The concept of masculinity and male suicide in North East England

Kimberley Atherton

University of Sunderland
United Kingdom

Correspondence: k.atherton2008@gmail.com

ISSN: 2515-138X

Male suicide is a major public health concern in the national and global arenas, with rates of suicide being several times higher for males than for females. The central rationale for conducting this literature review is that, to date, there is a plethora of literature about male suicide which have been conducted from biomedical, sociological and psychological perspectives. However, at the time of writing, there was no literature specifically dedicated to male suicide in North East England. This work, therefore, seeks to explore the concept of masculinity in terms of male suicide in North East England, by analysing the epidemiology of male suicide and the sociological concepts relating to this and offer a critical discussion on the concept of masculinity.

Keywords: epidemiology, male mental health, male suicide, masculinity, mental health

Annually, there are an estimated 800,000 suicides worldwide – of these individuals at least half are aged between 14 and 44 (World Health Organization, 2011). The number of suicides in the UK, particularly in England, have fluctuated moderately (Office for National Statistics, 2011, 2012b, 2013c), but one aspect that has remained consistent in national and global arenas is that there are significantly more suicides in males than in females.

In the North East of England, the numbers of suicides in males is lower than in London (Office for National Statistics, 2013c); however, the rate of male suicide is higher in the North East of England (Ministry of Justice, 2011, 2012). Although, this could be attributed to the levels of deprivation in the districts of Durham, Teesside and Sunderland, and that the hospital stays for self-harm were significantly higher in those three districts that they were for England (Public Health England, 2012a, 2012b, 2012c).

The main theories that have emerged through reading the literature and gaining an understanding of male suicide are social construction theory (Parsons, 1940), Bourdieu's (1979) theory of *capital*, *habitus* and *field*; and concepts of masculinity (Connell, 1987).

Masculinities

Upon exploring the literature around masculinity, it has been discovered that this concept is by no means a static entity and that it alters throughout time, space and culture and is influenced and intertwined with race, employment, social class and history (Carrigan, Connell, & Lee, 1985; Connell, 2009). Of particular interest to mention in this work are hegemonic, complicit, subordinated and homosexual masculinities.

According to Connell (1987, pp. 183–186), hegemonic masculinity is a cultural ideal within societies, constructed predominantly on ascendancy over women and the oppression of alternative masculinities. Carrigan et al (1985) claimed that hegemonic masculinity was that which belonged to 'white, educated, heterosexual, affluent males'. The ascendancy of these males is not achieved through violence or economic threat, but rather through the patriarchal hierarchy that empowers them. However, force can be utilised in the maintenance of hegemonic dominance as a cultural pattern within society (Connell, 1987, p. 184).

Complicit masculinity in itself is not dominant, but it does support hegemonic masculinity in return for the dividends of being compliant with patriarchal order (Kahn, 2009, p. 35). Subordinated masculinities occur through the identifying of people into social groupings that are not dominant (Connell, 2001, as cited in Kahn, 2009, p. 36) such as through racial or ethnic oppression, young men and homosexual men. Homosexual masculinity tends to be oppressed as it does not quite fit within the aforementioned definition of hegemonic masculinity and is associated with effeminacy.

Historically, Adler (1912, as cited in Aikins, 1927) claimed that when a male experienced a sense of inadequacy or a lack of virility, he would have ensued upon the 'masculinity protest': the strife between inferiority and superiority. This was commonly referred to in the paradigm of psychology as the inferiority complex (Adler, 1988; Freud, 1949, as cited in Coon & O'Mitterer, 2009, p. 399) and was among the emergence of literature relating to masculinity in the field of psychodynamic psychology.

During the feudal era, physical pursuits such as jousting were seen as highly valuable forms of training for the military (Lipman, 1962). In contemporary society, pursuits such as jousting are unnecessary. Nonetheless, contact sports and those which push and test physical stamina are still in existence today, because commercial sports institutions, media and businesses have an overwhelming address to males with a focus on competitive success (Connell, 2005; Messner, 2002). However, both authors also claim

that this particular version of patriarchy is not traditional. Lipman (1962) wrote that men would be more likely to be involved in physical sports than in arts and literature as hobbies in the 1960s. Additionally, he wrote that such inherent display of masculinity was dysfunctional to the urban industrial society of that time.

