

The Massachusetts Coalition for  
Juvenile Firesetter Intervention  
Programs

Eighth Annual Conference for  
Juvenile Firesetter Intervention  
Programs

**“FAMILY THERAPY FOR  
FIRESETTING”**

Jim Mahoney, M.S.W.  
1220 South Division - Spokane, WA 99202  
Fax & Phone (509) 838-2256  
Jim@JimMahoneyMSW.com

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## **PARENTAL BURNOUT**

Many special-needs parents become overwhelmed with overwhelming, legitimate and conflicting tasks of parenting and neglect or abuse their children. These parents present features described by Polansky et al. (1981). They described neglecting mothers as suffering from an “apathy-futility syndrome,” which also mirrors some of the elements seen in dependency disorders.

The key features of this syndrome include a pervasive conviction that nothing is worth doing, emotional numbness, loneliness, interpersonal relationships typified by desperate clinging, a lack of competence in many areas of living, the expression of anger through passive aggression, a reluctance to talk about feelings, and poor problem-solving abilities.

### **MAHONEY’S INVERTED PYRAMID THEORY OF FAMILIES**

#### **THE CLOSER TO THE “CHILD”**

The lower the status of the parent  
 The more responsibility “to do”  
 The harder the work  
 The lower the pay  
 Fewer benefits  
 The work is more dangerous  
 Greater chance of “Burn-out”  
 Poorer retirement benefits  
 Greater occupational hazards  
 More often misunderstood by community  
 More essential to getting the job done  
 Often the first to be criticized or fired

#### **THE FARTHER FROM THE “CHILD”**

The higher the parent’s status  
 More authority “to tell others”  
 The easier the work  
 The higher the pay  
 Higher benefits  
 The work is safer  
 Less chance of “Burn-out.”  
 Better retirement benefits  
 Fewer occupational hazards  
 High visibility and community position  
 Less essential to getting the job done  
 Often the one doing the criticizing

### **THE 12 STAGE BURNOUT SYMPTOM CYCLE (Freudenberger and North 1985)**

- |                                    |                                |
|------------------------------------|--------------------------------|
| 1. Compulsion to prove             | 7. Disengagement               |
| 2. Intensity                       | 8. Observable Behavior Changes |
| 3. Subtle Deprivations             | 9. Depersonalization           |
| 4. Dismissal of Conflict and Needs | 10. Emptiness                  |
| 5. Distortion of Values            | 11. Depression                 |
| 6. Heightened Denial               | 12. Total Burnout Exhaustion   |

### **THE EFFECT OF CHILDREN UPON THEIR PARENTS**

Literature is cited by Ambert (1992) that indicates couples who are happy with each other and provide companionship and support to each other are more likely than others to provide positive support to children. Such happy couples are also more likely to be affected by children in more rewarding ways. When such couples have difficult children they are likely to find in each other a compensatory outlet. Ambert states:

Studies have also found that paternal involvement and successful paternal parenting are more affected by the quality of the marital relationship than is maternal involvement (Dickie and Carnahan Gerber,1980; Belsky et al.,1984; Lamb and Elster, 1985). Such results add further proof to the theory that children affect mothers and fathers differently. In this case, additional parental characteristics, besides sex, act as mediating variables...

### **THE DEVELOPMENT OF ANTISOCIAL BEHAVIOR**

Many children who have experienced abuse and neglect and who live in chaotic and disorganized families, appear to be at risk for oppositional-defiant, conduct-disordered, delinquent and antisocial behavior as a result of their current experiences and generational parenting history. Dishion & Patterson (1993 p. 375) describe the progression of this disorder by stating in the beginning stages children may be described as oppositional or behavior-disordered. As they become older the children are relabeled as conduct-disordered or delinquent. The term antisocial is used in a way “that loosely maps onto these more specific labels, referring to troubled and troublesome youth who are at high risk for several adjustment problems.”

