vulnerability (genetically low levels of melanin in the skin) from leading to skin cancer in adulthood.

A second example—a bit closer to our focus on brain development— is the "0 to 3" campaign that has raised awareness about the importance of brain development in the first few years of life. This emphasis on biological processes has *not* been reductionistic, and has not been viewed this way by policy makers. Evidence of brain plasticity in the early years of life has not led to the conclusion that parenting and social experience are unimportant during this maturational period, but rather to its opposite: Developmental psychologists, neuroscientists, and policy makers are more likely to emphasize the value of social policies that protect and support infants and toddlers during this important period of brain development. There are, I believe, parallel opportunities regarding interdisciplinary approaches focusing on puberty and adolescent brain development.

I believe that these are crucial issues for our field. Basic neuroscientists, developmental psychologists, clinical investigators, and social scientists must work together to understand adolescence. A conceptual framework must be constructed that emphasizes the *interactions* of brain, behavior, and social context in the developmental pathways to positive and negative outcomes in youth. We need to examine, scientifically, specific components of these processes, without forgetting the complex nature of the problems.

WHY IS ADOLESCENCE A TIME OF SO MANY COMPLEX PROBLEMS?

Part of the problem of adolescent tendencies toward irrational, emotionally influenced behavior has been recognized throughout human history. As Aristotle noted more than twenty centuries ago:

> Youth are heated by Nature as drunken men by wine.

Or, in Shakespeare's words:

> I would that there were no age between 10 and 23, for there's nothing in between but getting wenches with child, wronging the ancientry, stealing, fighting... *(The Winter's Tale,* Act III*)*

Yet, there are also important differences in how we can approach understanding adolescents' problems in contemporary times. Today we can begin to parse these complex problems into empirical questions about adolescent development. We can now move beyond age-old observations and negative characterizations of impulsive and "hot-headed" youth, and start to ask specific scientific questions: What is the empirical evidence that adolescents are "heated by Nature"? Are these changes rooted in biology? Are some of these changes simply a function of greater freedoms and social influences? Are there neurobehavioral underpinnings to some of these adolescent tendencies that are universal across cultures? Are some of these changes related directly to increases in specific hormones? Are they linked to maturational changes in specific neural systems in adolescence? Which aspects of these developmental changes and problems can be modeled in animal studies? Are there unique types of neural "plasticity" during puberty and adolescence, when a particular set of individual experiences can have longstanding effects on the trajectory of development? How do these periods of plasticity create *vulnerabilities* that in turn contribute to the high rate of serious problems and disorders emerging in adolescence? How might this same type of plasticity create unique *opportunities* to intervene in positive ways at this point of development?

An analogy can illustrate the key principle: Consider the natural developmental window for learning fluency in a second (or third) language. While, a person *can* learn a new language at any age, the process of becoming easily fluent in a new language changes significantly after puberty. For an adult to achieve an even modest level of proficiency in a new language requires a great deal of motivation, special training, drills, persistent efforts, and an enormous amount of time. It is also exceedingly difficult to speak without a strong accent for persons who have learned a language as an adult. In contrast, during childhood and early adolescence, a simple immersion in an environment with a new language can result in mastery with little

or no formal teaching, and a gradual loss of an identifiable accent. (A good example of this is the contrast between Henry Kissinger, who came to the U.S. as an 15-year-old, and his brother, who was 3 years younger when the family moved to this country. His brother speaks English without a noticeable accent, while Kissinger, a brilliant man who has developed a masterful command of the English language, speaks with a heavy accent and retains a consistent set of speech patterns that identify him as someone who did not learn this language during the optimal developmental window.)

This concept of *plasticity* in underlying neural systems forms the basis of several crucial questions regarding puberty and adolescence—and in ways that are likely to have great clinical relevance. For example, is there an analogous natural window of plasticity for learning *emotional* regulation? Is there a developmental period when an individual can—with the right kinds of experience—easily achieve social and emotional fluency? And if something prevents or interferes with this emotional learning process during this natural period of development, is it fundamentally more difficult to achieve such refined or fluent control at a later point?

Human and animal studies are being conducted that are providing empirical data to address questions about the unique opportunities in this interval of development. The findings are likely to have enormous implications about clinical and social policy regarding the impact of early interventions. The pay-off for interventions that are implemented before these windows of plasticity become narrowed, or closed, may be much greater than the same interventions provided later in adulthood (when the underlying neural systems may be slower to adapt to change). We are at a very early point in the curve of scientific understanding of these complex issues, but a great deal of evidence exists that points toward unique opportunities, and vulnerabilities, that emerge in adolescence.

A PERIOD OF STORM AND STRESS?

Nearly 100 years ago, the pioneering psychologist G.S. Hall performed a body of work that began the modern study of adolescence. His work emphasized this developmental interval as a period of "heightened storm and stress," a phrase that has long been an influential metaphor for understanding adolescence. In the 1960s and '70s attempts were made to understand these problems in terms of "raging hormones." Those early investigations contributed some understanding of the role of pubertal hormones in some adolescent behavioral and emotional changes, but it also became clear that many models of these hormonal effects were overly simplistic. Pubertal hormones do not seem to *cause* behavioral problems or emotional turmoil: many of the youth with the highest levels of these hormones showed little or no problems with stress, emotions, or behavior.

J.J. Arnett[1] wrote a thoughtful review of these issues in 1999, asking what the empirical evidence is regarding stress, hormones, and puberty. His review provides a nice counterweight to many oversimplified views of these complex issues. First, many, and perhaps most, adolescents navigate this transition with minimal difficulties. Perhaps up to 80% of youth have little or no major problems during these "tumultuous" times. Arnett's paper, along with other influential papers by Steinberg *et al.* and Masten *et al.* (1999) over the past decade, reminds us to be careful not to

over-generalize the (sometimes) dramatic problems in some adolescents. In fact, most adolescents get along quite well with their parents and teachers most of the time, succeed in school, have positive relationships with peers, do not become addicted to drugs or alcohol, and become productive and healthy adults. However, there is also evidence that a significant proportion of adolescents *do* experience great stress, struggle, and emotional turmoil. As stated earlier, this developmental period shows a sharp increase in morbidity and mortality related to a wide range of types of behavioral and emotional problems. In addition, it is also a time when trajectories are set (or altered) in ways that lead to difficulties in adulthood. Adolescence often contains the developmental roots of lifetime problems with nicotine dependence, alcohol and drug use, poor health habits, relationship difficulties, and failure to develop skills and knowledge leading to a productive job or career. Trajectories are set in adolescence that can have a major impact later in life, and there are reasons to believe that altering these trajectories in positive ways prior to adulthood can have a larger scale effect than the same intervention applied later in the lifespan.

A NATURAL TENDENCY TOWARD RISK TAKING, SENSATION SEEKING, AND STRONG EMOTIONS?

Part of the vulnerability (and opportunity) in this period of development may be linked to a set of biologically based changes in neural systems of emotion and motivation, which contribute to what appears to be a natural increase in tendencies toward risk taking, sensation seeking, and some emotional/motivational changes during pubertal maturation. On one hand, these appear to be normative changes that affect most adolescents to some degree; on the other hand, in some individuals and in some social contexts, these normative tendencies can lead to serious problems—as will be discussed in greater depth as this book unfolds.