Prior to the slave trade era, African individuals lived in patriarchal society of Africa but this patriarchy did not subordinate others in the ways that European societies did in the same era (Staples, 1978). However, the emergence of the slave trade and the colonisation of Africa in later history, led to the oppression of African men by enforcing that any benefits of being male and their values of masculinity were outweighed by their country being overthrown and segregated by Europeans. This was also evident in Connell's work (2009, p. 17) on the African mines where the division of labour occurred between European men and African men, with the Europeans being in managerial positions while African men taking up the labour force. Although the binary of race was clear at the time, this enabled African miners to take advantage of the cultural barriers by maintaining their own culture and holding some control over their work.

O'Leary and Donoghue (1978) found in their work that irrespective of how masculine a male was perceived to be, it did not mean that he was any more or less valued by the other participants in the study. Another suggestion was that excessive masculinity such as a large muscular physique, an impressive sexual scorecard or acts of violence were the consequence of emasculation of humiliation of males (Buchbinder, 1994, p. 36). However, Aikins and Austin (1927) argued that physique was irrelevant in the concept of masculinity, but rather it was the qualities of building one's character with life experience and to be useful as a man that constituted masculinity. Similar values emerged more recently from the older men of a mining community in Pondoland, Africa. They described *ubododa* (manhood) as helping others in times of need as opposed to physical hardiness and violence (Moodie & Ndatshe, 1994, p. 38). Yet, it was found in another study that males who deviated from the common values of masculinity risked becoming depreciated within society (Costrich, Feinstein, Kidder, Marecek, & Pascale, 1975).

Some literatures (e.g., O'Leary & Donoghue, 1978) suggested that the construction of masculinity and sex roles occurred very early for boys compared to that of girls, as boys were sanctioned for engaging in cross-sex behaviours such as playing with dolls. These notions lend evidence to social construct theory (Parsons, 1940) and Bandura's (1977) social learning theory. Connell (2005, 2009, p. 7) further added that while some males who deviated from the societal expectations of masculine behaviour had experienced violence and verbal derogation, those who conformed to societal expectations would have also suffered because of the risks associated with industrial employment, health behaviours, insufficient help-seeking and higher rates of death by violent means, including homicide and suicide. There also observations that parental bonding affective depressive symptoms among male adolescents (Acharya & Relojo, 2017).

Connell and Messerschmidt (2005) claimed that the concept of hegemonic masculinity influenced contemporary literature about 'men, gender and social hierarchy'. Hegemonic masculinity began to be used in wide variety of fields such as education, criminology, sports and men's health because the concept was open to manipulation of definition within social and cultural arenas and could also be changed over time. Nonetheless, there are arenas where a specific type of hegemonic masculinity occurs that remains relatively static, such as those within military and police forces (Barrett, 1996); and organisations which institutionalise power and violence (Connell, 2009, p. 77). However, the fact that the type of hegemonic masculinity does not tend to evolve in military and police forces can lead to problems when men are socialising in wider society and how they are represented by the media. However, Connell (2009, pp. 102 & 107) argued that multiple masculinities existed in society, in organisations and within social groups that are shaped by wider determining factors such as ethnic

diversity, differences in geographical location, and major changes. Demetriou (2001) argued that hegemonic masculinity was the unity of a multitude of masculinities so that patriarchal order could be sustained.

In 2003, Nayak (p. 69) wrote that there was a displaced masculinity among *Geordie* men in post-industrial Newcastle, in that the concept of masculinity had altered from being centred on *production* (the colliery, shipyard, or factory) to being centred on *consumption* (football, drinking, and going out). This shift in the value placed on masculinity could have occurred through de-industrialisation of the city and the societal change that was brought about by it. Hollands (1995, p. 12) had said of Northern revellers, that he equated the term *Geordie* with a 'strong patriarchal and masculine occupational identity.' Lipman (1962) referred to the displacement of masculinity between urban and rural America in 1962, as a 'cultural lag'. This notion could also be attributed to the displaced masculinity seen between the industrial and post-industrial Newcastle. An issue of this would be how the expectations of men could change without changing society itself, but also if society had evolved then it would be expected that the dominant definition of masculinity should also evolve.

In the North East of England, being the *breadwinner* (main wage earner) and the craftsmanship involved in manual labour such ironmongery, blacksmithing and farming held a great deal of masculine pride and a sense of masculine heritage (Nayak, 2003, pp. 58 & 62). Nayak (2006) further explored the differences in masculinity between *real Geordie* and *chav* youth. The *real Geordies* associated masculinity with a culture of consumption of alcohol, muscular physique, maintaining the industrial reputation of the region and sexual prowess; whereas *chavs* associated masculinity with violence, a particular dress code and crime such as stealing and distributing stolen goods. However, the crime associated with *chav* youths occurs due to long-term unemployment that is reinforced by the economic downturn of the region and the lack of preparedness of the youth to partake in employment wherever it is available.

