UNDERSTANDING YOUR DIAGNOSIS

Pyromania

Also called Pyromania

Setting a fire releases a pressure nothing else touches. It is rare, it is treatable, and it is dangerous to sit on.

HOW COMMON	OFTEN STARTS	TREATABLE	YOU ARE NOT ALONE
Rare - under 1 in 100 adults	**Teens or the early twenties**	**Yes - therapy is the mainstay**	**Others have this and got help**

What this is

- Tension builds, the fire lets it go, and relief follows. The fire is not for money, revenge, or covering anything up.
- Fire pulls at you: watching it, reading about it, being near it. That pull is part of the condition itself.
- Most people who set fires do not have this. It is named only when there is no gain and no grudge behind the act.
- This responds to treatment. It is also the urge condition where the harm can be enormous, so it needs handling now.

What it can look and feel like

- Pressure builds beforehand, and the moment the fire catches, that pressure finally lets go.
- It has happened more than once, alone, and you know exactly when the last one was without having to think.
- You collect lighters or matches, or you find yourself watching fire videos far longer than you meant to.
- You go to fires, turn up early, hang around fire stations, or have called in an alarm for a fire that was not there.
- Excitement or relief comes from setting it, from watching it burn, or from standing in the aftermath.
- Afterward there is fear and shame, and the near-misses replay: what could have been inside that building.
- It picks up when you feel powerless, rejected, or bored, and especially when you have been drinking.

What is happening in your brain and body

- Serotonin, a brain chemical that helps brake impulses, appears to run low in people with impulsive fire setting.
- The same reward circuits involved in gambling release dopamine, a reward chemical, around the arousal and the relief.
- The front of the brain, which plans ahead and stops an action, often works less well, including for attention.
- Childhood head injuries, seizures, and learning problems all turn up more often in people who set fires repeatedly.
- Alcohol thins the brakes further, which is why being intoxicated is the most common thing right before an episode.

What can make it more likely

- The relief afterward is what keeps it going. Your brain learned that a fire reliably ends an unbearable feeling.
- Many people describe feeling powerless. A fire creates an enormous, immediate effect that nothing else in their life does.
- When anger and distress cannot be put into words, fire ends up saying it instead of the words you never found.
- Easy access to lighters and long unsupervised hours in childhood shape the pattern long before anyone names it.

What to expect

- This comes in episodes and can run for years, but it does respond to treatment aimed squarely at the urge.
- Cutting alcohol and drug use by itself lowers the risk a lot, because intoxication is the most common trigger.
- Fire setting is a crime, and your clinician may have to act if someone is in danger. Say it anyway - hiding it is worse.
- Progress is measured in fire-free time. Every stretch that gets longer than the last one is real, countable progress.

What helps

Treatment works. Most people get better.

Talking therapies

- **Cognitive behavioral therapy** is the main treatment, mapping the chain from tension to urge to fire to relief.
- You work out other ways to get relief and excitement that do not risk a life, then practice them under real pressure.
- Relapse prevention names your high-risk states - drinking, rejection, boredom - and rehearses what you do instead.
- **Family therapy** helps teenagers, covering supervision, conflict at home, and access to lighters and fuel.
- Fire safety education alongside therapy works better than either one alone, especially for children and teenagers.

Medicines

- No medicine is approved for this. **SSRIs** such as fluoxetine or sertraline are the ones most often tried first.
- These act on serotonin, a brain chemical that helps brake impulses. Your prescriber works out the dose with you.
- **Topiramate**, lithium, and **naltrexone** are sometimes tried, based on results in other urge-driven conditions.
- Treating alcohol or drug use is the highest-value step of all, since being intoxicated is the usual trigger.
- **Benzodiazepines** loosen the brakes and can make impulsive acts more likely, so they are best avoided here.

Everyday things that help

- Get lighters, matches, gasoline, and other fuels out of your space, and let someone else hold anything you truly need.
- Cut back on alcohol first. If stopping is hard, treat that as its own condition and get real help with it.
- Have a plan for the moment an urge hits: call someone, leave, walk, cold water. Decide it now, not in the moment.
- Fill the empty hours. Boredom and being alone are where the urge grows, and structure genuinely protects you.
- Tell your treatment team about a close call. Being honest about near-misses keeps you far safer than hiding them.

Get help right away if

- If you are thinking about ending your life, call or text **988** right now.
- If you are close to setting a fire, call **988** or go to an emergency room.
- Call 911 for any fire that is burning. Getting people out comes first.

Questions to ask your care team

- *What do you have to report to others, and what stays between us?*
- *Which therapy for urges do you offer, and how soon can I start?*
- *Would a medicine help me, and which one would you start with?*
- *How do I make my home safer while we get treatment going?*

Where this information comes from

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NOTE

Sources are listed in APA 7th edition style. This handout is general health information, not medical advice, and it does not replace talking with your own doctor, therapist, or prescriber. Medicine choices and doses are decided with your prescriber. If you are in danger or thinking about hurting yourself, call or text 988 in the United States, or go to your nearest emergency room.