It is valuable, therefore, to examine and better understand the neurobehavioral underpinnings of these normative affective changes, which may represent more than just simply adolescent brooding, moodiness, and romantic inclinations. There seems to be a natural biologic proclivity toward high-intensity feelings that emerges at puberty. Some emotional states—specific types of feelings—may be triggered more quickly and/or with greater intensity as a function of the biological changes attendent on pubertal maturation. For example, the tendency for increased parental conflict in early adolescence can be understood, at least in part, in relation to an increase in the *intensity* of emotion that is aroused during pubertal maturation.[2]

There is a second, somewhat related, set of observations about adolescent emotional development. Pubertal maturation is associated with a greater inclination to *seek* experiences that create high-intensity feelings. For example, studies of sensation seeking—a measure of how much an individual *wants* to experience risks, thrills, excitement, and intensity—reveal a similar developmental increase that is linked to puberty.[3]

Adolescents *like* intensity, excitement, and arousal. They are drawn to music videos that shock and bombard the senses. Teenagers flock to horror and slasher movies. They dominate queues waiting to ride the high-adrenaline rides at amusement parks. Adolescence is a time when sex, drugs, *very* loud music, and other high-stimulation experiences take on great appeal. It is a developmental period when an appe-

tite for adventure, a predilection for risks, and a desire for novelty and thrills seem to reach naturally high levels.

While these patterns of emotional changes at puberty are evident to some degree in most adolescents, it is also important to acknowledge the wide range of individual differences during this period of development. For some adolescents this tendency to activate strong emotions and an affinity for excitement can be subtle and easily managed. In others, these inclinations toward high-intensity feelings can lead to emotionally charged and reckless adolescent behaviors, and at times to impulsive decisions by (seemingly) intelligent youth that are completely outrageous.

ADOLESCENT EMOTIONAL BEHAVIOR: AN ILLUSTRATIVE ANECDOTE

A young guy scanning the crowd at a party notices a girl who he finds strikingly attractive. Immediately smitten, he approaches her and launches a shower of compliments. She tries to rebuff his flattery but finds something about the young man quite appealing. Romantic feelings kindle quickly. As he departs, with a kiss followed by a second kiss, emotions are flaring.

On the basis of one brief meeting, a conversation of less than a hundred words, and two kisses, the emotional lives of two adolescents have been turned upside-down. Each cannot stop thinking about the other. These two are obsessed with a desire to meet again. They manage a clandestine late-night rendezvous. Passionate feelings now accelerate at a feverish pitch. Their motivation to be together quickly rises above all competing priorities. They are willing to spurn friends and family, disregard dangers, ignore pain, and begin to act as if being together is more important than life itself—though they just met four days previously and barely know each other.

If evaluated by a psychiatrist who did not understand youthful passions, these two could easily be judged as meeting diagnostic criteria for serious mental disorders or cognitive impairments. Previously learned abilities to think logically and behave rationally seem to have evaporated in a matter of hours. When viewed with a sense of emotional detachment—without some feeling for the heat and power of young love—this scenario of adolescent behavior would appear simply ludicrous.

Yet the story of *Romeo and Juliet* has moved audiences to tears for centuries. The basic elements of the story date back to the Greek novelist, Xenophon. An Italian version of the story written in 1535 by Luigi da Porto placed the scene in Verona and named the feuding families Montecchi and Capellati. Then followed an English poem by Arthur Brooke in 1562 titled *The Tragical History of Romeus and Juliet.* But it was Shakespeare's adaptation in 1595 that made this tale what is probably now the most successful drama in history.

This story of two adolescents in love has evoked sympathetic responses across many translations and cultures because of a nearly universal human appreciation for the emotional intensity—and potential for tragedy—from rapidly igniting adolescent passions. It is also illuminating to reflect on Juliet's age: in the Luigi da Porto's version, Juliet (Giuletta) was 18 years old and the courtship developed over a few weeks. In contrast Shakespeare made Juliet only 13 years old and he compressed the action into four days.

One can only speculate why Shakespeare created a heroine so young in this romantic tragedy. It seems likely that for dramatic effect he intentionally juxtaposed adult-like passions with the naïveté of a very young teenager. As a shrewd observer of human nature Shakespeare recognized early adolescence as a time of life that creates a natural tinderbox for igniting passions.

So the emotional changes in adolescence have been generally recognized for many centuries. But over the past 50 years studies in developmental psychology have added considerable scientific substance to our knowledge of adolescent cognitive and emotional development. And, most recently, the tools of modern neuroscience as well as the use of animal models are empowering an even deeper understanding of this developmental period.[9] These advances are generating new insights into some of the roots of emotional, motivational, and behavioral changes that emerge at puberty. However, before turning to address some of these findings, it is first necessary to consider some broader questions about how we should best conceptualize, and *define,* adolescence.

WHAT *IS* ADOLESCENCE?

Adolescence has been defined in different ways by different groups of investigators and it is sometimes difficult to reach any convergence of opinion. This lack of clear definition becomes ever more challenging when attempting to bridge between animal and human models of puberty and adolescence. Yet, these are crucial issues for our field. In part, the difficulties reaching a clear consensus are related to ambiguities regarding how best to *conceptualize* the notion of adolescence. Other contributors to this symposium will present several perspectives on these issues.

I will begin this discussion by offering some opinions, including a definition that our research group has found useful, along with a brief introduction of a conceptual model of adolescence—one that reflects the work of our NIMH-supported interdisciplinary research network called ADAPT (Adolescent Development Affect-Regulation and the Pubertal Transition Research Network). Our research group[2] presents a more detailed account of this model and its relevance to using affective neuroscience to investigate the developmental psychopathology emerging in adolescence.

Let us then provisionally define adolescence in humans as *that awkward period between sexual maturation and the attainment of adult roles and responsibilities.* This defintion has proven useful in several ways. It captures the concept that adolescence begins with the physical/biological changes related to puberty, but it ends in the domain of social roles. It encompasses the transition from the social status of a child (who requires adult monitoring) to that of an adult (who is him- or herself responsible for behavior).

In other words, the end of adolescence and onset of adulthood cannot be understood solely on the basis of physical changes. To illustrate this point, consider the maturational classification of a girl, like Juliet, who is physically mature in every measurable way—fully grown in height, adult bone age, adult levels of hormones, sexually and reproductively mature, and highly intelligent, but who is 13 years old and in 7th grade. No one would argue that this individual should be considered an adult. Being an adult is not simply a matter of completing a certain category of phys-

ical development—it involves attaining a broader set of skills and knowledge that is part of the larger process of taking on adult roles and responsibilities.

Adolescence involves transitions in social roles (from that of a child to that of an adult) interposed with a multitude of pubertal changes in body and brain. Thus, it is optimal to have a working definition of adolescence that is consistent with a conceptualization of adolescence, which is, by its very nature, best understood at the level of *interactions* between biological, behavioral, and social domains.

Since, in this conceptualization, adolescence begins in the domain of physical changes (puberty) but ends in the domain of social context (adult roles), efforts to understand the transition period *must* entail interdisciplinary approaches. The very nature of this transition involves interactions between the biological, behavioral, and social domains. Understanding this transition will therefore require conceptual and methodological approaches that reflect the cross-disciplinary nature of the problem. While many scientific investigations will perforce focus on specific aspects or components of adolescence, it is equally important to place these elements within the framework of this larger perspective.

THE ONSET OF ADOLESCENCE: BIOLOGICAL CHANGES OF PUBERTY

One place to begin within the complex suite of maturational processes that we call adolescence is to focus on the biologic changes that occur at puberty. These are striking in several ways: First, puberty brings dramatic changes in body size and composition (including alterations in muscle and fat, as well as increased rate of growth and metabolic rate). Second, puberty leads to the physical changes of sexual maturation—breast or phallic development and the development of secondary sexual characteristics, including pubic and axillary hair, skin and odor changes, and deepening of the voice and development of facial and body hair in boys. Third, the physical changes of puberty lead directly to alterations in many aspects of social experience. The world treats an individual differently when he or she begins to look like an adult. (A fourth domain of changes—cognitive, psychological, and emotional changes linked to puberty—will be discussed later.)