Nayak (2006) goes on to conclude that neither group of youths are in a position to have configured a hegemonic masculinity in the North East of England, although the *real Geordie* youth had made a determined attempt to exert a sense of cultural prestige over the *chav* youth. Nayak (2006) further added that young North Eastern men responded to change by creating their identities through interweaving traditional and contemporary cultures. Hegemonic masculinity can be seen as part of the pastiche of the way that males project themselves to others, compared to whom and why they actually are (Morall, 2009, p. 49). Primarily, this idea lends evidence to the conflict between the *habitus* of which North Eastern males originate and the status they yearn for (Jenkins, 1992, pp. 74–76). However, there is also evidence towards the theory of social construction and how society expects individuals to fit into it, and of social learning theory where the behaviour of a male and what he learns is shaped by his peers.

Overall, it can be concluded that masculinities have altered between time, space and culture are likely to continue as society and cultural values evolve. It is also clear that North Eastern concepts of hegemonic masculinity are somewhat different to the definition offered by Carrigan and colleagues (1985), and therefore is also susceptible to change. It can also be concluded that the hegemonic masculinities can have positive and negative values to it.

The epidemiology of suicide

The WHO (2010) defines mental health as a 'state of well-being in which an individual realises his own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his community.' However, many people do not always cope well with life pressures and more than 70% of people from around the world with mental health problems do not receive treatment

from health professionals (Thornicraft, 2007). Stigma is a well-documented barrier that prevents people from accessing mental health services, globally and nationally (Department of Health, 2011, 2012; Henderson, Evans-Lacko, & Thornicraft, 2013; Shepherd & Rickard, 2012; WHO, 2011). This is despite it being known that poor mental health is a risk factor for health issues, as well as being a determining factor of intentional and unintentional injury. Depression, in particular, is said to be the world's leading cause of disability and is a significant risk factor for suicide, especially when it is left untreated (Department of Health, 2012).

Suicide is defined as 'the act of killing oneself' (WHO, 2012b). The Office for National Statistics (2012b) states that suicides included deaths recorded by coroners as intentional self-harm and those recorded as a poisoning or an injury of undetermined intent. Wennberg (1989, p. 35) claimed that the term *suicide* should only be used when there is absolute certainty that the individual intended to end their lives because of the emotions and moral judgement that is attached to the term *suicide*. The word *suicide* was first introduced in the English language by Walter Charleton in 1651 to neutralise judgements associated with *self-killing* and *self-destruction.* Over time, societal attitudes have tarnished the term *suicide,* and associated the stigma and the negative connotations of *self-killing* with it (Wennberg, 1989, pp. 17–18). In recent years, suicide has become recognised globally and nationally as a mental health issue (Department of Health, 2011, 2012; WHO, 2011). Meanwhile, Conroy (2006, p. 1) identified suicide as something that 'is not chosen, it happens when pain exceeds resources for coping with pain.'

It is estimated that globally, around 800,000 people die by suicide every year, and that over half of those that died by suicide are aged between 15 and 44 (WHO, 2011). Every day, at least 20 people will attempt to die by suicide for every one person that has a fatal outcome to a suicide attempt (WHO, 2012c). Among 93 member states of the WHO, between 2001 and 2010, it was observed that male suicide numbers were significantly higher than female suicide numbers (WHO, 2012a).

The Office for National Statistics (2011, 2012b) recorded 5,675 suicides in the UK for 2009 – 1.2% more than the number recorded for 2010. The suicide numbers in the UK were 7% higher in 2011 than in 2010 (Office for National Statistics, 2013c). The number of male suicides accounted for more than three quarters of the total suicides for the UK between 2009 and 2011 (Office for National Statistics, 2011, 2012b, 2013c). Suicide numbers remained highest in males aged 15–44 between 2000 and 2009 in the UK, before declining and overlapping with the increasing numbers of suicides in men aged 45–74 (Office of National Statistics, 2011, 2012b). Overall, male suicides rates decreased for England and Scotland from 2002–2004, compared to 1992–1994. There were marginal differences in the rates for Wales between the same interval and the rates for Northern Ireland remained the same (Office for National Statistics, 2006). The Ministry of Justice (2011, 2012) identified suicide as the second most common verdict decided for male deaths in England and Wales during 2009 and 2010.

