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THE DARK CONSEQUENCES OF MARITAL RAPE

BY JACQUELYN C. CAMPBELL/PEGGY ALFORD

Here's how nurse researchers turned their concern for women's health into a campaign that changed state law.

Ten to 14 percent of all married women and at least 40 percent of battered wives in the United States have been raped by their husbands(1-3).

Marital rape meets the legal criteria for criminal sexual conduct but with two crucial differences—the rapist and his victim are married and, in many states, the rapist is immune from prosecution (see the story in colored box). Previous studies have examined women's responses to rape within an intimate relationship as well as the long-term psychological effects of the rape. Although some studies have described the injuries accompanying forced sex and some have looked at psychosomatic illness, none has attempted to measure the physical effects that sexual violence has on the victims of marital rape(1-5). We set out to do precisely that.

RECRUITING OUR SAMPLE

We asked the staffs of wife-abuse shelters in Michigan to ask all incoming residents if they had been sexually abused. If a woman acknowledged marital rape, the shelter worker would explain the study and ask her if she wanted to participate. If the woman agreed, she would then sign a consent form and complete a 15-minute forced-choice (yes/no) questionnaire. Shelter advocates were available for emotional support, and to offer further information about marital rape and about the legal climate in Michigan at that time.

We later learned that many shelter advocates felt unprepared to deal with marital rape and feared

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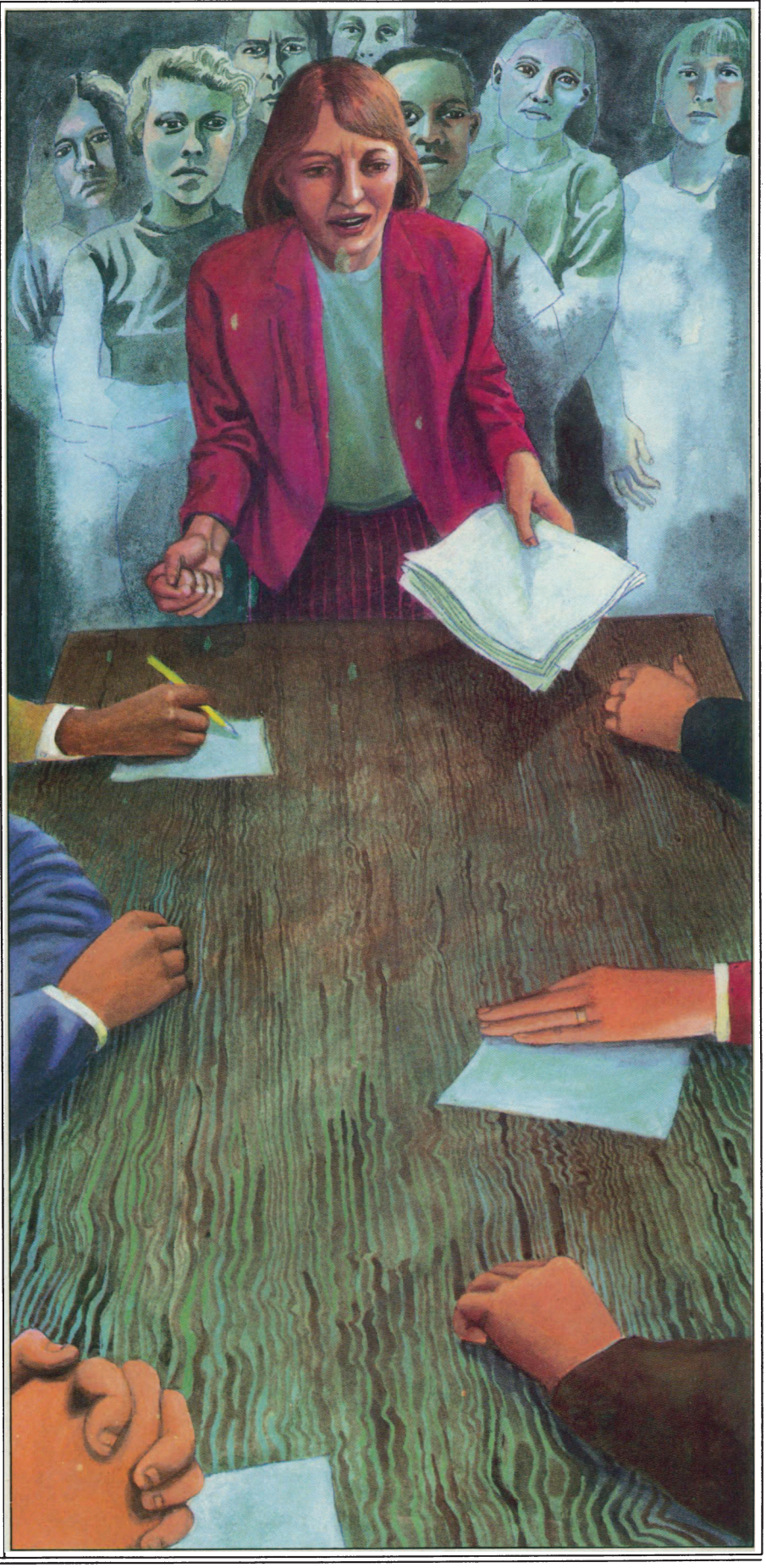
that asking about it might be too invasive or too traumatic for the women. Also, some victims felt that consenting to participate in the study meant they were agreeing to pursue legal action. As a result, even after we organized training sessions, briefed the shelter directors, and removed demographic data from the questionnaire, only 115 women (of the 1,000 sheltered in the state during our six-month data collection period) actually completed questionnaires. Based on clinical experience and prior research, we suspected that at least half of those 1,000 had been raped(1-3).