Thus there are several interrelated processes that contribute to the physical, emotional, and social changes that are encompassed by physical maturation. Even within this relatively narrow focus on physical changes at puberty (within the much broader set of developmental changes that stretch across adolescence) it is clear that there are still several component processes that can be considered separately. At least three sets of pubertal changes can be linked to specific sets of hormonal changes. For example, rapid physical growth and increased height is strongly linked to changes in growth hormone (GH) and the upstream neuroendocrine changes that result in very high rates of GH secretion in mid-puberty (with some added contribution by sex hormones).

In contrast, a second neuroendocrine axis, which leads to the *gonadarche*, works through the pulsing of gonadotrophins, which ultimately causes the onset of phallic or breast development at puberty. Gonadarche begins with the pulsing of gonadotrophin-releasing hormone (GnRH) in the hypothalamus of the brain, which stimulates the pituitary to release the hormones LH and FSH into the blood, where

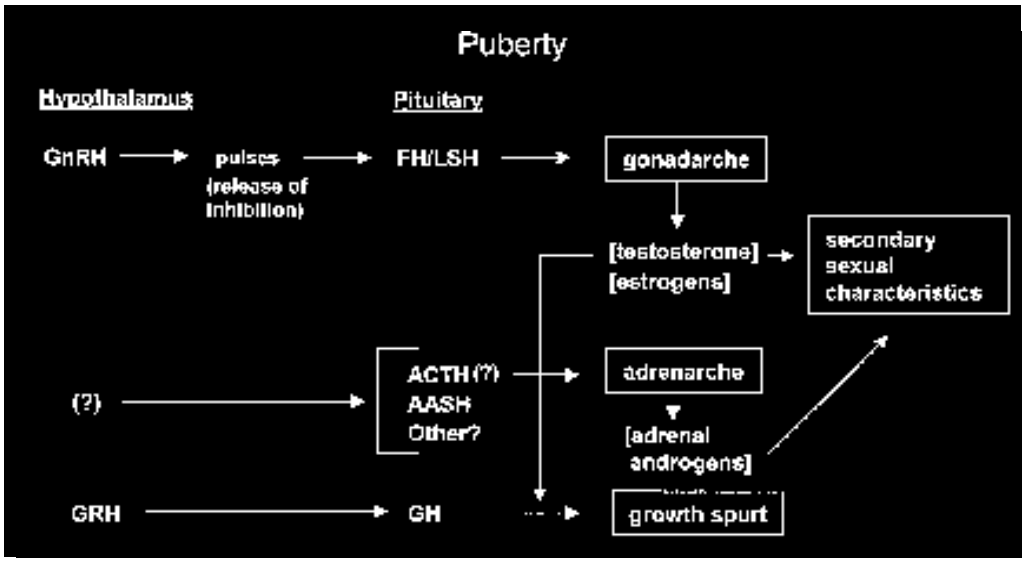

FIGURE 1. The neuroendocrine aspects of puberty include three components: gonadarche, adrenarche, and the pubertal growth spurt.

they then continue the cascade of changes by stimulating the gonads. Once the gonads are activated by LH/FSH, there is a sharp increases in estrogen in females and testosterone in males.The rising level of estrogen causes breast development in the female and the rising levels of testosterone lead to phallic growth, increased muscle mass, and voice changes in the male.

A third neuroendocrine axis, which leads to *adrenarche*, involves hormones released by the adrenal gland, including DHEA and DHEAS. These hormones often begin to rise by 6–9 years of age, but continue to increase throughout adolescence and typically peak in the early 20s. These adrenal hormones are often considered "weak" versions of sex hormones, and they bind to different receptors in the body, which contributes to adolescent changes in skin (e.g. acne) and the development of pubic and axillary hair (FIG. 1).

Clearly, puberty is *not* one process—it is a suite of changes that occur in relative synchrony. Moreover, as is apparent to those who have worked in a pediatric endocrine clinic, there is not only a wide range of variations in the precise sequence and timing of these various components, but also many types of disorders that can result in turning on a single component within this complex system. For example, some individuals can show premature adrenarche without any other sign of puberty; in other cases a girl may show premature breast development without any other sign of pubertal or adrenarchal maturation, while in some cases an individual may show an extremely early but otherwise normal spectrum of all elements of precocious puberty. Most importantly, these pubertal changes are only one set of maturational processes within the broader scope of adolescence, which includes the development of cognitive, emotional, and social skills and knowledge, as well as the maturation of judgment.

SOME ASPECTS OF ADOLESCENT DEVELOPMENT HAVE BEEN OCCURRING EARLIER

It is crucial to consider the various components of adolescence because there have been recent historical changes in the timing of (at least some aspects) of development, there now being an earlier onset of pubertal processes, particularly in females. FIGURE 2 provides data summarized by Rutter and colleagues[4] showing a great deal of historical evidence for changes in the *average* age of pubertal onset over the past century.

As shown, the age of menarche in Finland, Sweden, Norway, Italy, the UK and the United States between 1860 to 1960 has increased fairly markedly. (It is important to note here that menarche is a relatively *late* event in female puberty.) Individuals are usually at Tanner Stage 4 by the time menarche occurs, so the biological cascade has begun years earlier. Thus, when we talk about adolescence, we're not just talking about teenage years, but about this interval that often begins with a cascade of hormone changes by 9–12 years of age, with most of the physical changes of puberty often complete by the middle of the teen age years.

FIGURE 3 shows some more recent data in the U.S. on the early start of pubertal maturation. This study by Herman-Giddens and colleagues examinined a representative sample of 17,000 girls in pediatric practices. FIGURE 3 shows the number of girls at age 7 and 8 years of age that were at Tanner Stage 2 or above in breast or pubic hair development. It shows that by 7 years of age 7 % of European American, and 27% of African American, were already at Tanner 2—a stage that the level of estrogens or adrenal androgens had caused the body to develop breast tissue and/or pubic hair. By 8 years of age 47% of the African American girls were at Tanner 2! Therefore, when we talk about adolescence as an interval of development that begins with pubertal maturation, it is quite misleading to use the common convention of interchanging the word "teenager" and adolescent.

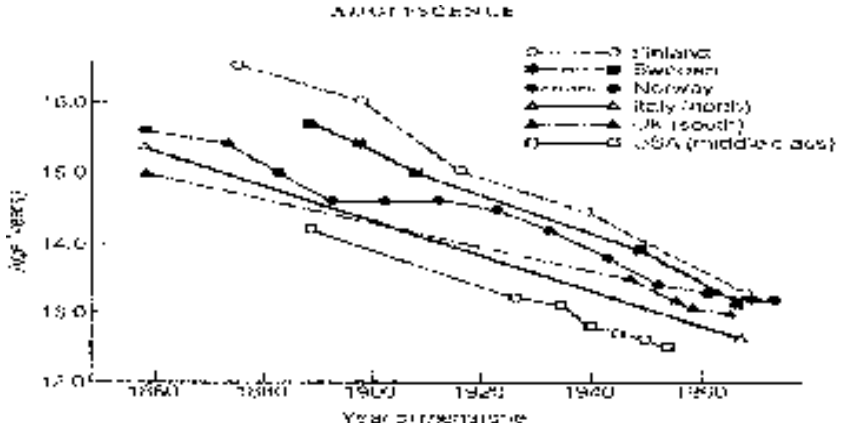

FIGURE 2. Age at menarche, 1860–1970. (Data from Tanner.[9])