The male suicide rates in the North East of England have varied slightly between 2009 and 2011; reducing from 19.2% per 100,000 in 2009, to 16.9% per 100,000 in 2010 (Office for National Statistics, 2012b). This was followed by a steeper increase to 21.5% per 100,000 in 2011 (Office for National Statistics, 2013c). Over those three years, the rate of male suicide has remained higher in the North East of England than in the UK and England. The rate of suicide among men aged 15–44 was higher between 1998 and 2004 for the North East of England and the UK than it was between 1991 and 1997, however, the rate in England for men for the same age was higher in the 1991–1997 period than it was in the 1998–2004 period. Coroners statistics (Ministry of Justice, 2011) for England and Wales showed that there were considerable differences in the numbers of male suicides within districts of the North East of England. There were no male suicides within districts of the North East of England. There were no male suicides recorded in Sunderland for 2010, but there were 27 in each of the districts of Durham and Teesside in the same year. In the following year there were no significant increases or decreases in the

numbers of suicide in Durham or Teesside, but there were 17 male suicides recorded for Sunderland (Ministry of Justice, 2012).

Changes in the way that data is presented by the Officer for National Statistics (2012b, 2013c) could be responsible for the changes in suicide numbers and rates as there have been alterations in the way that age categories have been presented between 2010 and 2011. This means that if there was a trend in the patterns of the age at which men were dying by suicide, it would be difficult to identify between 2010 and 2011. The trend that most male suicides were occurring in men aged 15–44 changed in 2010 when the rates started decreasing for this age group and increasing in men aged 45–74. However, this change could perhaps be explained by the increasing requirement of coroners to utilise narrative verdicts (House of Lords, 2004). In the UK, there was an overall increase in the use of narrative verdicts in 2010 compared with 2006 (Office for National Statistics, 2012b). Concerns have been expressed that the increase of the use of narrative verdicts was influencing suicide statistics with reductions appearing in the category of death by intentional self-harm because of inflation in the number of narrative verdicts (Gunnell, Hawton, & Kapur, 2011).

There have been distinctions made between determinant and indeterminant methods of suicide. Methods that are particularly violent such as hanging or shooting are regarded as determinant methods as they provide little opportunity for the mind to be changed and offer little chance of rescue. Wennberg (1989, p. 20) referred to these differences as active and passive methods, whereby one can die by suicide by acting (active) or failing to act (passive). For example, failing to take medications to manage a heart condition could result in a passive suicide, but jumping from a high place that would result in death would be considered an active suicide. Retterstol (1993, p. 92) claimed that a combination of methods is often used in suicides to ensure that outcome is fatal and that around half of those who die by suicide have alcohol in their blood. .

Durkheim (1952, pp. 152–294) wrote of four types of suicide: altruistic, egoistic, fatalistic, and anomic suicide. Altruistic suicide according to Durkheim is committed when the individual perceived their life as less worthy than the collective identity with which they were associated; for example, within religion, culture, or the military. In contrast, egoistic suicide occurs when an individual no longer see where they fit within society, possibly due to marginalisation or in post-industrial societies. Durkheim further wrote of fatalistic suicide where he theorised that individuals would die by suicide due to over-regulation in society as through a country's legislation or religious doctrine. Anomic suicide is different once again, as this occurs when there were dramatic and sudden changes within society or within an individual's life; for example an individual's traumatic life experience or perhaps loss of employment. Durkheim's theoretical insight into suicide is not utilised in contemporary health and social care around suicide. However, this insight could be valuable in providing insight into sociological factors that may influence suicidal ideation and suicidal attempts.

Some studies (Biddle, Gunnell, Sharp, & Donovan, 2004; Courtenay, 2000; Henderson et al., 2013; Oliver, Pearson, Coe, & Gunnell, 2005) concluded that men were less likely to seek help for mental health related issues than women. Interestingly, Sanchez, Bocklandt, and Vilain (2013) also found that there were differences in help-seeking behaviours between twin males of differing sexual orientation: Heterosexual males were less likely to seek help for symptoms of mental distress that their homosexual twin, although the heterosexual twins in the study displayed more symptoms of specific distress. The study concluded that the differences between the behaviours of the twins were constructed by societal values of masculinity. The unwillingness of men to seek help or only seek help in dire situations risk their health and well-being, and increase their susceptibility to suicide (Biddle et al., 2004; Connell, 2005, 2009, p. 7; Department of Health, 2012; Mahalik & Burns, 2011; Oliver et al., 2005; Rivera-Ramos, & Buki, 2011).

