Rape Trials, Medical Texts and the Threat Of Female Speech: The Perverse Female Rape Complainant

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Introduction

Despite more than three decades of law reform, debate and scholarship designed to improve the legal response to rape, reporting rates remain low, attrition rates high, conviction rates low and conviction appeals in sexual assault matters have one of the highest rates of success (Kelly, Lovett & Regan 2005; Fitzgerald 2006; Daly and Bourhous 2010; Brown et al 2015). Furthermore, dissatisfaction with the criminal justice system remains a key issue for victims of sexual assault (Clark 2010; Daly 2011). This dilemma led Penny Pether to state:

> But all the speech and the writing, the scholarship and the legislation and the training programs and manuals and the textual artifacts of law reform have changed nothing, except perhaps that a larger number of women in many cultures are reporting rapes, only to experience the various instantiations of the embodied institutional and discursive 'second rape' that is one of the predictors of attrition (2009: 243).

This article analyses the origins of one particular aspect of, and explanation for, this continuing dilemma: the persistent idea that rape is an easy allegation to make but a difficult one to disprove; that rape trials are about 'her word against his'. Jordan (2004: 244) has noted that by perpetuating this myth, men have effectively 'resorted to lying

about women' by perpetuating the lie that '*women* lie'.

Using interdisciplinary methodologies well known to Pether (1990; 1999; 2009), I trace the rise of the myth of women as liars, particularly from the 17th century in the law to its intensification through a medico-legal alliance during the 19th and 20th centuries. I draw attention to the part this alliance played in giving to this myth (ie that women routinely lie) a powerful 'truth status' (Jordan 2004: 247).

Understanding the history of this myth is an important condition for confronting its contemporary tenacity. One of the more disturbing manifestations of the myth that 'women lie' is that, in practice, the criminal justice system continues to prefer 'objective' evidence of rape, in the form of physical injury, despite the fact that the law has formally abandoned any such requirement (Quilter 2015). In the language made famous by Susan Estrich (1987), an alleged rape is most likely to be regarded as a 'real rape' if it involves a stranger; physical force was used; there was resistance; a weapon was used; and there was physical injury to the victim (Lievore 2003, 2004, 2005; Brown, Hamilton & O'Neil; ALRC 2010).

Since Estrich's pioneering work in the 1980s, feminist scholars have continued to attempt to account for the persistence of rape mythologies, attitudes and beliefs that confound progressive statutory reforms to criminal law and procedure (Easteal 1998; Tempkin & Krahe 2008; Horvath & Brown 2009; Larcombe 2005, 2014; Carline & Easteal 2014). In this article I will demonstrate how medical discourses were employed during the 19th and 20th centuries, to interrogate the woman as to whether she was lying about a rape charge.[1] I argue that these discourses were used purportedly to 'scientifically' diagnose the female rape complainant's motivations. However, they in fact actively constructed her as a vengeful liar (see also Crozier & Rees 2013). In the process men were represented as the *victims* of such 'perverse' women; a victimisation that could only be brought to 'light' by medical experts in the interests of Justice – a Justice developed within a patriarchal system. The Woman's story becomes immaterial as a series of experts 'speak' for her, evaluating her story on the basis of what is considered to be the

'truth' of rape. This part of the article intersects with a body of recent literature analysing how forensic medical examiners and other medical professionals shape the collection, processing and analysis of medico-legal evidence often to the detriment of the rape complainant (see for example, De Mont & Parnis 2001; Wells 2006; Parnis & De Mont 2006; Rees 2010; White & De Mont 2009; De Mont & White 2013).

Finally, I will show that these constructions draw upon an un/conscious series of historical, mythical and medical associations between the true woman as one who is radically 'closed' – virginal/chaste, silent and within the private sphere or home – whereas the 'false' woman is constructed as sexually promiscuous, talkative and in the public sphere. In turn, these characteristics of the true/false woman are tied to three particular sites of women's bodies: the genitals; the mouth; and her physical (im)mobility. Specifically, I will illustrate the many (and frequently bizarre) ways in which a connection has been made between the (female) mouth and the vagina – in medicine, literature, the fine arts, mythology and popular culture. Again, both as a founding editor of *Law Text Culture*, and in her own 'law and literature' scholarship (Pether 1996, 2007), Pether amply demonstrated the importance of critical engagement across a diverse range of texts and bodies of knowledge.

1 Early Legal Definitions of Rape

Before turning to the medical jurisprudential writings of the 19th century, it is important to recognise the changes to rape law that occurred in the 17th and 18th centuries. Rape came to be defined through legal commentaries as a crime of sexual intercourse *against the woman's will* (Quilter 2011, 2015). For example, in Hale's famous *Historia Placitorum* (1971: 628) in the 17th century, he defines rape as: '... the carnal knowledge of any woman above the age of ten against her will, and of a woman-child under the age of ten years with or *against her will*.' (emphasis added)

Hale followed this definition with the elaboration:

> The essential words in an indictment of rape are *rapuit & carnaliter cognovits*, but *carnal cognovits*, nor any other circumlocution without the word *rapuit* are not sufficient in a legal sense to express rape (Hale 1971: 628).

The defining feature is *rapuit*, here meaning 'force',[2] which gave rise to the requirement that the intercourse must be against her will, and so the woman must resist to her utmost and 'shew … circumstances and signs of injury …' (Hale 1971: 633). Later commentaries repeated this emphasis on force and against her will (Blackstone 1978; East 1987; Maitland and Pollock 1898) and subsequently the need to demonstrate injuries in order to show the 'true' rape (Quilter 2015).

Hale went on to elaborate a series of circumstances that were said to make the complainant's testimony more or less credible. These were perceived to be necessary since rape, while a 'detestable crime, […] is an accusation easily to be made and hard to be proved, and harder to be defended by the party accused, tho never so innocent' (Hale 1971: 635). In addition to showing signs of injury, Hale states that the woman must make a speedy report:

> For instance … if she presently discovered the offence and made pursuit after the offender … these and the like are concurring evidence to give greater probability to her testimony…
>
> But on the other side, if she concealed the injury for any considerable time after she had opportunity to complain … these and the like circumstances carry a strong presumption, that her testimony is false and feigned (Hale 1971 633. See also Blackstone 1978: 213-4; East 1987: 445-6).[3]

To 'guard' against the unreliability of women and their 'tendency' to make false allegations of rape, the common law developed a rule that, in rape trials, the judge must warn the jury about the danger of convicting the accused unless the complainant's evidence was corroborated (Brown et al 2015: 663).[4] Corroboration was required typically in the form of medical evidence of injuries.

