



**Developing and evaluating interventions for women
firesetters in high secure mental healthcare**

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Review

Developing and evaluating interventions for women firesetters in high secure mental healthcare

Abstract

Purpose

To discuss the implementation and evaluation of interventions for women firesetters in high secure mental healthcare at the UK's National Women's Service (NWS).

Methodology/approach

Two types of Arson Treatment Programmes for women, one delivered to individuals, the other within a group context, were developed, delivered and evaluated. The evaluation incorporated qualitative and quantitative data, including psychometric measures. Qualitative data was analysed using Thematic Analysis.

Findings

The evaluation evidenced very high engagement with and attendance at treatment programmes, and several post treatment gains. Participants' ratings of programmes and qualitative feedback were similarly very positive. The study demonstrated that engaging women firesetters in their treatment is paramount and can be facilitated by consistent boundaries around therapy provision balanced with sensitivity, empathy and flexibility; providing interactive and varied teaching methods; on-going service user involvement and recognizing participants' achievements; employing a mixed Cognitive Analytic Therapy (CAT) and Cognitive Behavioural Therapy (CBT) therapeutic approach; having input from fire service staff; and maintaining organisational support for firesetting interventions.

Practical implications

Twelve key recommendations are made for clinicians considering offering treatment programmes for women firesetters.

Originality/value

Amid few published papers on treating women firesetters this paper guides forensic clinicians in establishing and delivering interventions for women firesetters.

Keywords Arson treatment, firesetting, high secure, treatment delivery, mental health, United Kingdom

Paper type Research paper

Introduction

This paper discusses the implementation and evaluation of group and individual arson treatment programmes over eight years at the UK's National Women's Service (NWS).

The term firesetting (versus arson) is mostly used throughout the paper as it embraces a wider range of people who deliberately set fires. 'Arson' defines the specific criminal act of intentionally or recklessly setting fire to property or wildland areas (Dickens and Sugarman, 2012). A firesetter "displays a behavioural phenotype, the deliberate setting of fires, which may not have been prosecuted, for a number of reasons" (Dickens and Sugarman, 2012).

Overview of theories of firesetting

Early theories of firesetting included Social Learning Theory (Gannon, Ó Ciardha, Doley, and Alleyne, 2012); Jackson's functional analysis model: Firesetting as the Only Viable Option (Jackson, Glass, and Hope, 1987; Jackson, 1994); and Fineman's (1995) dynamic behavioural theory. Social learning theorists view firesetting as the product of learning principles and a form of learnt hostility/aggression. For example, firesetting can be instantly reinforcing through the sensory excitement, the sirens, crowd, and noise associated with the fire (Vreeland and Levin, 1980). Jackson et al., (1987) developed the first multifactorial theory of firesetting which postulates that the behaviour is likely to be repeated when the antecedents and consequences of arson are such that certain criteria are met. Key antecedents are psychosocial disadvantage, dissatisfaction with life and self, social ineffectiveness, specific psychosocial stimuli and a triggering stimulus. Clinicians have endorsed this theory but it lacks explanatory depth, such as its failure to explain why some individuals who experience psychosocial disadvantage do not engage in firesetting (Gannon and Pina, 2010). Fineman's (1995) model similarly views firesetting as a product of historical factors that predispose to antisocial behaviour in general; historical environmental factors that have legitimized firesetting; and immediate environment conditions that encourage firesetting. Whilst containing strengths this theory leans more towards juvenile firesetters than adult firesetters.

Addressing their concerns regarding earlier theories, Gannon, Ó Ciardha, Doley and Alleyne (2012) developed the Multi-Trajectory Theory of Adult Firesetting (M-TTAF). This theory positively organizes research into hypothesized dynamic risk factors or vulnerabilities associated with the facilitation and maintenance of firesetting behaviour; combines distal (background characteristics) and proximal factors (represent an immediate vulnerability) as contributors to firesetting; identifies key factors associated with repeated firesetting and firesetting desistence; and describes key firesetting trajectories (patterns of characteristics leading to firesetting). Five key trajectories are Antisocial Cognition, Grievance, Fire Interest, Emotionally Expressive/Need for Recognition and Multi-faceted. However, this theory lacks detail about how the process of setting fires unfolds for mentally disordered offenders (Tyler et al., 2014). Consequently, Tyler et al. (2014) developed the Firesetting Offence Chain Model for Mentally Disordered Offenders (FOC-MD). This

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3 model emphasizes childhood experiences of fire and mental illness as precursors to
4 firesetting.
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6

7 ***Firesetting in women***

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10 Coid, Kahtan, Gault, and Jarman (2000) observed that women were more likely than
11 men to have an index offence of arson and histories of firesetting. Indeed, firesetting
12 often precipitates women's admissions to secure treatment services (Cunningham,
13 Timms, Holloway, and Radford, 2011). Within the NWS in December 2015, 63% of
14 patients had histories of firesetting and among these 47% had received a conviction
15 for arson/firesetting. Comparable figures regarding male patients were unavailable.
16

17
18 Female firesetters are typically of low-average IQ (Noble and Nelson, 2001), have
19 low socioeconomic status and are poorly educated (Harmon, Rosner, and
20 Wiederlight, 1985; Stewart, 1993; Tennent, McQuaid, Loughnane, and Hands, 1971;
21 Wachi et al., 2007) and are likely to have experienced attachment difficulties and
22 trauma (Harmon et al., 1985; Puri, Baxter, and Cordess, 1995; Hickle and Roe-
23 Sepowitz, 2010). These findings are paralleled for women firesetters within the NWS
24 and have important implications for treating women firesetters, such as needing to
25 consider their lack of education and their attachment difficulties in providing
26 treatment.
27

28
29 The research literature on motives for women's firesetting is scant and
30 underdeveloped (Gannon, Tyler, Barnoux, and Pina, 2012). Studies with a male
31 firesetter comparison group (Rix, 1994; Dickens et al., 2007) show that there do not
32 appear to be large differences across female and male firesetters. Revenge appears
33 to be a common motivator for both genders. Firesetting as a cry for help however,
34 appears to be more prevalent among female firesetters (Dickens et al., 2007).
35 Promoting relocation was also found to be an important motivator for women (Rix,
36 1994) supporting Jackson et al.'s (1987) work which proposes that firesetting can
37 facilitate escaping or changing difficult circumstances.
38