Being a male from a disadvantaged background; suicide occurring within a close family or social circle, mental distress, chronic physical ill health; and striving to achieve the *masculine gold standard* (Samaritans, 2012) can all be risk factors for suicide. Other potential risk factors include socio-economic position, unemployment and drastic social change (Retterstol, 1993, pp. 142–146; World Health Organization, 2010). A further risk factor for suicide is a previous attempt or threat of suicide. Windfur and Kapur (2011) identified people with mental health issues as being at higher risk of suicide than the general population. However, the historical treatment of suicide, attempted suicide and mental illness might go some way to explaining the attitudes, values and stigma that society holds about it today and may also explain why help-seeking behaviours in some men are insufficient to lead a healthy life.

Historically in England, attempted suicide was considered a criminal offence up to until 1961 (Crown, 1961). The last conviction for this *crime* occurred as late as 1960, when a prisoner attempted suicide and was sentenced to an additional two years imprisonment (Retterstol, 1993 p. 240). The criminality of attempted suicide and the obligation of medical professionals to assist those in needs following attempted suicide would have presented many challenges for health professionals and others involved in the care of those individuals. It could, therefore, be suggested that the repealing of this legislation could have been the first step towards reducing the stigma associated with suicide and attempted suicide.

Suicide prevention strategies have been introduced by government departments throughout the UK (Department of Health, Social Services and Public Safety, 2012; The Scottish Government, 2002; Welsh Assembly Government, 2009) with the aim of reducing suicides occurring in the UK. In England, the government has invested an estimated £4 million, so that access to psychological therapies could be improved (Department of Health, 2011). Several charities (e.g., Grassroots, n.d.; Papyrus, 2013; Pieta House, 2013) also exist across the UK and have been involved in research, raising awareness about suicide and providing resources for those who are contemplating suicide or those who are concerned about someone else contemplating suicide. More recently, suicide has been discussed in the House of Commons (2013) so that more insight could be gauged of where things could be improved for those contemplating suicide; identifying risk factors and helping those who are bereaved by suicide.

However, when case study evidence (Samaritans, 2013) of the circumstances of men and the literature discussed are considered, it can make a little easier to understand why men do not readily access services even when they are available. Risk factors which have been discussed for suicidal ideation have all been identified as individual factors in suicide data and suicide prevention documents, but the majority of men probably identify with several of those risk factors, which could increase the propensity of suicide for some men. It is well-established from the literature presented that suicide is a major public health concern in the global, national, and regional areas.

There are also underlying sociological factors in the North East of England that may influence the risk factors for suicide such as: (1) the devaluation of men through changes in male and female roles; (2) hegemonic masculinity as strength and reluctance to seek help when needed; and, (3) the position of working class men in the North East of England with reference to the work of Bourdieu (1979).

DISCUSSION

It is clear from the literatures that male suicide rates are impacted by the concepts of masculinity, particularly the concept of hegemonic masculinity in the North East of England. However, there are also underlying sociological factors that influence how those concepts of masculinity are shaped and may therefore offer some explanation as to why some men die of suicide in the North East of England.

Since the closure of the coal mines and shipbuilding industries in the North East there has been continuous economic decline and rising unemployment (Office for National Statistics, 2012a, 2013b; Wilson, 2013). Men were forced to find employment elsewhere, generally within factory production where they could transfer their skills from the previous jobs they held. Some, however, were forced to completely re-train and pursue alternative career paths such as joinery, ironmongery or other trades of craftsmanship that would be passed down to future generations. This was a notion that Nayak (2003, pp. 58–59) referred to as the *masculine heritage.* It was during this time that the male role started to change in the North East, as men became employed alongside women in factory work. There was no view held at the time that factory work was men's work, unlike the coal mining and shipbuilding industries. This would likely to have led to changes in the use of some of the North Eastern dialect in the workplace, which was part of the culture of working in the mines.

A major change also occurred with regard to the discipline of men, particularly younger males who had worked in the mines. The coal mining industry was extremely hazardous and fraught with serious injury and disasters such as stone fall and explosions, so self-discipline became part of the job description. This concept of discipline ebbed out into society in the way that managers, also known as *foremen* and miners addressed each other even within the public sphere. This notion of respect is still visible in the former colliery villages, although it is beginning to decline as the population of former miners age and perish.

In more recent times, the economic recession of the UK has meant the decline of much of factory production as well. Again, many men have been forced to find jobs elsewhere or to depend on welfare benefits in the longer term. The unemployment of men has led to an uprising of women into further education and employment (Office for National Statistics, 2013a) while men have remained at home carrying out home duties and looking after children. It almost seems that once again, the roles of men and women have been reconstructed by the forces of de-industrialisation of North East and societal change.