As with the emphasis on resistance and injuries, the requirements

regarding recent complaint and corroboration were later repeated by other commentators (Blackstone 1978; and East 1987) and became entrenched as part of rape law until the late 20th century.[5] The cumulative effect of these assumptions about rape and rape complainants, and their repetition in the commentaries was that the 'true' rape came to be known by whether: the woman was of good fame; there was force used and consequently physical injury; a report was speedily made; and whether the rape occurred in a remote place (Quilter 2011).

Against this 'picture' of the 'true' rape, the woman's allegation was measured; she became an inherently suspect class of witness. Determining whether she was 'lying' became a central preoccupation of the investigation of rape complaints and rape trials. During the 19th century medical expertise was increasingly employed to assist with the task of determining whether a 'true' rape had occurred. In particular, medical experts were called upon to provide a purportedly 'objective' judgment as to whether or not the woman had in fact made such resistance by examining her body for 'signs' of the 'true' rape.

2 The Medico-Legal Construction of Rape

In order to understand the medico-legal construction of rape I have analysed a series of medical jurisprudential writings. In this article I will focus on texts from two broad periods: the 19th century and 1900s-1980s. These periods have been chosen as my interest in this article is primarily historical; providing the 'back story' to the significant statutory reforms to the laws of rape that began in the 1980s (Brown et al 2015: 664), and which, *in theory*, made many of these legal requirements redundant. This history provides another part of the story as to why progressive law reform has not worked to transform the practices of rape investigations and trials: law is not simply what is 'said' on paper but how it is put into practice. Formal law is *involved* (indeed, *complicit*) in the social space occupied by 'rape' but does not control that space. Knowledges and cultural lineages that reside outside statutory definitions and rules of evidence intersect with, without necessarily submitting to, law.

Perhaps unsurprisingly given Western medicine's emphasis upon the physical condition of the body, rape is largely represented in these texts as an event with physical, verifiable 'signs'. Thus, intercourse 'against her will' in these medical writings is understood as a state which can be known by analysing the woman's body for a series of genital/local injuries and/or non-genital/general injuries.

In the 19th and 20th century medical jurisprudential writings, female rape complainants are divided into two main classes: children and sexually active women. Depending on which classification the female belongs, certain injuries are *expected* to result from a rape.[6] In the case of children (and the sexually inexperienced pubescent), the medical texts stated there *should* be genital injuries – the older the child the more likely that there should also be general injuries. In the case of the adult, it was said that genital injuries may occur but more commonly non-genital or general injuries *should* be present since the adult woman is expected to physically resist.

As a result, for over a century the medical vision of the 'true' rape is constructed as a series of verifiable physical signs which may be read by the expert from the woman's body. In turn these 'signs' are utilised to assess the veracity of the woman's complaint:

> Females who have passed this age [ie twelve] are considered to be capable of offering some *resistance* to the perpetration of the crime, and therefore, in a *true* charge, we should expect to find not only *marks of violence* about the pudendum, but also *injuries* of greater or less extent about the body and extremities (Taylor 1854: 648-649, emphasis added).

> The principal point to attend to is whether the *statement* in regard to the violence used is duly corroborated, and this is done in the most unexceptionable way by such *physical* appearances as afford *real evidence* of the *truth* of her story (Ogston 1878: 90, emphasis added; see also: 105-6).

> It is essential that a woman should *resist to her utmost*, and hence *evidence* of such *resistance* on her person is to be *expected* and looked for (Smith 1949: 292, emphasis added).

> Damage to clothing and abrasions and contusions, particularly of the thighs and external genitalia, should always be looked for it involuntary [sic] rape is alleged to have occurred. Their presence tends to support the allegation that the attack was resisted, whereas their absence would be most unusual if such were the case. The author has never encountered a verified instance of rape that was accomplished by physical violence in which there were no marks of violence on the person of the victim (Moritz 1964: 72).[7]

These medical and legal understandings of rape do not merely *describe* a pre-existing reality or 'truth' of rape but are actively engaged in *prescribing* a particular notion of rape to the exclusion of others (see also Crozier & Rees 2012). Rape is constructed in these texts as a physically violent fight. In turn, the woman becomes a (defective) man versed in modes of physical battle like the male attacker. As a man may be said to fight for his 'honour', the 'true' woman is assumed to resist such an attack to her utmost in order to 'defend' her virginity or chastity. As one medical text put it: 'The resistance must be maintained to the last, and until the female is overcome by unconsciousness, complete exhaustion, brute force, or fear of death' (Glaister and Rentoul 1964: 243).

Many of the medical texts actually question the very possibility of raping a 'healthy woman', since she is assumed to be a skilled fighter. While the 19th century texts are sceptical that it is possible to rape a 'healthy woman' (Ogston 1878: 120), generally they accept it as a possibility (Taylor 1854: 653-654). However, later texts suggest it becomes a near impossibility. For instance, Smith says:

> ... whether one man can by his own unaided efforts rape a female in full possession of her senses has led to much argument ... . We must take into consideration the fact that the woman has to be overpowered, held on the ground and prevented from screaming, while at the same time her hands must be held or otherwise restricted, and her legs forced open after disposing of her clothes. This, coupled with the fact that she is still able to twist her body, renders the introduction of the penis extremely difficult, even in women used to coitus, and much more so in a virgin where the orifice has not been dilated (Smith 1949: 292).

While these medical texts constructed rape on the paradigm of a (masculine) 'fist fight' no attention is paid to the specificities of how this form of violence is also sexualised, or to how masculinity and femininity are produced. To give one obvious example, women are traditionally taught to disdain combat or aggressive sports being disciplined into feminine, passive modes of behaviour. These medical models fail to recognise, that the most common reaction to rape is to submit in fear rather than to 'fight back'.

The acceptance of this medical vision of rape is also dependent upon its status as an 'objective' and 'scientific' method of proof. This medico-legal account of rape is based on a 'system' of knowledge that makes distinctions between the 'true' and the 'false', accruing particular power effects to those of the 'true' (Foucault 1980: 131-2). Thus, the vision of rape offered by this system is based upon a series of binaries, revolving around the distinction between the visible or physical (injuries) and the invisible. The physical in turn is related to truth, objectivity, science, justice, the (medical) expert and the (true) rape. These are opposed to the invisible, fiction, subjectivity, and the woman/the false complaint. As with all binaries, the former are prioritised and endlessly repeated *as if* they were the 'truth' of rape, while the latter are devalued and excluded as 'false'. In this way the medical expert is assumed to prove the 'true' rape by *reading* the body of the woman.

