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# Module « Représentations et modèles de santé »

Les mécanismes d'exclusion liés à la politique de santé, dans le passé et à l'heure actuelle, sont étudiés dans le cadre de ce module; celui-ci s'intéresse par ailleurs comment les conceptions eugéniques en Suisse influèrent sur la pratique de la médecine, de la psychiatrie, du travail social et de la naturalisation. Les scientifiques tentent d'expliquer dans quelle mesure les pratiques institutionnelles de la psychiatrie, de la génétique et de la médecine de la reproduction intègrent ou excluent. Par ailleurs, un projet porte sur la comparaison des différentes cultures de la santé en Suisse, tandis qu'un autre concerne les stratégies d'intégration visant à faciliter l'accès aux systèmes de santé dans les zones urbanisées en Europe. Les effets de la stigmatisation opérés par de personnes psychotiques sur leurs enfants sont également étudiés dans le cadre de ce module.

## Projets

Cultures de la santé en Suisse: analyses comparatives des valeurs et normes relatives à la santé et de leur rôle dans les processus d'intégration et d'exclusion en Romandie et en Suisse alémanique
*Thomas Abel*

Barrières d'accès aux systèmes de santé et exclusion – étude comparative des stratégies mises en œuvre pour améliorer l'accès et combattre l'exclusion sociale dans des contextes urbains en Europe
*Sandro Cattacin*

Génétique, médecine de la reproduction et société: effets de l'intégration et de l'exclusion en médecine
*Hansjakob Müller, Ruth Ella Baumann-Hölzle*

Stigma et identité. Formes d'intégration et mécanismes d'exclusion liés à la biographie et au contexte psychosocial des enfants des parents psychotiques
*Daniel Sollberger*

Internement et intégration. La contrainte en psychiatrie: l'exemple de Zurich entre 1870 et 1970
*Jakob Tanner*

Concepts et mesures eugéniques en psychiatrie et dans l'administration. Des politiques de normalisation, d'intégration et d'exclusion, à l'exemple de la ville de Bâle entre 1880 et 1960
*Regina Wecker, Bernhard Küchenhoff*

Les services sociaux en relation avec l'eugénisme, le genre et les discours de normalisation médicale et psychiatrique à Berne et St-Gall (1918–1955)
*Béatrice Ziegler, Gisela Hauss*

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# Health cultures in Switzerland: Comparative analyses of health-related values and norms and their relevance for social integration and social exclusion in the French- and German-speaking parts of Switzerland

Thomas Abel

## Summary of the main results (extract from the final report)

The project examines health-orientated values and norms within the Swiss population with regard to their relevance to integration and exclusion. It concentrates on the question to what degree the population accepts or refuses the unequal distribution of social health chances. The results provide clues as to whether health-related value and norm patterns contribute to the coherence or diversification of the Swiss society. The project has a character of a comparative study. The centre of its interest is the distribution of health-relevant values and norms in both language areas, namely the French and the German speaking parts of Switzerland. Beside the language affiliation, gender, age and social status represent additional socio-cultural categories in the data analysis. A survey of individual attitudes and orientation allows conclusions to be drawn regarding the group-specific differences in health-related values and norms.

Subject of a concrete examination are specific health- and illness-related attitudes which will be assigned to the areas solidarity, equal opportunities, attribution of responsibility, stigmatization, and tendency to sanctions. These five concepts result from a specification, which gave the abstract terms of integration and exclusion their concrete dimensions. The concepts of integration and exclusion will be applied to three specific health problems, namely HIV, overweight and chronic headache. The study chooses the methodological approach of a standardized telephone population survey. The applied questionnaire was mostly self-developed and then translated into French; its controlled translation back into German made sure that a linguistically equivalent French version was obtained. To the population belong members of Swiss private households from the age of 18 years. The random sample was obtained by means of a two-step random selection from the electronic telephone directory. The exhaustion of the net sample (field work: March – July 2004) is 42% in the German speaking part and 37% in the French speaking part of the country. It can be assumed that the quota of interview refusals and interruptions (49%) was due to the length of the interview (average 39 minutes) as well as to the demanding and at the same time sensitive issue «integration and exclusion». The results show, at the bivariate level, a considerable number of statistically small, however with regard to their direction, consistent differences between both language regions. They indicate a more distinct sense of solidarity and equal opportunity as well as less sense of direct responsibility and willingness to sanction in the French speaking part.