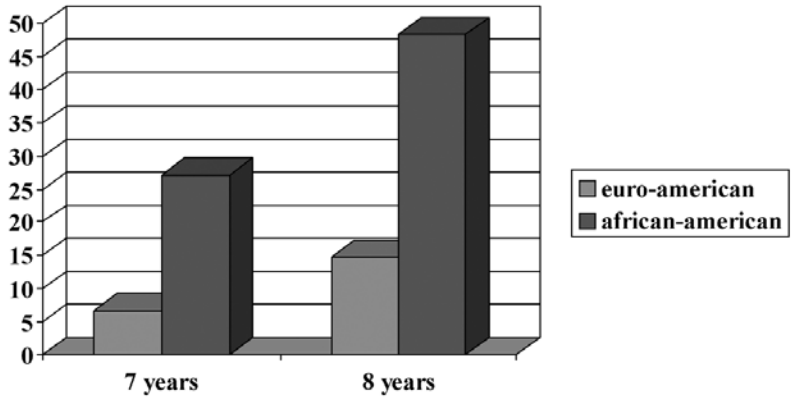

FIGURE 3. Percentage of girls who have reached at least Tanner State 2 of breast and/or pubic hair by ages of 7 and 8.

ADOLESCENCE: AN ANTHROPOLOGICAL PERSPECTIVE

The past 150 years have witnessed a quiet revolution in human development that still sweeps across the globe today: children nearly everywhere are growing faster, reaching reproductive and physical maturity at earlier ages, and achieving larger adult sizes than perhaps ever in human history.

—CAROL M WORTHMAN, PH.D.

In our conceptualization of adolescence as the interval beginning with the physical changes of puberty and ending with the assumption of adult social roles, it becomes clear that this period of adolescent development has undergone a notionally major expansion in recent history. Adolescence is much broader and longer than the teenage years alone. It now stretches, in many cases across more than a decade, with pubertal onset often beginning by 9 to 12 years of age and adult roles delayed until the early twenties.

These changes have been well recognized and discussed by many people in the field, including Carol Worthman, an anthropologist who has studied puberty around the world. Also, Alice Schlegel and Herbert Barry[5] quantified basic aspects of puberty, adolescence, and the transition to adult roles in 187 different societies and summarized their findings in a book that is a fascinating read for anyone interested in adolescent development. Their book, in addition to being rich in anecdotes and cross-cultural observations about adolescence, also contains quantified summaries of key variables using well-defined measures. These data show that the majority of these societies have a developmental period that we could recognize as adolescence—conceptualized as a transition from the status of a child to that of an adult. Moreover, in many societies, the end of childhood was clearly demarcated by some sort of ritual. The onset of adult status in traditional societies was usually defined in

terms of marriage, work roles, hunting, owning property, becoming a parent, or taking on some other specific adult role.

They found that in most traditional societies the interval between puberty and achieving adult status was relatively brief. Marriage among girls occurred within 2 years of the onset of puberty in 63% of the 186 societies studied. Among boys, where the ability to take a wife could require a specific level of achievement, such as making a first kill on a hunt, or developing a specific set of skills that increased the economic ability to provide for a family, the interval was significantly longer than for females, but still 64% of the males were married within 4 years of puberty. Thus, the adolescent interval between puberty and adult roles typically occupied a 2- to 4-year period in the majority of these societies.

Puberty versus Adult Social Roles in Contemporary Society

The situation in many contemporary societies is in sharp contrast to the data from traditional societies. While puberty is occurring earlier in many industrial societies, marriage and other adult roles are often delayed. In the U.S., the average age of menarche is now at age 12, while the average age of first marriage is 26—a 14-year transition, as opposed to the 2–4-year interval typical in females in the majority of traditional societies. This temporal elongation reflects not only the increasingly earlier development of puberty over the past 100 years, but also the increasingly longer time to marriage. In 1970 in the U.S. the timing of first marriage was age 21 for women and 23 for men; by the 2000 census, this had changed to ages 26 and 27, respectively.

A similar set of changes have occurred in other contemporary societies. In Japan, for example, the average age of menarche has decreased 4 years over the past century (from an average of 16.5 years in 1875 to an average of 12.2 years in 1975), while the average age at first marriage in Japan has increased to 26 years for women and 28.4 for men.

This is not simply a matter of changing attitudes about marriage. If one looks at other indices of adult social roles—starting careers, owning a home, choosing to become parents—it is apparent that these are also occurring more than a decade after puberty in most cases.

So, for most of human human history, adolescence has occupied a relatively brief time in individual and societal human development, lasting typically 2 to 4 years. Currently, however, it has stretched out into period that lasts 8 to 15 (or more) years in many contemporary societies.

This expansion of the period of adolescence has some advantages: Several types of opportunities are created by this prolonged interval—it permits adolescents more time to learn complex skills and to develop a variety of capabilities prior to taking on the constraints and demands of adult responsibilities. More time is available for formal education, for learning sports and arts, and for exploring a range of possible career choices; and it allows an individual more opportunities to explore different friendships, peer groups, and romantic relationships that may or may not lead to marriage. But stretching out these developmental processes does not come without costs and vulnerabilities, including the broad range of behavioral and emotional health risks that have an impact on so many youth.

HISTORICAL CHANGES IN ADOLESCENCE: IMPLICATIONS REGARDING THE BRAIN

These historical changes and the relative temporal expansion of the period of adolescence has important implications for understanding the component processes of adolescent brain development. The earlier onset of puberty results in a relatively earlier activation of *some* neurobehavioral changes, raaising several provocative questions about the interrelationship with components of adolescent development that occur on a different time scale—particularly those aspects of adolescent brain development that continue to undergo important maturational changes long after puberty is over. In other words, it appears that the rapid prolongation of adolescence as a developmental period has also contributed to alterations in the timing and interrelationship of components of adolescent brain maturation.

The key principle here can be illustrated by a couple of clinical cases. Consider the cognitive development of an 8-year-old girl with a simple case of precocious puberty. There is no reason to expect that the early activation of reproductive maturity would create a parallel advance of cognitive development; even if physical development, sexual maturation, and bone age are consistent with those of a 14-year-old girl, she will still still have an 8-year- old's level of experience, reasoning ability, logic, and other mental capabilities. In a similar way, consider the relative cognitive development of two otherwise normal 15-year-old boys, if one has already progressed physically through puberty and looks like a mature young man, while the other is still pre-pubertal with the physical development of a young boy. Is there any basis for assuming the more physically mature 15-year-old would show any specific areas of mental ability superior to the prepubertal boy's? In fact, there is a fairly extensive clinical literature that shows that most patients who are clinically delayed in the onset of puberty—or even among those who fail to go through puberty at all because of an endocrine disorder or physical intervention, as done to the *castrati* to provide high voices for a church choir—most aspects of mental development proceed in a completely normal manner. In other words, most elements of cognitive development show a trajectory that follows age and experience rather than the timing of puberty.

This principle has direct implications regarding the recent historical changes in pubertal timing. While some neurobehavioral changes (such as drives and emotional changes at puberty) are occurring at earlier ages, many other aspects of neurocognition progress slowly, and continue to mature long after puberty is over. Thus, the recent expansion of the adolescent period has also stretched out the interval between the onset of emotional and motivational changes activated by puberty, and the completion of cognitive development—the maturation of self-regulatory capacities and skills that are continuing to develop long after puberty has occurred.

