

Suicide as A Social Fact: Stigma, Family Honour and Reporting in Indian Society

Dr. Parul Pareek^{1*}

¹Associate Advocate and Independent Legal Researcher, Formerly Assistant Professor, School of Law, Mody University of Science and Technology, Lakshmangarh, Rajasthan, India

*Corresponding author: Dr. Parul Pareek

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Abstract: A suicide in India rarely dies once. It dies a second time in the telling, softened into an accident, a sudden illness, a fall, so that the family that survives it can go on living in the same village, the same lane, the same marriage market. Émile Durkheim proposed that suicide is a social fact, patterned by the structure of society rather than by private despair; this paper adds a less comfortable corollary, that the record of suicide is itself a social fact, shaped at every stage by stigma, family honour and the institutions that decide how a death is named. Drawing on National Crime Records Bureau data for 2020–2024, independent mortality surveys, the sociology of official statistics and recent Supreme Court intervention on student suicides, the paper argues that the official suicide rate should be read as a joint measure of self-inflicted death and of the social courage available, in a given family, caste, class or state, to name it. It closes with proposals for a more honest count that does not ask grieving families to pay the price of honesty.

Keywords: Suicide; stigma; family honour; official statistics; under-reporting; India.

1. INTRODUCTION

Every year, the National Crime Records Bureau (NCRB) hands India a single number and calls it the truth about how many of its people chose to die. The latest count, for 2024, is 1,70,746 deaths and a rate of 12.2 per lakh population (NCRB, 2026). Numbers of this kind travel well. They are quoted in Parliament, printed in newspapers, cited in judgments, and treated, understandably, as a fact about the country rather than as a fact about the paperwork the country keeps. This paper asks a plainer and more uncomfortable question than the ones such figures usually invite: not how many people died by suicide in India last year, but how many were allowed to be recorded as having done so.

Suicide is, in Durkheim's well-worn phrase, a social fact, its regularities explained by the structure of society rather than by the private failings of the dead. What Durkheim did not have to reckon with, writing in a France with a functioning civil registration system, is that in much of India the record itself is negotiated before it is written down, by a family, a doctor, a police officer and a clerk, each with reasons of their own to prefer one

account of a death over another. [1] The suicide rate that results is not a lie exactly. It is closer to a compromise, struck silently, between grief and reputation.

Three claims organise what follows. Stigma, and specifically the shame that spreads outward from the dead to the living, gives families a strong reason to conceal or relabel a suicide. Law and institutional habit have, for long stretches, reinforced rather than offset this reason, through the criminalisation of attempted suicide, the routines of the medico-legal system, and the presumptions attached to the deaths of married women. The resulting gap between what happened and what was recorded is not spread evenly; it falls more heavily on some genders, regions and classes than others, distorting not only how much suicide there is but who appears to be dying of it. A closing section asks what a more honest count would require, without asking bereaved families to bear the cost of that honesty.

¹This is a conceptual, desk-based analysis. It relies on published official statistics, published mortality surveys and the sociological literature, and does not report

primary data. Figures are cited as published by the sources named.

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2. Suicide as a Social Fact and the Social Production of Statistics

In *Suicide* (1897), Durkheim set out to show that an act apparently rooted in private despair displays regularities that psychology cannot explain. Rates differed systematically between religious groups, between the married and the unmarried, and between periods of economic stability and disruption, and they remained steady within a given society over time. Durkheim (1952) explained these patterns by the degree of social integration and moral regulation, distinguishing egoistic, altruistic, anomic and fatalistic forms. [2] The lasting insight is that suicide rates are properties of societies, not simply the sum of individual troubles.