The male role appears to have altered drastically since the closure of the coal mines and the shipbuilding industry in the North East. The issues of male unemployment and increasing higher education and employment in women may leave men feeling emasculated. Despite major societal change, the existence of a hegemonic masculinity that cannot be maintained prevails. There remains a notion that men should be strong and silent types; that men should not show emotion; and men should provide for their families. The constant effort of men trying to achieve the *masculine gold standard* is in some individuals too much to bear (Samaritans, 2012, 2013).

Younger males show a tendency not to apply for call centre and other office-based employment as it is seen as women's work; values that are instilled into by older generations of men who have been employed within the coal mines or other heavy industry. In addition to this, the coal mines supplied a kind of discipline that was enforced by physically demanding work. Men of the mining communities had to work extremely hard and long shifts to be able to take a wage home and put food on the table. The closure of mines and provisions of the welfare state have seen a youth culture emerge in which young men do not want to look for available jobs because they get money paid for them from the state. However, re-training for a different job role also costs even if individuals claim any kind of unemployment benefit. Individuals can only study up to 16 hours per week; otherwise their unemployment benefits are sanctioned. Being unemployed can lead to relative or even absolute poverty and feelings of hopelessness and emasculation. Above all, men can be left feeling devalued which can further lead to suicidal ideation and acts of attempted or actual suicide.

It has been well-documented in the literature that men do not show their emotions or access health services when they need to, thus increasing the risk of serious consequences for their health including

risk-taking behaviours, indulging in pathogenic lifestyles and exaggerating the risk of suicide (Connell, 2005, 2009, p. 7; Department of Health, 2012; Mahalik & Burns, 2011; Rivera-Ramos & Buki, 2011). As discussed, the characteristics of hegemonic masculinity are associated with emotional and physical strength and strong unwillingness of help-seeking behaviours (Carrigan et al., 1985) – something that remains a challenge today.

The concept of hegemonic masculinity in North East England is also associated with being emotionally and physically strong, but it appears through the evidence here that it is associated with dialect, football, consumption of alcohol and manual labour that employs the physical capital of men. Nonetheless, this regional concept of hegemonic masculinity maintains an attempt to retain patriarchal order. Nonetheless, it could be stated that the existence of the traditional gender order is diminishing, with women seeking out higher education and better paid occupations. It would seem that women are seeking out some form of feminism which mimics Carrigan's (1985) definition of hegemonic masculinity by becoming well-educated and affluent.

Some (Cockburn, 2004; Connell, 2005; Kenny, 2007) would argue that there is no change in the traditional gender order, because the hegemonic masculinity that is afforded to 'white, educated, heterosexual, affluent males' (Carrigan et al., 1985) allows them to main their positions as gatekeepers in the wider social sphere; but, men that hold those positions subjugate those they consider to be men of lower socio-economic class. This, again, can create an overwhelming sense of inferiority which can result in risk factor for pathogenic health behaviours, risk-taking behaviours, and increases the risk of death by violent means including suicide.

The work of Bourdieu (1979) on the concepts of *capital*, *habitus*, and *field* may also offer some insight as to how the concept of masculinity impacts the male suicide rates in the North East of England. Although *capital*, *habitus*, and *field* are separate concepts, they are intertwined and interdependent with each other. The *field* of young men in the North East is constructed by the prospect of unemployment and underachievement in secondary education. As the *fields* of education and employment interact with one another, academic *capital* is required to pursue further education or employment, but employment experience *capital* may also be required to gain further education or a better paid occupation. However, there are some men who do not hold relevant academic *capital* to get any further forward in the fields of education or employment or they may not possess the experience required to progress in their career path. However, the type of employment that young men are prepared to undertake will depend heavily on their *habitus* (the values and expectations they gain from life experiences). If the dominant masculinity of the North East expects a culture of football, alcohol consumption and the younger generations of men to be employed in heavy industry, then it is likely that this would be the *habitus* that is instilled to them. Deviation from this hegemony may result in better paid occupations, not working in heavy industry but can also lead to feelings of being emasculated which may result in propensity for self-harm or suicide.

Additionally, economic *capital* can only be legitimately gained with the possession of at least basic academic or vocation *capital.* However, economic *capital* is required to gain further academic or vocational qualifications and to up the career ladder in one's chosen profession or to even change career paths. Economic *capital* is also required to enable individuals to achieve a basic standard of living, but more money is required to live a healthy lifestyle and afford non-essential good which may improve mental health and well-being. Without economic *capital*, both relative and absolute poverty could be experienced, thus leading back to feelings of depression and hopelessness and increasing the risk of suicide.

