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Suicide among the elderly in France and Switzerland: What does the societal context tell us about the place of relatives?

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ABSTRACT

Based on a comparison of accounts by relatives of elderly people who died by suicide in France and by assisted suicide in Switzerland, this article analyzes the place of family members and their interpretations of the suicide of their elderly relative. It highlights the way the societal and legal context influences the collection of data, the feelings of relatives and their interpretations. While in France, relatives try to avoid the risk of the family being stigmatized and try to retrospectively reconstruct the reasons for the suicide, the institutionalization of suicide in Switzerland means that the reasons for suicide are formulated in advance.

Introduction

Undertaking a literature review that considers the family dimension of suicide sheds light on the scientific lenses used by researchers to examine the connections between suicide and the family. This approach draws attention to a number of studies that examine the family as either a risk factor or protective factor in relation to suicide. Following Durkheim's work on social integration and suicide (1897), critical attention has focused particularly on the extent, density and quality of the bond between the person who has died by suicide and their relatives. A weak family bond and isolation, which are frequently cited in relation to suicides among the elderly, are considered to be a possible reason for suicide. Other researchers (Baechler, 1975) have raised the issue of the potentially toxic nature of the family bond. The literature also refers to "suicide families" (Qin et al., 2002; Runeson & Åsberg, 2003), where the risk of suicide is raised through genetic risk factors (Brent & Mann, 2005) and/or psychoanalytical risk factors (Charazac-Brunel, 2014). While the family can be seen as a "site of concentrated trauma" (Charazac-Brunel, 2014, p. 27), other texts on suicidology present the family as one of the primary factors in prevention (Mishara & Houle, 2008; Prabhu et al., 2010). Mirroring these approaches, other studies have developed a focus on

the impact of suicide on the family (Cerel et al., 2008). This second branch of research primarily examines the trauma generated in relatives of the person who has died by suicide and, by extension, considers the way this trauma may reduce inhibitions that are likely to generate other suicides within the family (Charazac-Brunel, 2014).

This type of research perspective, which interrogates the concepts of "family" and "suicide" alongside one another, is illustrative of an assumption that is frequently associated with the idea of suicide, namely that the family can have a role in the mechanisms relating to the suicidal process, either by hindering it, or by "facilitating" it involuntarily. In the literature relating to suicide among the elderly—statistically the most frequent¹—this assumption often takes a particular form because of the stereotypes associated with age. Accordingly, after highlighting the physiological and pathological consequences of senescence, the literature generally refers to loneliness and isolation, frequently linked to widowhood and the disappearance of age peers (Campéon, 2012). Beyond those studies that examine the ethical dimensions of assisted suicide (Stavrianakis, 2020), the literature that focuses on assisted suicide, which mainly concerns the elderly, is primarily interested in the opinion of relatives as a means of understanding the motivations for the

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suicide (Dees et al., 2010) or of analyzing the specific nature of their bereavement (Swarte et al., 2003).

In undertaking this study, we have chosen to approach the role of relatives in the suicide of the elderly in a different way, by examining not their role in the suicidal process but their place in it. We agree with Hannig (2019) that categorizing suicide clearly and *a priori*—according to whether or not it is assisted—is of epistemological and methodological importance in the analysis of suicide among the elderly. By comparing the discourse of family members faced with the suicide of an elderly relative in France and family members who experienced the assisted suicide of a relative in Switzerland, we will analyze the way the societal context and the research protocol employed influence how the place of relatives can be understood. Even more importantly, we will consider how the latter interpret the suicide of their relative.

Even though the elderly relatives in question were integrated into the family in both situations, the place of relatives is greatly affected by the destigmatization that occurs as a result of decriminalization in Switzerland. This contrasts sharply with the transgressive dimension that can be attached to suicide in France, as it is seen as a disruption of the social order (Timmermans, 2005). On the other hand, it seems that decriminalization goes hand in hand with forms of institutionalization and medicalization, which impact in turn upon the normalization of relatives' discourse about suicide. In France, relatives' retrospective interpretations of suicide are less influenced by the legal framework.

