

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

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

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

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

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Relevant articles and legal cases were obtained via PubMed and LexisNexis. To our knowledge, this article is the first in 20 years⁸ to address firesetting-related forensic evaluations in the psychiatry literature. It also represents the first comprehensive discussion of civil evaluations related to firesetting.

The Behavior of Firesetting

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

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

taken. Pathological firesetting, which is the intentional setting of fires for psychological reasons, may be a symptom in a range of psychiatric disorders.¹⁷ Pathological firesetting is not pathognomonic of pyromania¹⁸ and does not always equate to arson.

The Crime of Arson

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

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

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

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

Most arsonists are male,^{3,5–7,24–27} although the proportion of female arsonists is increasing.^{24,26} Fe-

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

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

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

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

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

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

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

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

The Diagnosis of Pyromania

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

Pyromania is not a recent addition to psychiatric diagnoses. The term was first used by Marc in 1833.^{8,30,46,51} Kraepelin defined pyromania as an impulsive insanity, and Freud described it as resulting from aberrant psychosexual development.^{15,51} A landmark study by Lewis and Yarnell⁵ in 1951 heralded the modern age of pyromania and firesetting research. The Diagnostic and Statistical Manual of Mental Disorders, First Edition (DSM-I),⁵⁴ listed pyromania as an obsessive-compulsive reaction. There was no mention of it in the Diagnostic and

Table 1 DSM-IV-TR Diagnostic Criteria for Pyromania

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

Statistical Manual of Mental Disorders, Second Edition (DSM-II).⁵⁵ The Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III),⁵⁶ included it as a disorder of impulse, not otherwise specified.¹⁵ Pyromania currently is included in DSM-IV-TR⁵³ as an impulse-control disorder, and proposals for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), suggest that it will remain in this category.⁵⁷

Pyromania is a rare diagnosis, even among first-time and recidivist arsonists.^{3,7,24,28,31,32,39,49} Setting fires for sexual arousal is even rarer.^{5,7,21,30,31,58,59}

The overall prevalence of pyromania in adult populations is unknown, although three to six percent of psychiatric inpatients have been reported to meet the diagnostic criteria.^{60,61} Research on pyromania has been limited by its estimated low prevalence and the reluctance of individuals to disclose their ongoing propensity to set fires.

Grant and Kim⁵⁹ reported on a community sample of patients with an established diagnosis of pyromania. Most subjects began to set fires in adolescence or early adulthood. The frequency and intensity of firesetting increased over time. Two-thirds engaged in planning behavior before setting the fires (e.g., collecting combustible items). Common triggers for firesetting included stress, boredom, feelings of inadequacy, and interpersonal conflict. One-quarter reported no triggers. All experienced a rush when watching or setting fires. None experienced sexual arousal. A fascination with fire was common, and more than one-third reported traveling to fires when they heard fire engines. Another study observed an association between pyromania and volunteer fire fighting.³⁹

More than 90 percent of individuals with pyromania in the Grant and Kim study⁵⁹ had diagnoses of comorbid Axis I disorders, with mood, other impulse control, and substance use disorders being the most common. Symptoms of pyromania preceded the mood or substance use disorders in most cases. More than 90 percent reported experiencing severe distress after starting fires, and one-third considered suicide as a means of controlling firesetting.

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

Firesetting and Experts in the Criminal Courts

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

Criminal Responsibility: Not Guilty by Reason of Insanity

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

Table 2 Classification of Firesetters Based on Motive

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

communicative arson) have been described among firesetting mentally ill offenders.^{35,72}

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

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

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

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

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

Criminal Responsibility: Diminished Capacity and Requisite Intent

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

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

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

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

Sentencing Evaluations and Recidivism Risk

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

Most individuals who commit arson do not engage in further arson offenses.^{17,25,26,40,90,91} For ex-