The postulated scales on solidarity, equal opportunity, direct responsibility, stigmatization and willingness to sanction were tested by means of item and factor analyses; at the same time, in correspondence to the research question, the option of different scale composition according to the language region was considered. The resulting factors for both regions are independent of each other and basically correspond to the postulated concepts. At the same time, their composition shows partly identical, partly different scales for the German and French speaking parts.
At the multivariate level, the constructed scales were subjected to multiple linear regressions in order to examine the connections between selected social stratification characteristics and subject-specific aspects of integration and exclusion. Gender and political attitude appear to be important predictors, as women express themselves often more strongly in favour of social integra-

tion than men, and a stronger political right-wing view reflects a more frequent tendency towards favouring the exclusion. Social status and religiosity as statistically significant predictors of integration and exclusion in the German speaking part appear to be much more frequent than in the French speaking one. At the same time the results show that with increasing religiosity the views favouring social exclusion are more numerous.

The current study has shown that a complex and partly sensitive research topic as dealt with here can be realized within the scope of a representative population survey and that it can, despite mentioned failures (interview refusals), reach usable participation quota. The results of the study refer to interesting commonalities as well as differences between the German and French speaking parts of Switzerland: The views relevant to social integration and exclusion on health handicaps prove to depend most of all on gender and political views two determinants which are of similar importance in both parts of the country, whereas social status and religiosity play an important part almost exclusively in the German speaking part. As for integration and exclusion, the results refer to considerable differences that are language area-specific and also relevant from a socio-political point of view: The French speaking part shows a significantly stronger emphasis on the collective, the German speaking area on the individual responsibility.

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# Barrières d’accès aux systèmes de santé et exclusion – étude comparative des stratégies mises en œuvre pour améliorer l’accès et combattre l’exclusion sociale dans des contextes urbains en Europe

Sandro Cattacin

## Résumé des principaux résultats (extrait du rapport final)

De nombreuses études ont montré que les pays européens sont aujourd’hui touchés par des inégalités de santé et que la fracture sanitaire est en train de s’amplifier. Face à ce constat, nous avons voulu montrer comment les difficultés à l’accès en matière de santé publique sont approchées au niveau local et comment les réponses choisies deviennent une force motrice pour moderniser les systèmes de santé. La question de l’accès aux services de soins reste difficile à résoudre au niveau national où les politiques sont façonnées et c’est la raison pour laquelle des solutions pratiques ont émergé dans des contextes locaux urbains qui doivent faire face à des situations difficiles d’exclusion du système de santé. Ceci en particulier dans le contexte où l’accès aux systèmes de santé est considéré très souvent comme un droit humain que l’État social doit garantir.

Un des éléments principaux dans ce contexte est que les institutions de santé publique doivent faire face à des demandes de plus en plus diversifiées sans pour autant avoir été préparées à traiter la diversité. Beaucoup de problèmes d’accès naissent donc du système de santé lui-même, ce qui remet en cause son organisation interne et implique la mise en place de processus d’adaptation importants pour que le mandat d’assurer la santé de la population puisse être maintenu. Les institutions de santé publique sont aussi confrontées à des difficultés dans la communication, notamment dans la mise sur pied de stratégies d’information performantes et le contrôle de la qualité dans les services. De plus, les systèmes de santé affrontent la nécessité d’assurer une couverture sanitaire complète aussi à ces personnes qui ne bénéficient pas d’une caisse maladie ou qui font partie d’une couche socio-économique défavorisée.