Dishion & Patterson cite Kazdin (1987, p.376) as stating, “Most interventions for children with conduct problems are simply ineffective.” Effective interventions are dependent upon good theory regarding the developmental processes explaining why some children become delinquent early and others later. The authors cite the need for effective primary and secondary preventive interventions. These interventions need to systematically enhance parents’ family management practices. They report “...chaotic, harsh, lax, and generally poorly managed families best predict later delinquency (Loeber & Dishion, 1983).” Dishion and Patterson (1993, p. 376) state the family is the key socializer of their children. They cite the following principles regarding family cohesiveness and disruption:

1. There does not appear to be any one set of interventions that will either “fix” many clients or even significantly alter their pathological living and parenting patterns. To this end reliance upon the disease model doesn’t work, because there is simply no “cure,” for families in perpetual crisis.
2. The relation between parenting practices and future problem behavior is well established. Longitudinal research regarding predicting male delinquency found “that disorganized, chaotic, and lax supervision were found to be among the best predictors, even when compared with earlier behavior problems.
3. Chaotic, harsh, lax, and generally poorly managed families best predict later delinquency.
4. Interventions that systematically enhance parents’ family management practices are the most efficacious in reducing child behavior problems.

### **THE COERCION MODEL**

Dishion and Patterson (1993 p. 378-379) describe the Coercion Model which shows promise in explaining a number of features associated with chronic anti-social behavior.

1. Parent-child, moment-by-moment exchanges are gradually shaped over time. Exchanges are based upon immediate consequences and occur outside the awareness of both parent and child.
  - a. Maladaptive parenting responses can be insidious and occur in disruptions of family structure, or context, including divorce, unemployment, substance abuse, etc, can initiate or increase negative interaction patterns.
  
2. When children are provided with multiple opportunities to escape demands to cooperate with adults in the family they are likely to be particularly troublesome to adults in other settings especially schools.
  - a. This is most likely to occur when parents have been violent and abusive.
  - b. The children may resort to violent social tactics when professionals make demands that resemble the abusive interchanges within the family.
  - c. These tactics can be especially difficult to manage for most middle-class professionals operating in institutions like schools, where contingencies are loose and violence relatively rare.
  
3. The antisocial child is an unhappy and unskilled child. They experience failure in most conventional settings, and these failures lead to depressed mood and low self-esteem.
  
4. The child who displays problem behaviors both at home and in school is a sure sign of more severe family disruption, arrested skill development, delinquent behavior, and early substance abuse.
  - a. The child's early manifestation of antisocial patterns is both directly and indirectly related to later problem behavior.
  - b. Early antisocial behavior is indirectly related to later delinquency by disrupting the parent's child-rearing practices and by peer rejection, as well as involvement in a deviant peer group.
  - c. The early antisocial behavior of the child is the clearest signal of past and future disrupted socialization.
  - d. Measuring antisocial behavior in childhood is in screening procedures.

### **THE DENTAL MODEL OF HEALTH CARE**

Current research cited by Dishion & Patterson (1993, p. 390-391) describe early screening and intervention with families. They describe moving away from a disease

model for some adjustment behavioral problems and using the dental model of health care (Dishion, Reid & Patterson, 1988) instead. Using this framework they suggest that the community view the development of antisocial behavior “as a virtual risk process, as is the development of tooth decay.” Using this model, the probability of child and adolescent risk is fluid and can change from year to year and be dependent upon parental employment-unemployment, moves, etc. They suggest that periodic descriptive assessments i.e. “dental (behavior) checkups” of children’s behavior will serve as a signpost for intervention.

They state that it is feasible for schools and parents to adopt an active and voluntary approach to reducing the amount of antisocial behavior in the schools. They state that once risk is assessed, parents and teachers can collaborate to reduce the children’s antisocial behavior and promote their education.

The authors recommend a three-step process.

1. Community Consensus Building. This would include Community Forum Meetings, as well as workshops to parent groups, teacher groups, administrators, and school psychologists.
2. School-based assessment and Interventions involving routine screening, or universal interventions and evaluation. If and when the child’s behavioral and emotional risk status is identified as elevated by school, parent or other members of the community, teachers, counselors, parents and others collaborate to form an intervention team to reduce the child’s antisocial behavior and promote their education.
3. Services offered to parents and children including parent groups, teacher consultations, parent-teacher communication, parenting videotapes, parent training, child-directed interventions, and peer group interventions.

### **DEVELOPING APPROPRIATE INTERVENTION STRATEGIES**

Sue and Sue (1972) state cross-cultural counseling effectiveness is most likely made possible when the provider uses counseling modalities and defines goals consistent with

the life experiences and cultural values of the client. They state counseling has too long assumed that clients share similar backgrounds and cultural heritage. This has led to the false assumption that the same approaches are equally effective with all clients. They state studies have consistently demonstrated the following:

- a. economically and educationally disadvantaged clients may not be oriented toward “talk therapy,”
- b. self-disclosure may be incompatible with cultural values of Asian Americans, Hispanics, and American Indians,
- c. the sociopolitical atmosphere in which counseling occurs may dictate against self-disclosure,
- d. the ambiguous nature of counseling may be opposite to the life values of the minority client,
- e. many minority clients prefer an active/directive approach to an inactive/nondirective one in counseling.

