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Learning Disabilities & Serious Crime: Murder

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Abstract

Disruptive behaviour disorders have been suggested to be a focus of attention in learning disability psychiatry (Read, S, *Disruptive Behaviour Disorders*, Wiley, 2007). They comprise a grouping of conduct and personality disorders which emphasises the similarities between the various component diagnoses of:

Oppositional Defiant Disorder
Conduct Disorder
Anti-social Personality Disorder
Intermittent Explosive Disorder (DSMIVR, 2000) (or Emotionally Unstable Personality Disorder, Explosive Type (WHO, 2002)

Similarities include irritability, explosive type aggression, high levels of arousal, over-activity, and stereotyped behaviour.

What this review of murder and learning disability intends to do is to examine the associated psychiatric disorders including personality and conduct disorders of those who commit such crimes. It is the authors' intention that this paper will be one of three reviews; the second and third papers examining arson and learning disability, and sexual offences and learning disability respectively.

Learning disability itself and also mental illness have both been implicated in the past as causative factors in the production of homicide. This review aims to examine these factors alongside those of personality and conduct disorders in the inception of such an anti-social act.

People with a learning disability are involved in sexual offences, arson and homicide. If these crimes are arranged in a hierarchy of gravity – from sexual offences at the lower end of the hierarchy, through arson to homicide at the upper end, it can be postulated that as the seriousness of the crime increases, so the disproportionate contribution to it by learning disabled people dwindles.

Wherein lies those associations that remain?

The answer lies in the association of learning disability with disruptive behavioural disorders, that is psychiatric disorders of conduct and personality. These seem to be the essential intermediary factors which provide for the association of learning disability with murder.

That mental illness plays only a minor role is supported by Whitaker and Read (2007) who found, in an extensive literature review, very little evidence to suggest that learning disabled people experienced increased prevalence of mental illness.

To suffer a disruptive behaviour disorder may be collateral consequence of arrested or incomplete development of the brain which is characteristic of

learning disability. However, it may also be a consequence of aberrant learning and other environmental and social factors influencing childhood development.

This review paper unpicks these difficulties in interpretation of the evidence surrounding learning disability and murder.

Key Words: Disruptive Behaviour Disorders, Learning Disability, Serious Crime, mental states, environmental factors.

Introduction

In Western society, the deliberate killing of one individual by another is one of the greatest taboos, as it is essentially detrimental to the survival of society. Humans are gregarious in nature and rely on one another to remain physically and emotionally healthy. To intentionally end another person's life is a difficult act for most people to understand, much less actually commit. Such violent and destructive behaviour is not condoned by society, and the laws and subsequent punishments (judicial sentences, incarceration and/or detention under the mental health act) emphasise this.

Because murder is such an extreme act to commit, finding reason enough to justify it is quite a challenge. Deciding the level of culpability is also difficult – the gravity of the act needs to be reflected in the consequences. However, are there cases of murder where the offender cannot be held entirely to blame for their actions? If this is the case then surely the punishment should not be as great as that of someone who is held completely responsible for such antisocial behaviour.

This paper will focus on how opinions have changed over the role learning disability plays with regards to murder. Since the middle of the 20th century, murder suspects have received psychiatric assessment in order to determine their mental state. The diagnosis that an individual receives could have a direct impact on their subsequent punishment and/or treatment. Certain diagnoses could mean the difference between life and death for someone accused of murder.

In America, if an individual is diagnosed as being below normal intelligence they will not receive the death penalty if convicted. Since 2001, the Supreme Court has determined that it is unconstitutional to execute mentally retarded people (i.e. individuals with an IQ lower than 70). This makes the diagnoses of murderers more important than ever, as a borderline intelligence diagnosis could determine whether another individual's life also comes to an end.

For the remaining Western society countries, where capital punishment is no longer part of the judicial system, the diagnosis of any learning disability or mental disorder is again, extremely important. A suspect's official diagnosis still determines their level of responsibility. An individual's diagnosis again impacts on the form of their incarceration (i.e. if they are to be sent to a prison or a hospital), on the length of their sentence, or on any medical treatment they may need to receive.