The 19th century medical texts did recognise the 'limitations' of the woman's body as a source of evidence although, ironically, this uncertainty tended to perpetuate doubt about whether rape had occurred. For example, it was considered that the presence of genital injuries is *not* unequivocal proof of rape. For instance, Ewell says:

> These appearances may sometimes present themselves to some extent where the venereal congress has been entirely voluntary on the part of both, especially where the parties have been actuated by strong and ungovernable desire (Ewell 1887: 152).

Or Taylor says:

> But the physical appearance of rape about the pudendum may be found, whether the connection has been voluntary or involuntary.

> Thus rupture of the hymen, laceration of the vagina, with effusion of coagula of blood, swelling and inflammation of the vulva, and stains of blood upon the person or dress, may be met with in both cases (Taylor 1854: 649).[8]

The 20th century texts go further, suggesting that proof of general injuries is not unequivocal proof of rape (Pinto 1959: 147).[9]

What is marked in these accounts is that while the absence of injuries suggests that she has not been raped the presence of injuries may also be consistent with rough consensual sex. These conclusions should contradict the 'system' previously discussed, where the medical expert was supposedly able to scientifically prove the 'truth' of rape by analysing the woman's body for signs of physical injury. Nevertheless the system continues to look for these signs because they are said to be relevant in determining whether the woman is lying.

In each of the 19th and 20th century texts, the interpretation of the injuries only ever operates to suggest that rape did *not* occur and therefore the woman was making a false allegation. In all of the texts I examined, there is never an equivalent discussion of the absence of injuries meaning that rape may still have occurred. Views became more extreme in the 20th century suggesting that general injuries – dovetailing with psychoanalytic accounts of feminine masochism – are often consensual or self-inflicted. For example:

> When the victim is an adult, however, (as opposed to a child) it must always be kept in mind that severe injuries can be consistent with violent intercourse with a consenting party (Polson 1965: 406).

> Bruises or lacerations are sometimes self-inflicted in support of alleged forceful sexual intercourse (Simpson 1962: 126).

Not only were these medico-legal models based on the erroneous analogy of the masculine fist-fight and the assumption that physical injuries result from rape, but they also *presumed* that rape complaints were false. However, these medical experts could never produce an absolute and certain proof of whether rape had or had not occurred. Medical examinations always involve issues of interpretation in which

the examination may be put to a particular effect. These texts were imbued with a deep hostility to and scepticism of, the female rape complainant. As I will discuss in the next section, through these discourses, the female rape complainant was 'scientifically' constructed as a perverse individual who would 'cry rape' to the detriment of innocent men.

A Medical scepticism: the 'perverse' female rape complainant and male 'victims'

While medical jurisprudence was employed to 'objectively' analyse the 'truth' of the situation, an analysis of these medical jurisprudential texts reveals that they were not utilised to corroborate the complainant's story. Instead they were used to demonstrate that the complaint was false in order to save 'innocent' men from the gallows.

Taylor, arguably the best known medical jurisprudential author, for instance says in the introduction to his chapter on rape:

> Medical evidence is occasionally required to support a charge of rape; but is seldom more than corroborative ... . *There is, however, one case in which medical evidence is of some importance; namely, when a false accusation is made* (Taylor 1854: 640, emphasis added).

He follows this with an example from Mr Wilde's study of 'false' rape complaints, saying there is a 'great danger to which *innocent persons* are exposed by reason of false charges of rape' (Taylor 1854: 645, emphasis added). Referring to one of these cases Taylor says, '*Medically speaking* there appears to have been not the slightest pretence for charging the accused with the perpetration of rape' (Taylor 1854: 646, emphasis added).

Taylor's remarks are more forcefully reiterated by Dr Lawson, a surgeon for the Women's Hospitals at Birmingham, Nottingham and Southampton during the late 19th century. Indeed, Lawson was engaged to undertake medical examinations of rape complainants only *after* a highly publicised charge apparently turned out to be false. In his research, he argues that out of 100 cases he examined, he found

only six to be 'true' complaints. These determinations were based on whether the girl/woman presented with physical injuries (or the presence of a sexually transmitted disease) (Lawson 1834: 229). These six cases all led to convictions as opposed to the other 94 cases, the majority of which either remained unprosecuted – it seems largely on the basis of Lawson's reports – or failed to produce a conviction at trial. Lawson subsequently described this 'system' as, '[a] most remarkable confirmation of the *perfect justice* of the course adopted here ...' (Lawson 1834: 229, emphasis added).

Lawson claims that currently 'the male sex is so severely handicapped in all such charges [of rape] as to be practically helpless' and that women 'know full well that for a man to have the finger pointed at him with a charge of a sexual offence is to secure that man's extinction ... no matter what the evidence may be.' He says that this situation leads to 'injustice so awful as to pass far beyond words fit for its description' with 'thousands of innocent men ... hav[ing] been practically murdered' (Lawson 1834: 226). He argues that the 'remedy lies in having every case of this kind most carefully investigated by one (or better two) *perfectly independent* and competent experts ...' (Lawson 1834: 232, emphasis added).

Taylor and Lawson both argue that *innocent* men are the *victims* of false female complaints – a representation common to other discourses during this time (Peers 1992: 155-187; Allen 1990: 54-8, 66-88). They argue that medical examinations of these women would (objectively) prove the 'truth' of this situation. In this way the medical expert's evidence is linked to the pursuit of (male) 'justice', a narrative which is recounted across the medical jurisprudential texts. The medical expert, then, purportedly provides a panacea to the potential injustices of the law, by analysing the female rape complainant's body for the absence or presence of physical injury. However, as argued above, a medical examination can never make certain what the truth of the situation was. Instead, these examinations provide interpretations of the female body, framed with the assumption that men are the innocent victims of women's mendacity.

These medico-legal texts are littered with examples of vengeful women and warnings to treat female rape complainants sceptically because they are liars. This hostility is also not something of the distant past; the forms it takes simply mutate. For instance, the 19th century texts, constantly argue that rape is an easy charge to make and that women make such claims to protect their chastity; or for blackmail or revenge. Lawson describes 'the facts' of rape complaints as:

> ... such a shocking state of morality, not being of a sexual kind, as will leave it quite an open question as to whether it would not have been far better that many of these children and the mothers and women concerned with them, aiding, abetting and originating these vile sins, better that one and all of them had been prostitutes openly plying for hire in the market place than have been the vile conspirators and blackmailers that many of them, the great bulk of them, have proved to be (Lawson 1834: 228).

