experience that this father had, and the book that came out of it, is for us, as physicians, to look closely at some traditional aspects of our practice and wonder if it is as compassionate as it can be.

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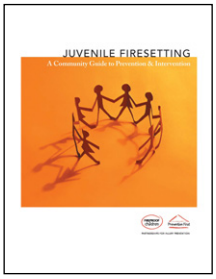

Juvenile Firesetting: A Community Guide to Prevention and Intervention. By Robert Cole, Robert Crandall, Carolyn E. Kourofsky, Daryl Sharp, Susan Blaakman, and Elizabeth Cole. Pittsford, NY: Fireproof Children/Prevention First; 2006; 157 pp. (softcover) $79.95.

Twenty-five years ago, mental health professionals rarely focused on inappropriate sexual behavior manifested by children and youth. If mentioned at all, discussion focused on the underlying emotional disorder of which the sexual behavior was considered symptomatic. Currently, sexually abusive behavior by children and youth is recognized as a problem in its own right, and a rich theoretical and treatment literature has accumulated. Unfortunately, the same cannot be said about firesetting. Even today, the specialist bookshelf is quite short, with only two new volumes since 2002: *Handbook of Firesetting in Children and Youth,* edited by David Kolko, and *Assessment and Treatment of Juvenile Firesetting Behavior,* by Robert F. Stadolnick. Now a significant third contribution, prepared by a collaboration of two groups, Fireproof Children and Prevention First, is available.

Twenty-seven years ago these researchers and clinicians joined with their local fire authority in Rochester, New York, in an effort to protect their community and young patients from the risks of child and youth firesetting. That cooperative spirit shaped the kind of intervention program that they developed and is embodied in the format of their impressive publication, *Juvenile Firesetting: A Community Guide to Prevention & Intervention*. The volume is almost equally divided among chapters on "Understanding the Problem" (theory and scientific issues), "The Fire Service Role," "Education" (how the school can contribute), the role of the community, and the mental health professional's role. The book has an accessible style, eschewing jargon. Where some technical term is absolutely necessary, the authors provide a brief, lucid explanation. Each chapter begins with a list of key points to be discussed, and ends with a pithy summary to reinforce learning.

In the first two chapters, the authors present a developmental formulation of child and youth firesetting. This is an easily understood, nontechnical discussion that should lower the anxiety of the general mental health professional seeking to understand firesetting behaviors in ayoung therapy client and encourage that professional to test some of the useful interventions offered. Readers more empirically oriented will find David Kolko's volume (subject of a future review) more satisfying. Not that *Juvenile Firesetting* is "research-lite." The authors adduce their own (substantial) research base, and work by others, including Kolko, to challenge some of the field's shibboleths.

For example, they assert that "curiosity" firesetting, a form of firesetting included in all existing typologies, is a misnomer. They argue that children are quite familiar with fire from multiple mundane experiences, e.g., birthday cakes, dining rooms, scented candles, fireplaces, barbeque grills, adults' cigarette smoking. Children play with fire, they assert, to increase their sense of power, and because they lack appreciation of the dangers. Extending this argument, they maintain that even older children/adolescents under the age of, say 15 years, are unable to manage fire safely because they cannot be relied upon to manage emergencies. The authors propose a developmental hierarchy of misapprehension. The youngest children cannot conceive that a tiny match flame can cause a fire big enough to burn an entire house. Try asking a four-year-old, they suggest, how many matches it would take to burn up a house. Older children, 10 years and older, may understand how fire extends, but lack the resources to respond effectively to unforeseen, emergency events. Consistent with their formulation of the motives underlying juvenile firesetting, they argue against providing young

children with experience managing fires, on the (mistaken, in their view) theory that this will somehow satisfy their curiosity and yield responsible fire and emergency management. Quite the contrary, the authors insist. They present data to support the notion that early experiences safely managing fire, with or without adult supervision, reduce fear of fire and actually increase the occurrence of unsupervised firesetting. The authors propose drawing a "bright line" at 11 years of age, below which children are rigorously prohibited by family practice and community ordinance from access to ignition sources and from any fire involvement.

This notion seems to be gaining traction in public policy. Several forward-thinking towns in Massachusetts (a regional leader in addressing the problem of juvenile firesetting) have already passed ordinances banning the sales of lighters and matches to individuals under the legal age to purchase tobacco. The authors advocate universal adoption of such restrictions as a key aspect of prevention that is the main focus of their work. Because their research demonstrates firesetting recidivism rates under 10%, they believe that most children who set a fire that is reported to fire authorities seem to learn from their experience. So, they conclude, public safety will be improved by preventing children from setting their first (and typically only) fire. Accomplishing this requires changing public policies and the attitudes of supervising adults. They are the ones who can most effectively restrict access to ignition sources, communicate clear unambiguously interdicting messages and limits to children and youth, and provide age-appropriate levels of supervision.

Unsurprisingly, these are exactly the principles for reducing accidental injuries of *all* types. The authors' present several studies demonstrating strong correlations between fire-related injuries to children and non–fire-related injuries, e.g., falls, lacerations, gunshots. An increase in parental and community effectiveness in reducing firesetting by children and youth could easily produce lower general accident rates, a happy by-product.

Less satisfyingly, the authors do not really address risks created by that 10% of juveniles who set two, three, or more fires. Perhaps the data are not available? A suggestive parallel can be found in research on recidivist juveniles with sexual behavior problems. Long-term outcome studies (1 to 5 years) usually show low (10% to 15%) rates of recidivism. Many of those recidivists, however, admit to multiple victims; some studies have indicated 50, 100, or more additional victims per juvenile. If persistent juvenile firesetters are similarly active, reallocating scarce resources to focus on primary prevention may not, in the long run, serve public safety needs. But, as the authors point out in the first chapter, reliable incidence data on firesetting are not yet available, so it may be some time before we can make an informed choice between targeting the most common form of juvenile firesetting, or addressing the most persistent. In the meantime, this book is the mental health professional's best source for understanding juvenile firesetting and crafting office-based interventions for young patients and their families.

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