### **Survey of Treatment**

Raines and Foy (1994) describe a number of interventions. They state earlier interventions were “somewhat simplistic,” adding “recent research and clinical experience have expanded our understanding of firesetting behavior as well as increased the complexity of the therapeutic process. They list the following interventions. Asterisks \* identify best and safest tx. approaches.

- \*1. Behavior therapy: the oldest and most common treatment method for juvenile firesetters.
2. Threat of punishment: The authors recommend against threats and use of logical consequences rather than destructive retaliation for firesetting behaviors.
- \*3. Positive reinforcement: Including rewarding their child for each book of matches turned in. This technique is helpful in initiating a more nurturing approach toward parenting.
4. Negative Practice: The child is taught a three-step process of lighting a match with the cover closed, properly extinguishing it, and how to clean up afterward. When the child wants to stop they are paradoxically asked to continue. When they no longer want to start a session by lighting matches the experiment is terminated.
5. Early interactional approach where the therapist deals with role conflicts and blocked communication patterns without addressing the firesetting behavior.
6. Structural Therapy: An example is directing the mother to competently teach the identified client how to light matches. In so doing the mother becomes elevated to the executive role in the family, resulting in a change in the family’s interactional patterns.
7. Strategic Therapy: Assumes firesetting constitutes a metaphoric response to problems in the family and uses the same approach as above.

\*8. Cognitive Therapy: Believes that rational thought can be an intervening variable between a child's feelings and actions. The authors state they have found such approaches useful in supporting a child's development of adult-thinking processes to deal with inevitable disappointments.

\*9. Alternative-Solution thinking: The child is asked to visualize the day of the fire (physical setting, clothes worn, etc.) and talk about their feelings immediately before and after the fire. Three types of feelings are elicited; sad/lonely, angry/hurt, and fearful/guilty. The hope is to uncover a sequence for their behaviors, 1. a triggering event, 2. followed by feelings that 3. result in behavior. Then identify alternative behaviors.

10. Consequential Thinking: A structured fantasy is presented to teach children how to handle ignition materials properly.

\*11. Group therapy: may be the most effective treatment for juvenile delinquents. The authors cite Zwimpfer (1992) who has observed that "one agency may not have enough firesetter referrals to create a group, but juvenile firesetters may be combined with other children who lack skills." Three approaches that are applicable in group work include:

a. Positive peer culture in which rebellious youth are reoriented by using peers as leverage. It provides conjoint problem-solving and mutual confrontation. This approach may be effective with youths who set fires in groups as part of the dynamic is their responsiveness to group pressure.

b. Rational-emotive approach: teaches social skills such as effective listening and communication; covert sensitization with imagined scenes and responses, and social skills training dealing with teasing. The author states "Given recent findings about the need for improved assertiveness (Kolko & Kazdin, 1991; Sakheim et al., 1991), this approach holds much promise. Raines' (1991) work with teaching social skills to learning-disabled adolescents could be adapted for firesetters.

c. Psychoeducational approach: attempts to provide a knowledge base to change attitudes. A graded curriculum, Learn Not to Burn, is available from the National Fire Protection Association (1992) Directed at younger children who are educated about the destructiveness of fires, how to handle fire tools, and fire escape.

### **Guidelines for Treatment**

Childhood firesetting has been associated with the diagnosis of conduct disorder, antisocial and delinquent behavior, aggression, parental dysfunction and family discord/disorganization (Kolko & Kazdin 1989). The literature indicates that one in every four firesetters may be a recidivist (Kolko 1985).

Successful treatment and rehabilitation of the severe firesetter requires early detection, accurate differential diagnosis, assessment of the degree of risk of recurrence, and appropriate intervention. "Minor" and "moderate" risk firesetters are usually treated safely in the community with parent and child counseling, fire safety education, and

social skills training. Only a program of long-term psychotherapy and behavior modification, however, augmented by casework with the parents to improve their understanding of the needs of their child, and their parenting skills, taking place within the confines of a structured residential treatment center, can help persistent firesetting children interrupt their attraction to fire (Lowenstein, 1989).