The 20th century texts, in addition to these reasons – dovetailing with psychiatric and psychoanalytic accounts of femininity – cite women's pathological and masochistic nature as the cause of such allegations. For instance Smith says:

> ... it must be remembered that women, especially those of a neurotic type, frequently have delusions or realistic dreams during narcosis, and as these are often of an erotic nature the patient may really believe that she has been the victim of rape ... (Smith 1949: 294).

Complaints were 'explained' in relation to the provocative female, using a variety of female stereotypes, ultimately blurring rape, seduction, flirtation and provocation (see Hood 1984, 34).[10] As late as the 1980s, Sandra Hood, a surgeon involved in training police what to expect from rape complainants says:

> However, all cases of rape, or possibly the correct terminology is alleged rape, are not so readily acceptable at first sight due to the complete absence of the above factors. The female of the species can often be a devious creature and for various reasons she will make false, misleading or indeed malicious complaints to the police. For instance –

1. a young girl out late and having indulged willingly in the act of intercourse with her male partner, on contemplating her return home to wrathful parents has been known to allege that she has been the victim of a sexual attack to detract from her own misdemeanour;

2. the prostitute on not being remunerated the agreed monetary sum for her sexual favours has been known to resort to making a complaint of rape to the police as a form of revenge against her customer;

3. the unfaithful wife or girlfriend being caught in flagrante delicto with her paramour by an irate husband or boyfriend has been known to allege that she was not a willing party to the drama – and you can't get more dramatic than that!

Flippant as these examples may sound, they and many others of an equally diverse nature are often reported to the police as the subject of complaint and investigation (Hood 1984: 34).

Constantly throughout these texts the female rape complainant is constructed as a dissembler, a 'fact' which the medical practitioner will establish through his investigations in order to prevent injustices to men so falsely accused. Suspicion about the woman runs deep, and influenced recommendations about how examination should be undertaken. For example, Knight (1976b) recommended that the doctor should have a 'chaperone' because the female rape complainant is so inherently untrustworthy that she may accuse the doctor undertaking the examination of some 'impropriety' (see also Clarke 1978: 600; Dhai et al 2011). From the moment she enters the doctor's examination-room, the doctor is told to observe her 'gait' – does she walk with her legs apart and with discomfort – her 'bodily habits' – are they in accordance with (their fantasies of) how a rape complaint should present? (see Casper 1864: 288-9; Taylor 1956: 72; Polson 1965: 403; Glaister 1966: 412). Distressingly, the pedagogical recommendation to doctors performing the examination is to seat the victim on the 'least comfortable chair; if she does not fidget, the genuineness of her complaint is suspect.' (Polson 1955: 360; 1965: 402).

The medical texts instruct doctors to be alert for inconsistencies in the woman's story. For instance, Polson and Gee (1973) discuss the way the medical examiner should analyse the woman's clothing – looking for mud, grass, blood, seminal stains or tears – and the condition of the footwear which might 'corroborate' her story. Immediately after this list of things that are to be looked for, they give the following example:

> When a young nannie returned to her employer's house late at night, she alleged that she had been raped and left to walk several miles. A police sergeant examined her shoes; they showed no signs of wear. The police surgeon found no signs of rape; she was menstruating. Later, other circumstances indicated she was a liar and a thief (Polson and Gee 1973: 501).

The distrust with which the female rape complainant is treated reflects that while these medical experts were meant to be carrying out 'perfectly independent investigation[s] and report[s]' to cite Dr Lawson (Lawson 1834: 227), they held the prejudice that the rape charges were false. This bias informs the interpretations made by medical examiners, meaning that the lack of physical injuries can *only* be read as a false complaint while the presence of injuries can be read as consistent with either consensual intercourse or the self-infliction of the injuries. These findings are endlessly repeated, becoming sedimented as if they were the 'truth'. However, far from providing objective proofs, these texts were involved in constructing the female rape complainant as thoroughly mendacious and monstrous.

My analysis and criticism of 19th and 20th century medical texts is not intended to merely replace one bias with another by assuming the veracity of all women. Rather, my aim has been to trace the way in which particular constructions of rape and the female rape complainant (as a vengeful liar victimising helpless men) have been produced and become sedimented as truisms. Why, we might ask, was this threat so prominent? Why were women constructed as so mendacious, particularly given the reality that rape has traditionally been a crime that is under reported and one for which convictions are low? In the next part of this article I attempt an explanation using a series of discourses that make distinctions between the true and the false woman.

3 The True Versus the False Woman

I have argued that 'truths' are formed through the repetition of particular constructions in and across disciplines *as if* they were natural, necessary or common sensical. Such representations are further sedimented through systems of knowledge – particularly scientific knowledges – which produce distinctions between the true and the false and designate power effects to those of the former (Foucault 1980: 131-2). This suggests that the way the law and medicine have constructed women as vengeful liars does not 'originate' in these texts but rather they are citing knowledges from other places, institutions and texts. Threadgold has argued, that such citations are a 'hybrid of both explicit and intended strategies and goals, and implicit and unintended performed and embodied ones', and furthermore, that such citations occur in 'ready made chunks' (Threadgold 1993: 17). This leads to a high degree of stability across institutions and practices. In this part, I explore some of these other knowledges or 'chunks' of texts, that are being cited and circulated in these medical and legal discourses.

The 'threat' women pose to men in the medico-legal texts examined in the previous part, comes from their power of speech: that is, to make a charge of rape. As Lawson put it:

> [Women] know full well that for a man to have the finger of a woman pointed at him with a charge of a sexual offence is to secure that man's extinction ... no matter what the evidence may be (Lawson 1834: 226).

Women who make complaints of rape are constructed as pathological, monstrous or false. They are said to actively engage in intercourse and then 'cry rape' to the detriment of innocent men – they are false in word and deed.

I will argue that these constructions draw upon an un/conscious series of historical, mythical and medical associations between the true woman as one who is radically 'closed' – virginal/chaste, silent and within the private sphere or home – whereas the 'false' woman is constructed as sexually promiscuous, talkative and in the public sphere. In turn, these characteristics of the true/false woman are tied

to three particular sites of women's bodies: the genitals; the mouth; and her physical (im)mobility. An 'associative logic' is made through these connections that suggests women who complain of rape are *a priori* false.

A Substitutions and Displacements

In 1922 Owen Richard Williams, a choirmaster at a Presbyterian chapel, was convicted of the rape of a sixteen year old girl, by whom he was employed to give voice lessons. He obtained 'consent' to sexual intercourse from the girl by representing it as a procedure to improve her voice. The court convicted the defendant of rape under the *Criminal Law Amendment Act 1885* (UK) section 3, which made criminal obtaining carnal connection with a girl by 'false pretences or false representations'. In the trial, Williams was quoted as saying to the girl when he was having sexual intercourse with her:

> It is quite all right; do not worry. I am going to make an air passage. This is my method of training. Your breathing is not quite right and I have to make an air passage to make it right (*King v Williams* [1923] KB 340: 341).