The 115 questionnaires came from at least 12 shelters (rural, suburban, and urban) located throughout the state. Marital status was the only demographic variable left in our revised questionnaire. Over half (55.6%) of the respondents were married; the remainder (44.4%) were divorced or had filed for divorce or separation. The limitations of sampling made possible only a descriptive analysis of our data.

WOMEN AS CHATTEL

Almost all (87.4%) of our respondents reported that their spouses believe that it is a husband's right to have sex with his wife whenever he wants it. The types of forced sex most frequently reported were vaginal intercourse (82.7%); anal intercourse (52.8%); being hit, kicked, or burned during sex (44.1%); and having objects inserted in the vagina and anus (28.6%). Some women wrote overwhelmingly graphic descriptions of abuse they had endured—being forced into homosexual sex, sex with animals, prostitution, public exposure, and other acts of extreme degradation.

Six (5.2%) of the women's husbands had physically involved their children in various sexual acts; another 17.8 percent reported that their children had witnessed sexual attacks. About half of the women (49.6%) had been threat-



CATY BARTHOLOMEW

ened with beatings for refusing sex. For 15 women, such threats involved a gun, knife, or other objects used as weapons.

More than one-third (36.7%) had endured beatings after refusing sex, while half (50.9%) had been forced to engage in sex immediately after beatings. One woman wrote a comment that we believe applies to many of our respondents: "I fear going to bed at night because I'm afraid of what my husband will do to me."

THE THREAT TO HEALTH

More than half (51.8%) of our respondents had been forced to have sex when ill; 46 percent were coerced immediately after discharge from the hospital (most often after childbirth). One woman reported needing a dilatation and curettage because of forced intercourse the day after delivery.

Most often, the women reported that they suffered pain because of marital sexual abuse—72 percent had experienced painful intercourse and 63 percent had had vaginal pain. One woman described "severe pain in my tubes from tubal infections because my husband was having sex with other women and then with me." Another wrote, "I have a fear of men and sex because now, to me, sex only means pain."

Other physical problems the respondents attributed to sexual abuse included anal or vaginal stretching (36.1%), bladder infections (50.9%), vaginal bleeding (37%), anal bleeding (29.6%), leaking of urine (32.4%), missed menstrual periods (25%), miscarriages and stillbirths (20.4%), unwanted pregnancies (17.6%), infertility (7.4%), and sexually transmitted diseases (6.5%).

Our data clearly indicate that these victims of marital rape were coerced into performing humiliating and painful sexual acts. We can also surmise from our findings that battered women interviewed in a shelter or clinic need to be asked specifically about sexual abuse(6). Information *that* sensitive is rarely volunteered.