39
40 In studies without a comparison group Harmon et al. (1985) similarly noted that
41 anger and a cry for help were predominant motivators in women firesetters. Stewart
42 (1993) in line with the M-TTAF (Gannon, Ó Ciardha, Doley and Alleyne, 2012) noted
43 that some female prisoners had multiple motives for firesetting including revenge
44 (33%), attention seeking (20%), instrumental (20%), mental illness (10%), suicide
45 (8%) and pyromania traits (5%). Additional motives in Tennent et al.'s (1971) study
46 of female firesetter in-patients were conflict with authority and self-harm/destruction.
47 Cunningham et al. (2011) found that female in-patients reported firesetting alongside
48 distressing life experiences.
49

50
51 Gannon's (2010) review of research regarding characteristics, psychopathologies,
52 and treatment efforts with female arsonists noted that key features that differentiate
53 female from male arsonists were the prevalence of sexual abuse, depression,
54 psychosis, and attention seeking/cry for help motivations; and the absence of desire
55 to witness firefighting activities or display firefighting skills; of firesetting in pursuance
56 of crime concealment or profit; and of sexual fetishism associated with fire. These
57 findings have important implications for treating women firesetters.
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The treatment needs of women fire-setters

Gannon (2010) suggested that female firesetters would benefit from an eclectic programme of flexible treatment modules covering offence analysis, the relationship between childhood history and adult functioning styles (including coping skills, anger management and assertiveness, problem solving and general communication styles), specific interest in fire, and relapse prevention work. She also advocated work on the effects of victimization on their interpersonal functioning, self-esteem and coping; and work to develop supportive relationships. Long, Fitzgerald and Hollin (2015) recommended that interventions include a focus on fire interest and offence-related cognitions and be fully informed by a sophisticated functional analysis.

Development of fire-setting interventions for women

Gannon, Tyler, Barnoux and Pina (2012) noted that the only published descriptions of treatment for female firesetters concerned either tailored treatment for unusual cases or treatment for women in psychiatric facilities using CBT (e.g. Swaffer, Haggett, and Oxley, 2001; Taylor, Thorne, Robertson, and Avery, 2002; Taylor et al., 2006).

In November 2006, alongside Into the Mainstream (DH, 2002), a national service for women in high secure mental healthcare was established and women were treated separately from men. In 2007, the authors started developing arson treatment programmes specifically for these women and since then they have developed two types of programmes specifically for women, one delivered within a group setting (Arson Treatment Group Programme (ATGP)) and the other for individuals (Arson Treatment Individual Programme (ATIP)).

Within the NWS, these programmes have been developed based on the available research evidence and theories described above. A combined CAT and CBT approach has replaced an initial pure CBT approach (Beck, 2013) as described later. CAT brings together understandings from cognitive psychotherapies and from psychoanalytic approaches and focuses on understanding and changing patterns of problematic behaviours (Ryle and Kerr, 2002). In CAT there is a focus on the therapeutic relationship in order to provide a non-collusive relationship in terms of not replicating problematic patterns of relating to self and others. CBT is based on cognitive and behavioural principles. People's emotional reactions and behaviours are seen to be strongly influenced by their thoughts, beliefs and interpretations about themselves or the situations in which they find themselves (Westbrook, Kennerley and Kirk, 2011).

More recently, Gannon, Lockerbie, and Tyler (2013) implemented a 28 week Firesetting Intervention Programme for Mentally Disordered Offenders (FIP-MO) mostly within medium secure units and one high-secure hospital (HSH) providing services just for men. Gannon et al. (2015) delivered the same programme to both women and men. Their pilot run suggested that CBT had a significant impact on

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3 reducing problematic psychological factors associated with deliberate firesetting in
4 males. However, their study pertaining to females is incomplete and does not
5 include women within high secure mental healthcare. Such women pose grave risks
6 to others, and often also to themselves. Treatment is therefore delivered within the
7 highest levels of physical, procedural and relational security and these very high
8 risks require constant consideration and management.
9

10
11 This paper describes the implementation and evaluation of two group treatment
12 programmes and two individual treatment programmes and aims to increase our
13 understanding of firesetting treatment programmes specifically for women in secure
14 hospital settings. Key differences between these programmes and the FIP-MO were
15 the development of programmes specifically for women (versus a programme for use
16 with both male and females in FIP-MO), the provision of programmes for individuals
17 and groups (versus just groups in FIP-MO); the length of group therapy programmes
18 (17-18 months versus 28 weeks for FIP-MO) and individual modules (Shorter in FIP-
19 MO), the number of group treatment sessions delivered (61/66 versus 28 for FIP-
20 MO); the number of staff delivering group programmes (3-5 versus 2 for FIP-MO),
21 the strong psycho-therapeutic aspect to treatment with an emphasis on learning
22 through therapeutic relationships (not a feature of FIP-MO), the incorporation of
23 modules on trauma (from 2009) and self-esteem (FIP-MO does not have a trauma
24 module and self-esteem is part of the social competence module), and the
25 incorporation of additional work.
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29 **Research questions**

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31 The research questions were:

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34 What are patients and other stakeholders' opinions of arson treatment programmes
35 delivered?
36

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38 How can treatment programmes be responsive to patients' needs?
39

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41 What are the benefits and drawbacks of group versus individual treatments?
42

43 **Ethics**

44
45 The Research Management and Governance Department of the NHS Trust where
46 the evaluation occurred gave ethical approval for the evaluation.
47
48

49 **Method**

50 51 **Participants**

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54
55 Participants were twenty two women (mean age 33 years, range=21-47) detained
56 under the Mental Health Act within a HSH because of their dangerousness to others.
57 Most women (95%) were white British. All had histories of firesetting and 19 (86%)
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3 had arson/firesetting convictions. One participant failed to complete the first
4 programme she started but completed a second. Participants were referred to Arson
5 Treatment Programmes by their responsible clinician and assessed by two Arson
6 Treatment Team members using a structured questionnaire developed by the team,
7 which included assessment of participants' motivation to engage in arson treatment.
8 Some motivation to engage in arson treatment was required.
9

10
11 Most participants (73%) had undertaken some prior preparatory work to develop
12 their emotional regulation and coping skills (e.g. Dialectical Behaviour Therapy) and
13 some completed such work (28%) whilst attending Arson Treatment Programmes.
14

15
16 A control group was not included due to ethical issues of withholding treatment.
17 Also, the population of women within the NWS is a specific population due to their
18 presenting risks and selecting controls from a wider population would be challenging.
19

20 21 ***The Treatment Team***

22
23 The Arson Treatment Team was led by a Consultant Clinical Psychologist and
24 comprised of nursing, psychology, and social care staff. Most staff were registered
25 practitioners with extensive experience in forensic settings. To develop the team's
26 knowledge and skills regarding women's firesetting the team networked and
27 attended study days and conferences, training events including training by the fire
28 service, and fortnightly team reading seminars.
29