Durkheim's method, however, assumed that official statistics recorded suicides accurately enough for rates to be compared. Later sociologists challenged this assumption forcefully. Kitsuse and Cicourel (1963) argued that rates of deviant behaviour are produced by the organisational processes through which officials identify and classify cases, and so cannot be treated as raw data about behaviour. Douglas (1967) went further, contending that a death becomes a suicide only when it is defined as one, and that definitions are shaped by the meanings which relatives, witnesses and officials attach to the act. Atkinson (1978), studying coroners in England, showed that officials relied on commonsense theories of what a typical suicide looks like, and were reluctant to return a verdict where a case did not fit. The

sociology of suicide has therefore had to hold two ideas together: that suicide is socially patterned, and that the pattern we see is filtered through social processes of recognition.

This dual character matters acutely in India. Goffman (1963) described stigma as an attribute that is deeply discrediting, and observed that discredit spreads to those associated with the stigmatised person, a phenomenon he called courtesy stigma. Link and Phelan (2001) later showed that stigma arises when labelling, stereotyping, separation and status loss coincide with an imbalance of power. In a society where the reputation of the family, the lineage and the caste or community is a collective asset that shapes marriage prospects, business relations and social standing, suicide is precisely such a threat. Those best placed to report a death, its family, are often those with most to lose by reporting it accurately.

3. The Indian Record: What the Official Figures Show

The NCRB compiles Accidental Deaths and Suicides in India from information supplied by state and city police, and it therefore counts only those suicides that have come to police notice. Table 1 summarises the national totals for 2020–2024. Recorded suicides rose by about 11.6 per cent between 2020 and 2024, while the rate has held at roughly 12 per lakh over the last three years.

Table 1: Suicides recorded in India, 2020–2024

Year	Suicides recorded	Rate per lakh population
2020	1,53,052	11.3
2021	1,64,033	12.0
2022	1,70,924	12.4
2023	1,71,418	12.3
2024	1,70,746	12.2

Source: National Crime Records Bureau, Accidental Deaths & Suicides in India, reports for the respective years.

The 2024 report attributes a third of suicides (33.5 per cent) to 'family problems' other than marriage-related problems, followed by illness (18.0 per cent) and drug abuse or addiction (7.6 per cent). Men account for 73.5 per cent of recorded suicides and daily wage earners for nearly a third; 22,113 homemakers and 14,488 students also appear among the recorded victims, and the rate in cities (16.3) exceeds the national rate (NCRB, 2026). The 2023 report shows a remarkable spread across states, from 0.7 per lakh in Bihar to 30.6 in Kerala, with the Andaman and Nicobar Islands at 49.6 (NCRB, 2025).

Two features of these figures deserve comment. The first is the gap between a rate of about 12 per lakh and the widespread view among researchers that it understates the truth, a point taken up in Section 8. The

second is the structure of the causal categories. The NCRB assigns a single cause to each recorded suicide, on the basis of what police learn from relatives, neighbours and the circumstances of the death. That the largest category is 'family problems' is at once plausible and suspicious. It is an answer that families can give without naming mental illness, debt, abuse or a quarrel with an in-law, and it is therefore a category whose size may reflect the vocabulary of respectable explanation as much as the causes of death.

4. From Death to Data: How a Suicide Becomes a Statistic

For a suicide to appear in the NCRB volume, a chain of steps must be completed. The family must recognise the death as self-inflicted, or at least not conceal it. A doctor or the police must be informed. The

²Durkheim's four types are egoistic (weak integration), altruistic (excessive integration), anomic (weak moral

regulation) and fatalistic (excessive regulation). The fatalistic type receives only passing treatment in his text.

police must conduct an inquest, which the law requires in cases of suicide (Section 174 of the Code of Criminal Procedure, 1973, now Section 194 of the Bharatiya Nagarik Suraksha Sanhita, 2023). [3] The case must be entered under the correct head, and district figures must then be aggregated by the state crime records bureau. A break at any link removes the death from the record, and most links are controlled by people who have reasons of their own to prefer a different outcome.