The framework of suicide among the elderly in France and Switzerland

In 2014, the suicide rate in France across all age groups was 14.9 per 100,000, while that of people aged 75 and over was 35.4 per 100,000. This rate rose to 47.9 per 100,000 for 85–94-year-olds, and was as high as 83.8 per 100,000 for 85–94-year old men (Observatoire National du Suicide [ONS], 2018²). As in many other countries, there are assisted suicide advocacy groups in France, such as the *Association pour le Droit de Mourir dans la Dignité* (Association for the Right to Die with Dignity, or ADMD). However, the legislative response to their campaign for the right to choose to die, in the form of the Claeys-Leonetti law of February 2, 2016, did not lead to the legalization of assisted suicide but to the right to stop intensive life-sustaining treatments.³ The arguments in favor of the rationality of suicide (Richards,

2017) and for an ethics of a good death for those confronted with severely life-limiting conditions (Gandsman, 2018) seem to carry little weight against the pathologization of suicide by French experts in suicidology (Balard et al., 2020) and ethics committees.⁴ By focusing on ageism and inclusive policies, these committees avoid engaging with the question of suicide in favor of that of assisted death.

Unlike in France, Swiss law permits assisted suicide, although the way it is implemented is not determined by the state.⁵ Assisted suicide is managed by the Swiss associations for the right to die with dignity (hereafter ADMD), created in the 1980s. Switzerland is the only country that does not assign sole responsibility to the medical profession to assess and manage requests for assisted dying.⁶ Thus, within the framework of their statutes, the Swiss ADMDs have constructed a new way of dying by suicide, which avoids the parties involved being accused of pursuing selfish motives, within the context of the penal code (see Hamarat et al., in this issue). Originally created for liberal thinkers who wished to control their own death (Dubois, 2013), this mode of dying was then envisaged for seriously ill or disabled people. It is now accessible to people suffering from debilitating polyopathologies linked to age, meaning a set of issues linked to age-related conditions, such as pain caused by osteoarthritis, sensory impairment, incontinence, risk of dependence or fear of loss of capacity for discernment. ADMD members are typically urban-dwellers, with good socio-economic status, and with a higher proportion of women and people over 65 (Pott, 2018). In Switzerland, the suicide rate⁷ was 12.6 per 100,000 inhabitants in 2017, while the total rate of people over 80 who commit suicide was 28.3 per 100,000. Assisted suicides have been counted separately from Swiss suicide statistics since the end of the 1990s, and their standardized rate is 12.5 per 100,000. This ratio varies greatly according to age in Switzerland: among people aged 75 and over, assisted suicide was more frequent than suicide in the period from 2010 to 2014 (Office fédéral de la statistique [OFS], 2016). Switzerland seems to have officially settled the question of the difference between suicide and assisted suicide by statistically accounting for them separately and by presenting assisted suicide as a rational act outside of the framework of suicide prevention. One ADMD attempted to redefine the act as one of “self-deliverance” (“auto-délivrance” in French), but this term

Table 1. Table of Swiss informants.

Informant	Person who died by suicide	Medical background	Family context of the person who died by suicide
Aliénor	Mother-in-law	Age-related polypathologies	Lives in a retirement home
Louis	Grandmother		
Lisa	Father	Cancer	Lives as part of a couple
Ariana	Partner		
Émile	Wife	Chronic pain	Married
Emmanuelle	Mother	Multiple cancers	Lives alone, helped by a neighbor and her daughter
Violetta	Mother	Cancer	Lives with her daughter
Marianne	Father	Severe arterial insufficiency	Lives alone

NB: All suicides were carried out by ingestion of barbiturates at a lethal dose, prescribed by a doctor.

was not adopted by its members, nor by relatives, who do not agree on whether it refers to suicide.

Methodology

This article is based on a comparison of two sets of interviews conducted with relatives of elderly people who died by suicide with assistance in Switzerland and without assistance in France.

The first set was collected between 2010 and 2012 as part of a qualitative study using semi-structured interviews conducted with 27 relatives who participated in an assisted suicide in French-speaking Switzerland as well as four volunteers from an ADMD.⁸ The aim of the study was to understand how loss was experienced in the context of a suicide that was planned and organized within the family. The interviews were fully transcribed, and the data was anonymized and analyzed using ATLAS.ti software to conduct a content analysis⁹ (Pott et al., 2015). For this article, we have used the data for the eight relatives of the six people who were over 75 years old (Table 1).