Since the 1950s, numerous studies have been conducted on murderers in order to establish their motivation and their mental state. Contrary to

constant media coverage, murder is not a common occurrence, so finding a large sample of subjects is difficult. A large sample is necessary to validate any general conclusions that may be drawn from the data collected.

In order to obtain an adequately sized sample group, researchers must look to institutions where individuals have been found guilty of the crime. Such sources include hospitals, prisons, and juvenile detention centres. The presence of learning disability may be misrepresented because of the source of the studies' sample. One reason for this might be that only murderers who have been caught, can be studied. The more intelligent perpetrators who have managed to avoid detection, capture or at the very least prosecution, cannot form part of the study. This could affect average IQ level of the murderers, making it appear lower than it may be in reality. The number of intellectually disabled murderers could be disproportionately large when compared to the overall number of convicted murderers, as their disability meant they were more likely to get caught, and more likely to be successfully convicted by the judicial system.

Mental States

The following studies focus on the mental state of murderers, as well as any external factors. Several studies conducted over the past decades have looked into the backgrounds of murderers and how this may have placed them at greater risk of committing murder. Their findings and subsequent theories have done much to aid our comprehension of such destructive behaviour, but caution needs to be applied when considering any general conclusions made based on the data from these studies. The methods used, accuracy of diagnoses, and clarification of definitive terms are, in some cases, misleading. This can lead to misrepresentation of certain groups (namely the intellectually disabled).

Wagner and Klein (1977) compared 12 convicted murderers to 12 'interpersonal attackers' and found support for the hypothesis that subpopulations may exist within murderers, with a possible relationship between low IQ and irrational behaviour. They report that this is due to the fact that individuals with low cognitive ability may have difficulty assessing reality due to organic brain dysfunction.

In support of Wagner and Klein's findings, Blake et al's 1995 study of 31 males awaiting trial/sentencing/appeal on the charge of murder, found five of those subjects had 'mental retardation' (four of which had borderline mental retardation [IQ 70-80]). Blake et al reported a large percentage (97%) of neurological findings consistent with brain dysfunction.

However, a study conducted by Inada et al (1995) looking at 1361 cases referred for psychiatric diagnosis in Tokyo, found a homicide rate of 12.5% among the 96 persons diagnosed with learning disability. This was not a statistically significant rate in comparison with other offences or to other psychiatric diagnoses. Further support for these findings come from a study conducted by Eronen et al (1996). Based on 693 Finnish murderers, they found that learning disability did not increase the risk of homicide in men. They did find, however, that there may be a slight increase in the risk for women, but weren't able to confirm this statistically.

Tiihonen et al (1993) studied the prevalence of mental disorders and intellectual deficiency among all subjects who had committed homicide in Finland from June 1990 to May 1991. There were 141 homicides in total, committed by 129 males and 11 females. For 98/129 males, five were diagnosed as schizophrenic, eight had major affective disorder, three had severe cognitive impairment, and all had personality disorder.

For 9/11 females, one was diagnosed as schizophrenic, one had severe cognitive impairment, and all had personality disorder. For the females, the corresponding figures were remarkably higher, but the small number of subjects made it difficult to calculate the increased risk reliably. With reference to the above study by Eronen et al, Tiihonen et al theorised that there was a subgroup of women who were more likely to commit acts of extreme violence, but that it was not possible to identify an association with any specific diagnosis.

The most important findings were the prevailing presence of mental illness, personality disorder and alcohol dependence in these murderers. Tiihonen et al surmised that men with schizophrenia were seven times more likely to commit murder than normal males. They also surmised that individuals with affective disorder or personality disorder and no alcohol dependence were twice as likely to commit murder, whilst those with personality disorder and alcohol dependence were ten times as likely. Males with antisocial personality disorder were twenty times more likely to commit murder. From these evaluations, it appears that personality disorders, mental illness and alcohol dependence are the conditions which put individuals at greater risk of committing murder, rather than the existence of an learning disability.

