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CASE REPORT

EXPLORING SPOUSAL HOMICIDE IN FORENSIC PSYCHIATRY: A CASE SERIES

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ABSTRACT

Introduction: Spousal homicide (SH) in the forensic psychiatry setting can be the result of multiple aetiologies working together within the dynamic nature of intimate relationships. Defences attainable in SH include insanity, automatism, battered woman syndrome, and diminished responsibility. This case series illustrates the diversity of psychosocial, criminological, and psychiatric pathways leading to SH and highlights the role of forensic psychiatric assessment in determining criminal responsibility within the Sri Lankan legal context.

Case Histories: A 48-year-old male with a history of alcohol dependence was charged with the murder of his wife. He had controlling and possessive behaviours towards his wife and inflicted repeated physical and psychological trauma. At the time of the offense, he was in a state of intoxication. A 32-year-old female was referred following the murder of her husband. She endured recurring physical and psychological trauma from her unemployed, psychoactive drug-dependent husband. She was diagnosed with a depressive illness earlier. A 28-year-old male from a dysfunctional family, who exhibited impulsive behaviours, was charged with the murder of his wife. He reported persistent physical and emotional abuse from his wife and discovered her extramarital affair a week before the incident. A 45-year-old male was referred for the murder of his wife. He suffered from a delusional disorder and harboured delusions of infidelity towards his wife. His wife had sought help from legal authorities multiple times due to physical and emotional violence.

Conclusion: Determining criminal responsibility in SH requires a comprehensive forensic psychiatric assessment, including retrospective reconstruction of the offender's mental state at the time of the offence. The psychiatrist must understand the relevant legal defences so that an assessment in accordance with legal criteria can be done. Early contact with mental health services and understanding their criminological characteristics may help in identifying high-risk individuals and establishing opportunities for possible interventions.

Keywords: *Homicide; insanity; psychiatry; spouse; Sri Lanka*

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INTRODUCTION

Global research shows that an intimate partner carries out one in seven homicides and that females are at a greater risk of being victims than males[1]. Spousal homicide (SH) can be the result of multiple aetiologies working together within the dynamic nature of intimate relationships. It appears that spousal or intimate partner homicides are not merely the endpoint of a series of non-lethal violent acts committed by the offender but a unique entity with a heterogeneous group of perpetrators. The majority of the offenders do not suffer from major psychiatric illnesses[2]. Poverty, psychoactive substance use, younger age, and history of violence have been identified as risk factors[3].

In Sri Lanka, one in three females suffers from intimate partner violence (IPV) that occurs within the context of legal marriage[4]. However, males too have been reported to be victims of IPV[5]. To our knowledge, no studies have been carried out to assess the nature and circumstances of SH in Sri Lanka. We report four divergent cases of SH referred to forensic mental health services by the criminal justice system for psychiatric assessment and treatment. These cases illustrate differing psychosocial backgrounds, psychiatric histories, and legal considerations relevant to criminal responsibility. The relevant information was obtained through clinical interviews of the offender, obtaining collateral information from family members, and reviewing past clinical records and police records.

CASE HISTORIES

Case 1:

A 48-year-old male was referred with charges of murder of his wife while under the influence of alcohol. Married for nearly two decades, the couple had experienced increasing marital conflicts, particularly regarding their daughter's recent relationship. He had a history of alcohol dependence and controlling behaviour, often inflicting repeated physical and psychological trauma on his wife. Following an argument, he reported setting fire to his spouse "as a joke" after she had doused herself with petrol. While he claimed the act was unintentional, he admitted that during the first attempt, she did not catch fire and that he repeated the act, which ultimately caused the fatal burn, a sequence confirmed by collateral accounts. A forensic psychiatric evaluation revealed no evidence of psychiatric illness at the time of the incident. He was voluntarily intoxicated with alcohol. It was opined that he was capable of understanding the nature and consequences of his actions, as well as their wrongfulness and illegality, at the material time. He was assessed as fit to stand trial. Psychological interventions were recommended to address alcohol dependence and impulsivity.

