# reviews

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## NYC Sex: How New York City Transformed Sex in America

The inaugural exhibition at the Museum of Sex, 233 Fifth Avenue, New York City
www.museumofsex.com/

Rating: ★★★

My friend said that she was "sexed out," in the way that Americans say "maxed out" when they've reached the limit on their credit cards. After two hours at the new Museum of Sex in New York we were tired. Sex, sex, sex—anyway, anyhow, multiple, on top, underneath, with friends, with men, with women, with three, with four, banned, censored, published, not published, in graceful 19th century prints and grainy 20th century stag films, or groaning blues—can become boring.

This establishment is trying to be a serious museum. The entrance fee is $17 (£11/€17.40), $7 higher than the Metropolitan Museum, which offers Rembrandts, Vermeers, Titians, Impressionists, Egyptian, Greek, and Roman art, French furniture . . . your feet will hurt, but at least the Met has restaurants. On the other hand, the Museum of Sex's entrance fee includes an audio device giving information about exhibits. There are crowds, mostly heterosexual young couples, including some British tourists, and queues at weekends.

This inaugural exhibition at this museum suggests that sex began in New York in 1836, although you might have suspected earlier origins. "NYC Sex: How New York City Transformed Sex in America" explains how this wicked town offered freedom to Americans from what my friend calls "those rectangular states" and was also full of decadent Europeans, now called Eurotrash.

In 1836 Helen Jewett, a high class prostitute, was murdered. James Gordon Bennett, founder of what is today's *International Herald Tribune*, knew a story when he saw one and covered it in titillating detail. Period tourist guides rated houses of prostitution in the same way that restaurants are rated today. Anatomical museums (from which women were banned) showed subjects of prurient interest, such as syphilitic destruction of nasal bones. Remedies for sexually transmitted diseases were sold by mail order.

Medical folk will be interested in abortion instruments, made in Paris in the mid 19th century, and Madame Restell, abortionist to the rich, who committed suicide after legal charges. Other exhibits show Margaret Sanger, the family planning pioneer who was jailed for her work; anti-vice crusader Anthony Comstock, who railed against contraception; and Julius Schmid, who developed and promoted condoms.

Sex and entertainment mingled in risqué shows and films. Warnings about "white slavery" were common. So were advertisements for muscular and sexually attractive men and women—Eugen Sandow

THE KINSEY INSTITUTE

**Mae West was jailed for her sexy plays**

and "Little Egypt," a belly dancer. Mae West was arrested and jailed for her sexy plays in 1928 (the publicity was fabulous). Art and artefacts show homosexuality, cheesecake and beefcake art (sexy women and men), sado-masochism (sample equipment), and society's changing attitudes. In 1952, tabloid headlines announced "Ex GI Becomes a Blonde Beauty," when George Jorgensen underwent sex change surgery in Denmark and became Christine Jorgensen.

The golden age of porn followed in the 1960s and 1970s, the days of the film *Deep Throat*, of Playboy clubs and Playgirl waitresses in bunny suits (there's one in the show), and of explicit sexual films (clips are shown). Then in 1981 there was AIDS, and the age of sexual freedom ended.

The museum is educational: why did we punish our friends and neighbours for their preferences and deny our own sexuality? Alas, the rich history of sex among our ancestors—how else did we get here?—is ignored. There is nothing about hetairai (concubines in ancient Greece), medieval mixed-sex baths, or sexual manuals like the *Kama Sutra*, and nothing like the directions to a brothel that I saw in the ruins of Ephesus—an erect penis pointing the way. Perhaps these will feature in the next exhibition.

THE LESBIAN HERSTORY ARCHIVES

**Football team from the Howdy Club, a lesbian bar in the 1930s and 1940s**


**Janice Hopkins Tanne** *medical journalist, New York*

# A Number

By Caryl Churchill
Royal Court Theatre, London, until 16 November 2002
www.royalcourttheatre.com/

Rating ★★★

How would it feel to find out that one is a clone? What would this knowledge do to one's sense of self and relationship to others, especially the other clone? This is this play's principal subject and it is handled in a creative and mostly fascinating manner.