Table 3 Arson Recidivism Risk Factors in Mentally Disordered Arsonists

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

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

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

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

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

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

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

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

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

Criminal Competency Evaluations

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

Firesetting and Experts in the Civil Courts

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

Negligence: Liability After Inpatient Discharge

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

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

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

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

Firesetting and the Forensic Evaluation

Table 4 Suggested Variables for Firesetting Risk Assessments

Firesetting history	Current firesetting ideation
Age first set fires	Firesetting ideation, intent, plan
Number of previously set fires	Access to firesetting materials
Frequency of previously set fires	Presence/Absence of stressors/circumstances similar to past fires
Duration of firesetting history	Personality variables
Intensity/quality of previously set fires	Assertiveness impairments
Impulsivity of past firesetting	Overall degree of impulsivity
Motives for past firesetting	Level of insight
Psychosocial circumstances precipitating past fires	
Psychiatric comorbidities	Other variables
Substance use disorders (alcohol)	Compliance with treatment recommendations
Psychotic disorders	Current stressors/coping techniques
Intellectual impairment/mental retardation	Available support system
Personality disorders (ASPD, BPD)	Marital status
Mood disorders	Feasibility of plan after discharge
Impulse-control disorders	
Pyromania	

In contrast, in *Onofrio v. Department of Mental Health* (DMH),^{8,101} a patient receiving DMH care was referred by a housing contractor to a boarding house. The contractor and DMH failed to inform the landlord that the patient was under DMH care and had a history of firesetting, destruction of property, and violence. The patient set fire to the residence. The landlord brought an action against the contractor and DMH. The trial and appeals courts found both respondents negligent because they owed the landlord a duty of reasonable care by taking actions that exposed the landlord to risk. They failed to meet that duty.