30
31 Three to five staff members delivered each group session depending on patient
32 numbers. Also, an additional ward staff member was outside the therapy room for
33 emergency situations.
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35 36 ***Development and components of Programmes***

37
38 Two Arson Treatment Group Programmes (ATGP1 and ATGP2) and two Arson
39 Treatment Individual Programmes (ATIP1 and ATIP2) were developed, delivered
40 and evaluated between 2007 and 2015. Table 1 illustrates programme components.
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45 Table 1: Components of Arson Treatment Programmes
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11 Programmes targeted treatment needs identified in the literature and in participants'
12 file reviews. Structured session plans guided the delivery of sessions and
13 participants completed work between sessions. Programmes were developed
14 alongside ongoing evaluation.
15

16 All modules incorporated introductions, and evaluation within the last session.
17 Additionally, Module 1 introduced participants to the overall programme and the final
18 module incorporated a whole programme evaluation.
19

20
21 The Dangerousness of Firesetting Module addressed the dangerousness and
22 possible consequences of firesetting, lifetime experiences of fire, and each person's
23 responsibility for their firesetting behaviours. In group programmes, fire service staff
24 contributed to an interactive session with participants on the dangerousness and
25 potential consequences of firesetting behaviours.
26

27 The coping and social skills module focussed on developing skills in communication
28 and assertiveness; problem solving and accessing support; managing stress, anxiety
29 and anger; and conflict resolution and negotiation.
30

31
32 In the module on trauma (not delivered in ATGP1) the meaning of, types of, and
33 impacts of trauma; potential links between trauma and firesetting; and coping with
34 trauma were explored.
35

36 The Self-Esteem and Self-Awareness module focussed on the meaning of,
37 understanding changes in, and improving self-esteem and self-awareness. Mask
38 work to consider how participants saw themselves and were seen by others, was
39 utilised to support women in becoming better observers of themselves, and their
40 interactions with others.
41

42
43 In the Relapse Prevention module participants considered possible commonalities
44 and patterns in their past firesetting, risk escalating and risk reducing factors, and
45 their current and future risks of firesetting. Arson signatures and crisis cards were
46 used to facilitate participants' recognition and management of their risks. In arson
47 signatures a traffic light system alerts participants to increasing risk and participants
48 consider how they can manage their risks and access support. Crisis cards contain
49 significant others' contact details for crisis situations. In group programmes this
50 module included a return visit by fire service personnel.
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53 ***Arson Treatment Group Programmes***

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56 Arson Treatment Group Programmes lasted eighteen months and consisted of a
57 weekly two and a half hour therapy group with a midway coffee break plus
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3 weekly/fortnightly individual sessions with a group facilitator to conduct functional
4 analyses of previous firesetting episodes, reinforce learning, develop a firesetting
5 formulation, and provide support.
6

7
8 Treatment groups were closed and 16-18 months to foster trust and safety within a
9 patient population that struggles to trust others (Compton Dickinson, 2006), and to
10 support the development of the therapeutic process and participants' skill acquisition.
11 Expectations around group participation were agreed to promote safety and
12 encourage individuals to own their contribution to sessions.
13

14 ***Arson Treatment Individual Programmes***

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17 Arson Treatment Individual Programmes were designed for patients who could not
18 access groups due to their exceptionally high risks to themselves and/or others.
19 Thirty two sessions were delivered over five modules. These programmes included
20 simple session plans and focussed on key topics. Programmes were designed to
21 increase preparedness to join a group programme later on pending participants' risks
22 reducing.
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25 ***Programme developments over time***

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28 Major developments over time included the introduction of a module on trauma in
29 2009; more experiential and diverse teaching methods; and greater patient
30 involvement, including in 2011, group programme graduates speaking to new
31 participants, and the introduction in 2012, of an end of programme presentation by
32 patients and facilitators to participants' clinical teams. The 2012 presentation was
33 filmed and educates professionals and new participants about programmes.
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36
37 Early on too, a combined CBT and CAT therapeutic orientation replaced a pure CBT
38 approach related to CAT's foci on creating and maintaining a safe and predictable
39 therapy space which facilitates participants' therapeutic engagement; and sharing
40 observations about occurrences within therapy which provides a vehicle for
41 considering events. Also, CAT's focus on how problematic patterns from people's
42 pasts can emerge within current relationships enables the consideration of links
43 between past and present within therapy and supervision. Further, CAT tools such
44 as CAT diagrams and goodbye letters assist facilitators and patients in considering,
45 and where appropriate, changing patterns of thinking, feeling and behaving. Finally,
46 CAT facilitates consideration of issues specific to the stages of therapy. For
47 example, the ending may evoke feelings linked to patients' previous losses.
48
49

50 ***Data collection***

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53 Information on patient attendances at group and individual sessions and patients
54 who did not complete programmes was recorded.
55

56
57 Participants completed rating scales and psychometric tests pre and post treatment.
58 Eleven pre and post measures were used to assess ATGP1 participants. These
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3 examined fire interest; reasons for firesetting and consequences; blame attribution;
4 perspective taking, empathic concern, fantasy and personal distress; problem
5 solving; aggression; anxiety; depression; impulsivity; social desirability; emotional
6 loneliness; and self-esteem. In some cases ranges rather than scores were saved
7 which means not all measures can be reported on. Those reported on are the
8 Blame Attribution Inventory (Gudjonsson, 1984); Fire Interest Rating Scale (Murphy
9 and Clare, 1996); Functional Assessment of Fire Starting (Unpublished);
10 Interpersonal Reactivity Index (Davis, 1980, 1983); Personal Reaction Inventory
11 (Unpublished); and the Emotional Loneliness Scale (Russell, Peplau, and Cutrona,
12 1980).
13

14
15 Measures used changed after ATGP1 related to patients' struggles to understand
16 some tests, difficulties administering numerous measures and researcher advice to
17 use fewer measures. From 2009 five core psychometric tests were utilised. The
18 Inventory of Altered Self Capacities (Briere, 2000) assesses difficulties in relating,
19 identity and affect regulation. The Social Problem-Solving Inventory Revised
20 (D'Zurilla, Nezu, and Maydeu-Olivares, 2002) assesses problem-solving abilities.
21 The Multidimensional Self Esteem inventory (O'Brien and Epstein, 1988) was initially
22 used but replaced with the more user friendly Rosenberg Self-Esteem Scale
23 (Rosenberg, 1965). The Coping Responses Inventory (Moos, 1993) assesses
24 coping strategies, and the Paulhus Deception Scales (Paulhus, 1998) identify
25 individuals who distort their responses.
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28
29 Questionnaire feedback from patients was obtained at the end of each module and
30 at the end of the programme overall. Within the End of Programme Feedback Form
31 participants rated the extent they agreed with 17 statements using a five-point Likert
32 scale (1 – strongly disagree and 5 – strongly agree). Examples included “The
33 content of group sessions was interesting” and “The group facilitators were sensitive
34 to participants' feelings”.
35