Cloning as a subject is both a benefit and a burden. It's hot. And many of those who chose to treat it in dramatic form have got burned in the process. Eva Hoffman's novel *The Secret* is but one disappointing example of works that sink beneath the weight of contorted scientific exposition, moral conceits, and characters who exist merely to prove a point. There is a bit of that here, but not much.

Dealing dramatically with moral issues is also highly topical but difficult. All too often, we are presented with unpersuasive drama clinging to a scaffold of moral points. Churchill largely avoids this trap as well. She touches on the central moral and metaphysical issues presented by cloning, but her focus is tight.

The play is spare in every sense—only an hour in length, with minimalist staging, and with only two actors, Michael Gambon and Daniel Craig.

Gambon is Salter, father of three sons who are clones. Craig is—sequentially—B1, B2, and Michael Black. Although he wears the same jeans and T shirt throughout, he transforms himself into three very different characters by accent, gesture, and facial expression. Gambon's performance is mannered, fussy, and emotionally unconvincing.

When he learns that he had been cloned from an older sibling, B2—a sensitive and gentle person—compares his reaction to finding out that he was a twin who'd been separated from his brother at birth. "A twin would be a surprise," he says, "but a number, any number, is a shock."

Whether the act of cloning is a moral and legal wrong is explored in various ways. The greedy Salter wants to sue. When he lies to B2—telling him that he was the original—he says that "the cells from which the other clones were made "were stolen from you and you should get your rights."

B2 feels that he's not authentic. "I'm just a copy. I'm not the real one," he says.

B1 is full of rage at the very real wrong that was done to him by a distant and unloving father. "You sent me away and had this other one made from some bit of my body . . . and you threw the rest of me away." Salter replaced him like a defective product.

What I liked best about the play is Churchill's evocation of the doppelganger—a theme that has fascinated psychologists, including Sigmund Freud and Otto Rank. In his essay on "The Uncanny," Freud describes various kinds of doubles. Some just look alike. Others show signs of mental telepathy. Still others undergo what

ROYAL COURT THEATRE

**Send in the clones: Daniel Craig and Michael Gambon in** *A Number*

he calls a doubling, dividing, and interchanging of the self.

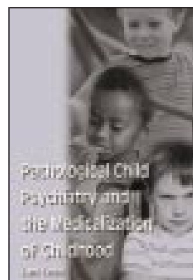
Particularly frightening are doubles whose appearance heralds psychological disintegration or death. B2 tries to run away from B1—the displaced and replaced first child—whom, he believes, has been stalking him. "Don't they say you die if you meet yourself?" asks B2.

So where does our individuality reside? Is it all in the genes? Clearly not. As Michael Black—the banal clone—tells Salter, "We've got 99% the same genes as any other person . . . We've got 30% the same as a lettuce. Does that cheer you up at all?"

**Arlene Judith Klotzko** *lawyer, bioethicist, and writer in residence at the Science Museum*

# Pathological Child Psychiatry and the Medicalization of Childhood

Sami Timimi



Brunner-Routledge, £15.99, pp 190
ISBN 1 58391 216 9

Rating: ★

When asked to review this book I leapt at the opportunity. Children who are in some way "failing" represent a significant proportion of the referrals to my clinic. Despite the rather scathing way that many professionals, including some doctors, refer to diagnosis as "the medical model" (always used pejoratively), many parents and many other professionals welcome a diagnosis. Being too lively is ADHD (attention deficit hyperactivity disorder); clumsiness is dyspraxia; failing any of the three Rs is dyslexia; odd mannerisms or a poor social mechanism suggests an autistic spectrum disorder. The medicalisation of childhood, perhaps? And resources and benefits (such as educational support and Disability Living Allowance, respectively) follow diagnosis. Health professionals, education services, social workers, and Benefits Agency staff sit up and take notice at certain diagnoses, however much they may claim not to.

I was disappointed. This book is very much a personal view and, I suspect, rather cathartic for Timimi. He writes in an autobiographical style, and draws on his experience as a teenage immigrant from Iraq. He clearly wants to get a few things off his chest about his training. Describing his book as "an act of resistance" shows that perhaps Timimi views himself as a maverick.