The second set of interviews is taken from the French project SUICIDAGE.¹⁰ We focused on seven cases of suicide of people aged over 75 that were specifically carried out by people living in a family context, either as part of a couple or living together intergenerationally (see Table 2). This context made it possible to focus the relatives' accounts on their observations and the discussions they had with the person who committed suicide before their death. None of these suicides can be defined as assisted, whereby relatives give their consent to the suicide. However, these suicides did take place "in the presence" of one (or more) relatives although without the latter being direct witnesses to the act itself. These are cases of suicide of married men and of women who lived in an intergenerational context. After being transcribed and anonymized, the interviews were analyzed following a classic qualitative methodology based on grounded theory and using open coding in NVivo software.

Allowing oneself to talk about suicide depends on differing family contexts

Even before examining the content of the informants' interviews, a comparison of the two data sets shows that the two "fields" did not give access to the same type of informant. Out of the eight Swiss informants, six—four daughters and two spouses—were very close to the person who committed suicide. Conversely, on the French side of the study, it was very difficult to gain access to spouses and offspring. Of the seven informants included, five are from the second generation, in other words grandchildren.

This fact is not insignificant. The Swiss study was intended to engage with members of a number of similar support networks, in order to compare their experiences of assisted suicide. While we were able to recruit relatives who were willing to tell their stories, it was nevertheless very difficult for them to involve other members of their networks. Three types of reasons were given: firstly, the impossibility of reopening this chapter of family history, which had required highly demanding negotiations to convince the ADMD to accept the request; secondly, the feeling that the assistance provided was a personal and intimate affair; and finally, the fact that some family members had been excluded from preparations for the suicide, because they were perceived as resistant to the very idea of assisted suicide.

For the French side of the study, the aim was to carry out case studies by collecting the testimonies of several family members in each case of suicide considered, but this attempt was not successful and only one relative was interviewed in each case. The other family members always avoided being interviewed, either because they refused to participate or to provide their contact details, or because the informant did not wish to talk to them about it. When we analyzed the informants' speech, the recurrent motifs were that the suicide of the elderly relative was not discussed in the family, and that it had become a kind of taboo. When the spouse of the person who had died by suicide was still alive, as is the case in four of the situations described, the surviving spouse spoke to relatives

Table 2. Table of French informants.

Informant	Person who died by suicide	Suicide method	Family context of the person who died by suicide
Dominique	Grandmother	Self-defenestration	Intergenerational cohabitation
Émeline	Grandmother	Medicinal products	Intergenerational cohabitation
Bertrand	Father	Firearm	Married
Odile	Great-uncle	Hanging	Married
Serge	Grandfather	Hanging	Married
Maryline	Father	Hanging	Married + in a partnership
Martine	Grandmother	Stab wound	Intergenerational cohabitation

of experiencing the suicide as a form of betrayal. In these four cases, the suicide was of a man over the age of 90. For these generations, it appears that the gender roles influencing the couple strongly conformed to the normative model of the male “breadwinner” and the female “housewife.” This meant that the women saw themselves as socially assigned to the tasks of caring for their aging husbands. The suicide of the latter might be perceived by the family circle, and even more so by the surrounding community, as a questioning of their capacity to be good, supporting wives toward their husbands.

As the literature and the French corpus show us, suicide, especially when it takes place in a context of family cohabitation, is perceived by cohabiting members of the family as a questioning of their role as relatives. Unlike spouses and cohabiting offspring, non-cohabiting grandchildren (or offspring) were less “constrained” by the situation and more able to talk about it. To an even greater extent than other types of death of the elderly that occur within the family circle, suicide in France creates upheaval in the family by damaging the image of the family as a site of solidarity and mutual support. Conversely, in Switzerland, assisted suicide is planned together with close cohabitants and those who are seen as favorable to the idea. The role of relatives is different (Gamondi et al., 2018): in addition to helping with the tasks of daily life, they provide administrative support to convince the ADMD of the validity of the suicide request, as well as care for the person who remains able to self-administer lethal-dose barbiturates. Solidarity and family support are factors that facilitate assisted suicide, as the ADMDs highlight during the initial meeting with members requesting assistance.