The first link is the most consequential and the least visible. A death at home, in a village, with no hospital contact and a family that would prefer a religious rite to a police enquiry, may never be recorded as a suicide at all. Where a death is registered without a medically certified cause, which remains common in rural areas, the entry reflects only the account given by the informant. Even when police are involved, the boundary between suicide and accident is porous for deaths by poisoning, drowning, falls and railway incidents, and a finding of accident is often the path of least resistance for every party. [4]

5. Stigma and Family Honour

The stigma attached to suicide in India draws on several overlapping sources. Religious and moral traditions often treat self-inflicted death as sinful or as an unnatural end, and in some communities, it calls for special rites. The picture is far from uniform, but the perceived spiritual fate of the deceased is a genuine concern for relatives. [5] Classical Hindu thought, notably, did not treat the ending of the body as the ending of the person. The Bhagavad Gita holds that *na jāyate mriyate vā kadācit* (the self is never born, and never dies) and that the self merely sets aside a worn body for another, as a person sets aside old clothes for new ones (Bhagavad Gita, 2.20, 2.22). A tradition capable of holding that death is not final has, alongside it, produced some of the strongest social penalties in the country for a death by one's own hand. The contradiction is only apparent: what a society polices about suicide is rarely the soul's fate, and almost always the families. Secular sources of stigma matter at least as much as any religious doctrine: fear that the family will be labelled 'mad' or hereditarily weak, fear of gossip in a close-knit neighbourhood, and above all fear for the marriage prospects of surviving children and siblings.

Honour (*izzat*) operates at the level of the collectivity. Individual conduct is judged as a reflection on the family and, in many communities, on the caste or clan. A death that suggests the family failed to protect, discipline or provide for one of its members threatens collective standing. Suicide is especially threatening because it announces, in the most public way, that something inside the household was unbearable. Where it follows a marital dispute, a failed examination, a forbidden relationship, a debt or an incident of abuse, disclosure invites judgement on the household and sometimes on named individuals within it.

Under these conditions families have rational reasons to shape the account. They may describe a death as an accident or a sudden illness, ask that a post-mortem be waived or hurried, cremate quickly, or use social and political influence, which varies considerably by caste and class, to persuade medical and police personnel to accept their version. Clinical and forensic accounts of Indian practice describe such behaviour (Radhakrishnan & Andrade, 2012; Vijayakumar, 2015), although exact measurement is impossible for the very reason that concealment, when it works, leaves no trace. Financial incentives point the same way. Life insurance contracts commonly limit or exclude payment for suicide within an initial period, so a family facing a loss of income may have a material interest in an 'accidental' classification.

Language is part of the mechanism. In everyday speech, families and neighbours often describe a suicide through euphemism, as a sudden death, an accident or a moment's lapse, and avoid the word itself. Euphemism is a kindness to the bereaved, and it is also a way of keeping the event out of the public register. Once a community has agreed on a softened account, the police, the neighbours and later the family's own children inherit it. What is recorded is then the socially agreed version of the death, which is precisely the kind of definitional work Douglas (1967) described.

Stigma also silences the living. Survivors of attempts and bereaved relatives find little language or institutional space in which to speak about suicide, which reduces help-seeking and prevents the accumulation of local knowledge on which prevention depends. The World Health Organization (2014) has noted that under-reporting and misclassification are likelier where suicide

³ The Bharatiya Nyaya Sanhita, 2023 (BNS), the Bharatiya Nagarik Suraksha Sanhita, 2023 (BNSS) and the Bharatiya Sakshya Adhinyam, 2023 (BSA) came into force on 1 July 2024, replacing the Indian Penal Code, the Code of Criminal Procedure and the Indian Evidence Act respectively.

⁴The NCRB reported 4,44,104 accidental deaths in 2023 (NCRB, 2025). Because deaths by poisoning, drowning, falls and railway incidents can be either accidental or intentional, small shifts in classification practice can change the suicide count materially.