The first six chapters are a mixture of philosophy and grievances with children's mental health services. I am not sure whether his previous consultants will recognise themselves from his descriptions, but this is obviously a book that Timimi could publish only once he had become a consultant himself. He might feel that this proves his point that child psychiatry is not open to novel ideas, approaches, or criticism. Chapter seven is the one bright spot, with examples focusing on ADHD (although there are other brief anecdotes scattered through the book). However, Timimi starts the next chapter with a sentence that occupies the whole of the first paragraph. The discussions of postmodernism and the philosophical arguments did just what the ball did to the goalkeeper of England's football team—they went over my head.

Child and adolescent mental health services certainly need a good shake up, but this book is not part of the answer. Although the book is aimed at professionals in mental health services, I think it is more likely to become popular as a text on sociology courses. It was of little value to this jobbing neurodevelopmental paediatrician in a district hospital.

**Charles Essex** *consultant neurodevelopmental paediatrician, Gulson Hospital, Coventry*
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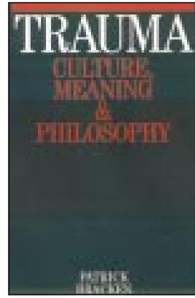
## Trauma: Culture, Meaning and Philosophy

Patrick Bracken



Whurr, £21, pp 230
ISBN 1 86156 280 2

Rating: ★★★★

Pat Bracken, who has doctorates in both psychiatry and philosophy, has written a remarkable book. He describes how Western societies now frame the impact of violence and other types of suffering, and questions of responsibility and morality, through the sciences of memory and psychology. Orthodox psychiatry presents us as creatures whose nature lies in the ways our brains are wired and our memories stored. Bracken is critical of the cognitivist view of the brain as a processing machine, in which the meaningful nature of reality is seen as something arising from programmes or schemas running in individual minds. Therapy is directed at these supposedly disrupted schemata. He queries the assumption that psychiatric classification systems capture universal truths about distress and madness when they largely ignore the meaning the patient attaches to what he or she has passed through. This connects to critiques of the medicalisation of life published in the *BMJ*'s recent theme issue (13 April 2002).

Psychiatry and psychology see a breakdown in the meaning of things as a scientific problem, but this is to ignore its anthropological, sociological, and philosophical dimensions. Bracken owes a debt to Ivan Illich, author of *Limits to Medicine* (reviewed *BMJ* 2002;324:923), and the French philosopher Michel Foucault, but he points in particular to the German philosopher Heidegger for an antidote to the dominance of Cartesianism in the humanities. Heidegger saw the meaning of being in the world as residing not in cognitive schemata, but in a background intelligibility generated by engagement in everyday life. This certainly chimes with my experience of working with refugee survivors of torture and war. Even in psychiatric referrals, the "trauma" seemed largely to be something that had happened in their lived lives, not in the space between their ears.

Is the spectacular rise of "trauma," both as psychiatric category and as cultural idiom, connected to the hopes and fears of modern life? We live in brittle, individualistic times, with social vitality dependent on ever widening patterns of consumption requiring identification of new needs and desires. At the same time there has been a withering of religious and other transcending meaning systems, and Bracken queries whether this has left us with a sense of vulnerability about our belief in a coherent and ordered world. Thus unpleasant experiences, which we now label "traumatic," may be more likely to leave us shaken and doubting.

As befits a consultant psychiatrist who started an innovative home treatment mental health service in Bradford, and who has the ear of the Department of Health, Bracken has written a book about practice as well as theory. He and his colleagues practise what they call "postpsychiatry," in which questions of social context, values, and the patient's own model of the illness are central. The emphasis is taken off diagnostic pigeonholing without refuting the tools of traditional psychiatry. Bracken also traces the export of Western psychiatric categories—not least post-traumatic stress disorder—and practices to non-Western settings, noting how this has promoted professional elitism and institutionalised responses to distress, as well as undermining indigenous healing systems. The Western medicotherapeutic view is culture-bounded and there are other interpretations of the world.

**Derek Summerfield** *honorary senior lecturer, Institute of Psychiatry, London*

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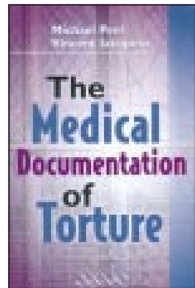
## The Medical Documentation of Torture

Eds Michael Peel, Vincent Iacopino



Greenwich Medical Media, £39.50, pp 228
ISBN 1 84110 068 4

Rating: ★★★

I spent some time last month at a medical centre in Dover that deals with the immediate health needs of asylum seekers arriving from the continent. Asylum seekers are routinely pulled off the backs of lorries and freight trains: 40 to 50 claim asylum at these docks every day. Many have travelled for months in poor conditions, and are inevitably exhausted and traumatised. The general practitioner at the medical centre will deal with anything from sprained ankles—often the result of being pushed from lorries at haste—and cuts from scaling barbed wire border fences, to minor ailments stemming from fatigue and anxiety.