The effects of the institutionalization of suicide on the place of relatives

The difficulty of normalizing suicide in France

In the seven French cases of suicide, all the testimonies agree that the suicide was unexpected even if, in some cases (see below), it could retrospectively be considered “predictable.” For suicides taking place at

home in the presence of family members, the relatives—especially when they live together—fear that they will be suspected of having participated in the death, whether by a direct act—murder—or a form of assisted suicide, or by neglect or mistreatment. The police investigation or the notes made by the certifying doctor can therefore be experienced as a form of challenge, as we see in Odile’s words:

A doctor said it was a suspicious death, they couldn’t necessarily confirm suicide straight away, it was a suspicious death [...] they couldn’t say that it was a suicide, it could have been a disguised homicide.

Bertrand’s father, who lived with his wife, took his own life using a firearm that Bertrand had given him more than 30 years ago. The police investigation inevitably focused on the origin of the weapon and where it was stored, but also on his relationship with his father.

Since a number of these suicides took place in rural areas, where local connections were very strong, it was common for the family to worry about the way the event would be perceived by the community and that the reputation of the family would be damaged. The suicide of an elderly relative burdened the family with others’ suspicion that they had not cared for the deceased. This explains why the doctor who came to record the death of Émeline’s grandmother noted “cardiac arrest,” which, according to our informant, was done “to prevent the family from having to go through a police investigation.” Indeed, any suicide entails a police investigation since, in legal terms, suicide is classified as a violent death whatever its context.

With regard to the normative expectations surrounding the family, suicide takes on a transgressive dimension that places relatives in the position of potential culprits in relation to the law and, more generally, in relation to the stereotypes that establish the family as the primary support when its members are in distress.

Institutionalized suicide in Switzerland

While family stereotypes also affect the relatives of the elderly in Switzerland, the legality of assisted suicide

opens up a different space for the family. Certain family members participate in preparations for the suicide, either because they are living together, because of their adherence to ADMD values, or perhaps because they have made a promise to help.

Whether or not they agreed with the idea of choosing the time and conditions of death, the eight relatives interviewed in Switzerland had been made aware of their relative's intention to die and all participated in preparations for the suicide. Any suspicion that may exist before the act with regard to relatives is alleviated by the procedure that surrounds the preparations for suicide. Instead of being forced to prove after the fact that they had not been involved in the suicide, as is the case in France, they find themselves engaged in discussions about the conditions of suicide and in particular the concept of the "right time" (Pott et al., 2014). Moreover, although assisted suicide is still considered a form of violent death that necessitates a police investigation, the ADMDs prepare the person choosing to die by suicide and their relatives for the questions that will be asked by the police and the coroner. The police investigation is meant primarily to eliminate the possibility that relatives may have incited the suicide to gain an inheritance or for reasons of jealousy or hatred, rather than having to focus on suspicion of negligence or mistreatment.

The introduction of a code of good practice by the ADMD means that these investigations have been modified and even simplified: a file detailing all actions undertaken is prepared, and the police are familiar with the association volunteers, as confirmed by one volunteer from the ADMD:

The first time that they [the police] have to fill this all in, they write down all the details at length. But for those who have already done it several times, it's much shorter. They need to be reassured too. But generally, they're happy when it's an Exit suicide because when they have to attend suicides or accidents it's usually dramatic. With EXIT,¹¹ they appreciate things—everything is in order, the papers... there's no problem, it's almost like a day off...

The support provided by the ADMD thus contributes to the institutionalization of suicide, which in turn contributes to a form of normalization by allowing relatives to avoid certain forms of social blame. Although society as a whole may not agree on the ethical issues surrounding assisted suicide, their increasing numbers and the way they are represented in the media and in films have helped to create a favorable social context. Violetta has seen television scenes of assisted suicide that she hopes to experience

with her mother. Marianne and Émile are registered with the association, and Aliénor and Louis have already experienced the assisted suicide of their husband and father respectively, which they have described as a family experience within the ongoing adventure of life and then of illness.

A contextualized interpretation of suicide

The interview guide used in the study in France was intended to help us collect the narrative (as perceived and told by the informant) of the life of the person who died, and of the suicide itself, as well as their reasons and/or motives from the informant's point of view. While some informants explained that they were not certain of the reasons that led their relative to choose suicide, all were willing to share their own interpretation.