Nous exposons dans notre projet différentes orientations et initiatives qui ont été développées au niveau local ces dernières années et qui ont vu le jour pour pallier les lacunes dans le domaine sanitaire et pour agir sur les barrières d’accès. Celles-ci sont de différents types et les réponses diffèrent aussi, notamment selon les contextes locaux. Elles sont caractérisées par le désir de tenir compte de la diversité sociale dans les services de santé, d’offrir des nouvelles formes d’affiliation à des assurances maladie, elles incluent des interventions menées par des acteurs de mondes parallèles pour réinstaurer les soins pour les exclus, des organisations communautaires qui tentent de remplir les brèches et concernent aussi la diversification dans l’offre de services par des acteurs institutionnels. Ces stratégies peuvent être résumées par une typologie d’orientations qui comprend des approches marquées par le mainstreaming de la différence vs. la spécification de la différence et l’accès indiscriminé aux institutions sanitaires vs. un accès sélectif.

L’analyse de ces différentes orientations nous permet de montrer comment se différencient les procédures qui visent à diminuer les mécanismes d’exclusion. Celles-ci ont un impact distinct sur les barrières d’accès au système de santé en constituant des points d’entrée supplémentaires pour permettre, dans un deuxième temps, l’accès au système de santé général. Ces orientations montrent qu’une force innovante peut surgir quand on introduit de la réflexivité dans les services ou quand on procède à l’ouverture de ces derniers par l’intérieur, notamment par la spécification des services. Les barrières peuvent aussi être diminuées par des mécanismes de généralisation, en particulier par la généralisation de l'inclusion de la diversité et par des structures de représentation de groupes d'utilisateurs (minorités, handicapés, etc.). L'analyse montre que la sensibilité à la différence dans un système universel et le développement d'une approche basée sur le «fait du pluralisme» (Rawls) – c'est-à-dire la sensibilité à la différence comme résultat d'une modernisation qui s'oriente par rapport à l'équité – sont des conditions fertiles pour introduire des mesures dans le domaine de la santé. Le cas de Bradford (Royaume-Uni) le montre clairement. C'est en même temps un modèle risqué, parce qu'il s'appuie sur l'idée qu'une orientation peut s'appliquer de manière hiérarchique par des lignes directrices. De plus, l'aspect de la différence est dans ce modèle particulièrement mis en évidence ce qui peut avoir des conséquences négatives. Tenir compte de l'aspect de la différence peut en même temps être une solution pour réduire le cloisonnement des communautés qui est souvent observé.

L'ouverture qui marque le système universel est certainement une bonne base pour agir contre les discriminations, mais la perspective statique (de Marshall) de la société, qui part du point de vue que la société inclut continuellement des groupes désavantagés pour créer ainsi une société de classe moyenne contraste avec la réalité d'une société extrêmement mobile qui est moins déterminée par la classe que par le monde vécu. Du fait que la culture influence les comportements, les interventions doivent se situer proches des communautés et de leurs logiques reproductives. L'introduction de l'équité dans les systèmes de santé est dans ce contexte plus facile quand il existe une orientation communautaire de la différence. Le problème est, comme nous l'avons décrit dans ce projet de recherche, de choisir des changements de stratégies qui permettent d'introduire une orientation générale (sur une base légale) qui prône l'idée d'équité et de non-discrimination. L'inconvénient majeur du modèle basé sur les communautés est la faible institutionnalisation des choix politiques. Comme le montre la lutte des femmes pour des droits égaux, les systèmes ne s'adaptent que lentement d'un point de vue législatif et des solutions subsidiaires fragiles sont alors privilégiées qui sont souvent dépourvues de bases légales claires.

La discussion de ces résultats montre que la recherche d'un modèle idéal d'intervention dans le domaine sanitaire ne peut pas se faire en faisant abstraction des réalités existantes, elle doit inclure les différents aspects historiques et les différentes valeurs qui prédominent dans un contexte local.