Some of the asylum seekers will have experienced torture in their home country. Not only will they perhaps need the help of healthcare professionals to overcome the trauma of such experiences, but they may also need them to help verify their claims of torture for legal reasons. A medical report can be the evidence that either enables asylum seekers to stay in the United Kingdom or leads to their deportation. Increasingly GPs are being called upon to write medicolegal reports, but it is a skill that many of them do not have. Also, when an asylum seeker recalls a traumatic history of prison beatings and solitary confinement, and says he fears for his life should he be forced to return, how do you know if he is telling the truth? What are the physical and psychological signs that a doctor should look out for? Signs of torture are rarely obvious; most lesions heal within about six weeks of torture and leave non-specific scars or no scars at all. So carrying out a balanced and accurate assessment requires expertise, time, and a great deal of patience, especially when working through an interpreter.

*The Medical Documentation of Torture* comes at a time when there is a real need for discussion and information on these issues, especially when asylum seekers are increasingly being dispersed to areas outside of London to general practitioners who have little or no experience of such patients. The authors offer a thorough and informative reference source, with contributions from many of the key players in the field of health and human rights. The book supports the work of healthcare professionals, lawyers, psychologists, and human rights activists, and provides an overview of the asylum issues with respect to torture. There is practical guidance for medical professionals in ways to approach, treat, and document torture in individual patients. Being able to distinguish physical signs of recent torture from late signs of torture is vital if a doctor is to differentiate a claim of torture from accidental and self-injury.

Fifteen years since the United Nations Convention against Torture came into force, torture and ill treatment continue to be recorded in at least 111 countries throughout the world. The convention remains the least ratified of the six existing international human rights treaties. The time has come to start asking hard questions about how governments in host countries respond to the health needs of asylum seekers arriving on their shores, and this book offers a solid foundation.

Healthcare professionals are in a unique position to push for change, both through working to dispel myths and reverse the prejudice that is increasingly being directed towards refugees and asylum seekers, and by assisting those who have suffered torture in their home countries to start rebuilding their lives.

**Sally Hargreaves** *medical writer and researcher, International Health Unit, Hammersmith Hospital and Imperial College, London*
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PERSONAL VIEW

# After September 11: a doctor's perspective

Since September 11, an unruly world has got worse. For us in the Arab and Muslim world, the change has touched us deeply and negatively. Firstly, there was the adventurous war on Afghanistan and unprecedented oppression in Palestine; and now there is the probability of war against Iraq. We are entering an era of massive action by a rising militarism obsessed with security and domination.

Internally, we face more restrictions on political rights under the pretext of security, economic conditions continue to worsen, and religious extremism driven by hopelessness rises. People's needs—national, political, and economic—remain unaddressed, while unmatched wealth is squandered and cheap oil is exchanged for expensive arms. All this has laid the ground for more conflict. This terrible situation is not our problem alone. Because the tremendous suffering associated with ongoing conflicts has affected many communities all over the world, before, on, and after September 11, everyone is concerned.

Doctors must find a way to confront the widespread hopelessness. Instilling hope is one of our main duties in patient care; shouldn't this be the case when confronting our social and global ills? In an increasingly polarised world, we doctors from across the divides should recognise our common histories, interests, and interlinked futures. While some see threatening cultural differences, we see a history of exchange that has left interconnected cultures. While some speak of the inevitability of war and division, we speak of the indispensability of peaceful co-existence and of tackling global threats, such as growing inequalities, economic uncertainty, the consumption of natural resources, and health catastrophes, including the AIDS epidemic.