Further evidence that supports the case for individuals with below normal IQ not being at greater risk of committing murder comes from a study conducted by Puri et al (2000). They conducted a study on two medium secure units, one for individuals with normal IQ levels and one for those with learning disability. With regards to murder, they found that individuals with average and above-average IQ levels were more likely to commit this act than those with a learning disability. Incidentally, the crimes most likely to be committed by those with a subnormal IQ were sexual in nature. They also noted that patients with a normal IQ were more likely to suffer from a psychiatric disorder, particularly schizophrenia, or from a mood disorder.

Age and Education

The following studies looked more specifically at the difference in the homicidal crimes committed by those of a certain age. How old a person is when they commit murder could provide useful insights into their motivation, mental state, and of the circumstances that induced them to behave in such an extreme manner.

In 1992, Nestor studied the psychological and clinical correlates of murder and other forms of extreme violence in a forensic psychiatric population. The neuropsychological and clinical correlates of extreme violence in both the young and older inpatients were examined retrospectively.

The young group exhibited significantly higher rates of both a learning disability and a history of childhood conduct disorder. These findings support the research previously conducted by Lewis et al (1988), which

reported a relatively high incidence of neuropsychological and neurological deficits in a sample of fourteen juvenile offenders convicted of murder. Caution needs to be applied however, as Lewis et al reported that ten out of the fourteen juveniles scored significantly below grade level on standardised academic tests, which they suggest is evidence of a learning disability, but this is clearly not a psychiatric diagnosis.

The older group had a significantly higher rate of psychosis. The older individuals who had been charged with murder were also more likely to have acted alone and to have had an intimate relationship with the victim.

Nestor concluded that the clinical correlates of extreme acts of violence in a forensic psychiatric population differ as a function of age. Young offenders are more likely to have a history of prior arrests (which suggests anti-social/conduct disorder), and to show a 'developmental disability'. Both groups had a relatively high rate of substance abuse. A history of conduct disorder and high prevalence of anti-social personality disorder indicates the presence of disruptive behaviour disorder

What should be noted, however, is that the intellectual levels of both groups charged with murder were within the average range. Another point worth considering is that the youngest offender in this study (convicted of three murders at 17), scored in the superior range of IQ, but in the defective range in both oral reading and spelling. This could indicate the inaccuracy of using the results of various educational assessments rather than well-established standardised IQ assessments to ascertain the intelligence levels of those that commit murder.

Results from such tests could quite clearly be misleading with regards to a person's IQ. If, as in the above case, an individual has difficulty reading and spelling, this does not necessarily mean that that individual has a learning disability. Instead, that individual could be dyslexic, could have paid little if no attention to any education received, or could have failed to have gained any schooling at all. There is no mention of these possibilities in Nestor's summary of his research findings.

Busch et al conducted a study in 1990 that looked at adolescents who had killed. They took a sample of 1956 adolescent delinquents referred by the courts for physical, psychological, psychiatric, educational and social examinations. 71 juveniles had been convicted of homicide, and these youths were matched with 71 non-violent delinquents. With regards to learning disability, 21% of homicidal delinquents were found to have below normal intelligence, compared to only 10% of non-violent delinquents.

Overall, the study's most significant findings were the contributing factors of criminally violent family members, gang participation, alcohol abuse and 'severe educational difficulties'. What needs to be pointed out is the study's definition of 'educational difficulties'. It not only incorporated learning disability, but also Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder (ADHD), and underachievement in reading, language and mathematics.

Environmental Factors

Following on from this study, Zagar et al (1990) conducted further research on 30 homicidal adolescents and added their data to that of Busch et al. They also found that these adolescents shared four common symptoms (criminally violent families, gang participation, alcohol abuse, and severe 'learning difficulties'). The definition of severe 'learning difficulties' incorporated retardation, lowered perceptual and full scale IQs, epilepsy and CNS disorders. With such a broad spectrum for the definition of 'learning difficulties', this term must not be interchanged or be confused with 'learning disability'. This would imply a psychiatric diagnosis of a learning disability had been given to the offending youth, when this may not have been the case.