#### Coercive Interventions Recommended for Juvenile Firesetters and Their Families.

Sixty percent of all fires set in large cities are caused by juveniles under the age of eighteen (Webb et al 1990). Child firesetters are often under nine years of age. Often when a child is believed to be at risk for firesetting they are referred to a mental health agency. Often, however, the child's family resists such a referral for a number of reasons. Parents may resist involvement in the child's treatment believing that services need to be directed towards the child who is the alleged fire setter. There are several factors which are critical in work with juvenile firesetters and their families. These factors include the following:

- a. Assessment of the degree of risk of recurrence
- b. The challenge of engaging families in mental health treatment
- c. close liaison and aggressive outreach by collaborating agencies
- d. implementation of appropriate treatment intervention

Because firesetters often come to the attention of fire departments rather than mental health clinics, fire departments and mental health agencies need to develop collaborative programs to develop constructive preventive efforts. Webb et al (1990) recommend that because families are often resistant to mental health interventions, such interventions should include a coercive component, with the fire department providing surveillance to encourage attendance of the firesetter and his or her family at recommended services.

#### **Three Promising Family and Community Approaches**

The development of family and community-based services for juvenile firesetters and their families can benefit from drawing upon empirically-based and service models that have been effective with other populations. Although these models can be expected to need adaptation to fit the needs of families of juvenile fire-setters, they all have sound theoretical and empirical groundwork in place.

In regard to family and community-based interventions for this population, three approaches have been selected as among the most promising- Multisystemic Therapy (MST); Community Oriented Primary Care (COPC), and Assertive Community Treatment (ACT). These are generally considered stand alone approaches which are usually not combined with or adjunct to existing services. All appear promising in regard to the essential features of juvenile firesetters and their families. The framework, model and methods of each treatment approach are clearly described. Each approach has been widely disseminated, and each approach has support from a body of empirical evidence.

### **Multisystemic Therapy (MST)**

MST (Henggeler & Borduin, 1990), provides a family and home-based treatment approach. MST is consistent with family preservation models of service delivery which focus upon intensive, time-limited goal-oriented services with a focus of keeping children in their homes. MST interventions are designed to address a broad range of problems that may contribute to identified problems (Borduin, 1994). MST uses treatment strategies derived from family therapy (e.g. Haley, 1976; Minuchin, 1974) and behavior therapy (e.g., Kendall & Braswell, 1985).

MST (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998) is regarded as one of the few mental health treatments with demonstrated effectiveness in treating youth with serious conduct problems (Kazdin, & Weisz, 1998). “MST is a comprehensive and individualized treatment approach that addresses the multiple determinants of identified youth and family problems “ (Brown, Henggeler, Shoenwald, Brondino, & Pickrel, 1999, p. 84). MST is based on nine treatment principles:

1. Understanding the “fit” between identified problems and their broader systems,
2. emphasizing positive and using systemic strengths as motivators for change,
3. promoting responsible behavior and discouraging irresponsible behavior,
4. targeting specific, well defined problems,
5. working inter-systemically to change targeted problems,
6. creating interventions which are developmentally appropriate,
7. requiring daily or weekly effort from family members,
8. evaluating interventions continuously from multiple perspectives,
9. empowering caregivers to maintain therapeutic change after termination.

MST directly deals with intrapersonal, familial, and extrafamilial (peer, school, and neighborhood) factors that are known to be associated with adolescent antisocial behavior. MST interventions are individualized and flexible to the intervention needs of adolescents.

Rigorous evaluation of outcome has been a cornerstone of the development of MST . “MST has strong effects on decreased behavior problems, decreased association with deviant peers, and improved family relations...reducing recidivism for both sexual offenses and nonsexual crimes...lower rate of recidivism for drug related crimes...(decreased) rates of rearrests, self-reported delinquency, and time incarcerated.. (Borduin, 1994). The success of MST compared with other treatment approaches is attributed to two factors:

1. The match between MST intervention foci and empirically identified correlates/causes of antisocial behavior (e.g. parental discipline, family affective relations, peer associations, or school performance, and
2. The flexible use of well-validated intervention strategies in the natural environment (Henggeler & Borduin, in press.) MST is effective because it

directly addresses the multiple determinants of antisocial behavior in youth's naturally occurring systems.