Doctors can do much to undermine those who contemplate war and lay the ground for more conflict. Just as we are in the business of disease prevention and health promotion, we are, or should be, in the business of war prevention and peace promotion. Just as we try to expose and treat the social, economic, and political determinants of ill health, so can we directly expose and seek to treat the determinants of war and conflict. Frequently, these determinants are the same. What can we do? Use our credibility to educate the public about peace and our clout to put pressure on leaders to adopt more sensible policies, join other social and political groups concerned with the prevention of war, and exercise our voting rights, where we have them, in favour of peace.

We have to concentrate our efforts on exposing powerlessness, injustice, and oppression, both within countries as well as in international relations, and on confronting the language of intolerance, labelling, and the generalisations of the powerful war machine and its servile media. How can we accomplish these tasks if medicine does not return to the social activism that German pathologist and statesman Rudolf Virchow called for in the 19th century?

There is great potential for effective work in peace promotion among our frustrated physician grassroots. Since September 11, there has been little visible action by international doctor groups to cultivate the energies of these silenced grassroots to address the rising tensions and confront the drums of war. Solidarity among doctor groups can be a source of hope at a time when the future of the world, our region in particular, is being drawn according to misguided security priorities, not the demands of reason. Today, broad dialogue among doctors on war prevention and peace promotion using visible and effective global platforms is sorely missing.

Providing humanitarian aid is not an adequate response by doctors to conflict

In the early 1980s, doctors from nuclear countries moved to organise the global medical community against nuclear war. By 1985 their umbrella organisation, International Physicians for the Prevention of Nuclear War, grew to include 140 000 doctors and won the Nobel peace prize. As the nuclear threat was of most concern to US and European doctors, the involvement of doctors from the South was limited. While the prevention of nuclear war remains an important priority, the agenda for physician activism in war prevention now needs to be expanded. Doctors from the South need to be more visible. We need to bring back the energies of global physician movements to promote models of dialogue and joint work, to educate and enlist the public, to urge international and local political leaders to adopt more sane policies, and to provide a voice of reason in ongoing conflicts. Providing humanitarian aid to people in war torn areas, while important, is not an adequate response by doctors to conflict.

The state of world affairs is a source of despair. Doctor solidarity can do much to instil hope. We must recognise that while our lives may seem more disconnected after September 11, we share common destinies that require our collective action.

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SOUNDINGS

# *Bill and Bob*

We had been asleep for more than an hour when the phone rang. Assuming a wrong number, we ignored it. Fifteen minutes later the bedroom filled with slowly strobing blue light and there was a loud rap-rap at the door. I pulled on a dressing gown and went down to face the policeman.

He read out my full name and I confirmed my identity. He spoke into a walkie-talkie. "Located the next of kin, Sarge, over." At my kitchen table, he introduced himself as Trevor, our family liaison officer. "Your uncle," he said, "has been reported missing. The police are out combing the streets. We need a full description and a recent photograph."

Uncle Bob had always been incorrigible. Large, bewhiskered, and irrepressibly gregarious, he had appeared periodically throughout my childhood with his pockets stuffed with forbidden lollipops. His love life had been colourful but unenduring, and following a series of cerebral infarcts, he had transferred his attentions to the nurses at a home for elderly mentally infirm people.

We had no pictures of him. In his striped pyjama top and long grey mac, Uncle Bob would be indistinguishable from the thousands of half-cut tramps on London's streets.

My husband joined the search, leaving me pacing the kitchen and trying not to think of inquests and funerals. Uncle Bob had taken his insulin but no food, hence (apparently) the heavy turnout of foot police, sniffer dogs, and—as the search wore on—a helicopter with heat seeking equipment.

Later, I remembered Uncle Bob's passport and took it round to the home, where the lounge had been turned into an incident room and 20 rain soaked officers were temporarily regrouped around a large-scale map. Some of the residents had awoken and placed themselves in their usual chairs. "It's very exciting, isn't it?" said one lady.

Suddenly Trevor's walkie-talkie crackled. The game was over. Uncle Bob had been found by a panda car, curled up by a statue of a naked lady—hypothermic, normoglycaemic, and refusing hospital admission. He had, he claimed, received a message about an impending Iraqi invasion, and had gone off in search of the secret agents.

The nurses and I hugged one another and the traditional cup of tea was offered all round. "Thanks," said Trevor, "but we've just been redrafted. There's an 80 year old lady on the run from a care home in Walthamstow."

**Trisha Greenhalgh** *professor of primary health care, University College London*