36 Finally, to assess the benefits and drawbacks of group versus individual treatments
37 information on this theme was collated from team supervision records.
38
39

40 41 **Data analysis**

42
43 Psychometric tests scores were entered into SPSS for programme completers. Due
44 to the small sample sizes, data was aggregated for participants in individual
45 programmes. Data was not aggregated for participants in group programmes
46 because of changes in psychometric measures after ATGP1.
47
48

49 Data for group and individual programmes is presented separately because of the
50 different nature of these programmes. Descriptive analysis of psychometric data
51 was conducted, with inferential statistics impossible because of small sample sizes.
52

53
54 Participants' comments on modular and end of programme feedback forms was
55 transcribed verbatim and collated. Team members coded and categorised this
56 qualitative data using a thematic approach (Braun and Clarke, 2006). In terms of
57 resultant themes the authors fully acknowledge the active role they as researchers
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3 played in identifying patterns/themes, selecting which were of interest and reporting
4 these to readers.
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6

7 **Results**

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10 The attendance and completion rates for the arson treatment programmes for groups
11 and individuals are presented in Tables 2 and 3 respectively. Table 2 shows that
12 only one out of fourteen patients (7%) decided to leave a group programme and
13 attendance rates were very high for programme completers.
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18 Table 2: Arson Treatment Group Programmes: Number of completers, reasons for
19 non-completion and attendance rates
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37 Table 3: Arson Treatment Individual Programmes: Number of completers, reasons
38 for non-completion and attendance rates
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53 Table 3 shows that across both individual programmes one third of participants did
54 not complete programmes because of mental health deterioration. Attendance rates
55 for completers were extremely high.
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3 ***Arson Treatment Group Programmes psychometric test results***
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5 In some cases ranges rather than scores were saved which means that not all
6 measures can be reported on for participants in ATGP1 in Table 4.
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8 Table 4: Psychometric scores for ATGP1 participants
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54 Post ATGP1 participants reported much less interest in fire, less use of fantasy, less
55 personal distress and less loneliness. Socially desirable responding and blame
56 attribution remained very similar pre and post treatment. Participants reported the
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3 important roles of social attention, depression and anger as motivators for fire setting
4 and post treatment recognised anxiety as an additional important factor.
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8 Table 5: Psychometric scores for ATGP2 participants
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For Peer Review

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3 Table 5 shows that ATGP2 participants showed improvements post treatment in all
4 areas of self-capacities, all areas of problem solving, all areas of emotional problems
5 and on self-liking and global self-esteem. Scores for impression management and
6 self- deceptive enhancement varied slightly but remained with the average range.
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10 ***Arson Treatment Individual Programmes psychometric test results***

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12 Table 6: Psychometric scores for ATIP1 and ATIP2 participants
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For Peer Review

For Peer Review

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Participants in ATIP1 and ATIP2 showed improvements in 10/11 self-capacities scales and all areas of emotional problems. Overall, there was little change in problem solving abilities. Caution is advised regarding the findings from the Fire Interest Rating Scale as one participant's fire interest increased and another's

1
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3 decreased. In terms of self-esteem ATIP1 participants reported a small improvement
4 in global self-esteem with biggest improvements in terms of competence and
5 lovability. ATIP2 participants demonstrated a big improvement in self-esteem, with
6 improvements in both self-competence and self-liking. Scores for impression
7 management changed slightly from the average to slightly above average range
8 whilst scores for self-deceptive enhancement remained in the average range.
9 Depression, anger and anxiety were the greatest motivators for firesetting. The
10 greatest perceived consequence of firesetting pre and post treatment was anxiety.
11
12

13 **Arson Treatment Programmes Questionnaire Feedback**

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17 Participants' questionnaire feedback was analysed to describe their mean scores on
18 the Feedback Form Likert scale items.
19

20 Participants' mean rating for ATGP1 across seventeen questions within a rating
21 scale (1 - strongly disagree and 5 – strongly agree) was 4.08/5. Their mean rating
22 for ATGP2 was 4.40/5. High ratings indicate favourable feedback.
23

24 Participants' mean rating for ATIP1 across seventeen questions was 4.88/5. Their
25 mean rating for ATIP2 was 4.37/5.
26

27
28 The remaining items on the Questionnaire Feedback forms were analysed
29 thematically. The emerging themes are presented separately for Group and
30 Individual Programmes.
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32 **Arson Treatment Group Programmes feedback themes**

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35 Five main themes emerged which crossed both groups.
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38 Good group, great benefits

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41 All parties within ATGP1 valued the respect commitment, and reliability shown by all.
42 Similarly, participants within ATGP2 liked working as a team and described the
43 group as "a good calm group" where "patients and facilitators have respect for each
44 other". The words "trusting", "trust", "considerate" and "care" were also used to
45 describe what people liked about the group. ATGP1 participants described receiving
46 "great benefits" including how the group programme helped with self-understanding:
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48

49 *"I've learnt to understand myself better even though it was very scary."*
50

51 Similarly ATGP2 participants emphasised how the programme had helped them to
52 build their skills, confidence and their awareness of themselves and others:
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54
55 *"The Arson Treatment Programme has helped me with confidence and my skills in*
56 *talking and communicating with others."*
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3 *"I've learnt coping skills and strategies to help me like keeping busy, getting support,*
4 *talking about my problems and saying when I don't understand things."*
5

6 *"I've built up my self- esteem, I'm stronger."*
7

8 ATGP2 participants also valued learning about the dangers and consequences of
9 firesetting and developing insight into their reasons for firesetting:
10

11 *"Knowing the consequences for myself and others are some of the most helpful*
12 *things."*
13

14
15 Interestingly, ATGP1 participants commented that positive things sometimes came
16 out of things they did not like:
17

18 *"Although I severely didn't like this part of the group [Self -Esteem and Self-*
19 *Awareness Module] it was probably the most beneficial part of the group for me."*
20

21
22 Finally, ATGP2 participants commented that the programme had "helped
23 immensely", they had "enjoyed it" despite their anxieties and it had brought "a lot of
24 hope for the future."
25

26 27 Changing attitudes to the group over time 28

29 ATGP1 participants reflected on their changing attitudes to the group over time as
30 illustrated here:
31

32
33 *"I never even thought I was an arsonist, I thought the group was going to be a waste*
34 *of time. If you're honest with yourself and others it can be tough and very painful but*
35 *in my experience this has been my turning point and it's been well worth it in the end.*
36

