

PYROMANIA :

The Clinical Picture and A Case Study

Society is keenly interested to know how and why children set fires; yet there is not much information provided about these questions. This paper summarises some of the main findings and research dealing with firesetting children, and dwells on the case history and treatment of a young client seen for a period of 18 months at Mount Carmel Hospital.

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From various studies (Strachan, 1981; Vandersall & Weiner, 1970; Nurcombe, 1964) certain common features emerge among children who set fires. Such clients are usually referred to psychiatric clinics for symptoms other than firesetting, the great majority being involved in fighting, disobedience and destructiveness. Most of them set fires at home and on their own. Boys greatly outnumber girls, and a high proportion of these children come from disrupted homes. A major shortcoming of the studies is a lack of specificity and consistency in diagnosis, but the broad outlines of the clinical picture are fairly well drawn.

Stewart et al (1980) found a series of antisocial behaviour in many of these children, featuring never admitting guilt, going out with bad company, persistent lying, stealing from family members, truancy, drinking without parents' permission, and precocious or excessive interest in sex.

In a study on 46 pyromaniacs, Stewart and Culver (1982) related the firesetting behaviour to variables such as age, IQ, and psychiatric disorders in parents, and to the distinction between children who present with firesetting as their chief problem and those in whom it is a secondary complaint. Thirty subjects were followed up after 1 to 5 years. The central finding of the follow up was that 7 out of the 30 (23%) were still setting fires. However, these fires

were less serious than the ones set before treatment. The persistent fire-setters may have come from less stable homes and they tended to be more antisocial at followup than children who no longer set fires.

Case History

Client was admitted as a court referral in January 1992, aged 13. He had been involved in cases of arson of vehicles and property, as well as arson at home. He always liked to play with fire, as it gave him a feeling of a hero, as well as a feeling of pleasantness. Regarding other antisocial behaviour, client used to throw objects at people passing by, stole money from home, and played truant from school since the age of 5 years.

Family History: his single mother married when client was 5, and the adoptive father was an alcoholic and physically abusive. Mother then separated when client was 9. There are three other siblings, and he gets on well with his mother.

Medical History: client suffered from severe epileptic fits since age 2. Scan investigations revealed agenesis of a larger part of the midline region of the forebrain (prosencephalon), extending posteriorly to involve the third ventricle as well as resulting in dilatation of the lateral ventricles.

Psychometric testing indicated that the client's intellectual functioning was rather dull but not subnormal. Certain traumas and social isolation had affected him negatively. Personality testing showed impulsiveness

traits, as well as a slight feminine inclination.

Treatment.

The client was seen and treated by OTs when he was in the male admission ward, as well as when he was eventually transferred to the newly opened Young People's Unit. Treatment involves a multidisciplinary team approach, involving doctors, nurses, a social worker, a psychologist, and a teacher. The aim of the team was to formulate and implement a structural programme directed at improving his emotional stability and eliciting pro social behaviour.

The admission goals were threefold:

- control of his conduct disordered behaviour, with specific stress on firesetting activity
- improving communication abilities and other sociopersonal skills
- prevocational/aptitude test in view of future work placement

The treatment plan featured:

- a coping skills programme
- regular school attendance and followup (client was registered at an Opportunity Centre)
- evening programme (carried out with the help of volunteers too)
- group activities
- counselling sessions
- reintegrating into the community

Specifically, the OT involvement featured activities of daily living (appropriate tasks like bedmaking, sorting clothes, tidying up); personal hygiene (for increase of self esteem); negative emotion control (impulsiv-

-eness and rage decrease through music); advice and counselling. Projective techniques have been ruled out as he felt threatened by the medium.

Evaluation

The client's programme was evaluated at regular intervals; a number of case conferences were held to gauge the effectiveness of treatment measures, with the participation of community agencies as well. Overall there has been a marked improvement in the behaviour and attitude of the client. Stumbling blocks to the future resettlement in the community include an unstable family home, as well as the non existence of an appropriate community facility where he can be referred.

Conclusion

There is a crying need for more details on children who set fires, the context in which they carry out their activities, and their motives. More urgently one needs to know how long this behaviour continues, and which children are likely to persist. Possibly the difference between those who stop and those who continue fire setting is found in the trend of those who stopped to have stable parents, or to have been taken out of their disrupted homes and put into better settings of foster and group homes. From research, the conclusion one draws is that the short term prognosis of firesetting in young children, at least in those who are admitted to a child psychiatry ward, is only fair, and that there are no reliable ways as yet to tell whether a child will stop setting fires or continue.

References:

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