Assessments are conducted in multiple settings, including home, school, and the community, with information from multiple sources including parents, child, and teachers. Once the treatment goals have been agreed upon by therapist and family, interventions are designed to create change in target settings in accordance to the family's needs and strengths (Henggeler et al., 1998)

### **Community Oriented Primary Care (COPC).**

The basic premise of COPS is that healthy public policy is more likely the result of a policy of collaboration, cooperation, and coordination, rather than competition based on the managed care approach, which, when it works "provides better access and higher quality care at a reasonable cost..."

Through the use of COPC, the Social Policy Corporation (1994) has tested bridging the divide between public health and medical care for over forty years on the Navajo Indian reservation, South America, Israel and in selected practices and health centers in the United States. The COPC approach is a way for communities to work with health professionals to identify and address health problems through partnerships. By embracing a community empowerment approach to health issues, health professionals learn to work with, rather than "on" communities, learning to respect and value the knowledge, wisdom, and expertise of the people they serve.

In this system of care, all health is viewed as having public-health components and medicine is viewed as incorporating preventive medicine. Using this model, community-based public health becomes decentralized and personalized.

The steps of COPC are carried out in a cyclical manner, resulting in learning, fine-tuning and at the same time, promoting and developing the community-professional partnership.

1. First, a primary-care or public health program defines and characterizes the the community for which it has assumed responsibility.
2. The program organizes and involves the community so that the groundwork for a community-based professional partnership is laid.
3. A community diagnosis/needs assessment and a resources inventory is conducted.
4. Community-based interventions are developed and implemented.
5. Ongoing monitoring and evaluation procedures are put in place.

The COPC model focuses upon the "denominator population," which could include, for example juvenile firesetters and their families. They would serve as "a clearly defined

group of people who are potentially served by the clinical practice.” At the same time, practice responsibility is assumed for the health of the entire community as a whole, and not just the “numerator” population. To be effective, the practice has to develop ways of reaching out to everyone in its denominator population-through

1. health education,
2. changes in the environment,
3. outreach to reticent members of the community,
4. or broad community health screenings for example.

In focusing upon a defined population several goals are articulated:

1. The practitioner team accepts responsibility for the community’s health.
2. A defined population focus enables the team to develop partnerships with the community which are essential towards identifying and solving community problems.
3. An attempt is made to fully identify the health problems and resources of a community.
4. Community diagnoses may begin with a community study, identifying its background, history, geography, natural resources, sociodemography, and sociocultural and socioeconomic factors.

A community-health resource inventory should be included, containing the following:

1. a comprehensive list of all agencies and types of services available in the local community, as well as the numbers served.
2. other workload data,
3. an analysis of referral patterns,
4. inventories of both natural support systems and informal helping networks,
5. lists of leaders from community organizations, religious groups, small business, labor unions, and cultural groups.

Health status indicators are gathered including:

1. obtaining community opinion data, morbidity/mortality data, and behavioral risk data.
2. A complete diagnosis encompasses information about community resources and problems.

Once this information is gathered the health professional team and community rank the problems in priority for intervention. The community needs are ranked and identified by the community members and health professionals together which then drive the COPC practice.

### **Assertive Community Treatment (ACT)**

The Assertive Community Treatment ACT model developed by Stein and Test (1980) for the seriously mentally ill, is the most widely studied form of outpatient treatment for persons with mental illness and has substantial empirical support. “ACT is the single comprehensive intervention for adults with severe mental illness that has a well-

established research base” (Burns, 1998, p. 261). ACT has gone through twenty years of development and testing and is being replicated under a national initiative lead by the National Alliance for the Mentally Ill (NAMI). ACT is an intensive form of casemanagement that has been used to provide outreach, with continuous treatment teams, community referral, practical assistance, service coordination, instruction, monitoring, and supervision for difficult to serve and unmotivated clients. ACT has been used with adults with schizophrenia and other mental disorders, as well as with substance abusers, people who are homeless, and with families (Teague, Bond, & Drake, 1998).

Models like ACT could provide a framework for services to special-needs families at the highest level of distress, whose children require repeated placements into more secure levels of care (Smith & Howard, 1999).

### **Conclusion**

Three innovative family and community interventions for use with firesetting youth and their families have been discussed. Review of these treatment modalities was not meant to be comprehensive and other programs certainly exist. It is hoped that this brief review will encourage additional research and discussion on best ways to work with firesetting youth and their families that encompasses their many life domains inasmuch as multisystemic approaches appear to result in more positive treatment outcomes. The future of treating special-needs families lies in systematic conceptualizations of behavior change. Well-controlled outcome research is needed to document the effectiveness and cost-effectiveness of interventions with juvenile firesetters and their families.

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