Méthode: Ce projet s'appuie sur les instruments de recherche de l'approche comparative. Des recherches documentaires et des entretiens semi-structurés ont été les outils principaux de la collecte d'information. Avant de débuter la phase de la collecte de données, un cadre analytique a été conçu pour effectuer le travail empirique. Ce cadre analytique a été constitué en tenant compte des monographies thématiques et contextuelles ainsi que de la littérature concernant les différents systèmes de santé et en particulier les aspects de déprivation sociale en matière de santé.

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# Genetics, reproductive medicine and society: Exclusion and integration effects in medicine

Hansjakob Müller, Ruth Ella Baumann-Hölzle

## Summary of the main results (extract from the final re-port)

Recent developments in technically assisted reproductive medicine and gene diagnostics have opened up new possibilities of preventing the birth of children with serious disabilities. Two fundamentally different studies have been conducted to identify the various questions that have inevitably arisen concerning the effects of exclusion and integration over the last few decades and to find ways in which to deal with the inherent risks of discrimination against the people concerned.

The lawyer Christoph Keller explored what remedies legal systems and regulations offer with regard to the potentially discriminatory effects of these technologies. Among other findings, he discovered that there is an increasing willingness to make the new procedures accessible without pressure to as many people as possible, but that, on the other hand, the pertinent authorities are very reluctant to state what exactly is excluded by an abortion. Unfortunately, a parallel project which was designed to explore the development and potential effects of ethical guidelines could not be realised.

The sociologist Denise Hürlimann evaluated and systematically enhanced guidelines for counselling discussions with expectant mothers, their partners and the doctors that treat and advise them. After using these guidelines, doctors appear more confident on a professional and scientific level, but less confident on an emotional level, which puts the necessary emphasis on the problems inherent in the decisionmaking process. Following these guidelines, a counsel-ling concept was formulated in close cooperation with additional experts and the Swiss Society for Gynaecology and Obstetrics. This concept will serve as a basis for coaching and advanced training and will doubtlessly have a considerable impact on doctors' counselling competence in prenatal diagnostics.

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# Children of parents with mental illness. Psychosocial and biographical mechanisms of exclusion and integration

Daniel Sollberger

## Summary of the main results (extract from the final report)

### Abstract

The topic of children and adults with a mentally ill parent is still largely neglected in scientific research. Little is known about the prevalence of children affected in Switzerland: estimates yield a number of 50,000 children, without taking into account the presumably high number of unreported cases. About 50% of mentally ill people in Switzerland have children; about half of the affected women are mothers, and approximately one-third are fathers. According to the prognoses of the World Health Organisation (WHO) in 2010, depression will be the second most widely prevalent illness worldwide. In the face of the increasing number of mental illnesses, we assume that simultaneously the number of relatives affected will also increase.

### The burden of the children

Children growing up in families with a parent suffering from a severe mental illness are affected by the parental psychiatric disorder and its consequences in many ways. Several studies show an increased risk of these children to develop mental disorders themselves. They are also exposed to highly stressful experiences such as neglect, separation from the parent, disordered relationships (parent-child-attachment), family disruptions, or restricted living conditions.

This raises the psychologically, sociologically, and public health-related relevant question: Why do the majority of the offspring of mentally ill parents not become mentally ill?

### The research project

Using quantitative and qualitative methods the research project "Identity between integration and exclusion. Psychosocial and biographical mechanisms of integration and exclusion of children of mentally ill parents" explores how the children of mentally ill parents cope with the parental illness and its consequences and how they manage to develop a healthy identity.

### The quantitative part of the research project

In the quantitative part we used a specifically designed questionnaire to study the particular situation of 105 adult sons and daughters, all older than 18 years of age and with a parent suffering from schizophrenia, bipolar, or unipolar affective disorder.

We found that during childhood, these children were heavily troubled and worried about their parents. They were barely informed about their parents' health problems, neither by their own parents nor by professionals (the younger the child, the less informed). Moreover, they were not allowed to talk to others about their problems due to mental illnesses being perceived as a social taboo. If they were informed at all, then mostly not in a helpful way: Many of them were not capable of grasping the strange behavior of their parent in spite of their knowledge pertaining to the parent's mental illness or knowledge of a diagnosis.