But sexual assault and abuse is not always accompanied by battering. We suggest that nursing histories on *all* adolescents and adults include the question, first formulated by Diana Russell, "Has anyone ever forced you into sex that you did not wish to participate in?"(1).

That question can also uncover other types of sexual trauma, such as incest, childhood sexual assault, and date rape, even when the victim does not necessarily perceive the incident(s) as rape. Because

USING NURSING RESEARCH TO CHANGE THE LAW

Late in 1985, Diana Russell, author of *Rape in Marriage,* addressed a Michigan audience about marital rape. Until May 1988 it was legal in that state for a man to rape his wife. The state's sexual-assault laws afforded husbands "spousal immunity."

Surprised? Only eight years before that, marital rape was not considered a crime in any of the 50 states. The spousal exemption dates back to English Common Law, circa 1736. American state laws later promulgated the idea that a woman's consent to marriage constituted irrevocable consent to sexual availability whenever and however her husband desired it.

Oregon was the first state to repeal the marital rape exemption, and due in large part to feminist advocacy, 35 other states repealed or weakened the exemption. Yet Arizona, Colorado, Idaho, Indiana, Kentucky, Maryland, Missouri, New Mexico, North Carolina, Oklahoma, South Carolina, South Dakota, Tennessee, and Utah still retain the marital rape exemption.*

The 1985 conference galvanized a group of about 20 advocates, including lawyers, social workers, a psychologist, and a nurse (myself), who began to chip away at the Michigan law. We called ourselves the Coalition to End Legalized Rape (CELR). We were a curious combination of talents; some of us were politically astute, others had research skills, while still others worked daily with women who had been raped by their spouses. We found friends in the media, in the prosecutors' offices, and in the state legislature.

Early on, we realized we would need data to support our demand for legislative reform. We decided that the most persuasive statistics would be those that could connect the problem with the *health* of women and children, rather than with women's rights. We also needed to demonstrate the magnitude of the problem in Michigan. To fund the research, I was able to get a small grant from Wayne State University in Detroit.

Our first strategy was to get a test case before the Michigan Supreme Court in the hope that, as in every other state where such a case was presented, the court would rule the marital rape exemption unconstitutional. We found what looked like a perfect case, a brutally raped woman who had filed for divorce before establishing residency in Michigan. On that basis, the husband's conviction for the crime was struck down under the marital rape exemption almost two years later.

CELR filed briefs supporting a ruling of unconstitutionality on the exemption using the data from my study (detailed in the accompanying article), as well as legal arguments. We held press conferences and generated media attention. The court ruled that the rapist should remain in jail, but refused to consider the constitutionality of the exemption.

CELR picketed the state's supreme court. Partly in response to the publicity we generated, two Michigan legislators introduced bills to end the marital rape exemption. We released my nursing study results to the media and reported them before the house and senate judiciary committees. My testimony was so graphic and compelling that "the nurse researcher" became known throughout the state capital. Victims of marital abuse came forward and testified. What started out as a controversial bill passed unanimously in both the house and senate. Commitment, persistence, coalition building, political savvy, persuasion, media representation, and nursing research coalesced to change the law in favor of women's health — *Jacquelyn C. Campbell*

* The author invites any nurses willing to work to change the law in any of these states to write to her at Wayne State University College of Nursing, Detroit, MI 48202.

young boys and men are hardly immune to sexual assault and abuse, they also need to be asked about forced sex(7).

Whenever a patient answers the first question positively or hesitantly, further information can be obtained with gentle questions like, "Can you tell me about a time like that?" and "About how often did that occur?" and "Were there any other incidents of forced sex in your past?"

A physical examination of the genitalia for genitourinary infection and trauma is essential in all cases of known or suspected wife rape or battering. Standard rape protocol (like that followed in emergency departments) assures that any evidence of rape is preserved for future legal action, whether for prosecution for assault or for child custody determinations(7). Careful documentation by nurses is often a critical factor in courtroom proceedings.

The damage done to a woman's sexuality warrants as much attention as does any physical damage. Victimization of children and rape during or immediately after pregnancy pose further health hazards(8). Finally, the woman realistically may fear for her life, since rape in association with physical abuse has been proved to be a risk factor for homicide(9). Such women need to be told that their lives may be in danger and advised of legal alternatives and the possibility of protection in a shelter or at the homes of relatives or friends.