Interpretations relating to the gender of the person committing suicide and to their family network

The first noticeable aspect is that, contrary to dominant interpretations within French suicidology, none of the informants mentioned any sign of a mental health disorder in the person committing suicide. In the absence of an explanatory letter, the relatives tried to find a rational justification for the act. While Dominique, Maryline and Émeline drew attention to the personality or "unusual" character of the relative who died by suicide as one of the explanatory elements, all of the relatives spoke of specific aspects of the last years of the deceased's life. Odile was the only one to consider that the physical frailty and the feeling of uselessness that she pointed out as the reasons for the suicide of her great-uncle could have been generating discontent, even depression, although she emphasized that the doctor had seen her great-uncle the week before the suicide without diagnosing depression. For men who died by suicide, informants systematically mentioned physical frailty and a decrease in activity, and even the associated weakening of their social identity. However, these explanations do not exclude other explanatory factors such as family circumstances. Our informants also pointed out the attitude of the wives of men who were described as lacking empathy or indeed even almost tyrannical. While Odile told us that her great-aunt did not understand that her husband could no longer manage certain tasks related to the maintenance of his house, Maryline accused her father's partner of a form of abandonment when her father was no longer able to drive. Bertrand, one of the few sons included in the

research, explains that in addition to his father's physical suffering, he was in a state of emotional suffering caused by the lack of consideration his wife showed him and the unkind remarks she directed at him.

A different set of explanations are given by our female informants relating to the suicide of women who did not live in a couple but in a context of intergenerational cohabitation. Even when physical frailty caused by old age as well as the loss of capacity were mentioned, these reasons were secondary to the personality of the deceased and, even more so, the strained or even conflicted relationship with cohabiting offspring.

In the cases of Martine, Dominique and Maryline, the suicides of their respective grandmothers and father took place after each had repeatedly, throughout their lives, "threatened" (in the words of the informants) to commit suicide. In the case of Dominique's grandmother, her words had prompted Dominique's father to put bars on all the windows of the first floor except the bathroom, where the window—from which she committed suicide—was thought to be inaccessible. Maryline had heard her father say throughout her life that he was going to commit suicide, to the point that she felt it had become a family joke and that the other members of the family would reply "Well, whatever you do, don't mess it up." While Maryline said she never really believed that her father would kill himself, and interpreted his suicide as the result of his breakup with his new partner, Dominique sees her grandmother's suicide more as the culmination of family tensions created by a difficult context of intergenerational cohabitation. Dominique's grandmother's suicide took place a few days after Christmas in the house where the family had gathered, with most of its members still present. During the interview, Dominique talked about her grandmother's recurrent complaint of a lack of attention from her relatives and the fact that her suicide was committed in the presence of her descendants. She saw the suicide as a kind of act of denunciation intended to make the survivors suffer by making them responsible for the deterioration of her life. Émeline's words echo this story, describing the person committing suicide passing from the status of victim to that of "persecutor." Her grandmother died by suicide at the age of 82 by swallowing her entire packet of medication after having dinner with her son and daughter-in-law. Émeline describes living with her grandmother as "complicated" because of the generation difference but also because she considered her grandmother to be "not easy." She recalls having

searched the house thoroughly for a letter from her grandmother that, she says, might have left her father "unable to recover."

So, really, I searched, and I searched thoroughly because, given the circumstances, I said to myself that it was quite possible that she might have left something and I'm not sure my father would have got over it. Maybe some kind of accusations... because, because like I told you my grandmother was a really unusual character and uh yeah with... yeah, I think she was quite manipulative actually...

These last accounts fit into the model of "aggressive" suicide that employs a form of blackmail, as developed by Baechler (1975), or of revenge suicide as seen in certain cultures such as the Trobriand Islands (Malinowski, 1926).

Differing interpretations within the family

The last point to be made about the interpretations we gathered is that our informants insisted that these were their interpretations, but that they knew some family members did not share them. Bertrand explained that his brother and mother did not share his view of his father's suicide. They placed the emphasis on his weakness of character and viewed his suicide as an emotional paroxysm. Elective family bonds and symbolic filiations are revealed within these differing interpretations. Thus, Bertrand admits that he had always been closer to his father than to his mother, while his brother is closer to his mother. In his account, the reasons for the suicide seem intrinsically linked to these bonds and to the reproaches that reside within his explanation that they never "really understood [his father]."