37
38 Similarly, ATGP2 participants commented on their "poor participation" initially and
39 this changing over time with developing trust in others and confidence in speaking
40 up.
41

42 43 44 Important role of the fire service 45

46 Input provided by fire service personnel had a big impact. An ATGP1 participant
47 appreciated the fire service "taking time to talk to us". An ATGP2 participant
48 commented:
49

50 *"I found his visit very interesting and helpful" and "I will always store in memory his*
51 *advice, support and care".*
52

53 54 55 Dislikes 56 57 58 59 60

1
2
3 Some ATGP1 participants disliked the day and times of the programme because of
4 clashes with other things. Subsequent programmes ran on a different day. ATGP1
5 facilitators did not like the return of homework not being tracked and felt the coping
6 and social skills module was too long. Consequently, a homework monitoring
7 system was established and the coping and social skills module was shortened.
8

9
10 Some participants in ATGP2 did not like the group check-ins and check-outs and
11 giving feedback at the end of group sessions. This may have related to feeling
12 exposed.
13

Suggested changes

14
15
16
17 All parties within ATGP1 suggested more experiential exercises and more hand-outs
18 to support teaching. Additionally, facilitators suggested the inclusion of a trauma
19 module and participants suggested that future participants would benefit from
20 hearing from participants who had completed the programme.
21

22
23 *“If there is any future groups, I think it would or could be useful for them to hear the*
24 *opinion of what we thought when we first started and what we think now we’ve*
25 *finished.”*
26

27 Consequently, all of these suggestions were actioned.
28

29
30 Some ATGP2 participants suggested greater consistency with facilitators being
31 present. This may have related to two ATGP2 facilitators experiencing unexpected
32 events and missing much of the final module.
33

New additions to group were well received

34
35
36
37 ATGP2 participants liked the diverse teaching methods and specifically named role
38 plays, newspaper stories and real life articles, poems, raps, games and art. The
39 newly introduced trauma module was also well received with comments such as “I
40 enjoyed this module, I learnt a lot about myself and my peers; “very helpful and
41 interesting”; and “upsetting at times but apart from that I found this module ok”. The
42 end of treatment presentation by participants and facilitators to participants’ clinical
43 teams was very successful as illustrated:
44

45
46 “The presentation was a success, I really enjoyed the experience.”
47
48

Arson Treatment Individual Programmes questionnaire feedback

49
50
51
52
53 Two main themes crossed both groups:
54

The Programme had meaning, value and learnt a lot

1
2
3 Participants in ATIP1 noted the overall importance of the programme.
4

5 *"It meant a lot to me, taught important things."*
6

7 *"I have learnt a lot ..."*
8

9 One participant said she had learnt to think before taking action:
10

11 *"They taught me is to think before actions."*
12

13
14 Participants in ATIP2 valued the "help and support" and "1-1 attention" related to
15 their struggles to "mix with others" and mental health issues. They also valued
16 activities such as drawing, card sorting, and CAT goodbye letters.
17

18 19 20 Different perspectives on work between sessions

21 Participants noted different perspectives on work between sessions. For example
22 this ATIP1 participant commented:
23

24 *"Some are interesting, some are hard, but I managed them."*
25

26
27 ATIP2 participants noted that the work between sessions helped keep them
28 focussed on the work as illustrated here:
29

30 *"Liked doing it, kept me thinking about the work I was doing in my session."*
31
32

33
34 Additionally two further themes emerged from ATIP2:
35

36 37 Sometimes hard and intense but pride in completion

38 ATIP2 participants said the programme at times was "hard", "quite intense" and "a
39 challenge", but noted many achievements and pride in completion as shown here:
40

41 *"I've learned to trust someone I didn't want to, I've learned to push myself to do
42 therapy even when I'm unwell, I've learned there are other ways and help than
43 setting fires, I've learned what help me to do therapy to be able to focus in the here
44 and now"*
45

46 *"I'm really really proud of myself. I never thought I would complete it or get this far"*
47
48

49 50 51 More visuals, less repetition with Arson Signature

52 In terms of changes one ATIP2 participant suggested using more visual materials
53 and making the arson signature less repetitive.
54
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Benefits and drawbacks of group versus individual treatments

The perceived benefits and drawbacks of group versus individual treatment were extracted from team supervision records and are outlined in Figure 1.

Figure 1: Facilitators' assessments of key advantages and disadvantages of group versus individual arson treatment

Intervention	Advantages	Disadvantages
Arson Treatment Group Programme	<p>Participants learn from and gain motivation and support from other participants.</p> <p>Facilitators gain experience from observing other facilitators.</p> <p>Longer programme facilitates consolidation of learning and greater topic coverage</p> <p>Participants can 'hide' within this setting.</p>	Pace may not suit everyone.
Arson Treatment Individual Programme	<p>Can adapt programme to meet individuals' specific needs.</p> <p>Easier to track participants' focus.</p>	No sharing with or motivation or support from peers.

Discussion

The study in context

This study is the first study of a mixed treatment approach combining CAT and CBT developed specifically for treating women firesetters. This approach has been highly successful, enabling a focus on understanding and working positively with therapeutic processes, whilst also facilitating the integration of CAT tools and structured CBT activities. For example, CAT's focus on noticing and working with processes within therapeutic relationships assisted the authors in working with issues as they arose in therapy. For example, at the beginning of ATGP2 the

1
2
3 facilitators noticed that two participants were positioning their chairs away from the
4 other group members. Discussion around this led to these participants
5 acknowledging their fears of being in the group and other group members offering
6 them support. On another occasion within a group session facilitators noticed how
7 participants were struggling to voice their opinions. Following discussion, a
8 "Feedback Box" was implemented at the end of every group session, to support
9 participants in practising and developing skills in, addressing issues and giving
10 constructive feedback. CAT Goodbye letters were also incorporated at the end of
11 treatment programmes to enable reflection on participants' journeys through
12 treatment including gains and any disappointments; to acknowledge feelings related
13 to the ending; and to end well. This is important as therapy endings with HSH
14 patients require careful management (Compton Dickinson, 2006).
15
16

17
18 This study has also, as a first, involved the development of two types of treatment,
19 one delivered within a group context, and one for women being treated individually.
20 Whilst all patients within high security pose grave risks towards others, and
21 sometimes also to themselves, patients who received treatment individually posed
22 exceptionally high risks and treatment delivery was impacted by this. For example,
23 some of this work was conducted through a hatch (for segregated patients) and
24 when patients were seen in therapy rooms there were often additional security
25 measures such as an observing nurse within the room plus physical adjustments
26 such as a special seat to prevent the patient exiting the seat quickly. Facilitating
27 patients in staying in treatment, whilst simultaneously managing these risks, is
28 considered by the authors to have been a huge achievement, in and of itself.
29
30