Case 2:

A 28-year-old male was charged with the murder of his wife during a confrontation stemming from marital discord with verbal altercations and mutual physical abuse. Raised in a dysfunctional family, the accused had experienced significant childhood adversities alongside maternal psychiatric illness. On the day of the incident, the couple had fought over a perceived betrayal involving explicit communications between the wife and an alleged male partner via letters and mobile text messages. In response to repeated provocations, the man had struck his wife with a wooden pole, leading to her fatal injury. Despite demonstrating impulsive personality traits, a forensic psychiatry assessment revealed no psychiatric illness at the time of the incident, and he was deemed fit to stand trial.

Case 3:

A 32-year-old woman was referred following fatally injuring her husband during a domestic altercation. The couple had been married for four years, had a turbulent relationship with ongoing verbal and physical abuse fuelled by the husband's alcohol consumption and psychoactive drug dependence. On the day of the incident, she had returned home to find her child unattended and her husband intoxicated. A heated argument ensued, escalating into physical violence, and she reported having stabbed him with a kitchen knife. She had a history of postpartum depression two years before the index event, referred to psychiatric

services, but defaulted soon after. She did not display evidence of a major psychiatric illness at the time of the event and was not on any psychotropics. A forensic psychiatry evaluation concluded that she had the capacity to understand the nature and consequences of her actions and that she is fit to stand trial.

Case 4:

A 45-year-old male was referred with charges of murder of his wife, during which he had struck her head with a rock. He had exhibited symptoms of a long-standing delusional disorder, with persistent delusions of infidelity directed towards his wife, even at the time of the offense. He had previously been treated with risperidone but defaulted five years before the index event. His wife had previously sought legal protection on multiple occasions due to ongoing physical and emotional abuse and lived separately. On the day of the incident, the individual had acted in accordance with his delusional beliefs, leading to his wife's death. Although his psychiatric condition was acknowledged, the forensic psychiatry evaluation concluded that he had an understanding of the nature and consequences of his actions at the time of the incident. He was fit to stand trial.

DISCUSSION

Observational studies have reported that most victims of SH are young, unemployed females[6]. Female victims of SH have been reported to be as high as 3.1 per 100,000 population[7]. While two of our female victims were in their thirties, one was in her fifties. Female victims of SH have often been continuously physically and emotionally abused by their partners, while this is found to be extremely rare in male victims[8]. While two of our female victims suffered long-term IPV, the female victim from case 2 was reported to be abusive both physically and emotionally by the perpetrator since the onset of their relationship. Most victims of SH have not been in contact with legal or medical services for protection from the perpetrators, which was affirmed in this series, where only one of four victims had sought legal support before the index event[6].

In cases such as those presented in this paper, forensic psychiatrists are expected to assess the presence of any mental illness that would affect the criminal responsibility of the offender and also ascertain the risk of recidivism, which may determine sentencing. Psychiatrists need to be aware of the different legal defences: insanity, automatism, battered woman syndrome, and diminished responsibility. The assessment involves retrospective reconstruction of the mental state of the offender at the time of the crime. The four cases described above portray how substance use, mental illness, and provocation in the background of long-term interpersonal conflict led to SH.

Case 1 describes an act of violence under the influence of alcohol. Substance abuse is less clearly associated with SH than homicide in general or spousal assault[9]. Under Sections 78 and 79 of the Penal Code of Sri Lanka, voluntary intoxication does not generally constitute a defence. However, Section 79 allows for an exception if it can be shown that the accused was incapable of forming the required *mens rea* for a specific-intent crime, such as murder[10]. In practice, this requires the accused to establish that intoxication so impaired his cognitive capacity that he was unable to form the requisite *mens rea* for the offence. In Dayaratne v. The Republic of Sri Lanka (1990 2 SLR 226), the Court of Appeal held that, in a charge of murder, Section 79 applies only where the evidence shows that intoxication deprived the accused of the capacity to form a murderous intention[11].