To the modern eye this is an extraordinary statement, however, I will show that in medicine, literature, the fine arts, mythology and popular knowledges, an historical connection has been made between the (female) mouth and the vagina. At times this relationship has been said to figure as an 'intimate' connection with changes in one leading to changes in the other; at other times it is a relationship of substitution via displacement.

B Etymological Connections

Etymologically 'mouth' has the same root as the word 'mother', and in Anglo-Saxon *muth* is related to the Egyptian Goddess Mut. Vulvas have *labiae* or 'lips' as Irigaray has made famous (Irigaray 1985). Walker has pointed out that the Yanomamo word for pregnant also means satiated or full-fed; and 'to eat' is the same as to 'copulate' (Walker

1983: 1037). The Greek *sema* means both 'seed' and 'food' and Walker has demonstrated that early writers describe the male sex role not as 'taking' or 'possessing' the female, but rather 'being taken' or 'putting forth'. Ejaculation was literally viewed as a loss of a man's vital force, which was 'eaten by a woman' (Walker 1983: 1035).

C Medical Writings

In the early texts of Soranus and Hippokratus it was common to make metaphoric connections between the mouth and the functions of the female genitalia. Soranus in his text *Gynecology* explicitly connects eating and desire:

> A woman ingesting and a woman conceiving are engaged in analogous functions; food eaten when one has no appetite is not properly digested, and seed received by a woman when she has no sexual urge is not retained (cited in Laqueur 1990: 51).

The emissions of both male and female during sexual intercourse were also said to be deposited in front of the 'neck' of the womb, which were then thought to be drawn up 'with the aid of breath, *as with* the mouth or nostrils' (cited in Laqueur 1990: 36). Hanson, in analysing ancient Greco-Roman medical treatments of women, describes the way Hippokratic medical writers thought that the uterus was like a mouth which opened when the woman was sexually excited to receive the male seed and then closed its lips tightly to retain it. The 'mouth', however, sometimes remained opened leading to fears of a second impregnation and malnourishment of the foetus. Uterine amulets depicting a uterus with a lock at the 'mouth' were worn by women, in order to ward of this fear of the 'gaping womb' (Hanson 1990: 234).

The pre-Enlightenment body was based on a series of checks and balances in which health was perceived to be a product of 'equilibrium' – for instance, 'balancing' hot and cold, inflows and outflows of substances. This idea of equilibrium suggested that for a woman to remain healthy, that among other things, she must frequently menstruate, engage in sexual intercourse, and give birth to children. If she did not Soranus and Hippokratic writers thought that she would

suffer 'uterine suffocation'. However, this terminology was not simply metaphoric. As Laqueur has demonstrated, in pre-Enlightenment thinking the 'metaphorical and corporeal are so bound up with one another that the difference between the two is really one of emphasis than kind' (Laqueur 1990: 109). Barbara Duden (1991), in her work on an early 18th century German physician, Johannes Storch, demonstrates that the body was based on a series of 'pathways' – which today we would assume are anatomically impossible – through which 'substances' flow in order to keep the body in balance. Thus, the mouth and the womb/uterus/vagina were said to be correspondingly related, such that changes in one led to changes in the other. Thus, the symptoms of 'uterine suffocation' were the loss of voice, choking, gnashing of teeth and rolling of eyes (Hanson 1990: 319, 316). A woman who was treated too roughly during sexual intercourse complains about 'a wind' in her uterus and then reports the next day that it has gone out through her ear or mouth (Duden 1991).

The direct relationship between uterus/vagina and the mouth/neck was also underlined in supposed 'signs' of defloration. It was believed by Soranus that a girl's neck enlarges after she loses her virginity: widening of the 'neck below' resulting in enlargement of the one above (Hanson 1990: 328). It is also probably why singers in ancient medical texts were assumed not to menstruate, since substances were removed through the upper mouth rather than the lower (Lloyd 1983: 194; Laqueur 1990: 36), and why one test for a woman's fertility was placing garlic or onion in her vagina overnight and checking in the morning if her mouth smelt (Lloyd 1983: 65)!

D Hysteria

Probably the classic example of these connections is the 'disease' of 'hysteria'. The term is derived from *ustera* or uterus/womb and in ancient medical texts it was believed that the womb 'wandered' around the woman's body and could literally rise up and choke the woman at the (upper) neck. These connections were continued by Freud's theory of hysteria in the 19th century. Freud believed that hysteria resulted

from the displacement of sensations, through repression, from the lower body to the upper body. Consequently, he argued that while the 'origin' of hysteria lies in some kind of genital sensation, it was said to be displaced onto the upper body into symptoms such as breathlessness, mutism, coughing and hysterical vomiting – the classic case of which was Freud's analysis of Dora.

Elizabeth Grosz (1994) in her work on the 'imaginary body' implies that the reason why changes to one part of the lower body may lead to other changes in the upper body, is that bodies are neither simply real nor imaginary but are rather a 'map' of the meanings of bodies for the subject and society. Thus, while symptoms of hysteria in the 19th century were commonly those involving forms of coughing and mutism, today the most common forms of hysteria are eating disorders, anorexia nervosa and bulimia (Grosz 1994: 40, 77-8; see also Gatens 1996: 12).

E Literature and Myths

These links were also made in ancient literary sources and myths. For instance, the Greek lamiae – she-demons, born from the Libyan snake-goddess Lamia – meant either 'lecherous vaginas' or 'glutinous gullets' (Graves 1995: 206)! Hanson (1996) has documented the way fifth century Greek tragedy assumed a correspondence between the 'upper neck' and the 'lower neck'. In ancient literature a test for virginity was thought to be whether the girl's necklace could still be fastened the next day and whether her voice had deepened. In patristic discourses 'virginity' was not understood simply on an anatomical model of the 'intact' hymen rather the virgin had to 'socially' constitute her purity by remaining, among other things 'silent' (Salisbury 1991). It seems that the 'closed' mouth continued to maintain the 'closure' of the one below! The tenacity of these connections is reflected in Bouce's work on 18th century British sexual beliefs, in which it was commonly assumed that, 'Large as their Mouths, are Women too below' (Bouce 1991: 32). More recently Irigaray (1985) has mimicked these connections in her emphasis upon the multiplicity of female sexuality through her well known phrase, 'when these two lips speak together'.