Zagar et al concluded that these 101 adolescents who had committed murder showed more retardation, epilepsy and CNS conditions during infancy. They had lived in violent homes and had learnt and developed aggressive responses in childhood. They go on to state that the result of these circumstances meant 'they were at greater risk from the cumulative combination and the sequential interplay of developmental biopsychosocial factors.'

It is clear from these studies' findings, that 'learning difficulties' may place adolescents at greater risk of homicidal behaviour, when accompanied by other prevailing factors – namely substance/alcohol abuse, violent family backgrounds. However, having 'learning difficulties' is not the same as having a psychiatrically diagnosed 'learning disability'. Scoring below average on a standardised academic test, or failing to read and spell sufficiently for your age group indicates a lack of education. They may be used to support a claim for a learning disability but can in no way be used as stand alone evidence of a learning disability.

If these violent adolescents have not been diagnosed as having a learning disability, it does not necessarily mean they do not have one, just that it has not been psychiatrically recognised. Without medical acknowledgement, general conclusions cannot be made with regards to what role, if any, intellectual disability plays in the act of murder committed by juveniles.

Other studies looking at juvenile murderers do not specifically mention intellectual disability as an increasing risk factor. Hardwick & Rowton-Lee (1996) found that background factors including the witnessing of serious violence, both live and on the screen, as well as abuse through neglect and deprivation put juveniles at greater risk of committing violent acts, including murder. They stated that such traumas can assist in the creation of morbid identity and a cognitive set that make murder possible in certain situations. Again 'learning difficulties' were also cited, including impulse control, but individuals with these problems are by no means diagnosed as intellectually disabled. However, they are more likely to be suffering disruptive behaviour disorder.

Myers & Kemp (1990) diagnosed 14 young American murderers. They found that the main diagnoses were conduct disorder and substance abuse, and these often overlapped. They found few instances of psychotic disorder in these youths, which supports the findings of Nestor's study of

juvenile and older murderers, which found that the older murderers had a significantly higher rate of psychosis.

Labelle et al conducted a study in 1991 that looked at Canadian adolescents who had committed homicide. Her diagnoses again feature substance abuse, this time linked to personality disorder. Myers & Mutch (1990) described eight American homicidal juveniles who showed language disorder ranging from mild to severe. One theory is that seeing as these youths have fewer coping skills, they are at greater risk of acting out in order to either vent frustration or express themselves.

With regards to intellectual disability, any existing link to homicidal behaviour should be classed as rather indirect in its existence. An individual with a learning disability is at a higher risk of also having a conduct or personality disorder, and research has shown that having a conduct or personality disorder increases the likelihood of difficulties in education and the learning of social skills, and this compounds the disruptive behaviour disorder.

All of these studies cite educational difficulties as a significant contributing factor to the act of murder. Research into those who commit murder has shown that having educational difficulties, when combined with other prevailing factors (such as witnessing violence and alcohol/substance abuse), leaves some juveniles more predisposed to homicidal behaviour. The increased risk for individuals with a learning disability also having a conduct or personality disorder appears to be the only link intellectual disability has to the act of murder.

As mentioned at the beginning of this paper, whether an individual receives a diagnosis of intellectual disability is crucial to their future. It also affects the research conducted on these individuals to understand their behaviour.

Dwyer and Frierson (2006) looked at the presence of low IQ and 'mental retardation' amongst murder defendants referred for pre-trial evaluation. Subjects with an IQ of below 70 who had received a diagnosis of mental retardation were compared to subjects with an IQ of below 70 who had not received this diagnosis.

They found that females were more likely to receive a diagnosis of mental retardation. They also found that mental retardation was more commonly diagnosed in those with an Axis 1 cognitive disorder mental illness and that having an IQ of below 70 was more common in those with a psychotic and substance use disorder. However, this did not necessarily lead to a diagnosis of mental retardation.

Here, it can be seen again that those with a subnormal IQ appear at greater risk of also suffering from other difficulties that increase the chance of extremely violent behaviour. However, it cannot be stressed enough that not all individuals with a learning disability (diagnosed or not) also have psychosis or substance use disorder, and not all those with psychosis or substance use disorder have a learning disability.