⁵Cultural meanings of self-willed death are not uniform. Sati and jauhar were once valorised as honourable, and the Jain observance of *sallekhana* is regarded by adherents as a religious vow rather than suicide. In *Nikhil Soni v. Union of India* (2015) the Rajasthan High Court held *sallekhana* to be punishable, and the Supreme Court stayed that ruling the same year. That one act can be sanctified or condemned depending on who defines it illustrates the social construction of the category.

is illegal or heavily stigmatised, and cautioned that reported figures are affected accordingly.

6. Law, Police and Institutions

Law has magnified the incentive to conceal. Section 309 of the Indian Penal Code made attempted suicide punishable for well over a century. The Supreme Court struck it down in *P. Rathinam v. Union of India* (1994) but reversed course in *Gian Kaur v. State of Punjab* (1996), and the Law Commission of India (2008) had to recommend repeal again in its 210th Report. Only with the Mental Healthcare Act, 2017 did Parliament introduce a presumption of severe stress, under which a person who attempts suicide is not to be tried or punished (Government of India, 2017, Section 115). The Bharatiya Nyaya Sanhita, 2023, which replaced the Penal Code, does not reproduce Section 309, although it retains a narrow offence of attempting suicide in order to compel or restrain a public servant in the discharge of official duty (Section 226). Abetment of suicide remains an offence (Section 108).

For a century, therefore, a survivor of an attempt was a potential accused, and a family that took the person to hospital risked bringing the police into the home. Hospitals treated attempts as medico-legal cases requiring police intimation, and the reluctance this bred among families and doctors alike is well documented (Radhakrishnan & Andrade, 2012). Attempts do not enter the NCRB suicide count, but they matter here for two reasons. They are the most visible signal of suicidal distress in a community, and a legal culture that penalises help-seeking depresses the reporting of completed suicide as well. Reform of the statute does not erase habits formed over generations, since hospital practice, police routine and public understanding change slowly.

Police and institutional incentives complicate matters further. A suicide registered in a police station's jurisdiction calls for an inquest, an enquiry into possible abetment and, often, pressure from families, employers or local politicians. Where the death occurs inside an institution such as a hostel, a coaching centre, a workplace or a custodial facility, registration may implicate the institution itself. The Supreme Court's recent interventions on student suicides are instructive. In *Amit Kumar v. Union of India* (2025) the Court constituted a National Task Force on student mental health, and its later directions require higher educational institutions to report every student suicide and unnatural death to the police and call for central maintenance of data. In *Sukdeb Saha v. State of Andhra Pradesh* (2025) it issued fifteen guidelines for schools, colleges and coaching centres. That the Court found it necessary to mandate reporting suggests that non-reporting had been a practical concern.

7. Gender, Marriage and Classification

Under-reporting is not evenly distributed. The suicides of married women attract particular scrutiny

because of the legal presumption of abetment. Under Section 113A of the Indian Evidence Act, 1872 (now Section 117 of the Bharatiya Sakshya Adhiniyam, 2023), where a married woman dies by suicide within seven years of marriage and cruelty is shown, a court may presume abetment by her husband or his relatives. Dowry deaths are separately covered by Section 304B of the Penal Code (now Section 80 of the Bharatiya Nyaya Sanhita). In these circumstances the in-laws have strong reasons to present a death as an accident, such as a kitchen burn or a fall, and the woman's natal family, fearing the consequences of accusation for its other daughters or for its social relations, may acquiesce. The result is a zone of ambiguity in which the same death may be recorded as suicide, accident, dowry death or homicide according to who defines it and who holds power in the encounter with the police (Douglas, 1967). NCRB data show that homemakers form the largest occupational group among women who die by suicide, but they cannot show how many further deaths of married women were classified otherwise.

Class and social power shape recorded outcomes in a similar way. About two-thirds of recorded suicides in 2023 occurred among people with an annual income of ₹1 lakh or less (NCRB, 2025), a figure that may reflect real deprivation and may also reflect who is visible to the state. Poorer families have little capacity to negotiate with the police or arrange a private medical certificate, and their deaths are more likely to pass through the inquest system unaltered; households with money, standing or political connections are better placed to secure a gentler classification. This is a hypothesis, not a demonstrated finding, but it implies that recorded suicide may be tilted towards those least able to conceal it.