PUBERTY AND BRAIN DEVELOPMENT

Given these changes in the timing of puberty and the expansion of adolescent maturation more broadly, it is important to consider what is known about puberty and brain development. First we know that some brain changes *precede* the pubertal increases in hormones. Pubertal maturation *starts* in the brain, some neural changes

leading directly to the hormonal cascade at the beginning of puberty. I will refer to these as *upstream* changes as they occur prior to pubertal changes in the body.

Second, clearly there are some brain changes that are the *consequence* of pubertal processes. Once these hormone levels increase in the body, there is some feedback to specific brain systems, what I will call *downstream* changes since they occur as a consequence of the physical development and accompanying increase in hormone levels affecting the brain. One recent area of research regarding pubertal hormone effects on the brain has focused on the discovery of a new type of estrogen receptor in several regions of the brain—the beta-estrogen receptor; this will be discussed in much greater detail by Judy Cameron in Part 3 of this book. This system appears to be the mechanism for some of the behavioral or emotional changes resulting from the increased reproductive hormones of puberty, such as changes in serotonergic regulation mediated by beta-estrogen.[6]

Third, some aspects of adolescent brain maturation and cognitive development appear to be independent of pubertal processes and continue long after puberty is over.

The existence of these three different categories of links—upstream changes, downstream changes, and puberty-independent maturational changes—makes it clear that changes in pubertal timing create the *potential for internal dys-synchrony* among the components of adolescent brain maturation.

This also highlights the importance of considering *puberty-specific changes* in neurobehavioral maturation within a broader range of developmental changes across adolescence, which has important conceptual as well as methodological implications. In most studies in adolescents, these domains become confounded in ways that do not allow investigators to disentangle these effects. Many studies do not contain any measures of puberty; and even among those that collect some data about level of reproductive maturity, these measures of pubertal development, age, and social experience can be correlated in ways that make it impossible to examine the effects of age versus [ubertal maturation. There are, however, some interesting and provocative exceptions— studies that have been designed to disentangle puberty-specific changes that point to important issues and questions. Examples of research showing puberty-specific changes in affective domains are discussed next.

PUBERTY-SPECIFIC CHANGES IN AFFECTIVE DOMAINS

A study that has found behavioral changes that are specifically linked to puberty is that of Martin and colleagues,[7] who investigated the development of smoking and other risk-taking behaviors in adolescents. They included a measure of sensation seeking as well as measures of pubertal maturation in a sample with a relatively narrow age band: most subjects were 11 to 13 years old. Interestingly, within this age range, there were no significant correlations between age and sensation seeking—the older kids were no more likely to rate themselves as higher in their desire for thrilling or exciting experiences. However, there was a *significant positive correlation between pubertal maturation and sensation seeking* in both the boys and girls, and this was associated with greater risk taking and smoking. Among individuals of similar age, those who were more advanced in puberty were more likely to seek exciting experiences and to show risk-taking behavior.

TABLE 1. Developmental domains having evidence for puberty-specific maturational changes

- romantic motivation
- sexual interest
- emotional intensity
- changes in sleep/arousal regulation
- appetite
- risk for affective disorders in females
- increase in risk taking, novelty seeking, sensationseeking (reward-seeking)

There are several developmental domains where there is evidence for *puberty-specific* maturational changes (TABLE 1). It is important to emphasize the need for more studies that are designed to examine (and disentangle) age and pubertal effects. However, from the handful of studies that have succeeded in examining some of these issues, some themes are emerging. The existing evidence indicates that there are several domains that seem to link more strongly to puberty than age during adolescent development, and most of these are *affective* measures—related to emotion, motivation, arousal, and appetitive or drive systems. These include pubertal changes in romantic and sexual interests, mood lability, emotional intensity, reward seeking and/or sensation seeking, changes in sleep/arousal regulation, increased appetite, and risk for affective disorders among girls.

Some important caveats should be mentioned here: Remember that there is a wide range of individual differences with respect to these pubertal changes. Many adolescents show very subtle changes in the direction of sensation seeking, and these problems are easily managed without any reckless behavior or emotional problems. On the other hand, taken together, this pattern of findings suggests that the primary puberty-specific changes are related to activation of the strong drives, appetites, emotional intensity, and sensation seeking that occurs at puberty. In addition, this set of adolescent changes is occurring relatively earlier as puberty is occurring relatively earlier. In contrast, most aspects of cognitive development—including reasoning, logic, and capacities for self-regulation of emotions and drives—are still developing slowly, and continue long after puberty is over.

STARTING THE ENGINES WITH AN UNSKILLED DRIVER

This metaphor—of an early activation of strong "turbo-charged" feelings with a relatively unskilled set of "driving skills" or cognitive abilities to modulate strong emotions and motivations—has been used a great deal by our ADAPT Research Network.[8] This metaphor is one way to capture the relatively earlier timing of these "igniting passions" at puberty—passions that refer not only to romantic and sexual interests, but also to the intensification in many kinds of goal-directed behaviors that emerge in adolescence. Early adolescence is a time when many teenagers become passionate about a particular sport, hobby, music, art, or literature. It is also a time of passionate commitments to idealistic causes.

These motivational and emotional changes at puberty represent a relatively understudied aspect of adolescent development. Yet, this is an enormously important dimension of understanding the neurobehavioral underpinnings of vulnerability in adolescence. It is crucial because this early activation of intense motivations and passions, which can be channeled into a wide range of activities and types of pursuits, can be shaped by the particular experiences at this point of life. Moreover, when these passions flare up to intense levels, these young peoplet often have not yet developed the skills that can harness these strong feelings (nor have they yet achieved the neural maturation of underlying control systems).

Being a responsible adult requires developing self-control over behavior and emotions to appropriately inhibit and modify behaviors—despite strong feelings—to avoid terrible consequences. It requires that individuals be capable of initiating and carrying out a specific sequence of steps toward a long-term goal even though it may be difficult (or boring) to persist in these efforts. Adolescents need to learn to navigate complex social situations despite strong competing feelings. Skills in self-regulation of emotion and complex behavior aligned to long-term goals must be developed. These self-regulatory processes are complex and mastering behavioral skills involves neurobehavioral systems served by several parts of the brain. The ability to integrate these multiple components of behavior—cognitive *and* affective—in the service of long-term goals involves neurobehavioral systems that are among the last regions of the brain to fully mature. This point is a central focus of this symposium.

We come back to the question of what happens to cognitive development when puberty occurs earlier. A strong body of work suggests that most measures of cognitive development correlate with age and experience—not sexual maturation. Measures of planning, logic, reasoning ability, inhibitory control, problem solving, and understanding consequences are probably not puberty-linked, but depend on age and experience. And these abilities clearly continue to develop long after puberty is over as many aspects of brain development continue to occur long after puberty is over. Jay Giedd and other presenters in Part 2 describe these issues in much greater detail. Elizabeth Sowell and her colleagues at UCLA also have contributed a great deal of data (and conceptual and methodological advances) in these areas. Taken together, a large body of work has shown that structural maturational changes in the brain are continuing long after the interval of puberty is over.

So we return to the metaphor of turbo-charging the engines of a fully mature "car" beloinging to an unskilled driver, whose navigational skills are not yet fully in place. The pubescent youth has several years with a sexually mature body and brain systems that are activated for sexual and romantic interest and passions, but a relatively immature set of neurobehavioral systems for self-control and affect regulation. This "disconnect" predicts risk for a broad set of behavioral and emotional problems, and not just through recklessness, risk taking, and sensation seeking, but also in just navigating complex social situations and attempting to master strong emotions. The affective disorders of adolescence are as informed by this model as are more impulsive and externalizing disorders. Adolescence proves to be a difficult period to develop positive abilities to use strategies, make plans, set goals, learn the social rules, and navigate ambiguous situations as the cognitive and emotional systems are integrated.