31 The incorporation of a module on trauma also differentiates this study from previous
32 evaluations. This assists women in considering possible links between traumas
33 experienced and firesetting behaviours and gives them ideas on coping in the
34 aftermath of trauma. By recognizing these links, new areas of treatment need can be
35 identified and considered, and participants' relapse prevention plans can be updated.
36 Within the module on trauma much sensitivity has been required to assist
37 participants to authentically and fully participate whilst also supporting them to keep
38 focussed on the module aims. Participants have required support to maintain
39 appropriate boundaries around discussion of traumas experienced in order to
40 prevent themselves, and in group interventions, other group participants, becoming
41 overwhelmed and very distressed. The incorporation of CAT with its emphasis on
42 working positively with therapeutic processes has facilitated programme facilitators in
43 grappling with and managing such issues within treatment.
44
45
46

Patients and other stakeholders' opinions of arson treatment programmes

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48
49 The overall evaluation has evidenced very positive feedback and high levels of
50 satisfaction with arson treatment group and individual programmes delivered.
51 Attendance rates for programme completers were extremely high across all
52 programmes. This is a very significant achievement as women in high secure
53 mental healthcare are some of the most complex and challenging patients to engage
54 within the UK. Further, results from pre and post psychometric tests demonstrated
55 improvements in self-capacities, overall problem solving, emotional problems and
56 self-esteem. These gains are important as these areas have been identified as
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1
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3 significant areas for women firesetters to address (Gannon, 2010). Notably, the
4 extent of change was mainly greater for group participants than individual
5 participants. This is perhaps unsurprising given that group programmes were longer
6 than individual programmes, although this might also have reflected the severity of
7 problems experienced by participants who received treatment individually.
8

9
10 In interpreting the findings it is important to note that they are based on self- report
11 although results from the PDS do not suggest invalid scores or areas of concern. In
12 future however, it is recommended that clinicians also complete some pre and post
13 treatment ratings of participants, including risk ratings, to enhance the evaluation.
14 Also, future programmes could usefully incorporate pre and post measures of anger,
15 assertiveness, ability to access support, fire interest and offence related cognitions.
16

17
18 In terms of motivators for firesetting social attention, depression, anger and anxiety
19 were the greatest motivators for firesetting echoing aspects of other studies (Harmon
20 et al., 1985; Stewart, 1993; and Tennent et al., 1981), Jackson et al.'s (1987) work
21 suggesting that a key antecedent for firesetting is dissatisfaction with life and self
22 and Gannon et al.'s (2012) M-TTAF.
23

24 25 ***How to make treatment programmes responsive to patients' needs*** 26

27
28 Gannon (2010) noted the need to provide detail on "What Works" in treating female
29 firesetters. Over time, the authors' clinical experiences and the evaluation data have
30 demonstrated that making treatment programmes responsive to patient needs
31 requires a whole system approach with attention to both treatment delivery itself and
32 the system around this. Within the treatment setting implementing changes based
33 on feedback and evaluation is key, as demonstrated within the evaluation data.
34 Being responsive to patients' needs from the outset has also been vital, related to
35 patients' wariness towards others. The authors' clinical experiences and the
36 evaluation data demonstrate that initial engagement and the development of trust
37 can be fostered by clear and consistent boundaries pertaining to therapy provision
38 and behaviour within therapy. Examples include the importance of starting and
39 finishing on time and having empty seats for absent group members. Programme
40 graduates also provide positive role models for good engagement with the group
41 process and the evaluation suggests developing programme graduates for individual
42 programmes. Once engaged on-going participation can be supported by close
43 attention to boundaries and therapeutic processes, pacing the therapy (e.g.
44 introducing firesetting through talking about other firesetters), helping patients
45 establish and maintain realistic treatment goals, interactive group exercises and
46 varied teaching methods; celebrating patients' achievements and by remaining
47 flexible and responsive to patients' needs.
48
49

50
51 Making treatment programmes responsive to patient needs has also included
52 involving others. Firstly, all treatments have been guided by a Firesetting Treatment
53 Strategy developed in consultation with stakeholders. Secondly, fire service
54 personnel have contributed to all group programmes and the success of this
55 suggests they additionally input into individual programmes. Thirdly, learning from
56 other hospital treatment programmes has been imported such as very successful
57 end of programme presentations to clinical teams. Fourthly, the Arson Treatment
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3 Team has continually developed through innovation, networking, training, and
4 presentation including the implementation of a quarterly newsletter and
5 presentations to stakeholders such as at international conferences.
6

7
8 Whilst individual programmes were initially introduced to support later attendance at
9 a group programme some participants who completed an individual programme
10 progressed to lesser security without completing a group programme. The ATIP
11 has therefore become an important treatment in its own right as supported by the
12 positive evaluation data. The evaluation suggests a longer individual programme
13 with more emphasis on problem solving and coping skills, maximising the use of
14 visual materials, recruiting graduates of individual programmes to assist new patients
15 in engaging with individual programmes and making work between sessions even
16 simpler.
17

18 19 20 21 ***The benefits and drawbacks of group versus individual treatments***

22
23 Group and individual treatments have been noted to have specific advantages and
24 disadvantages. Whilst group interventions offer greater opportunities for learning
25 with peers, in settings where risks towards self and others are exceptionally high the
26 authors strongly advocate the provision of both group and individual treatment to
27 enable women to access treatment and progress along their treatment pathways.
28

29 30 31 ***Limitations and key areas for future development***

32
33 The evaluation is limited by the small number of participants who were involved and
34 the lack of follow-up data to monitor recidivism. Future research could usefully
35 incorporate follow-up of participants to track for possible re-offending.
36 Understanding factors that predict recidivism in women firesetters is necessary so
37 that these can be targeted through treatment. Also, offence paralleling behaviours in
38 firesetters and the relationship between self-injury and firesetting behaviours require
39 further investigation. The authors' clinical experiences suggest that some women
40 engage in firesetting when attempts to elicit help through self-injury have not had the
41 desired outcomes. Another important area for future development will be greater
42 networking with Professor Theresa Gannon following her evaluation of the FIP-MO.
43
44

45 46 **Conclusion**

47
48 This study contributes to research on treating women firesetters, by developing and
49 evaluating both group and individual treatment programmes specifically for women
50 firesetters, and by incorporating a mixed CAT and CBT therapeutic approach and a
51 module on trauma. This study evidenced high levels of engagement with group and
52 individual arson treatment programmes, several post treatment psychometric gains,
53 and very positive qualitative feedback and ratings. This study evidenced the
54 importance of a whole system approach to treating women firesetters and the
55 importance of all stakeholders including participants as powerful motivators for other
56 participants and fire service personnel as important educators regarding fire related
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1
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3 matters. The study validated the importance of the ATIP for individuals who could
4 not access group programmes.
5
6
7