The role of a psychiatrist here is to assess the mental state of the perpetrator at the time of the crime retrospectively to help the legal system identify if he was able to form the guilty mind of committing murder while under the influence of alcohol. By evaluation of all information available and recreating his mental state at the time of the crime, his behaviour from the time leading to the event, during the event, and afterwards, clearly showed his ability to restrain, act rationally, and make reasonable choices despite the use of alcohol. Thus, despite being intoxicated, his cognitive capacity to form the *mens rea* was unaffected and did not qualify for a defence.

Cases 2 and 3 demonstrate homicides executed during periods of extreme distress following long-standing IPV by the partner. Here, the perpetrators demonstrate similar characteristics in their development and upbringing. Both reported an unhappy and insecure childhood, emotional dysregulation during adolescence, and impulsive personalities in adulthood. The intimate relationship with the victim turned out to be the only confiding relationship they had experienced. This striking pattern of similar inter-relational disputes and circumstances leading to SH has been described as 'spousal homicidal syndrome'[12]. When a female is the perpetrator in SH, there is often a history of long-term battering or an immediate victim precipitation[3]. Battered women tend to lose hope in the criminal justice system due to the socially sanctified nature of wife beating and the patriarchal community standards that exist, especially in the South Asian context[13]. Although it arouses great sympathy for the offender, psychiatrists need to express their opinions respecting objectivity while adhering to legal criteria.

A defence of automatism has been raised in similar cases where the act had been thought to be committed in a dissociative state under extreme distress[12]. In Sri Lanka, automatism is not recognized as a separate statutory defence but may be considered in limited circumstances under common law principles. For such a defence to be applicable, there must be evidence of a complete loss of voluntary control and awareness at the time of the act[14]. It is therefore necessary to distinguish involuntary behaviour from actions carried out in states of intense emotion, anger, or impulsivity, which do not in themselves amount to automatism. From a forensic psychiatric perspective, this distinction is often challenging, particularly in spousal homicides involving prolonged intimate partner violence, where stress and emotional arousal can mimic dissociative states. A careful assessment is required, focusing on the individual's behaviour around the time of the offence, including the organization and purposefulness of actions, as well as the ability to recall events before, during, and after the incident. A detailed forensic psychiatry assessment of the offenders in cases 2 and 3 revealed they were able to recall the events completely, which made it unlikely that they were in a state of dissociation.

Battered woman syndrome (BWS) is a psychological framework used to describe the effects of prolonged intimate partner violence and was originally conceptualized to explain the behavioural and emotional responses observed in women exposed to repeated abuse[15] and is not a defence by its own, but has been used as an adjunct to either provocation or self-defense[16]. Although BWS is not a formal psychiatric diagnosis, it refers to a state of psychological distress arising from sustained physical and emotional abuse by an intimate partner, commonly characterized by fear conditioning, hypervigilance, and altered perception of threat[15]. To ascertain a defence of such requires the offender to identify an imminent threat to life or serious injury that requires a proportionate response of self-defense[10]. The role of the forensic psychiatrist is to objectively assess the psychological impact of prolonged abuse and explain its relevance to the accused's perception of threat and decision-making at the material time, while maintaining a clear distinction between psychological vulnerability and legal responsibility[17].

Nearly one third of all SH offenders have been treated for a psychiatric disorder during their lifetime, which includes schizophrenia and other primary psychotic disorders, affective disorders such as depression, and a minority with personality disorders[18]. Two offenders in our series from cases 3 and 4 suffered from a depressive disorder and a delusional disorder, respectively, during their lifetime. Section 77 of the Penal Code of Sri Lanka requires an individual to lack the cognitive capacity to appreciate the nature, wrongfulness, and illegality of an act due to a reason of unsoundness of mind to meet the criteria of the insanity defense[19]. The forensic psychiatry assessment here was directed at identifying symptoms of major mental illnesses at the time of the crime and how they influenced the relevant capacities mentioned above. The mere presence of a mental illness, including a delusion, is insufficient to establish unsoundness of mind. To meet the legal criteria for insanity, the offender must have been

unable to understand the nature, wrongfulness, or illegality of his act at the material time.