F Singing

Understanding of singing also reflects these relationships with the voice 'box' in particular, being taken as analogous to the female genitalia. While Wayne Koestenbaum's (1991: 159) study of opera attempts to relate opera (queens) to queer life especially through the falsetto, he recognises that the 'voice' box has traditionally been 'clothed with a feminine aura' – particularly because it is hidden from view. Koestenbaum reproduces photographs of the singing larynx and glottis after the invention of the laryngoscope, which revealed them to look undeniably labial! (Koestenbaum 1991: 213; 1993: 160) (See Figure 1 opposite).

However, such inventions were unnecessary to make this connection, as Kostenbaum documents in 1756 Jean Blanchet had described the glottis as 'a horizontal cleft terminated by two lips' and Robert Weer in 1948 described the vocal cords as 'two thick membranes', 'two lips' (cited in Kostenbaum 1993: 160). In quite a different discipline Max Muller in the 19th century in his *Lectures on the Science of Language*, had depicted the 'organs of speech' as the female genitalia.'[11]

G Vagina dentate myth

All of these sources reflect the historical connections made between a woman's mouth and her genitals, meaning that on some (un/conscious) level the one must evoke the other. The most famous of these connections is the myth of the *vagina dentate* – which literally means the 'toothed vagina' – stories of which are legion throughout the world (Hays 1966: 55-62; Lederer 1968; Weigle 1982; Gershon 1975; Gohr 2013). It is here that we see why the 'open' mouth is perceived to be such a threat to male being. A literal reading of these myths suggests that women have 'teeth' within their vaginas which will bite off the man's penis during intercourse. Many of these stories focus on the 'Tooth Breaker' (the hero) – often Coyote in the legends of some Native American peoples – who makes Woman 'safe' for men, usually by throwing a rock under her which is 'eaten' by the 'teeth below' and in the process they are broken off![12]

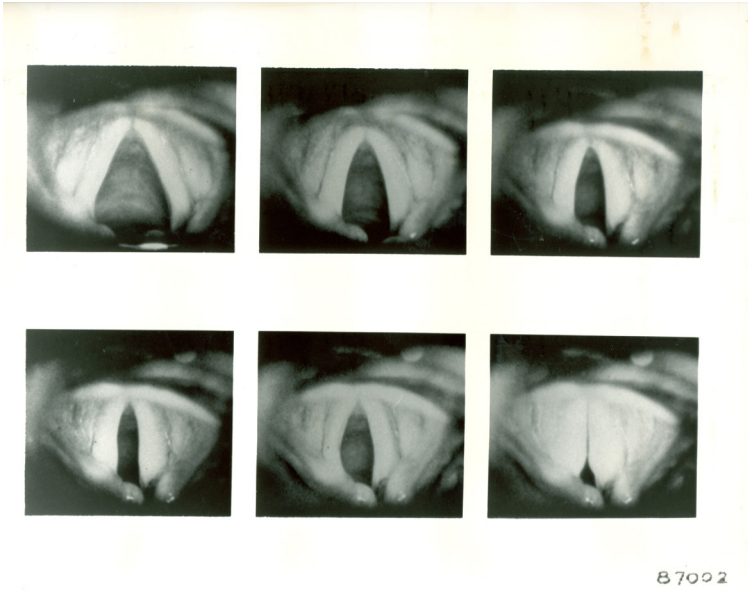

Figure 1: 86-300122: Change in position of vocal cords from breathing to voicing, photographed by a high speed camera.

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The *vagina dentat*e stories are not only of ancient origin. Bram Dijkstra (1986) has demonstrated that during the late-19th century it was common to portray women with feline creatures (tigers, lions, and cats) – the teeth/jaws of which evoke the toothed vagina (Dijkstra 1986: 294). They were also common to surrealist painters such as Magritte (See Figure 2 opposite),[13] and Barbara Creed (1993) has convincingly demonstrated its centrality to the horror film genre.[14]

Curiously, medical research has offered a physiological explanation for this myth, with the discovery of a fairly common syndrome affecting the ovaries called *cystic teratoma*. One form these cysts take are 'dermoid cysts' which are extremely clever in their ability to reproduce literally any organ within the human body and most strikingly teeth: '... hair, teeth, bone, sebaceous material resembling fat ... Up to 300 teeth have been found in one cyst' (Jackson 1971: 341).

'Vaginal teeth' have also been a suggested technique for rape prevention – along with impotence rays. Brodsky (1976) has described the 'vaginal teeth' as an 'oval-shaped object with sharp, inward directed points that are vaginally worn. Working somewhat on the principle of shark's teeth, it would lacerate a penis inserted past it' (Brodsky 1976: 4). Such a contraption was presumably based on the old chastity belt. A Jakarta based ethnic Chinese entrepreneur, Simon Ayasanjava, designed an 'anti-rape corset' and apparently sold 5000 during the Jakarta riots in May 1998 (On Guard 1998: 18).

A related motif is that of the of the *vagina loquens* – the 'talking vagina' – which featured in 12th century French *fabliaux*. One such fable from the mid-13th century was called *Du Chevalier Qui fit les Cons Parler* ('The Knight Who Made Cunts Talk'). Rees has described this particular *fabliaux* as one which '[carries] a moral, focused on the virtue – for a woman – of silence over speech' (Rees 2013: 61).

H The threat of the vagina dentate

As the 'vaginal teeth' device suggests, the literal threat that the *vagina dentate* poses to men's bodies is the threat of castration. What I view as significant in the fables is that they present the threat of corporeal

Figure 2: René Magritte
(The Rape)

extinction to men through the power of women – whether by castration or incorporation or a combination of both. These myths operate through a structure which reverses the active/passive roles ascribed typically to men and women today. Men are viewed as the vulnerable (innocent) victims of powerful women – in the process women were often associated with evil.[15] It is now well documented that during the latter half of the 19th century – notably corresponding with the production of many of the medico-legal texts previously discussed – images of 'feminine evil' proliferated particularly in European art and literature (Bade 1979). The 'femme fatale' also embodied a feminine destructive power over men – indeed, many of the representations deployed the *vagina dentate* image (Dijkstra 1986).

This focus upon the feminine power to castrate/incorporate/extinguish men through these stories is not unlike the representations haunting the medical, legal and psychiatric texts I have documented previously. It is to be noted, however, that such depictions are associated with the 'false' or 'abnormal' woman, not the true or normal woman. As I have argued, the medical texts constructed the rape complainant as a deranged, vengeful, liar – their mouths giving rise to false charges of rape which quite literally pose threats of 'decapitation' or 'extinction' to men. (It is noted that rape was a capital offence in Australia until 1955 - although hanging was the usual means of death.)[16] It is the words coming forth from women's mouths that give rise to this threat – and to where do the medical men go to analyse her words but to her 'lower mouth', to disprove what she has said.