8 **Implications for Practice**

9
10
11 In offering treatment programmes to women firesetters the authors suggest the
12 following:
13

- 14 ▪ Ensure organisational support and develop a Firesetting Treatment Strategy
15 with stakeholders.
- 16
17 ▪ Utilise standards for report writing, therapeutic work and supervision.
- 18
19 ▪ Recruit a diverse team who embrace reflection and can commit to seeing a
20 programme through.
- 21
22 ▪ Ensure a safe, consistent, and confidential therapy space which fosters the
23 building of therapeutic relationships.
- 24
25 ▪ Incorporate a therapeutic model that facilitates the exploration of therapeutic
26 processes including how participants' difficulties and specific treatment needs
27 pertaining to firesetting manifest themselves within therapeutic relationships.
28 CAT is recommended.
- 29
30 ▪ Give participants information about the treatment programme and individual
31 modules and advance notice of breaks, changes, and cancellations.
- 32
33 ▪ Keep learning simple but varied to ensure patients' comprehension and
34 incorporate session summaries within handouts.
- 35
36 ▪ Invite your local fire service to input into treatment programmes.
- 37
38 ▪ Celebrate successes (e.g. completion certificates and newsletter features).
- 39
40 ▪ Incorporate patients and professionals' assessments of firesetting risks.
- 41
42 ▪ Maximise service user involvement and experiential learning.
- 43
44 ▪ Utilise pre and post measures targeting key areas for change.
- 45
46
47
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For Peer Review

Table 1: Components of Arson Treatment Programmes

Programme	No. of patients completing	Years delivered	Module name and number of sessions per module				
			1.The Dangerousness of Firesetting	2: Coping and Social Skills	3: Trauma	4: Self-esteem and Self-Awareness	5: Relapse Prevention
Group 1 (ATGP1)	4	2007-2008	11	28	Not included	9	13
Group 2 (ATGP2)	5	2011-2012	13	20	10	10	13
Individual 1 (ATIP1)	2	2009-2010	7	6	6	6	7
Individual 2 (ATIP2)	4	2013-2015	7	6	6	6	7

Table 2: Arson Treatment Group Programmes: Number of completers, reasons for non-completion and attendance rates

Programme	Number of completers	Reasons for non-completion	Attendance rates of completers
ATGP1	4/6 (67%)	Early drop-out (1) Patient died (1)	95%
ATGP2	5/8 (63%)	Transferred to lesser security (2) Transferred to prison (1)	93%

Table 3: Arson Treatment Individual Programmes: Number of completers, reasons for non-completion and attendance rates

Programme	Number of completers	Reasons for non-completion	Attendance rates of completers
ATIP1	2/4 (50%)	Deterioration in mental health (2)	100%
ATIP2	4/5 (80%)	Deterioration in mental health (1)	99%

Table 4: Psychometric scores for ATGP1 participants

Scale and sub-scale	Pre-treatment			Post-treatment		
	N	Mean	SD	N	Mean	SD
Blame Attribution Inventory						
External Attribution	4	4.00	2.45	4	4.25	5.32
Mental Element Attribution	4	6.50	2.65	4	6.00	2.16
Guilt Feeling Attribution	4	11.25	3.30	4	10.50	6.14
Fire Interest Rating Scale	4	55.00	11.75	4	34.50	14.53
Functional Assessment of Fire: starting						
Self-Stimulation	4	1.25	1.03	4	1.25	1.33
Anxiety	4	1.50	1.73	4	3.00	0.82
Social Attention	4	3.50	1.00	4	2.75	1.89
Peer Favour	4	0.00	0.00	4	0.75	1.50
Auditory Hallucination	4	0.00	0.00	4	0.00	0.00
Depression	4	2.25	1.26	4	3.25	0.96
Anger	4	2.50	1.00	4	3.50	0.58
Demand, Escape and Avoidance	4	0.50	0.58	4	1.00	2.00
Functional Assessment of Fire: consequences						
Self-Stimulation	4	1.75	1.71	4	1.50	1.91
Anxiety	4	2.50	1.00	4	2.50	0.58
Social Attention	4	2.50	1.73	4	3.00	2.00
Peer Favour	4	0.00	0.00	4	0.25	0.50
Auditory Hallucination	4	0.00	0.00	4	0.00	0.00
Depression	4	1.75	1.71	4	1.25	0.96
Anger	4	2.50	1.91	4	2.25	1.29
Demand, Escape and Avoidance	4	0.75	0.96	4	1.00	2.00
Interpersonal Reactivity Index						
Perspective Taking	4	13.75	7.72	4	14.50	8.54
Empathic Concern	4	20.75	4.27	4	18.50	6.45
Fantasy	4	14.25	7.89	4	9.25	4.99
Personal Distress	4	21.50	4.80	4	18.25	4.99
Personal Reaction Inventory	4	55.25	9.18	4	56.25	7.37
Emotional Loneliness Scale	4	51.75	8.26	4	45.0	7.75