Classification problems extend to other groups. The category of 'farmer' has been contested, with critics arguing that definitions tied to land title exclude women who work the land, tenant cultivators and family labour; in some years several states reported no farmer suicides at all, a result many observers found implausible. More broadly, the cause codes limit what can be recorded, since a death can be attributed only to a category that the schedule provides and that informants are willing to name.

8. Independent Estimates and Regional Puzzles

Independent mortality studies suggest that police-based figures are substantial undercounts. The Million Death Study, which used verbal autopsies in a nationally representative sample of households, estimated about 1,87,000 suicide deaths in India in 2010, against about 1,35,000 recorded by the police in that year

(Patel *et al.*, 2012).[6] The Global Burden of Disease study estimated roughly 2,30,000 suicide deaths for 2016, well above the figure of about 1,31,000 recorded by the police (Dandona *et al.*, 2018). These modelled estimates carry their own uncertainty, but the direction of the difference is consistent: on these figures the police record captures somewhere between roughly 55 and 75 per cent of estimated deaths.

The regional pattern raises a related puzzle. Rankings of states on recorded suicide do not track development or distress in any simple way. Kerala, with high literacy, well-developed health and registration systems and a relatively open public conversation about mental health, records one of the highest rates, while Bihar recorded 0.7 per lakh in 2023 (NCRB, 2025). It would be remarkable if a difference of more than forty-fold were entirely real. More plausibly, recorded rates combine genuine differences in risk with differences in the density of registration, in literacy and in the willingness of families and police to name a death as suicide. States that report more honestly thereby look worse, a reporting penalty that gives governments little incentive to improve the record.

9. Towards Better Reporting

If reporting is a social process, improving it requires changing the incentives and meanings that surround it. Five measures follow from the analysis above. First, decriminalisation should be made complete in practice as well as in statute. The residual offence in Section 226 of the Bharatiya Nyaya Sanhita should be reviewed, and hospitals and police should be trained in the presumption introduced by Section 115 of the Mental Healthcare Act, 2017, so that seeking care never carries the threat of prosecution. Second, the system of cause-of-death certification should be strengthened, and verbal autopsy in the Sample Registration System should be used routinely to triangulate police data.

Third, public-health surveillance should be separated from criminal investigation. A confidential, non-punitive health-sector registry of suicide and attempts, in line with the surveillance component of the National Suicide Prevention Strategy (Ministry of Health and Family Welfare, 2022), would allow families and clinicians to report without exposing households to police enquiry, while abetment cases continue to be investigated through the criminal process. Fourth, state crime records bureaus should audit implausible patterns, such as zero counts for a category or sudden shifts between suicide and accidental death, and publish the results. Fifth, sustained community engagement, including responsible media reporting, work with faith and community leaders, and support for the bereaved, is needed to weaken the honour-based logic of concealment.

One caution follows. Better reporting will probably raise recorded rates before any real decline is achieved. Policymakers and the media should anticipate this and avoid treating a rising figure as evidence of policy failure, since doing so would restore the very incentive to conceal that the reforms are meant to remove. The national strategy's target of a ten per cent reduction in suicide mortality by 2030 can be assessed only if the baseline is measured honestly.

CONCLUSION

Durkheim closed the nineteenth-century argument that suicide was a purely private act. What this paper has tried to close, more modestly, is the assumption that a national statistic is a neutral window onto that social fact. Between a death and a number in an NCRB table stands a family deciding what can be said out loud, a doctor deciding what to write, a police officer deciding what to pursue, and a clerk deciding which column to tick. Each decision is reasonable on its own terms, and each is shaped by the same thing: the knowledge that a household's standing, and sometimes a woman's natal family's standing, can turn on how a single death is named. The number that survives this chain is real, but it is not the whole truth, and treating it as the whole truth has costs of its own, since a state that believes its own undercount has less reason to act.