The threat of women's words – in marking a charge of rape – does not originate with these medico-legal texts but has rather been a source of (male) anxiety throughout time.[17] The classic example of such a fear, is the Biblical story of Potiphar's wife (Genesis 39), in which purportedly, fabricated rape allegations against Joseph led to his imprisonment. It also occurs in classical texts for instance, in the *Metamorphoses*. After Terus's rape of Philomela, she cries out that one day Terus would pay for his deed as she will:

> ... throw aside all modesty, and ... tell [her] story. If I am to be kept shut

> up in the woods, I shall fill the forests with my voice, and win sympathy from the very rocks that witnessed by degradation (Ovid 1955: 149).

The violent 'opening' of Philomela's 'lower mouth' by Terus, unexpectedly gives rise to the power of her upper mouth. This threat is so powerful that Terus – 'roused' to 'anger' (Ovid: 149) – violates her upper mouth by cutting out her tongue. However, the mouth(s) once opened cannot again be closed, and she 'tells' her story through her weaving, ultimately leading to Terus' downfall.

Another famous example is Shakespeare's *The Rape of Lucrece*. While Tarquin thinks that through the rape he has mastered Lucrece's mouths:

> The wolf hath seiz'd his prey, the poor lamb cries,
> Till with her own white fleece her voice controll'd
> Entombs her outcry in her lips' sweet fold. (Lines 677-9)

However, the structure of the poem once again dramatises the way rape 'opens' a mouth that ultimately ends Tarquin's existence. Tarquin's voice dominates the poem prior to the rape, yet the rape gives birth to the loquacity for which Lucrece has become famous – we hear only from her after it. In turn, it is through her 'upper mouth' that she names Tarquin to her husband which leads to Tarquin's death.

It might be thought in these last two examples that women are portrayed as 'victims', however, while the rape is acknowledged in the texts, the structure of the active monstrous woman is maintained. As Joplin has pointed out, Philomela is not vindicated. Instead, the two women (Philomela and her sister Procne), in devising their plot for revenge against Terus (by sacrificing the child Itys, significantly through an act of cannibalism), are reconstructed as more violent than the original violence of rape. In this way, the complaint of rape is represented as giving rise to (female) monstrosity (Joplin 1991: 48-9, 62).

Kahn has also noted, that Lucrece not only blames herself for the rape – becoming an 'accessory yielding' (line 1657) – but commentators have often been unsympathetic to Lucrece because she is garrulous:

> Not only is she a less *interesting* character than Tarquin; she is forced

> to express herself in a way which dissipates the real pathos of her situation. … After her violation, Lucrece loses our sympathy exactly in proportion as she gives *tongue* (F T Prince cited in Kahn 1991: 142).

Kahn argues that Prince, the commentator cited above, links Lucrece's speech 'with a physical organ and makes it sound unseemly (even faintly obscene) for her to use that organ to speak about her violation. That violation, of course, also brought into prominence physical organs about which it was unseemly to speak; to be raped and to speak about it are thus similarly indecorous, alluding to matters about which women in particular ought to be silent' (Kahn 1991: 142).

Kahn here understates the 'indecorousness' of Lucrece's 'speaking'. As documented above, there is evidence to suggest that the opening of a woman's mouth in speech, particularly within the context of sexual violation, must on some un/conscious level evoke the open mouth of her vagina. In turn this openness suggests the sexually 'loose', false or monstrous woman. The charge which must be made 'publicly' brings to bear the final connection between the 'open' or false woman.

I The True Woman

There has been considerable feminist work documenting how the 'true' woman is constructed as the one remaining within the private sphere, and especially within the home, versus the false woman being in the 'public' sphere. It seems that it is no accident that the Hebrew word for 'modesty (*zeni'ut*) literally means being hidden' (Epstein 1948: 178). Among such works is that of Clark (1987), who has argued that during the late-18th and 19th centuries the middle class ideology of separating spheres into the public and private, led to a warning for women to stay out of the public spaces for 'fear' of rape. Clark argues that the 'chaste' woman was defined as the wife or daughter who stayed at home or ventured into the public only under the protection of a father/husband. Subsequently, a woman who complained of rape was in a catch 22: by the 'logic' of this system, being 'raped' meant she was in the 'public', so placing herself outside the logic of the 'chaste' woman – in turn, putting her allegation on a 'suspect' footing.

There is also a large amount of theoretical work demonstrating the analogies made in literature between the chaste woman's genitals and the home or closed city walls (Stallybrass 1986; Kahn 1991; Joplin 1991). It is perhaps why a newly married woman was to be carried over the 'threshold' of the house. In medical texts, comparisons between the female genitals and a house are also familiar. For instance, Dr J Peter Bush says:

> The female genitalia can be compared with the doorway to a house. The hymen is the front door set back in the porch. The door may be close fastened, bolted and barred or it may be loosely hinged as a swing door which opens with a puff of wind. An intruder may enter the porch without opening the front door, leaving no marks yet trespass has occurred. He may however leave a muddy footstep on the porch or on the mat (Bush 1977: 11).

The subject of female, physical enclosure also dominates the writings of many feminists. Young (1990) for example, has documented the way girls are *trained* to literally 'enclose' their movements – from the simple carrying out of tasks, to sport and actual bodily comportment.

All of these relationships mean that a series of un/conscious connections runs between 'openness' – of mouth, genitals, publicness – and the false woman, versus the 'closure' of the true woman. The classic example of this is the prostitute (the public, 'open' woman), who because of her apparent 'falseness' in deed was also legally assumed to be untrue in 'word'. Note for instance, Wigmore's examples of such legal precedents:

> It has been pressed upon us with earnestness and eloquence that the condition of a public prostitute... necessarily presupposes the absence of all moral principle, and especially that of regard for truth; and it is therefore contended that a common reputation of public prostitution necessarily includes a common reputation for falsehood ... (Walworth C, cited in Wigmore 1970: 734-5).