Negligence: Firesetting During an Inpatient Admission

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

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

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

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

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

Negligence: Duty to Warn and Protect

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

Negligence: After Criminal Conviction

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

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

Other Civil Evaluations

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

Conclusion

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

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

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

References

1. Federal Bureau of Investigation: Crime in the United States, 2008. Washington, DC: U.S. Department of Justice, 2009. Available at <http://www2.fbi.gov/ucr/cius2008/documents/arsonmain.pdf>. Accessed February 2010
2. Brett A: 'Kindling theory' in arson: how dangerous are firesetters? *Aust N Z J Psychiatry* 38:419–25, 2004
3. Ritchie EC, Huff TG: Psychiatric aspects of arsonists. *J Forensic Sci* 44:733–40, 1999
4. Jackson HF, Glass C, Hope S: A functional analysis of recidivistic arson. *Br J Clin Psychol* 26:175–85, 1987
5. Lewis ND, Yarnell H: Pathological fire-setting (pyromania). *Nervous and Mental Disease Monograph No. 82*. New York: Coolidge Foundation, 1951
6. Anwar S, Langstrom N, Grann M, et al: Is arson the crime most strongly associated with psychosis?—a natural case-control study of arson risk in schizophrenia and other psychoses. *Schizophrenia Bull* 37:580–9, 2011
7. Yesavage JA, Benezech M, Ceccaldi P, et al: Arson in mentally ill and criminal populations. *J Clin Psychiatry* 44:128–30, 1983
8. Geller JL: Pathological firesetting in adults. *Int J Law Psychiatry* 15:283–302, 1992
9. State v. Stewart, 493 So.2d 227 (La. Ct. App. 1986)
10. Rum River Lumber Co. v. State, 282 N.W. 2d 882 (Minn. 1979)
11. People v. Overman, 542 N.E.2d 1250 (Ill. App. Ct. 1989)
12. Yount v. Deibert, 147 P.3d 1065 (Kan. 2006)
13. People v. Ruppert, 35 A.D.2d 1017 (N.Y. 1970)
14. Geller JL, McDermeit M, Brown JM: Pyromania?—what does it mean? *J Forensic Sci* 42:1052–7, 1997
15. Geller JL, Erlen J, Pinkus RL: A historical appraisal of America's experience with "pyromania": a diagnosis in search of a disorder. *Int J Law Psychiatry* 9:201–29, 1986
16. Barreto SJ, Zeff KR, Boekamp JR, et al: Fire behavior in children and adolescents, in Lewis's Child and Adolescent Psychiatry (ed 4). Edited by Martin A, Volkmar FR. Philadelphia: Lippincott Williams & Wilkins, 2007, pp 483–93
17. Geller JL, Fisher WH, Bertsch G: Who repeats?—a follow-up study of state hospital patients' firesetting behavior. *Psychiatr Q* 63:143–57, 1992
18. Geller JL: Firesetting in the adult psychiatric population. *Hosp Community Psychiatry*. 38:501–6, 1987
19. West ME: Arson and related offenses, in American Jurisprudence (ed 2): Edited by Eagan MN: Thomson West, LexisNexis, 2008, §§ 1–6
20. Federal Bureau of Investigation: Crime in the United States, 2008, Table 1: Arson rate. Washington, DC: U.S. Department of Justice, 2009. Available at http://www2.fbi.gov/ucr/cius2008/offenses/expanded_information/data/arsontable_01.html. Accessed February 2010
21. Hill RW, Langevin R, Paitich D, et al: Is arson an aggressive act or a property offence?—a controlled study of psychiatric referrals. *Can J Psychiatry* 27:648–54, 1982
22. Rice ME, Harris GT: Fire setters admitted to a maximum security psychiatric institution. *J Interpers Violence* 6:461–75, 1991
23. Federal Bureau of Investigation: Crime in the United States, 2008, Table 2: Arson by type of property. Washington, DC: U.S. Department of Justice, 2009. Available at http://www2.fbi.gov/ucr/cius2008/offenses/expanded_information/data/arsontable_02.html. Accessed February 2010
24. Rasanen P, Hakko H, Vaisanen E: Arson trend increasing: a real challenge to psychiatry. *J Forensic Sci* 40:976–9, 1995
25. Soothill KL, Pope PJ: Arson: a twenty-year cohort study. *Med Sci Law* 13:127–38, 1973
26. Soothill K, Ackerley E, Francis B: The criminal careers of arsonists. *Med Sci Law* 44:27–40, 2004
27. Barnett W, Richter P, Sigmund D, et al: Recidivism and concomitant criminality in pathological fire setters. *J Forensic Sci* 42:879–83, 1997
28. Harmon RB, Rosner R, Wiederlight M: Women and arson: a demographic study. *J Forensic Sci* 30:467–77, 1985
29. Stewart LA: Profile of female fire setters: implications for treatment. *Br J Psychiatry* 163:248–56, 1993
30. Rix KJ: A psychiatric study of adult arsonists. *Med Sci Law* 34:21–34, 1994
31. Koson DF, Dvoskin J: Arson: a diagnostic study. *Bull Am Acad Psychiatry Law* 10:39–49, 1982
32. Rasanen P, Hakko H, Vaisanen E: The mental state of arsonists as determined by forensic psychiatric examinations. *Bull Am Acad Psychiatry Law* 23:547–53, 1995
33. Leong GB, Silva JA: Revisiting arson from an outpatient forensic perspective. *J Forensic Sci* 44:558–63, 1999
34. Leong GB: A psychiatric study of persons charged with arson. *J Forensic Sci* 37:1319–26, 1992
35. Bradford JM: Arson: a clinical study. *Can J Psychiatry* 27:188–93, 1982
36. DeJong J, Virkkunen M, Linnoila M: Factors associated with recidivism in a criminal population. *J Nerv Ment Dis* 180:543–50, 1992
37. Repo E, Virkkunen M, Rawlings R, et al: Suicidal behavior among Finnish fire setters. *Eur Arch Psychiatry Clin Neurosci* 247:303–7, 1997
38. Repo E, Virkkunen, Rawlings R, et al: Criminal and psychiatric histories of Finnish arsonists. *Acta Psychiatr Scand* 95:318–23, 1997
39. Lindberg N, Holi MM, Tani P, et al: Looking for pyromania: characteristics of a consecutive sample of Finnish male criminals with histories of recidivist fire-setting between 1973 and 1993. *BMC Psychiatry* 5:47, 2005
40. Repo E, Virkkunen M: Criminal recidivism and family histories of schizophrenic and nonschizophrenic fire setters: comorbid alcohol dependence in schizophrenic fire setters. *J Am Acad Psychiatry Law* 25:207–15, 1997
41. Jayaraman A, Frazer J: Arson: a growing inferno. *Med Sci Law* 46:295–300, 2006
42. Puri BK, Baxter R, Cordess CC: Characteristics of fire-setters: a study and proposed multiaxial psychiatric classification. *Br J Psychiatry* 166:393–6, 1995
43. Barron P, Hassiotis A, Banes J: Offenders with intellectual disability: a prospective comparative study. *J Intellect Disabil Res* 48:69–76, 2004
44. Geller J: Arson: an unforeseen sequela of deinstitutionalization. *Am J Psychiatry* 141:504–8, 1984
45. Mannynsalo L, Putkonen H, Lindberg N, et al: Forensic psychiatric perspectives on criminality associated with intellectual dis-