Capital, *habitus* and *field* from a diffused kind of power (Foucault, 1991) that exists throughout society, but only those who earn it by contribution to society can benefit from it. Considering this, if males of the

North East of England did not possess a great deal of any form of *capital* and did not possess a societally accepted *habitus* and perhaps if work was too far to travel from the *field* in which they existed, then they would not achieve much the reward of this diffused power.

CONCLUSION

Suicide is recognised as a public health threat in the regional, national and global health spheres. Through the data presented here, male suicide has been identified as a large-scale issue over at least two decades, lending thought to the ways in which masculinity is socially constructed and coerces men into roles that makes them more susceptible to the risk of suicide. If the masculinity in which males identify does not correspond with the dominant in the *field* in which they live, then they may experience internal conflict with their identity.

The concept of hegemonic masculinity in the North East of England does differ from the original concept offered by Carrigan and colleagues (1985), but in its own way it still subordinates other masculinities. This concept of masculinity remains through generational patriarchy but – without the means for men to continue to do as expected by their elders – it can lead to issues with seeking employment, changes in male and female roles; with women becoming the *breadwinners* and increased pathogenic health behaviours. The works of Bourdieu, Foucault and Parsons have provided theoretical underpinnings for the social construction of the roles of men. They have also provided insights to how masculinities are constructed in different social arenas and how the male role and masculinities influence the suicides of males.

Some limitations were that the Office for National Statistics changed the way in which their suicide data were presented between the years that were explored. The alterations were in the age categories for which suicide data were correlated, making identification of trends in male suicides impossible. However, this could have been done deliberately so that trends in specific age groups did remain the same, and therefore would not be as much of a concern to any reader comparing those statistics. However, it could also have occurred due to statisticians working in different ways.

Recommendations for future research would be to continue with qualitative and quantitative approaches so that further insights into suicide in general, and into male suicide and the role of hegemonic masculinity can be gained. Sociological concepts such as Durkheim's concepts of suicide and the concept of masculinity could also be considered for suicide prevention strategies, taking into account legal, global and cultural diversity. The Samaritans have made good progress with this in their work, but it must be incorporated into government and public health literature. The final recommendation is that there should be more support for grassroots initiatives for men's mental health and well-being so that access to support networks is improved for men.

References

Acharya, S. & Relojo, D. (2017). Examining the role of cognitive distortion and parental bonding in depressive symptoms among male adolescents: A randomised crossover trial. Journal of Innovation in Psychology, Education and Didactics, 21(1), 7–20. https://doi.org/10.5281/zenodo.1289149

Adler, A. (1988). The child's inner life and a sense of community (L. Fleisher, Trans.). *Individual Psychology: The Journal of Adlerian Theory, Research and Practice, 44*(4), 471–423. https://doi.org/10.1891/9780826168665.0004

Aikins, H., Austin. (1927). Woman and the masculine protest. *Journal of Abnormal Psychology, 22*(3), 259–272. https://doi.org/10.1037/h0072767

Bandura, A. (1977). Social learning theory. Oxford, England: Prentice Hall.

Barrett, F. J. (1996). The organizational construction of hegemonic masculinity: The case of the US Navy. *Gender, Work and Organization, 3*(3), 129–142. https://doi.org/10.1111/1468-0432.00011

Biddle, L., Gunnell, D., Sharp, D., & Donovan, J. L. (2004). Factors influencing help seeking in mentally distressed young adults: a cross-sectional survey. *British Journal of General Practice, 54*(501), 248–253.

Bourdieu, P. (1979). *Distinction: A social critique of the judgement of taste* (P. Kegan, Trans.). London: Routledge.

Buchbinder, D. (1994). *Masculinities and identities.* Melbourne: Melbourne University Press.

Carrigan, T., Connell, B., & Lee, J. (1985). Toward a new sociology of masculinity. *Theory and Sociology, 14*(5), 551–604. https://doi.org/10.1007/bf00160017

Cockburn, C. (2004). *The line: Women, partition and gender order in Cyprus.* London: Zed Books.

Connell, R. W. (1987). *Gender and power: Society, the person and sexual politics.* Cambridge: Polity Press and B. Blackwell.

Connell, R. W. (2005). Change among the gatekeepers: Men, masculinities and gender equality in the global arena. *Signs: Journal of Women and Culture and Society, 30*(3), 1801–1825. https://doi.org/10.1086/427525

Connell, R. W. (2009). Gender: Short introductions. Cambridge: Polity Press.

Connell, R. W. & Messerschmidt, J. (2005). Hegemonic masculinity. *Gender and Society, 19*(6), 829–859. https://doi.org/10.1177/0891243205278639

Conroy, D. L. (2006). Out of the nightmare: Recovering from depression and suicidal pain. Lincoln: iUniverse.