None of this argues for abandoning the NCRB record, which remains the only annual, nationwide count India has. It argues for reading that record the way one reads any account given under pressure, with an ear for what silence, euphemism and a suspiciously round number might be doing. It also argues for a simple reversal of instinct. A state whose suicide count keeps rising after genuine reform is not necessarily failing; it may, for the first time, be listening. The harder and longer task is social rather than statistical: to make it possible, in a village, a hostel, a police station and a family's own kitchen, to say what happened without fear of what saying it will cost. Only then will the number in next year's report tell us what it claims to.

REFERENCES

1. Amit Kumar v. Union of India, Criminal Appeal No. 1425 of 2025, Supreme Court of India (judgment dated 24 March 2025, with subsequent interim directions).
2. Atkinson, J. M. (1978). *Discovering suicide: Studies in the social organization of sudden death*. Macmillan.
3. Bhagavad Gita, Chapter 2, verses 20 and 22 (translation and interpretation by the author).
4. Dandona, R., Kumar, G. A., Dhaliwal, R. S., Naghavi, M., Vos, T., Shukla, D. K., *et al.*, (2018). Gender differentials and state variations in suicide

⁶ Verbal autopsy is a method in which trained interviewers question relatives or caregivers about the

signs, symptoms and circumstances preceding a death, and physicians then assign a probable cause.

- deaths in India: The Global Burden of Disease Study 1990–2016. *The Lancet Public Health*, 3(10), e478–e489.
5. Douglas, J. D. (1967). *The social meanings of suicide*. Princeton University Press.
6. Durkheim, É. (1952). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Trans.). Routledge & Kegan Paul. (Original work published 1897)
7. *Gian Kaur v. State of Punjab* (1996) 2 SCC 648.
8. Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice-Hall.
9. Government of India. (2017). *The Mental Healthcare Act, 2017* (Act No. 10 of 2017). Ministry of Law and Justice.
10. Kitsuse, J. I., & Cicourel, A. V. (1963). A note on the uses of official statistics. *Social Problems*, 11(2), 131–139.
11. Law Commission of India. (2008). *Humanization and decriminalization of attempt to suicide* (210th Report). Government of India.
12. ILink, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology*, 27, 363–1. 385.
13. Ministry of Health and Family Welfare. (2022). *National Suicide Prevention Strategy*. Government of India.
14. National Crime Records Bureau. (2025). *Accidental deaths & suicides in India 2023*. Ministry of Home Affairs.
<https://www.ncrb.gov.in/uploads/files/1ADSIPublication-2023.pdf>
15. National Crime Records Bureau. (2026). *Accidental deaths & suicides in India 2024*. Ministry of Home Affairs.
16. *Nikhil Soni v. Union of India*, 2015 Cri LJ 4951 (Rajasthan High Court, 10 August 2015); special leave to appeal granted and interim stay ordered, Supreme Court of India, 31 August 2015.
17. *P. Rathinam v. Union of India* (1994) 3 SCC 394.
18. Patel, V., Ramasundarahettige, C., Vijayakumar, L., Thakur, J. S., Gajalakshmi, V., Gururaj, G., Suraweera, W., & Jha, P. (2012). Suicide mortality in India: A nationally representative survey. *The Lancet*, 379(9834), 2343–2351.
19. Radhakrishnan, R., & Andrade, C. (2012). Suicide: An Indian perspective. *Indian Journal of Psychiatry*, 54(4), 304–319.
20. *Sukdeb Saha v. State of Andhra Pradesh*, 2025 INSC 893 (Supreme Court of India, 25 July 2025).
21. Vijayakumar, L. (2015). Indian research on suicide. *Indian Journal of Psychiatry*, 57(Suppl. 2), S195–S202.
22. World Health Organization. (2014). *Preventing suicide: A global imperative*. World Health Organization.