- ability: a nationwide register-based study. *J Intellect Disabil Res* 53:279–88, 2009
46. Geller JL: Arson in review: from profit to pathology. *Psychiatric Clin North Am* 15:623–45, 1992
 47. Mouridsen SE, Rich B, Isager T, et al: Pervasive developmental disorders and criminal behaviour. *Int J Offender Ther Comp Criminol* 52:196–205, 2008
 48. Barnett W, Spitzer M: Pathological fire-setting 1951–1991: a review. *Med Sci Law* 34:4–20, 1994
 49. Geller JL, Bertsch G: Fire-setting behavior in the histories of a state hospital population. *Am J Psychiatry* 142:464–8, 1985
 50. Dickens G, Sugarman P, Ahmad F, et al: Characteristics of low IQ arsonists at psychiatric assessment. *Med Sci Law* 48:217–20, 2008
 51. Harris GT, Rice ME: Mentally disordered firesetters: psychodynamic versus empirical approaches. *Int J Law Psychiatry* 7:19–34, 1984
 52. Smith J, Short J: Mentally disordered firesetters. *Br J Hosp Med* 53:136–40, 1995
 53. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
 54. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, First Edition. Washington, DC: American Psychiatric Association, 1952
 55. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Second Edition. Washington, DC: American Psychiatric Association, 1968
 56. American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Third Edition. Washington, DC: American Psychiatric Association, 1980
 57. American Psychiatric Association: DSM 5 Development. Arlington, VA, 2010. Available at www.dsm5.org. Accessed February 2010
 58. Quinsey VL, Chaplin TC, Upfold D: Arsonists and sexual arousal to fire setting: correlation unsupported. *J Behav Ther Exp Psychiatry* 20:203–9, 1989
 59. Grant JE, Kim SW: Clinical characteristics and psychiatric comorbidity of pyromania. *J Clin Psychiatry* 68:1717–22, 2007
 60. Grant JE, Levine L, Kim D, et al: Impulse control disorders in adult psychiatric inpatients. *Am J Psychiatry* 162:2184–8, 2005
 61. Lejoyeux M, Arbaretz M, McLoughlin M, et al: Impulse control disorders and depression. *J Nerv Ment Dis* 190:310–14, 2002
 62. Dell'osso B, Altamura AC, Allen A: Epidemiologic and clinical updates on impulse control disorders. *Eur Arch Psychiatry Clin Neurosci* 256:464–75, 2006
 63. Roncero C, Rodriguez-Urrutia A, Grau-Lopez L, et al: Antiepileptic drugs in the control of the impulses disorders (in Spanish). *Actas Esp Psiquiatr* 37:205–12, 2009
 64. Bourget D, Bradford J: Fire fetishism, diagnostic and clinical implications: a review of two cases. *Can J Psychiatry* 32:459–62, 1987
 65. Parks RW, Green RD, Girgis S, et al: Response of pyromania to biological treatment in a homeless person. *Neuropsychiatr Dis Treat* 1:277–80, 2005
 66. Grant JE: SPECT imaging and treatment of pyromania. *J Clin Psychiatry* 67:998, 2006
 67. Felthous AR: Firesetting and investigating experts: the 2008 forensic sampler—a double feature. *AAPL Newsletter* April 2009, p 1
 68. Inciardi JA: The adult firesetter: a typology. *Criminology* 8:145–55, 1970
 69. Barker AF: Arson: a review of the psychiatric literature. *Maudsley Monographs*, No. 35. New York; Oxford University Press, 1994
 70. Prins H, Tennent G, Trick K: Motives for arson (fire raising). *Med Sci Law* 25:275–78, 1985