Since social stigmatization of mentally ill people is a well-known fact, we were surprised by the finding that 80% of the respondents reported only few or no experiences of stogmatization. On the other hand, the feeling of being different from the others was very prevalent among the interviewees. Supposedly, the lack of stigmatization experienced is a result of coping strategies: the fact that mental illness is put under a taboo in the families and in society protects the children against the anticipated stigma.

## The qualitative research project

In the quantitative part of our project, we conducted 22 autobiographical interviews with children of persons with mental illnesses. We explored what relevance the parental mental illness has and how the offspring cope individually with this burden by developing a specific biographical and narrative identity.

Most of the children live in two separate worlds, that of their own family and an extra-familial world. They live equally in both worlds, intervene and mediate between them, and they comment differently on these two worlds according to the position that they choose. The experience of sudden changes in their parents' personality, facets of violence and coercion, or attempted or completed suicides lead to deep confusion and disorientation and question the reliability of the relationship. This causes severe crises in the parent-child-relationship and leads to low self-esteem in the children.

As grown-ups our interviewees are challenged to deal with public representations of normality, illness, and health. They manage this by assuming different narrative positions; either by emphasizing the normality in their family or by constructing an "ideal world." Discourses of illness enable children to apprehend abnormal behavior as normal within the framework of a psychiatric disorder. The violence of the ill father, for example, becomes forgivable knowing him to be mentally ill. But as a consequence, children also see themselves confronted with a personal risk for a hereditary psychiatric disorder. Questions of illness and hereditary transmission receive an important meaning in the constructing of a narrative identity. Finally, conflicts of loyalty, guilt, and shame in public contexts can be observed in the discursive self-positionings of the narrators.

## Recommendations for clinical and social practice

Much more attention should be paid to children of mentally ill parents. It is necessary to offer in-depth information and to give advice especially concerning interaction with the ill parent and concerning coping strategies with specific and individual problems. Likewise, specific programs of treatment are needed that encourage parents to realize, to exercise, and to improve their parenting abilities. It can be expected that this will not only decrease the objective and subjective burden of the children but also reduce the risk of the children of becoming ill in a preventive way. Last but not least, improvement of familial coping strategies will also help to minimize the risk of relapses of the ill parent.

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# Internment and integration. Coercion in psychiatry: The example of Zurich, 1870–1970

Jakob Tanner

## Summary of the main results (extract from the final report)

### Topic

Presently there are negative connotations associated with the use of restraints. In psychiatry compulsory measures are also disputed, however their application is justified as being necessary for the self-security of the patients. A historical review however demonstrates that the lunatic asylums constantly had to deal with the reproach of enforcing restraining measures. This critic was not only raised by the public but also by the psychiatrists themselves. Starting from the so-called non-restraint-movement, which was initiated in the 1860s, until a century later when the notion "anti-psychiatry" appeared, we can observe an intensive discussion about restraint and mental institutions.

But what does restraint mean? Do objective criteria exist or does the question depend on under which circumstances a psychiatric measure has to be considered as restraint, or on the corresponding motive or on the perspective of the people involved? The present research project discusses these central questions on a theoretical and methodological basis and uses the results obtained in this way for a development of a historical perspective of the evolution of the psychiatry in Zurich. In this context it is important to realize that restraint is not a phenomenon confined to psychiatry. Therefore the question of restraint in psychiatry is studied in a social context in which norms as well as different forms and degrees of restraint in particular restraint measures which are used to enforce legal rules have generally a great significance. In this way it is possible to analyze the ambivalent handling of individuals as for instance mentally ills by democratically organized societies.

The project is based on two assumptions: Firstly, restraint in psychiatry cannot be studied by particular measures but results from the interaction between patients, institutions and society. With the example of the psychiatry in Zurich it is studied which measures have been applied between 1870 and 1970 and which patients were involved. Simultaneously we ask the question about the motivation and social ideas about order that suggested and legitimated these measures. Secondly, internment and integration are not just opposites, but are connected in a complex manner. If measures were performed against the will of the patients, the right for self-determination is refused. In this way psychiatric patients are excluded from the society and the community of autonomous individuals. At the same time such measures also exhibit potential to protect and reintegrate. This mutual interaction is studied with the example of incapacitation, sterilization, occupational therapy and psychosurgery. Thereby the analysis of discourse and practice of these four measures elucidates the interplay between the definition of illness, the order of the asylum and tendencies for social normalization.