As for Maryline, although she blames her father's partner for neglecting him, she recognizes that the latter accuses her of the same thing. Family history is called into question by the motives for suicide. The story reveals that at the time of death, the father, who had left his wife to form a new relationship, was living alone most of the time because his new partner had kept her own home. The partner and the daughter therefore accuse each other of a form of abandonment; the former because she considers that it is a daughter's role to help her father, and the latter because she thinks it was the partner's role to support him.

Apart from Émeline, who suggests that her parents share her understanding of the grandmother's suicide—a form of revenge suicide committed by (in her words) an "unusual" character—the other second generation informants say that the reasons for suicide that they envisage are quite different from those of

the first generation, who are less able to discern reasons and explanations for this act. As we have seen, it appears that the grandchildren (and nieces or nephews) quite frequently demonstrate greater empathy than the offspring and spouses. Perhaps because they are more challenged and implicated by the act of suicide, it proved more difficult to include spouses and cohabiting offspring in our research, suggesting that the “symbolic distance” of the second generation facilitated analytical discourse.

In Switzerland, interpretations are framed by the legal context and the integration of suicide into the family history

While the interpretations of suicide gathered during the French study were all constructed retrospectively, the interpretations that emerge from the accounts of relatives in Switzerland are the result of a process that started before the death took place. In this respect, suicide is only possible when it is certain that the person still has capacity for discernment and with a minimum of consensus among relatives who are aware of the reasons leading the person to assisted suicide. The ADMDs also strongly insist that at least one relative take part in the proceedings and approve the decision. Emmanuelle describes the care her mother took to obtain the approval of all her children before submitting a request for assisted suicide to the ADMD. Aliénor recounts how she helped her mother-in-law prepare for her suicide, explaining what points she would need to present in her request letter.

Six of the relatives shared the values of the ADMD and considered the decision to die by suicide to be strictly personal, a decision made because of unbearable pain, to avoid debilitating surgery, or after having fought hard to maintain health. Emmanuelle describes a “better” death than the one awaiting her mother because of the advanced stage of her cancer. Louis felt that his grandmother was “transfigured” when her request was granted. He wished to assist in her suicide, “so that things were not left unfinished.” Lisa and Ariana, who are opposed to the idea of assisted suicide, view it fundamentally as suicide, with its characteristics of violence and disruption. Lisa was opposed to the idea and would do anything to prevent her father from committing suicide and would argue against it right up to the day before his death to try to change his mind. She felt that age makes it more possible to endure the suffering and debilitating surgery that typically accompany cancer. Ariana could not bear the thought of losing him. Both nevertheless decided to support their father and partner out of

love and respect for his determination. Ariana, his partner, did not actually attend the suicide, to “avoid preventing him from drinking the potion.”

The analysis shows that the discussions and preparations that precede the assisted suicide do not involve the whole family group but, in fact, reveal forms of elective bonds which do not necessarily correspond with emotional bonds. Thus, whether or not there is agreement about the act, the reasons for the request for assisted suicide are discussed with the person planning it and are, in a manner, co-constructed with him or her within the framework imposed by the legislation. This means that we are seeing an institutionalization and a form of medicalization of assisted suicide. Indeed, the reasons described in the interviews are closely aligned with the existing medical files. We should also remember that the rationality of the request must be medically confirmed three times. This is why the data shows frequent reference to the suffering endured by the person, to their disease, their complaints of restricted independence or their reduced life expectancy. Psychological suffering and/or an aversion to being bed-ridden are also described. However, potential family enmities or feelings of abandonment or even a depressive state are not mentioned for the simple reason that the context does not permit them and that they could constitute a selfish motive within the definition of the law (namely hatred or jealousy) or a cause of denial (on the grounds of a lack of the capacity for discernment).