Thus, this connection between a woman's capacity to tell the 'truth' and her sexuality, was the basis for Wigmore's creation of a separate approach to admitting evidence in sexual assault cases by deeming

that a woman's character for chastity was always directly relevant to her credibility (Wigmore 1970: 736). In light of these assumptions, it is perhaps less surprising now, why a successful defence to rape was the charge of a woman's prostitution or sexual activity: false in deed, false in word – the two are inseparable.[18]

The law suggests it is only protecting men from the 'false' woman. However, as my earlier discussions of medical and legal texts reflect, 'falsity' was *always already* presumed to be proved once the woman made a charge of rape. Thus, the medical jurisprudential texts begin with enormous hostility and scepticism of the female rape complainant. The way these texts then go on to justify these assumptions – by making a diagnosis of a lack of physical injuries – 'scientifically' consolidates the age-old, presumed logic that the 'open' woman, namely the woman who complains of rape, is false.

Jordan (2004: 243) has noted a paradox embedded in the myth of the 'false woman':

> When women accused men of wrongdoing, they are doubted; when they recant, they are believed. If they allege abuse, their word is suspect if they retract an abuse allegation, their word suddenly becomes credible. One is prompted to ask: Why is women's word to be trusted only when it excuses and absolves men of responsibility for their violence against women? What makes the voice of retraction more credible than the voice of accusation? Is women's word primarily believed when it says what men want to hear and doubted when it challenges?

At this point it is interesting to remember that historically, women were excluded from being a witness in the law courts. In early times the hieroglyph for a 'witness' was represented pictorially by the male genitals (Freud 1963: 68).[19] The word 'testimony' is itself etymologically related to *testes* and a witness who testified in the early Roman courts had to swear on (a bull's) testicles. 'A witness who testifies to something before a (German) court of law is called '*Zeuge*' [literally, 'begetter'] in German, after the part played by the male in the act of procreation' (Freud 1963: 68, brackets in original). In this sense, testimony has

always been antithetical to the female morphology.

4 Conclusion

I have argued that the rise of medico-legal jurisprudence in the 19th century was utilised by the law to purportedly interrogate the woman's motivations for complaining of rape. These new discourses redeployed the common law's emphasis upon the use of force and a woman's character for chastity in particular, to prove not the truth of the complaint but its falsity.

I have suggested that the assumptions made by these discourses rework a long history of associating the 'true' woman with 'closure' and the 'false' woman with 'openness'. Within this framework, the rape complainant – with her open mouth and her position in the public domain – is *a priori* associated with falsity. While I am not suggesting that each of the medical texts is *consciously* citing such a 'logic' there are elements of these connections circulating – even if only peripherally – amongst these texts. The fact that these discourses are related to science meant that their reformulations of older historical assumptions, were credited with particular power to create truth-effects, giving rise to the 'perverse rape complainant'.

Notes

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1 This study follows important works that have been undertaken into the way women are constructed in legal textbooks (Naffine 1992; Frug 1985; Becker 1989; Coombs 1988; Hunter1991; Tobias1988; Conaghan 2003), criminological works (Smart 1977; Young 1996; Naffine 1997; Britton 2000; Heidensohn 2012) and medical writings (Edwards 1981; Scully and Bart 1973; Martin 1987; Katz, Seaman and Diamond 2008). These studies argue – a finding also common to the argument that will be made here – that women are constructed as vengeful liars victimising innocent men (Naffine 1992).

2 The term rapuit has a more complex series of legal meanings and historically could mean everything from a consensual love affair, abduction to violent rape: see Dunn 2011 and 2012; Block 2013.

3 Modern studies have demonstrated that the more typical reaction to sexual assault is for the complainant to delay in complaining and that there are many good reasons for doing so: Cossins 2010; Grey 2007. This has been expressly recognised by many Legislatures see for example: *Criminal Procedure Act 1986* (NSW) s 294(2); *Jury Directions Act* (Vic) s 52; *Evidence Act 1929* (SA) s 34M.

4 By contrast today the mandatory corroboration warning has been abolished in most Australian jurisdictions and legislative provisions provide that a judge cannot warn a jury about the danger of convicting on the uncorroborated evidence of any sexual assault complainant or comment about the unreliability of the class in general: see for example, *Evidence Act 1995* (NSW) s 164 and *Criminal Procedure Act 1986* (NSW) s 294AA.

5 I have argued that even after these requirements were formally removed from rape laws, they continued to operate in the practices of rape trials (Quilter 2011).

6 For recent scholarship critiquing this position see Baker and Sommers 2008.

7 See also Ewell 1887: 151-2; Taylor 1956: 74-75, 79-80; Glaister 1964: 404, 408; Modi 1969: 339; Robinson 1971: 738-739.

8 See also Taylor 1854: 653; Smith 1900: 196-7; Ogston 1878: 90, 105-6.

9 See also Taylor 1956: 67, 80; Polson 1955: 360; Polson 1965: 406-7; Camps 1956: 297-8; Simpson 1962: 123, 126.

10 See also Schiff 1973, 342, 346; Shciff 1979, 97; Ringrose 1975, 442; Knight 1976a, 167; Knight 1976b, 290-1; Underhill and Dewhurst 1978; Theilade 1986, 19; Plueckhah and Cordner 1991, 150; Bowers 2006.

11 Max Muller's depiction of the 'organs of speech' is reproduced in Boy (1998: 5).

12 See for instance the story cited in Trejo 1974: 71.

13 See for instance, René Magritte's painting 'The Rape' (reproduced in Figure 2) in which the woman's torso – breasts, bellybutton and vagina – are displaced into a face, respectively, eyes, nose and of course the genitals becoming the mouth. The picture is reproduced in Gablik 1970.

14 See also Beckett's lesser known play, *Not I*, in which a pair of lips, eight feet high, utter a stream of words with such speed and so elliptically that they become unintelligible – in the process saliva and tongue predominate, obviously invoking the aroused female genitalia. McMullan 1990 has emphasised the play's focus on the *vagina dentate*. For a recent example see Michael Lichtenstein's horror/black comedy 2007 film *Teeth*.

15 Walker documents that during the Middle Ages Christian authorities likened women's genitals to the 'yawning' mouth of hell- the underworld gates always having been 'yoni of Mother Hell' (Walker 1993: 1036).

16 See *Crimes (Amendment) Act 1955* (NSW) s 5(e) which replaced the death penalty with life imprisonment.

17 Similar fears circulate in relation to witchcraft: see Sprenger and Kramer 1969.

18 Today, 'rape shield' laws (eg *Criminal Procedure Act 1986* (NSW) s 293) operate in many jurisdictions to make evidence of sexual reputation inadmissible.

19 It is noted that in Australia it was not until 1923 that women were allowed to serve as jurors; women were not admitted to the bar until 1905; and the first woman Supreme Court judge was not appointed until 1965: Easteal 1998: 3.

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