### Research Methods

The project combines quantitative and qualitative historically-critical methods, emphasizing the latter. We apply a random sampling procedure on patient records of the Psychiatric University Hospital, the Psychiatric University Polyclinic of Zurich and the Psychiatric Hospital of Rheinau with the help of a database, in order to get an overview of the number of patients, diagnoses, measures and their motives. Subsequently we analyze selected cases qualitatively and complement them with additional sources, in particular published scientific papers and records of the board of administration.

## Main Results

This work demonstrates that from a historical perspective it makes sense to not constrain oneself to a single definition of restraint. In a methodological context it is fruitful to ask for the system of reference that motivated a particular compulsory measure. The study suggests a social and cultural historical perspective that connects the compulsory measures and perception in psychiatry with ideas about orders that are culturally binding. The quantitative analysis demonstrates that in the gender category, but not in the social class category, differences that are always significant and notable can be observed. The results therefore underscore the thesis that the diagnoses and treatment of patients are shaped by gender-specific images of roles, which in contrast to the self declaration and the claims of the medical people strongly influenced the psychiatric practice. This thesis is corroborated by the qualitative analysis of selected measures.

## Recommendations

Restraint is often considered as a phenomenon from dark ages. The progress of civilization, politics and medicine has freed the mentally ills from their chains. This one-dimensional history goes along with tabooing the still existing social constraints which are mostly justified and with an individualization of social and political problems. These social mechanisms and discoursive dispositives require an interdisciplinary analysis and clarification. Even today a conflict of interests between compulsory measures and rights of freedom exists in psychiatry. The possibilities of therapy by medication have complicated the evaluation and decision processes, thereby emphasizing the importance of discussion of these questions in politics and public as well as in different scientific disciplines.

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# Eugenic concepts and measures in psychiatry and administration. On the politics of standardization, integration and exclusion: The case of Basel-City, 1880–1960

Regina Wecker, Bernhard Küchenhoff

### Summary of the main results (extract from the final report)

This research project investigated the roles of psychiatry and public administration in the establishment and propagation of eugenic measures in social and health policy. In order to discover how these measures were legitimized, the study examined developments in the Canton of Basel-Stadt from 1880 to 1960.

Patient records from psychiatric institutions in Basel were investigated on a large scale for the first time for a historical research project. Systematic indexing and analysis of the source documents revealed that eugenic measures were established and legitimized in a tight institutional network. The research shows that a eugenic indication in the strict sense - for example, to prevent hereditarily diseased offspring and to promote genetically healthy offspring - was only one of the various grounds for measures and interventions such as sterilization, castration, abortion, prohibited marriages, or divorces, and it was often not even the most important reason.

Contrary to the contemporary scientific or popular scientific writings in which "improvement of the 'Volkskörper' ['national body'] was as central in Switzerland as it was in most European countries, the reason given for the eugenic measures in the patient records is the patients' individual situation. The patients were considered unable to raise children and care for them financially, to run a household, or to lead a marriage in accordance with societal norms, or to guarantee that they would not become a financial burden to society. The "hereditary health" of the unborn child was - astonishingly - less important. Instead, the focus was on the actual living conditions of the future parents and especially on the very broadly defined health of the parents, in particular the health of the future mother. This also explains why eugenic ideas and measures centred on women - in particular on women in the lower social classes. Gender and class became significant parameters of eugenic measures.