THE DEVELOPMENT OF AFFECT REGULATION

I would like to mention here the links to one line of investigation—the development of affect regulation in adolescence—which has been the focus of investigation in my laboratory and of the ADAPT nterdisciplinary research network. First, it is important to delineate what is meant by the term *affect regulation.* It is not simply the process of experiencing and/or expressing emotions, but rather involves controlling one's feelings—modulating them in *adaptive* ways in order to achieve goals, to act with the norms of social rules and expectations and in ways that *support* rather than interfere with decision-making. Several investigative teams are beginning to address some of these issues of emotion and decision-making, including the role of strong emotions during adolescence. The term "hot cognition" refers to the process of thinking under conditions of high arousal and/or strong emotion, as opposed to "cool cognition," thinking under conditions of low arousal and calm emotions.

Adolescents often appear to be relatively good at making decisions under conditions of low arousal and cool emotions, this same highly intelligent youth, under intense emotional arousal, can have a much more difficult time making a responsible can experience a much more difficult time making a responsible choice. This leads, then, to another set of pragmatic questions: at what age (or based on what maturational criteria) should society *expect* individuals to make reliable independent decisions?—and be held legally responsible for these choices? As will be discussed later, Laurence Steinberg and several of his colleagues have been grappling with legal and scientific aspects to these questions. What if the average 15-year-old is capable, under "cool" conditions, of understanding the consequences of his behavior in a way that is comparable to that of adults, but is more emotionally reactive to irrational influences under conditions of "hot" cognition? How should we interpret data that show that a particular 16-year-old has adult capabilities to use logic and understand the consequences of his behavior, if we observe him, when in a group of friends, making reckless choices that the average 9-year-old would say was a pretty dumb thing to do? The point is that the age at which one has the ability to understand cognitively that a particular course of action is wrong may not be the same age as having reliable self-control over his strong emotions "hijacking" his decision-making.

There is much ambiguity and controversy in state, national, and even international policies about when society should allow individuals to make which type of decisions as adults. Why is that a young person is not able to drive a car until 16, vote until 18, drink alcohol until 21, rent a car from a commercial agency until 25, but, in some states, can stand trial for murder at age 12 or 13? At what age should youth be free to make decisions about their own health risks—such as smoking or having (or refusing) an operation, or having an abortion? At what age should he or she be able to decide to quit school, join the armed services, or get married? At what age should he or she be free to make potentially self-destructive choices such as body piercing, tattoos, acting in pornographic films, or gambling?

Leaving aside the personal and political controversies that such questions often stir up, the compelling issue for this symposium focuses on the potential for *science* to contribute to these important debates. Scientific study can shed light and offer rational approaches to these questions. If science can provide clear evidence for an im-

maturity of neural systems that affect decision making or abilities to regulate affect in adolescence—and if there are objective criteria for assessing the level of maturation that are not simply based on an arbitrary number of birthdays—science can be said to be making very important contributions to the legal, ethical, and moral questions about adolescent responsibility.

SOCIAL CONTEXTS AND ADULT SCAFFOLDING OF ADOLESCENT EXPERIENCE

During this period of gradual and inconsistent emergence of skills and knowledge needed to take on adult roles and decisions—and the still maturing neurobehavioral systems that undergird these skills—there is a need for a social context that can provide the appropriate amount of support to adolescents. It is crucial for adolescents have the appropriate social *scaffolding*—the right balance of monitoring and interest from parents, teachers, coaches and other responsible adults—in which to develop the skills of self-control while still being afforded sufficient support and protection. Ideally this scaffolding should, gradually fade, allowing adolescents to make increasingly independent decisions without placing them in situations that they are not yet ready to handle. Clearly, this is an ideal scenario that far too many adolescents—especially those in high-risk social contexts—never experience. Ann Masten has noted that adult monitoring is all too frequently and too prematurely withdrawn during this vulnerable period, leaving the adolescent to have to navigate situations alone or with peers at a relatively early age. This kind of mismatch between biological maturity, without equivalent cognitive-emotional maturity, in a sometimes dangerous social context and with only minimal adult supervision, plays a part in creating a great deal of vulnerability for youth in our society.

At the conference on which this book is based, we had the opportunity to view excerpts from a recent movie called "Thirteen" that illustrate these issues. This movie was co-written by a 13-year-old (who is also one of the actors in the film) along with the director. It captures, among other things, the intensity and abruptness, of making the transition from a period of playing with Barbie dolls and stuffed animals to an urban world of a teenager plunging into a confrontation with drugs, sex, and the exciting, but highly destructive allure of reckless adventure. It is a distressing clip— and a disturbing movie— which is worth seeing by anyone who wants to witness an example of the real-world difficulties facing so many early adolescents in contemporary society—a movie that raises many provocative questions about the dangers of this period of suddenly igniting passions that we have been talking about.

THE ADOLESCENT BRAIN: A NATURAL TINDERBOX

The natural adolescent inclinations toward novelty, arousal, and excitement that emerge in association with puberty create an emotional tinderbox in which passions—both negative and positive—are ignited. This creates both a great deal of vulnerability among the young as well as a great opportunity to harness these emotions in the service of positive goals. And young people are often eager to face a great deal of risk to achieve the high-intensity feelings that can be so appealing in adolescence.

Puberty itself seems to increase the appetite for a specific type of emotional experience: surges of arousal and cravings for exhilaration. This type of appetite even seems to feed on itself, as it moves behavior toward seeking yet more and more arousal and stimulation.

Fortunately, these emotional and motivational changes at puberty—these igniting passions—do not lead only to to bad outcomes: Sex, drugs, loud music, and reckless behavior are not the *only* ways to activate the kinds of high-intensity feelings that are so appealing to adolescents. The efforts necessary to achive a goal or to face a challenge can also become sources of positive, high-intensity feelings. And struggling to overcome adversity or to master a skill can also lead to inspired actions and the high-intensity feeling that can come from achieving a much-desired goal.

So these igniting passions can be aligned in *healthy* ways—in the service of higher goals. Feelings of passion are rooted in the same deep brain systems as biologic drives and the primitive elements of emotion. Yet passion intertwines with the highest levels of human endeavor: passion for ideas and ideals, passion for beauty, passion to create music or art. And the passion to succeed in a sport, business, or politics, and passion toward a person, activity, object, or pursuit can also inspire transcendent feelings.

One of the most important questions facing parents, teachers, clinicians treating adolescents, political leaders, and those of conducting science that can inform social policyis: *how* are adolescent passions being captured in modern society? How are these new intense motivational systems in the adolescent brain being shaped in ways that are healthy or unhealthy? For example, the emergence of religious zeal in adolescents can fuel positive humanistic efforts to feed the poor and care for the sick, yet, it can also lead to dogmatic attitudes, intolerance, or rash polical action. Igniting passions can lead to idealistic efforts by youth who strive to make the world a better place or these passions can be captured by a negatively charismatic figure like Adolf Hitler or Osama bin Laden, who instead inspire destructive, despairing and evil deeds.

IGNITING PASSIONS IN ADOLESCENCE: A PERIOD OF SCIENTIFIC OPPORTUNITIES

These questions about emotional and motivational changes in adolescence have profound implications for the future of youth in our society, and represent part of the reason greater scientific detail is needed to understand these maturational processes and to provide further insights regarding the types of experiences needed to shape these igniting passions in ways that serve larger humanistic goals.