Discussion

This comparison between the place of family members and their interpretations of the suicide of their elderly relatives in France and Switzerland reveals the way in which societal context influences their accounts. We have shown that suicide, assisted or not, creates elective bonds but also potential distancing between the various members of the family. However, these reconstructions take place in different ways, depending on whether the suicide is part of a process that is discussed in advance, as is the case in assisted suicide in Switzerland, or of retrospective reconstruction, as in the French case. This temporal dimension clearly has an effect on the interpretations gathered by the researchers, who are themselves subject to a selection bias in their quest for informants. It is clear that the relatives’ interpretations are affected by context. As we have seen, the accounts of family members in Switzerland are in closer agreement about the reasons that led the elderly relative to choose suicide, and this

helps to construct a vision of a suicide that is better accepted and supported by the family. On the other hand, in France, the sudden nature of the death and its socially transgressive character make it difficult to collect objective interpretations from people who lived with the deceased, since their suicide challenges the quality of the family bond. For this reason, the grandchildren turn out to be better able to offer interpretations of the suicide, which, in some cases, can identify the family tensions relating to caring duties or to forms of cohabitation. We can hypothesize that if these forms of discourse are less apparent in the Swiss data, it is because they are discouraged by the context, both of assisted suicide and of access to informants. Institutionalization and medicalization mean that Swiss suicide is more normalized in the sense implied by Elias (1973).

By considering both the societal and legal context of the suicide and the context in which the interviews with relatives were conducted, we were able to relativize the explanatory value that the researcher would be tempted to seek in relatives' interpretations. These interpretations reflect implicit norms that relate to the speaker feeling empowered to speak out about what it is socially acceptable to think and say. For this reason, it seems essential to maintain a critical view of research protocols that are based on psychological (Cavanagh et al., 2003) and sociological (Fincham et al., 2011) autopsies.

By proposing a comparative analysis between suicide and assisted suicide, this article runs counter to most approaches in suicidology, including that of the American Association of Suicidology (AAS), which advocates a distinction between suicide and voluntary “medically assisted dying.” Behind what may appear to be a simple question of terminology lie epistemological, theoretical, methodological and even political issues. Indeed, not considering assisted suicide to be a form of suicide makes it possible to distinguish it from those other forms, and to assert that 100% of suicides are the result of mental health disorders, as stated by one expert gerontopsychiatrist providing training relating to suicide prevention for the elderly in France.¹² However, and although we have seen the importance of applying caution when considering the interpretations given by relatives, the suicides reported in our data do not align with this stance.

Suicide, then, may either be “institutionalized” by being enshrined in law and framed within a set of procedures intended to maintain moral standards (by prohibiting selfish motives), or may disrupt the established order by contravening the contemporary norms

of a “good death” (Castra, 2004). In either case, interpretations, both by relatives and by suicidology experts, tend to normalize this act to ensure the peace of the living. However, these processes of normalization belong to different ways of thinking depending on the social context. Accordingly, assisted suicide is rationalized in Switzerland, while suicide in France tends rather to be pathologized by the field of suicidology. In this regard, the authoritative discourse of the experts may—as shown by Garfinkel (1967)—provide certain relatives with ready-made justifications to help them avoid the social stigma that can accompany suicide within the family.

Notes

1. For France and Switzerland, the countries discussed in this article, all age groups over 45 have a suicide rate higher than the national average. It is twice as high for those aged 75 and over, and three times as high for those aged 85 and over.
2. ONS figures are based on death certificates. The ONS estimates that the rate of death by suicide is underestimated in the order of 10-30% because some suicides are not recorded as such on the death certificate.
3. <https://solidarites-sante.gouv.fr/soins-et-maladies/prises-en-charge-specialisees/findevie/ameliorer-la-fin-de-vie-en-france/article/loi-fin-de-vie-du-2-fevrier-2016>
4. https://www.ccne-ethique.fr/sites/default/files/ccne_avis_128.pdf
5. Some Swiss cantons have legislated on requests from people living in state-subsidized social care establishments.
6. In Canada, nurse practitioners are also authorized to provide medical assistance in dying.
7. <https://www.obsan.admin.ch/fr/indicateurs/suicide>
8. “Participating in assisted suicide: an exploratory study on the experience of relatives and their representations of the end of life, death and bereavement”. This project was funded by the Network for Applied Studies of Rehabilitation Health Practices (RéSaR).
9. Some categories were drawn from the literature review and others were identified during the analysis, by applying an iterative method to the theory and data. The software allows the researcher to add categories throughout the analysis, commenting on them and grouping them as needed. This analysis did not use grounded theory.
10. This project was funded by the Fondation de France.
11. EXIT is the term used by ADMD members to designate the organisation.
12. An expert interviewed as part of the Suicidage project.

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