The issue of accurate diagnosis of a learning disability is a complicated one. Whether or not an individual is intellectually disabled can be difficult to ascertain as other problems such as language defects and behavioural

problems (which may be caused by a disorder) can impede the diagnostic methods used, and the end results. External factors may also have an impact on accurate diagnosis. If an individual's future rests on the outcome of their diagnosis, the professional with the responsibility of providing it may feel inclined or pressured to diagnose one way or the other.

With cases where individuals are given a borderline IQ level, again more issues are raised. Just how responsible are these people for their actions? Do they have the capacity to comprehend that such behaviour is essentially wrong, and if so why should they not be held responsible for it? What would be gained by holding them responsible for their actions? Would they understand why they were being punished, would they learn anything from their judicial sentence, and would they be 'better' people at the end of it? All these issues are raised on the back of a learning disability diagnosis.

In summary, it seems that the factors of substance/alcohol abuse, the witnessing of violence, educational difficulties (whether or not indirectly brought on by the presence of a learning disability), and the presence of a conduct or personality disorder, are what increase the risk of younger individuals committing murder. These issues may work in conjunction with one another, as youths often suffer from more than one of these problems.

Filicide

Over the past years, there have been numerous studies that have looked at ascertaining whether a link exists between intellectual disability and filicide. Research has been conducted into the theory that parents with a learning disability are at greater risk of committing filicide.

In 1988, twelve men convicted of filicide were studied by Campion et al. Their records were sourced from a forensic psychiatric service from the year 1970-1982. The majority suffered from severe mental impairments due to psychosis, neurological disorders, substance abuse or 'mental retardation'. However, only five out of the twelve cases studied had available IQ levels, and how these were tested is not specified. Three subjects were cognitively impaired, with two (possibly three) being moderately intellectually disabled. Caution needs to be applied here, as 'mental impairment' does not just mean learning disability, but also incorporates psychiatric disorders and substance abuse. All are listed as being critical factors when it came to these men committing filicide.

Most of the filicidal acts committed by these chronically impaired men resulted from isolated explosive behaviour. This is characteristic, but not diagnostic of intermittent explosive disorder. Nine out of the twelve subjects had neurological or psychiatric disorders during childhood, and several had been physically or sexually abused, with seven being separated from their families. Seven of these twelve men were intoxicated at the time of the filicidal act, and all these seven were also psychotic, either from acute substance induced psychosis, or chronic psychoses exacerbated by alcoholism.

Campion et al stated that 'excluding the two cases of reckless endangerment these filicidal fathers were severely mentally impaired.' Campion et al concluded that 'organic impulse disorders, substance-induced disinhibition, and delusional or cognitive impairments of judgement

all served to break the fragile sense of reality and impulse control in these men.'

Older Individuals

Psychosis seems to be a contributing factor not just specifically to filicide, but to murder by older individuals. As mentioned earlier, Nestor's 1992 study found that the rate of psychosis was significantly higher in older murderers.

A 2003 study by Farooque and Ernst looked at the act of filicide. They examined and reviewed eight years of clinical experience of this act of killing children. They focussed on the factor of intellectual functioning. Results regarding the significant presence of both mental illness and substance abuse found by previous studies was supported by the results of this study, but what Farooque and Ernst also found was the significant frequency of intellectual impairment, which they argue has been overlooked.

Data obtained on the intellectual assessments of those who commit filicide indicated that eight out of the 19 individuals (42%) studied had some level of 'mental retardation' (four borderline [IQ 70-84], four mild [IQ 55-70]). The study showed a positive relationship between intellectual disability and evidence of child neglect/abuse prior to the actual act of murder, (seven out of eight cases).

This could be an indicator of the important role intellectual functioning has for the safety of children. Parenting skills and stress management skills are probably deficient in persons with impaired intellectual functioning and this could figure significantly in the unfortunate final act of filicide. One possibility is that the deaths caused by this neglect may not have been entirely intentional but could be the result of these intellectually disabled individuals being unable to provide sufficient care to ensure the survival of their children.