As required by law, patients had to consent to sterilization or abortion in writing, and in fact the law was largely adhered to. However, the records show that patients' consent was often obtained under duress, in that release from a clinic, "permission to marry", or a desired abortion was made dependent upon a woman consenting to sterilization. Also in this context, psychiatrists or physicians tried to convince patients that sterilization necessitated by their personal situations. Nursing personnel were assigned an important role in this process of persuasion as well. However, patients that did not give in to the pressure exerted by their psychiatrists - especially at the Policlinic (PUP) - found ways to avoid undesired sterilization.

Although eugenic concepts were hardly ever mentioned directly in patients' records or experts' reports, they were nevertheless a part of a comprehensive sexual and gender policy, and they made possible and legitimized interventions into the family and marriage, which were otherwise defined and protected as private areas of life. In this context psychiatry was established as the expert for advice or decision-making concerning issues in birth control and sexual policy.

The research also shows that out of the exclusionary and repressive patterns of interpretation and action through which part of the population was to be excluded from marriage, sexuality, and reproduction, patterns of interpretation became slowly established that in the Canton of Basel-Stadt led to a relatively liberal practice of birth control through abortion and a more liberal understanding of sexual norms early on (from the 1930s on). On the other hand, it was maintained that certain population groups (in particular, young, "feeble-minded" or "morally deficient" women) were still to be treated repressively. The question as to how those trends coexisted, whether they mutually influenced or even caused each other, and what role eugenics played in those processes, is a question that has remained unanswered.

**Significance**

Up to now, eugenics has been analysed for the most part as a part of German National Socialist policy. However, National Socialist eugenics in their application is an exception. For this reason, research on "eugenic networks" in democratic and non-totalitarian states like Switzerland is better suited to documenting the "normal" interaction of science, policy, and government and thus better suited to critical analysis of present-day developments of "biopolitics".

Eugenic measures were not gender neutral. They were based on normative concepts of different "biological" and social gender roles, and they were applied differently to men and women. Sterilization was mostly applied to women, while in the (comparatively few) cases of prohibited marriages, the verdict focused on the situation and behaviour of the man in question. For analysis of policy and concepts of national identity, linking the gender category to eugenic interpretations brings to light new findings.

**Aim and method**

The project is based on the analysis of about 1,200 patient records. Through systematic indexing and analysis of the source documents the project brought to light the way in which eugenic concepts were established and put into practice.

To operationalize the research goals, first the project examined how knowledge about the hereditary transmission of mental illnesses was produced in the clinics and then - in a second step - how that knowledge was used in psychiatric assessments pertaining to questions of civil law and criminal law and in the grounds for administrative measures or surgical interventions. A third research step was to ask what indications (social, medical, eugenic - as defined and differentiated in the scientific literature of the time) for the carrying out of the measures were decisive.

The question as to whether and how eugenic ideas and concepts changed sexual norms will be investigated by the research group in a further, connected project. The findings of that project will be published in 2009 along with the results of the present project.

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# The place of social services in relation to eugenics, gender and the discourse of medical and psychiatric normality (1918–1955)

Béatrice Ziegler, Gisela Hauss

## Summary of the main results (extract from the final report)

This project examined the issue of eugenic practice in municipal guardianship authorities in two regions, considering also the input of medical psychiatric experts as assessors in matters of sterilisation. This puts the study into a national as well as an international research context concerning eugenics in democratic states, a research context for which the practice of sterilisation is a special indicator. The more concrete research context in this study is the debate in German-speaking countries on the relationship between welfare, or social work, and eugenics. Our research thus contributes to other findings about the biologistic interpretation of social issues and the practice that develops as a result. In addition, the study makes a contribution to the debate on the thesis of social 'disciplinisation' both as the core of youth welfare and in the manner in which it limits the scope of action of the men and women who are affected.

The study analyses the ambivalent nature of the support provided by guardianship authorities in the context of abortion and sterilisation, particularly in situations involving the input of psychiatric professionals. It grounds exclusion measures in the context of various discourse practices, where evidence can be found of the many and diverse linkages among eugenic, medical psychiatric and disciplining orientations.