WHAT WE CAN DO

Generally, nurses are relatively comfortable with sexuality and with physical examinations and are often better prepared than shelter staff to explore the issue of marital rape(10). Also, women see nurses as empathic and knowledgeable about sexual concerns.

To disclose the extreme violation of marital rape is an expression of trust. But if a woman shares such information and the nurse immediately refers her elsewhere, the nurse's behavior implies that the problem is too thorny or too distasteful for the nurse to handle, or that the patient is psychologically disturbed(11). This then reinforces the woman's shame.

Thus, questioning a woman about marital rape carries with it a responsibility to intervene. Intervention does include subsequent referral—to social-service agencies, battered women's shelters and support groups, and legal and counseling services. But at the time of disclosure, the woman needs a nurse.

Encouraging a patient to talk when she is ready to do so and conveying a willingness to listen without judging her are so basic to our profession that we often underestimate their value. Open-ended queries help prompt full disclosure and the expression of deep feelings. When the issue evokes shame and secrecy, listening is critical.

Even when a marital rape victim has not been battered, she struggles with the same issues of control, physical pain, and coercion as do battered women. In fact, in one sample, poor body image and low self-esteem were more of a problem for battered and raped women than for those who had been battered but not raped(12). Overall, therapy that works well for battered women also is appropriate for those who have been sexually abused(13).

Assuring a woman that her emotional and sexual responses to her situation are normal helps to relieve some of the damage to her self-esteem. Gentle use of touch and information about "normal" sexual responses may help the woman feel better about her body. Many of these women's husbands have told them that they are sexually undesirable. A sexually abused woman needs reassurance during a physical examination that she is not repulsive or ugly.

Post-traumatic stress syndrome, severe depression, and substance abuse are not unusual sequelae of marital rape. The victim needs to understand that her stress-related symptoms have real, physiological bases; labeling them "psychosomatic" can only do further damage to her self-esteem.

One marital abuse victim wrote, "I would like to see other women protected from this kind of abuse and humiliation. We don't deserve this and we shouldn't have to accept it just because there are no laws to protect us." As the account on the previous page illustrates, the physical and emotional health of wife-rape survivors as described and testified to by nurses is a powerful instrument of persuasion for legislators. We need to continue to explore the consequences of this violation to women's health. But for now we certainly have enough information available to help these victims both therapeutically and legislatively.

REFERENCES

1. Russell, D. E. *Rape in Marriage*, New York, Macmillan Publishing Co., 1982.
2. Finkelhor, D., and Yllo, K. *License to Rape: Sexual Abuse of Wives*. New York, Free Press, 1987.
3. Shields, N. M., and Hanneke, C. R. Battered wives' reactions to marital rape. IN *The Dark Side of Families*, ed. by D. Finkelhor and R. J. Gelles. Newbury Park, Sage Publications Inc., 1983, pp. 131-148.
4. Frieze, I. H. Investigating the causes and consequences of marital rape. *Women Cult.Soc.* 8(3):532-553, 1983.
5. Shields, N. M., and Hanneke, C. R. *Comparing the Psychological Impact of Marital and Stranger Rape*. Paper presented at the National Conference for Family Violence Researchers, held in Durham, NH, July 1987.
6. Risin, L. I., and Koss, M. P. The sexual abuse of boys. *J.Interpers.Violence* 2(3):309-323, 1987.
7. Di Nitto, D., and others. After rape: who should examine rape survivors? *Am.J.Nurs.* 86:538-540, May 1986.
8. Helton, A. Battering during pregnancy. *Am.J.Nurs.* 86:910-913, Aug. 1986.
9. Campbell, J. C. Nursing assessment for risk of homicide with battered women. *ANS* 8:36-51, July 1986.
10. _____, and Humphreys, J. C. Providing health care in shelters. *Response* 10(11):20-23, 1987.
11. Kurz, D. Emergency department responses to battered women: resistance to medicalization. *Soc.Probl.* 34:69-81, Feb. 1987.
12. Campbell, J. C. Women's responses to sexual abuse in intimate relationships. *Women's Health Care International.* In press, 1989.
13. _____, and Humphreys, J. C. *Nursing Care of Victims of Family Violence*. East Norwalk, CT, Appleton & Lange, 1983.