Evidence from these studies indicates that children of individuals with a learning disability may be at greater risk of harm from neglect, and subsequently, death. Whether this neglect is intentional (i.e. as a form of abuse) or unintentional (i.e. the parents are not aware that the level of care they are providing is not sufficient to maintain their children's well being) is not always easy to devise.

As mentioned earlier, intellectually disabled individuals are at risk from suffering from personality/conduct disorders. This additional disorder can put them at greater risk of antisocial behaviour towards others, including their own children. However, research has also shown that having a learning disability can impede the learning of basic social and parenting skills, and it could be deficiencies in these areas that lead to their offspring's death, and researchers finding a significant link between cognitive impairment and filicide.

These parents may end up neglecting their children to such an extent that they die, but they may not have had any extreme violent tendencies towards the child. The outcome is still as tragic, but the consequences for

the guilty parent are impacted on when the circumstances of the filicide are analysed.

More recent studies looking into murder have redirected their focus onto the significance of personality disorders and conduct disorders, and alcohol and substance misuse. In 1997, Asnis et al looked at violence and homicidal behaviours in psychiatric disorders, and found that the presence of substance/alcohol abuse and dependence as well as antisocial personality disorder are particularly associated with an increased risk of violent and homicidal behaviours. This again emphasises the relevance of disruptive behaviour disorders.

Another example, a study by Hill et al (2007), looked at psychiatric disorders in single and multiple sexual murderers. They found high rates for substance abuse, paraphilias, sexual dysfunctions and personality disorders.

With this shift away from intellectual disability being seen as a major contributing factor, individuals who commit murder are not now necessarily expected to receive a diagnosis of intellectual disability. They are instead expected to be diagnosed as having a personality or conduct disorder, psychosis (in particular schizophrenia), and to have a substance/alcohol dependence or abuse problem.

Individuals with a learning disability are at increased risk of also having one or more of the above diagnoses, which could explain the increased presence of intellectual disability in the findings of some studies. On closer analysis of research findings, individuals who commit murder and have a diagnosis of intellectual disability will more often than not have a diagnosis of personality disorder, conduct disorder, and/or substance or alcohol dependence. The intellectual disability increases an individual's risk of having a disruptive behaviour disorder, but research has shown that it is these disorders and dependencies which increase the chances of a person committing murder, not their intellectual disability.

Intellectually disabled murderers, if convicted, can be detained under the Mental Health Act or imprisoned. The action chosen will largely depend on whether or not that individual has also received a diagnosis of mental illness or severe personality disorder. Such a diagnosis would lead to hospitalisation rather than imprisonment in jail.

Due to researchers' limited sources for their studies on murder, individuals who have committed such crimes and have been detained under the mental health act for their actions are often the subjects of these studies. These individuals have been detained on account of their mental illness or personality/conduct disorder. This could account for any significance in statistics which appear to show a higher number of intellectually disabled individuals committing murder than expected.

Conclusion

In conclusion, research over the years into intellectually disabled murderers has shown that it is not that individual's actual disability, but the subsequent internal and external factors that combine to increase the risk of homicidal behaviour. A murderer will often have multiple diagnoses including any or

all of the following; intellectual disability, mental illness, conduct disorder, personality disorder, substance and/or alcohol dependence or abuse.

With so many factors involved, such as disruptive behaviour disorder, as well as environmental and social issues (witnessing violence, gang participation, poor education), it is not possible to pinpoint any one factor as the main culprit. However, it seems more likely that an amalgamation of any or all of these factors is enough to make a person act in such a destructive and inhumane way.

Considering that this review has found that the act of murder is often carried out upon a background of disruptive behaviour disorder, permits a certain separation between the presence of a learning disability and the final illegal act. It is not that the learning disability itself would be considered a cause of the act of murder but that there is an intervening diagnosis of a disruptive behaviour disorder. This focuses therapy on the disorder rather than the disability. There are numerous techniques by which disruptive behaviour disorders can be treated, including pharmacological and psychological approaches. Getting the right focus is more likely to ensure a successful outcome for the individual and for society.

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