Due to the sources available, the investigative layout is not perfectly symmetrical for Bern and St. Gallen; the selection of the cases had to follow different logical paths. For both cities, however, the study investigated the everyday institutional practice of guardianship, guardianship by the authorities and related youth welfare for the period 1920-1950. Of particular interest in this context was the question how measures for eugenic purposes and measures intended to have a disciplining effect on behaviour and environment were implemented side by side. In addition, the study also analyses sterilisation and abortion practice in the Canton of Bern in the years following the First World War up to the 1950s, based on psychiatric case files and assessment reports (produced for abortion requests), with a focus on their eugenic function to prevent certain women from reproducing.

The selection of institutions to study was based on the consideration that a large imbalance of power leads to situations where the people affected are restricted in their freedom to act by means of situational, institutional and procedural coercion. People really have no choice as to whether to agree to or reject measures. This applies to measures restricting a person's capacity to act (i.e. by providing guardianship), as well as in the case of women in need, for instance due to unwanted pregnancies.

The differences in the economic and political backgrounds of St. Gallen and Bern led to two distinct models of youth welfare and guardianship in the field of tension between the concept of common public interest and the social responsibility of the welfare state. Also, the municipal youth welfare authority of Bern (which was in the process of becoming professionalised) took part in the public discourse on eugenics and sterilisation, whereas in St. Gallen sterilisation was a subject for debate only within the non-political forum of voluntary child protection work and youth welfare.

Comparison of the two cities reveals clearly that the guardianship authorities exercised regulatory power flexibly and in response to the situation particularly in their "hard", disciplining measures but also in their eugenically motivated measures. This was so in both Bern and St. Gallen, irrespective of the given differences in the municipal structures. The further development of social welfare state structures can therefore not be seen as an absolute requirement for the "hard" - and also eugenically motivated - treatment of the population.

Despite the structural differences, the municipal authorities in Bern and St. Gallen show comparable eugenic practice. In the 1930s and 1940s, the moral educational models of thought exploring the social environment were increasingly characterised by medicalisation and biologisation. However, explicitly eugenic reasons for the measures implemented by the two cities were rare. The number of sterilisations and castrations documented in the files and reports of the guardianship bodies is very low. "Hard" measures such as sterilisation but also committing people to institutions in order to keep them from having unwanted sexual intercourse and to prevent them from reproducing, were ordered based on financial, moral educational, psychiatric and eugenic arguments. The recommendation to sterilise a person depended on a psychiatric evaluation. This strengthened the position of psychiatry vis-à-vis the guardianship authority and other public authorities. Nevertheless, sterilisation proceedings were initiated by guardianship authorities as well as by psychiatric services. In disciplinary connections, the mutual cooperation between guardianship authorities, welfare authorities and psychiatric services was not consistent with regard to content or concepts, was not regulated comprehensively, and was fast, situational and pragmatic.

In the case files maintained by the guardianship authority as well as in a considerable proportion of the abortion evaluations filed, the intention to impose social discipline can be detected in the moral arguments used, in which welfare and psychiatric paradigms are intermingled. In order to justify sterilisation, it was common to use both disciplining and eugenic arguments that breached the boundaries of the professional fields in a manner that those concerned found difficult to understand. Eugenic indications were of lesser importance and were mentioned, at the most, as an additional factor and to cement psychiatric, medical and social indications. Whereas mechanisms of coercion could be reconstructed particularly clearly in the sterilisation cases handled by the guardianship authorities, it is also clear that these mechanisms can be found not only in the field of guardianship field but also in the field of psychiatric assessment. Thus, many women consented to undergo the operation only after they had initially refused and after doctors' efforts to persuade them. Agreement to undergo the procedure in the sense of "informed consent" was often given under psychological pressure had been exerted, following the recommendation of the psychiatric evaluation and out of fear of alternative measures.

The guardianship authority sources prove that from the perspective of the people affected sterilisation was often seen as exclusion from social roles and connections. Sterilisation denied young, childless women the highly valued role of wife and mother, which in turn resulted in social stigmatisation. Thus, the socially intended integration had the opposite effect and excluded women from a key social role, costing them both function and status.

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