This igniting of passions—this activation of overwhelming levels of emotion that can transiently block the capacity to think, reason, and proceed logically according to consequences—has an underlying neural circuitry. There are several important scientific questions about the neurobehavioral changes underpinning this temporary loss of the ability to plan and to reason. Adolescence is a developmental period when new links are established in the brain that create connections between affective and cognitive processes. For example, adolescence is a time for developing a new sense of self and identity along with the cognitive ability to imagine oneself in the future in ways that can create positive emotions (picturing oneself as highly successful) as well as linked to negative affective appraisals (imaging the consequences of failure

or humiliation). This cross-temporal processing of thoughts and images can create strong feelings in adolescence that are capable of altering motivation. Most importantly, many of these more complex cognitive-emotional experiences are happening for the first time in adolescence. These new experiences are creating new patterns of neural connections. Understanding more of the details of how and when these are occurring can create opportunities for investigators to identify ways to intervene in high-risk youth at a time when some of these systems are more plastic to change. Scientific knowledge can thus be brought to bear in preventing some of the destructive negative spirals that can begin in adolescence.

Adolescence thus offers a period of scientific opportunity: it's a chance to identify key developmental processes in puberty and adolescence that are amenable to intervention. We need to learn what *kinds* of interventions will work with *which* problems and what is the best *time* to apply them. Increasingly, the advances in basic neuroscience, genetics, developmental psychology, and the use of animal models will be combined with clinical and social policy work to implement change and point to the key questions that should be priorities for the more basic investigators. My hope for this symposium is that it will spark a series of dialogues across these disciplines to integrate current knowledge, refine our conceptual models, and to focus the directions of future work that will—in the long run—have a large positive impact on the health and well being of the youth in our society.

We search, on our journeys,
for a self to be, for other selves to love,
and for work to do...
We find by losing. We hold on by letting go.
—FREDERICK BUECHNER

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GLOSSARY/ACRONYMS

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GLOSSARY

Anxiety and Depression

When a person has a depressive and/or anxiety disorder, it interferes with daily life, normal functioning, and it causes pain for both the person with the disorder and those who care about him or her. There are a variety of anxiety disorders, including but not limited to Panic Disorder, Obsessive-Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD), and Social Anxiety Disorder. The same is true with depression. Types include Major Depressive Disorder, Dysthymic Disorder, Psychotic Depression, and Seasonal Affective Disorder.

Arson

The FBI's Uniform Crime Reporting (UCR) Program defines arson as "any willful or malicious burning or attempt to burn, with or without intent to defraud a dwelling house, public building, motor vehicle or aircraft, personal property of another, etc. Only fires determined through investigation to have been willfully or maliciously set are classified as arson" (FBI, 2002).

Attention-Deficit Hyperactivity Disorder (ADHD)

One of the most common cognitive disorders that develops in children. Children with ADHD often struggle to pay attention and/or control their behavior. The principal characteristics of ADHD are inattention, hyperactivity and impulsivity.

Authority Having Jurisdiction (AHJ)

The people/group(s) responsible for setting and enforcing local public policy.

Autism

The most common condition in a group of developmental disorders known as the Autism Spectrum Disorders (ASDs). Autism is characterized by impaired social interaction, problems with verbal and nonverbal communication, and unusual, repetitive or severely limited activities and interests.

Autism Spectrum Disorders (ASDs)

Include Asperger's syndrome, Rett syndrome, childhood disintegrative disorder, and Pervasive Developmental Disorder-Not Otherwise Specified (usually referred to as PDD-NOS).

Bipolar Disorder

Characterized by mood cycling between periods of intense highs and lows. In children, bipolar disorder often seems to be a rather chronic mood disregulation with a mixture of elation, depression and irritability. Youth with bipolar disorder experience unusually intense emotional states that occur in distinct periods called "mood episodes."

Budget Cycle

The time allotted to expend the resources dedicated to a specific budget.

Case Management Information	Information that is specific to an individual firesetter and his or her family.
Community Outreach	Advertising (marketing) the Youth Firesetting Prevention and Intervention (YFPI) program and the services that it provides.
Community Risk Assessment	In the context of youth firesetting, a good risk assessment will identify who is setting fires, how, where and why; identify logical target populations to receive services; locate hidden, hard to reach or underserved populations; identify high-risk occupancies, populations and neighborhoods; and build a foundation to suggest use of integrated prevention interventions (five E's).
Coordinating Agency	This is the agency that ultimately leads a youth firesetting prevention and intervention task force. All agencies on the task force must agree who is serving as the lead organization. The agency that agrees to serve as lead must ensure that its leaders are supportive of this responsibility.
Crisis/Troubled/ Cry-for-help Firesetting	A typology of firesetting whereby the youth is attempting to communicate a level of need for attention from adults.
Curiosity/ Experimental Firesetting	The most common typology of firesetting; the child is exploring his or her interest in fire through experimentation.
Definite Risk	Firesetting behaviors that have progressed to repeated and intentional events. Upon investigation, underlying psychological or social problems and issues may be discovered as factors influencing the firesetting. These types of fires are deliberate and may include the gathering of fuels and the possible selection of a target to be affected by the fire. The fires may be set for different reasons including anger, revenge, attention getting, malicious mischief, concealment of a crime, problem-solving, an intent to harm people or destroy property or to make something or someone go away.
Delinquent/ Criminal/Strategic Firesetting	A typology of firesetting whereby there is a planned and willful intent by the perpetrator to cause destruction.
Demographic Data (firesetters and their families)	Data that reports the general circumstances of an event and information about the participants. Demographic data **cannot** be connected back to a specific individual.

Economic Incentives

This form of intervention entails enhancing safety measures through incentives. One example would be providing economic incentives to builders who install sprinkler systems. Another type of economic incentive may be in the form of a negative incentive, such as the payment of fines, fees, and/or restitution for acts of firesetting.

Educational Intervention

The goal of educational interventions is to provide awareness, change behavior, and eliminate risky behavior. This medium can be utilized to teach both youth and careproviders the basics of fire safety and the ramifications associated with repeat acts of firesetting. Nearly all firesetters and families can benefit from fire safety and prevention education.

Emergency Response

This intervention entails having an adequately staffed, equipped and trained cadre of responders to mitigate emergency incidents when they occur. It also includes being able to respond to youth firesetting situations with supportive resources that can prevent future acts of firesetting.

Enforcement Intervention

This entails enforcing or obtaining compliance with fire laws and codes. For firesetting situations, this means involvement of the legal system or action from a social services child protective division to assist in mitigating future firesetting events.

Engineering Intervention

Entails modification of an environment to enhance safety. This type of intervention can be utilized to ensure that the homes of firesetters are equipped with working smoke alarms and that child-resistant lighters are used as needed.

Evaluation Plan

Describes in precise **measurable** terms how a prevention program is to be developed, implemented, operated and monitored.

Extreme Risk

A firesetter ultimately included in this category may reflect the same aspects as listed in the definite risk level. The extreme risk firesetter's behaviors usually involve more severe forms of firesetting influenced by psychological, social and environmental factors. These youth generally reflect a small subgroup of firesetters, but they are often considered at-risk for engaging in future firesetting incidents.

Follow-up

Contact from youth firesetting program staff that should take place with each family who participates in a youth firesetting intervention program. A primary follow-up should occur four to six weeks after completion of the program. A secondary follow-up can take place between six to 12 months after close-out of the file.