Table 5: Psychometric scores for ATGP2 participants

Scale and sub-scale	Pre-treatment			Post-treatment		
	N	Mean	SD	N	Mean	SD
Inventory of Altered Self-Capacities						
Interpersonal Conflicts	4	81.50	6.76	4	79.00	13.93
Idealisation Disillusionment	4	76.00	10.86	4	71.00	19.71
Abandonment Concerns	4	90.50	5.80	4	70.00	11.22
Identity Impairments	4	88.25	10.21	4	72.00	12.83
Identity Self-Awareness	4	87.75	6.40	4	72.50	12.71
Identity Impairment-Diffusion	4	86.25	16.07	4	69.50	15.84
Susceptibility to Influence	4	85.50	12.29	4	67.25	17.23
Affect Dysregulation	4	91.00	8.16	4	79.50	12.29
Affect Skills Deficits	4	85.00	6.93	4	72.25	12.92
Affect Instability	4	91.50	8.96	4	89.25	11.24
Tension Reduction Activities	4	79.00	17.80	4	66.00	11.69
The Social Problem Inventory Revised short version						
Positive Problem Orientation	4	89.00	9.80	4	93.50	10.47
Negative Problem Orientation	4	105.25	7.41	4	98.75	14.01
Rational Problem Solving	4	98.00	6.93	4	102.00	13.66
Impulsivity	4	105.00	17.22	4	100.50	12.69
Avoidance Style	4	104.00	9.38	4	101.25	12.61
Total	4	90.25	6.29	4	95.75	7.14
Coping Responses Inventory						
Logical Analysis	4	47.00	9.13	3	40.00	6.58
Positive Reappraisal	4	53.50	3.32	3	51.67	1.15
Seeking Guidance	4	53.00	7.61	3	46.00	11.53
Problem Solving	4	51.50	9.11	3	48.67	7.09
Cognitive Avoidance	4	52.00	6.06	3	52.67	8.08
Acceptance and Resignation	4	47.00	5.77	3	47.67	15.95
Seeking Alternative Rewards	4	56.00	9.38	3	60.33	10.97
Emotional Discharge	4	64.50	15.20	3	68.00	3.46
Emotional Problems Scale						
Thought/Behaviour Disorder	4	54.00	13.37	4	49.00	9.06
Impulse Control	4	59.50	15.20	4	42.50	4.73
Anxiety	4	59.75	13.57	4	48.75	6.02
Depression	4	58.00	12.52	4	49.75	6.80
Low Self-Esteem	4	60.00	12.96	4	58.50	8.54
Total Pathology	4	58.75	14.22	4	47.25	7.41
Rosenberg Self Esteem Scale						
Self-Competence	4	8.50	2.65	4	7.75	3.10
Self-Liking	4	4.75	1.89	4	7.25	4.19
Global Self-Esteem	4	13.25	3.77	4	15.00	7.16
Paulhaus Deception Scale GP2						
Impression Management	4	51.00	5.23	4	48.25	5.32
Self-Deceptive Enhancement	4	51.25	9.74	4	53.00	10.10

Table 6: Psychometric scores for ATIP1 and ATIP2 participants

Scale and sub-scale	Pre-treatment			Post-treatment		
	N	Mean	SD	N	Mean	SD
Inventory of Altered Self-Capacities						
Interpersonal Conflicts	6	89.00	11.06	6	84.00	14.23
Idealisation Disillusionment	6	79.00	15.67	6	79.17	14.58
Abandonment Concerns	6	90.67	9.33	6	87.33	18.27
Identity Impairments	6	88.50	10.46	6	82.17	14.91
Identity Self-Awareness	6	91.00	10.47	6	80.33	18.85
Identity Impairment-Diffusion	6	82.50	17.65	6	80.17	10.70
Susceptibility to Influence	6	89.00	14.99	6	80.50	18.78
Affect Dysregulation	6	96.83	5.67	6	86.17	13.64
Affect Skills Deficits	6	94.00	5.87	6	84.50	17.88
Affect Instability	6	95.67	7.81	6	85.17	14.05
Tension Reduction Activities	6	95.17	9.60	6	77.83	18.37
Social Problem Inventory Revised						
Positive Problem Orientation	5	77.80	27.75	5	92.00	18.44
Negative Problem Orientation	5	100.40	31.88	5	126.20	10.80
Rational Problem Solving	5	78.80	22.58	5	91.80	10.73
Impulsivity	5	102.60	33.98	5	117.80	9.73
Avoidance style	5	104.80	28.58	5	116.00	16.73
Total	5	77.20	9.73	5	79.60	7.47
Coping Responses Inventory						
Logical Analysis	3	40.00	1.73	3	49.33	11.01
Positive Reappraisal	3	50.33	3.05	3	54.67	6.66
Seeking Guidance	3	47.67	6.03	3	45.67	5.77
Problem Solving	3	48.67	1.15	3	52.33	7.50
Cognitive Avoidance	3	56.67	11.59	3	69.33	6.43
Acceptance and Resignation	3	58.00	8.54	3	55.67	3.79
Seeking Alternative Rewards	3	63.00	3.61	3	59.00	5.57
Emotional Discharge	3	72.67	8.74	3	73.67	7.09
Emotional Problems Scale						
Thought/Behaviour Disorder	5	58.20	11.86	5	52.20	9.96
Impulse Control	5	61.40	5.08	5	57.00	8.89
Anxiety	5	60.20	7.92	5	58.80	10.01
Depression	5	67.00	8.83	5	59.80	12.19
Low Self-Esteem	5	61.60	9.45	5	61.40	9.94
Total Pathology	6	65.00	9.72	6	60.00	10.72
Fire Interest Rating Scale (ATIP1 only)						
2	28.00	1.41	2	44.50	21.92	
Functional Assessment of Fire: starting						
Self-Stimulation	6	1.33	1.51	6	1.00	1.26
Anxiety	6	2.33	1.86	6	2.50	1.91
Social Attention	6	1.50	1.34	6	2.00	1.55
Peer Favour	6	0.67	1.63	6	0.00	0.00
Auditory Hallucination	6	1.00	1.10	6	1.00	1.26
Depression	6	3.50	0.84	6	3.00	1.26
Anger	6	2.83	0.98	6	2.33	1.36
Demand, Escape and Avoidance	6	1.17	1.33	6	1.17	0.98

Functional Assessment of Fire: Consequences						
Self-Stimulation	6	0.50	0.84	6	0.67	0.82
Anxiety	6	2.33	1.97	6	1.50	1.64
Social Attention	6	1.17	1.60	6	1.33	2.07
Peer Favour	6	0.67	1.63	6	0.67	1.63
Auditory Hallucination	6	0.67	1.21	6	0.50	0.84
Depression	6	1.40	1.67	6	0.83	1.33
Anger	6	1.17	1.33	6	0.67	1.03
Demand, Escape and Avoidance	6	1.33	1.21	6	1.00	1.10
Multidimensional Self-Esteem Inventory (ATIP1 only)						
Global Self-Esteem	2	47.50	7.78	2	50.00	8.48
Competence	2	43.00	0.00	2	57.50	2.12
Lovability	2	32.00	0.00	2	44.00	5.66
Likability	2	46.00	19.80	2	45.00	24.04
Self-Control	2	44.00	5.66	2	53.00	5.66
Personal Power	2	46.50	0.71	2	50.00	0.00
Moral Self-Approval	2	34.00	0.00	2	38.00	0.00
Body Appearance	2	48.00	7.07	2	46.00	9.90
Body Functioning	2	43.50	2.12	2	49.50	6.36
Identity Integration	2	44.00	1.41	2	44.50	0.71
Defensive Self-Enhancement	2	43.50	6.36	2	58.50	2.12
Rosenberg Self Esteem Scale (ATIP2 only)						
Self-Competence	4	6.00	2.58	4	8.50	1.73
Self-Liking	4	2.25	2.22	4	5.75	3.30
Global Self-Esteem	4	8.25	4.65	4	14.25	4.99
Paulhus Deception Scales						
Impression Management	6	55.50	8.09	5	59.00	10.27
Self-Deceptive Enhancement	6	50.67	7.92	5	54.60	9.07

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