 71. Dolev R: Making sense of arson through classification. *Psychiatry Psychol Law* 10:346–52, 2003
 72. Geller JL: Communicative arson. *Hosp Community Psychiatry* 43:76–7, 1992
 73. State v. Floyd, 2001 Tenn. Crim. App. LEXIS 550 (Tenn. Crim. App. 2001)
 74. Williams v. Commonwealth, 444 S.E.2d 16 (Va. Ct. App. 1994)
 75. People v. Kokkeneis, 632 N.E.2d 158 (Ill. App. Ct. 1994)
 76. Tavares v. State, 871 So.2d 974 (Fla. Dist. Ct. App. 2004)
 77. State v. Catlett, 536 S.E.2d 721 (W. Va. 1999)
 78. United States v. Carbullido, 307 F.3d 957 (9th Cir. 2002)
 79. Foust LL: The legal significance of clinical formulations of fire-setting behavior. *Int J Law Psychiatry* 2:371–87, 1979
 80. Briscoe v. United States, 248 F.2d 640 (D.C. Cir. 1957)
 81. State v. Burress, 272 N.E.2d 390 (Ill. App. Ct. 1971)
 82. Veverka v. Cash, 318 N.W.2d 447 (Iowa 1982)
 83. Henderson v. State, 715 So.2d 863 (Ala. Crim. App. 1997)
 84. Dean v. State, 668 P.2d 639 (Wyo. 1983)
 85. People v. Nance, 102 Cal. Rptr. 266 (Cal. Ct. App. 1972)
 86. State v. Doyon, 416 A.2d 130 (R.I. 1980)
 87. Commonwealth v. Glenn, 503 N.E.2d 39 (Mass. App. Ct. 1987)
 88. People v. Ross, 2007 Cal. App. Unpub. LEXIS 2429 (Cal. Ct. App. 2007)
 89. People v. Atkins, 18 P.3d 660 (Cal. 2001)
 90. Sapsford RJ, Banks C, Smith DD: Arsonists in prison. *Med Sci Law* 18:247–54, 1978
 91. Rice ME, Harris GT: Predicting the recidivism of mentally disordered firesetters. *J Interpers Violence* 11:364–75, 1996
 92. Quinsey VL, Harris GT, Rice ME, et al: Violent Offenders Appraising and Managing Risk (ed 2). Washington, DC: American Psychological Association, 2006
 93. State v. Bailey, 2002 Tenn. Crim. App. LEXIS 734 (Tenn. Crim. App. 2002)
 94. Faulkenberry v. State, 649 P.2d 951 (Alaska Ct. App. 1982)
 95. Toole v. State, 479 So.2d 731 (Fla. 1985)
 96. Ritt v. Dingle, 2001 U.S. Dist. LEXIS 15220 (D. Minn. 2001)
 97. United States v. Martino, 648 F.2d 367 (5th Cir. 1981)
 98. Geller JL, Fisher WH, Moynihan K: Adult lifetime prevalence of firesetting behaviors in a state hospital population. *Psychiatr Q* 63:129–42, 1992
 99. Tardiff K: A survey of five types of dangerous behavior among chronic psychiatric patients. *Bull Am Acad Psychiatry Law* 10: 177–82, 1982
 100. Seavy v. State, 21 A.D.2d 445 (N.Y. 1964)
 101. Onofrio v. Department of Mental Health, 562 N.E.2d 1341 (Mass. 1990)
 102. Hilscher v. State, 314 N.Y.S. 2d 904 (N.Y. Ct. Cl. 1970)
 103. Vattimo v. Lower Bucks Hospital, Inc., 465 A.2d 1231 (Pa. 1983)
 104. Stone AA: Vermont adopts Tarasoff: a real barn-burner. *Am J Psychiatry* 143:352–5, 1986
 105. Peck v. The Counseling Service of Addison County, Inc., 499 A.2d 422 (Vt. 1985)
 106. Buncina v. City of Ketchikan, 902 P.2d 817 (Alaska 1995)
 107. Sherrod v. State, 50 Ill. Ct. Cl. 23 (Ill. Ct. Cl. 1997)
 108. Brecka v. State, 179 N.Y.S.2d 469 (N.Y. Ct. Cl. 1958)
 109. Cropper v. Brown, 6 Vet. App. 450 (Vet. App. 1994)
 110. Home Insurance Co. v. Aetna Life and Casualty Co., 663 A.2d 1001 (Conn. 1995)
 111. Congregation of Rodef Sholom v. American Motorists Insurance Co., 154 Cal. Rptr. 348 (Cal. Ct. App. 1979)
 112. Weathers v. American Family Mutual Insurance Co., 793 F. Supp. 1002 (D. Kan. 1992)