Formative Evaluation	Conducted during the planning and implementation stages of a program or when an existing program is having difficulties.
Goals	A statement that explains overall what the program seeks to accomplish. It sets the fundamental, long-range direction of the program. Typically, goals are broad, general statements. A goal summarizes expected results and outcomes rather than program methods and activities.
Impact Evaluation	Conducted during the intermediate stages of a program to measure if the program is helping to increase knowledge levels, change behaviors, or modify living environments/lifestyles.
Intake	The process of collecting initial information about the youth firesetter, his or her family, and the incident(s) that brought the youth to the program (National Fire Protection Association (NFPA), 2010).
Intake Forms	Should be standardized for the jurisdiction and designed to gather basic information about the youth, his or her family, and the fire event/situation that led to the program referral.
Interagency Task Force	A team of representatives from stakeholder organizations that can help guide the development, implementation and operation of a YFIP program.
IRONIC	An easy to remember method that identifies the procedures involved in conducting a screening and determining the facts of the event. IRONIC is an acronym that stands for Introduction, Rapport, Opening Statement, Narrative, Inquiry and Conclusion.
Knowledge, Skills and Abilities (KSAs)	The knowledge base and demonstrable skills/abilities a person must possess to complete job performance requirements (JPRs).
Learning Disabilities	A disorder that diminishes a person's capacity to interpret what he or she sees and hears and/or to link information from different parts of the brain.
Life Cycle of a YFPI Program	Includes performing the following actions: conducting a community risk assessment, identifying the firesetting problem, identifying and recruiting stakeholders, developing and implementing a program, delivering the program, and evaluating the program.
Mental Health Intervention	The act of referring a family to a qualified mental health practitioner who can help identify the root causes contributing to firesetting behaviors.

NFPA Standard 1035	The NFPA standard that outlines the JPRs and KSAs expected from Fire and Life Safety Educators (FLSEs), Youth Firesetting Intervention Specialists (YFISs), and Youth Firesetting Program Managers.
Objectives	A concise statement of the desired product of the risk-reduction initiative. Objectives should be written in a format that follows the acronym SMART. Objectives should be Specific, Measurable, Achievable, Relevant and Timeframed.
Organizational Mission Statement	Drives the goals, objectives and services delivered by their organization.
Outcome Evaluation	Conducted over the long term of a program to measure if a program has reduced incidents, saved lives/property, or improved the quality of life in a community.
Pathological/ Severely Disturbed/ Cognitively Impaired/Thought-disordered Firesetting	A typology of firesetting whereby the perpetrator uses fire as a means for receiving gratification without regard to the safety of others.
People-related Data	Explores the human component of involvement and factors associated with vulnerability to juvenile firesetting incidents. It will include the demographics of the local community.
Prevention Interventions	Forms of interventions that are designed to prevent or mitigate youth firesetting events. Interventions include Education, Engineering, Enforcement, Economic incentives, and Emergency response to incidents.
Primary Prevention	Designed to teach individuals what to do so that an event that could cause property damage, injury or death does not happen at all.
Problem-related Data	Examines the occurrence of incidents.
Process Evaluation	Performed once the program has been implemented and showing signs of activity/outreach into the community. It measures program outreach, distribution of materials, and performance of those conducting program delivery.
Program Budget	The expenses required to develop, implement and maintain (and potentially expand) youth firesetting program services.

Program Operations Handbook	Provides the user with examples of each document used by the YFPI program.
Recidivism	Acts of repeat firesetting.
Resources Directory	Contains the names, addresses, phone numbers and email addresses of agencies that work with youth firesetters and their families.
Screening Form	A form (also can be called tool or instrument) that uses numeric scoring process to identify, record and evaluate factors contributing to a child or youth's firesetting behaviors. The form must be developed and validated by professionals who are qualified to develop such instruments.
Screening Process	The goal of the screening process is to determine why firesetting is occurring, what satisfaction the juvenile receives from starting fires, and the risk level for future firesetting events.
Secondary Prevention	Seeks to change or modify events and/or behaviors that reduce the severity of the event.
Social Services Intervention	The act of referring a family to the local Department of Social Services so supportive services such as parent mentoring, transportation to intervention programs, and other pertinent actions can take place. Many social service agencies also include a children and youth or child protective services division that handles child abuse/neglect issues. Youth firesetting can be viewed as a form of child neglect.
Some Risk	This is the most common and lowest level of risk for repeat firesetting. The child (or youth) has engaged in at least one unsupervised fire motivated by curiosity. Fires resulting from these incidents are often unintentional and generally do not create a significant fire event. Curiosity and experimentation with lighters and matches is the most common motive of children involved in unsupervised firesetting.
Stakeholders	Agencies/people that have a vested interest in the impact of youth firesetting on the community.
Standard Operating Procedures (SOPs)	Define what the program is to do and the actions to be taken by whom, when, where, how, why, and to what degree. SOPs/guidelines help ensure that the program offers services that are safe, ethical, legal and comply with the local AHJ.

Tertiary Prevention	Seeks to reduce a negative impact of an event over a long-term span of time. Its goal is to prevent complications and/or work with case management/rehabilitation regarding an event.
Thrill-seeking/ Risk-taking Firesettting	A typology of firesetting whereby adolescents are attempting to duplicate forms of dangerous behaviors observed in various mediums such as in-person, through video gaming, or on the Internet.
Typologies of Firesetting	Explain the types and motivations of youth firesetting.
Youth Firesettting Intervention Specialist	The Level 1 intervention specialist provides services at the program delivery level. He or she may help identify firesetters, conduct intakes, provide screenings, deliver educational interventions, perform follow-ups, and evaluate program services/results.
Youth Firesetting Program Manager	The Level 2 program manager must be proficient in all of the skills required for a Level 1 intervention specialist. In addition, he or she needs the skills to develop, implement, lead and evaluate a YFPI program.
Youth Justice System Intervention	The act of referring a youth and his or her family to the youth justice system so legal action(s) will take place that will (hopefully) help mitigate future acts of firesetting. In many states, this referral is mandatory once a child has reached the age of accountability (culpability).

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ACRONYMS

ADHD	Attention-Deficit Hyperactivity Disorder
AHJ	authority having jurisdiction
ASD	Autism Spectrum Disorder
CPSC	Consumer Product Safety Commission
FBI	Federal Bureau of Investigation
FEMA	Federal Emergency Management Agency
FI	Fire Investigator
FLSE	Fire and Life Safety Educator
IAAI	International Association of Arson Investigators
IEP	Individual Education Plan
IFSTA	International Fire Service Training Association
IG	Instructor Guide
IRONIC	Introduction, Rapport, Opening Statement, Narrative, Inquiry and Conclusion
JCNFSO	Joint Council of National Fire Service Organizations
JFIS	Juvenile Firesetting Intervention Specialist
JPR	job performance requirement
KSAs	knowledge, skills and abilities
LDs	learning disabilities
NFA	National Fire Academy
NFDC	National Fire Data Center
NFPA	National Fire Protection Association
OCD	Obsessive-Compulsive Disorder

OJJDP	Office of Juvenile Justice and Delinquency Prevention
PDD-NOS	Pervasive Developmental Disorder-Not Otherwise Specified
PIO	Public Information Officer
PTSD	Post-Traumatic Stress Disorder
SM	Student Manual
SME	subject-matter expert
SOGs	standard operating guidelines
SOPs	standard operating procedures
SRO	school resource officer
UCR	Uniform Crime Reporting
USFA	U.S. Fire Administration
YFIS	Youth Firesetting Intervention Specialist
YFPI	Youth Firesetting Prevention and Intervention