The forensic psychiatrist's role is to collect and evaluate all relevant information—including clinical history, collateral accounts, behaviour before, during, and after the offence, and mental state at the time of the act—to reconstruct the offender's retrospective mental state. This assessment involves analysing whether the symptoms present were sufficient to impair the offender's capacities in accordance with the legal criteria. The psychiatrist then presents these findings to the court in a structured and objective manner, explaining the reasoning and evidence used to reach conclusions, including observed behaviours, clinical signs, and collateral information[20].

In case 4, although the offender held a delusional belief regarding his wife's fidelity, this belief did not impair his understanding of the nature, wrongfulness, or illegality of his actions. Therefore, he was considered of sound mind at the time of the offence, and the criteria for an insanity defence were not met. Similarly, although the offender in case 3 had a diagnosis of a depressive disorder, her mental state at the time of the crime did not display any depressive symptoms. Therefore, both offenders were considered to be of sound mind at the time of the offence and did not qualify for a defence of insanity.

These four cases also highlight the importance of understanding the criminological characteristics of IPV offenders, which may help in identifying high-risk individuals early and establishing opportunities for possible interventions. Across all cases, certain criminological characteristics emerged as indicators of elevated risk for spousal homicide. For example, impulsivity was prominent in cases 2 and 3, contributing to the rapid escalation of conflicts into lethal acts. Substance misuse, notably chronic alcohol dependence in case 1, impaired judgment, and increased aggressive tendencies. A history of IPV was evident in cases 2–4, reflecting entrenched patterns of control, abuse, and conflict within the relationship. Finally, psychiatric conditions, such as depression in case 3 and delusional disorder in case 4, further complicated the risk profile.

Empirical research supports the observations made in the 4 cases. Studies of intimate partner homicide perpetrators show that substance use disorders and other psychiatric conditions feature prominently among offenders referred for forensic psychiatric assessment, helping to identify individuals at elevated risk of lethal violence. Typologies of intimate partner violence and homicide perpetrators indicate that criminological, situational, and psychological traits—such as controlling behaviour, emotional dysregulation, and altered threat perception—distinguish profiles at higher risk for intimate partner homicide[22]. Meta-analytic evidence further confirms that substance abuse and abusive relational dynamics consistently predict intimate partner homicide, emphasizing the importance of behavioural and contextual risk factors in prevention strategies[23].

Understanding the aforementioned risk factors may help identify high-risk individuals early and establish opportunities for possible interventions. Timely referral to mental health services could prevent SH that occurs as a result of mental health conditions. Substance-related disorders may require both psychological and pharmacological interventions, while psychotic illnesses, such as delusional disorders, are treated with pharmacological agents such as antipsychotics[24]. Long-term interpersonal difficulties within marriages are well managed with psychological interventions such as family therapy that aim to improve communication, autonomy of each partner, agreement about roles, and reduce conflict[25].

CONCLUSION

SH results from a multifactorial interplay of psychosocial, personality, and psychiatric variables. Comprehensive psychiatric evaluations and understanding of available defences facilitate accurate assessments of criminal responsibility and legal defences. Early identification of high-risk individuals, coupled with timely mental health interventions and legal safeguards for victims, may contribute to reducing the incidence of such fatal events.

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CONFLICTS OF INTEREST

The authors declared no conflicts of interest.

ETHICAL ISSUES

The findings of the presented cases were used for academic purposes, with the informed consent according to the institutional guidelines, without divulging the identity of the individual.

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None.

AUTHOR CONTRIBUTIONS

DM: Conception and design of the work; the acquisition, analysis, and interpretation of data for the work; drafting the work and revising it critically for important intellectual content; final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. **DW:** Conception and design of the work; the acquisition, analysis, and interpretation of data for the work; drafting the work and revising it critically for important intellectual content; final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved. **CA:** Conception and design of the work; the acquisition, analysis, and interpretation of data for the work; drafting the work and revising it critically for important intellectual content; final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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