Coon, D. & O'Mitterer, J. (2009). Introduction to psychology: Gateways to mind and behaviour (12th ed.). Belmont, California: Wadsworth.

Costrich, N., Feinstein, J., Kidder, L., Marecek, J., & Pascale, L. (1975). When stereotypes hurt: Three studies of penalties for sex-role reversals. *Journal of Experimental Social Psychology, 11*(6), 520–530. https://doi.org/10.1016/0022-1031(75)90003-7

Courtenay, W. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine, (50),* 1385–1401. https://doi.org/10.1016/s0277-9536(99)00390-1

Crown. Suicide Act 1961. , § c.60 (1961).

Demetriou, D. Z. (2001). Connell's concept of hegemonic masculinity: A critique. *Theory & Society, 30*(3), 337–361. https://doi.org/10.1023/a:1017596718715

Department of Health. (2011). No health without mental health. Retrieved from https://www.dh.gov.uk

Department of Health. (2012). Preventing suicide in England: A cross-government outcomes strategy to save lives. Retrieved from http://www.dh.gov.uk

Department of Health, Social Services and Public Safety. (2012). The Northern Ireland suicide prevention strategy. Retrieved from https://www.health-ni.gov.uk

Durkheim, E. (1952). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Trans.). London: Routledge.

Foucault, M. (1991). *Discipline and punish: The birth of a prison.* London: Penguin.

Grassroots Suicide (n.d.). About us. Retrieved from https://www.prevent-suicide.org.uk

Gunnell, D., Hawton, K., & Kapur, N. (2011). Coroners' verdicts and suicide statistics in England & Wales. *British Medical Journal, 343*. d6030. https://doi.org/10.1136/bmj.d6030

Henderson, C., Evans-Lacko, S., & Thornicraft, G. (2013). Mental illness stigma, help seeking and public health programs. *American Journal of Public, 103*(5), e1–e4. https://doi.org/10.2105/ajph.2012.301056

Hollands, R. (1995). Friday night, Saturday night: Youth culture in the post-industrial city. Retrieved from https://research.ncl.ac.uk

House of Commons: Hansard. (2013). Opposition day: Suicide prevention, 6th February 2013. Retrieved from https://publications.parliament.uk

House of Lords. Judgments – Regina v. Her Majesty's Coroner for the Western District of Somerset (Respondent) and another (Appellant) exparte Middleton (FC) (Respondent). (11 March 2004).

Jenkins, R. (1992). *Key sociologists: Pierre Bourdieu.* London: Routledge.

Kahn, J. S. (2009). *An introduction to masculinities.* Chichester: John Wiley & Sons.

Kenny, M. (2007). Gender, institutions and power: A critical review. *Politics, 27*(2), 91–100. https://doi.org/10.1111/j.1467-9256.2007.00284.x

Lipman, A. (1962). Cultural lag and masculinity. *Journal of Educational Sociology, 35*(5), 126–220. https://doi.org/10.2307/2264567

Mahalik, J. R., & Burns, S. M. (2011). Predicting health behaviours in young men that put them at risk for heart disease. *Psychology of Men and Masculinity, 12*(1), 1–12. https://doi.org/10.1037/a0021416

Messner, M. A. (2002). *Taking the field: Women, men and sports.* Minneapolis: University of Minnesota Press.

Ministry of Justice. (2011). Coroners Statistics 2010: England & Wales. Retrieved from https://www.justice.gov.uk

Ministry of Justice. (2012). Coroners statistics 2011: England & Wales. Retrieved from https://www.justice.gov.uk

Moodie, T., & Ndatshe, V. (1994). *Going for gold: Men, mines and migration.* Johannesburg: Witwatersand University Press.

Morall, P. (2009). *Sociology and health: An introduction* (2nd ed.). Oxford: Routledge.

Nayak, A. (2003). *Race, place and globalization: Youth cultures in a changing world.* Oxford: Berg.

Nayak, A. (2006). Displaced masculinities: Chavs, youth and class in the post-industrial city. *Sociology, 40*(5), 813–831. https://doi.org/10.1177/0038038506067508

Office for National Statistics. (2006). Health Statistics Quarterly-No.31, autumn 2006: Suicide trends and geographical variations in the United Kingdom, 1991-2004. Retrieved from https://www.ons.gov.uk

Office for National Statistics. (2011). Suicide rates in the United Kingdom, 2000-2009. Retrieved from https://www.ons.gov.uk

Office for National Statistics. (2012a). Regional labour market statistics, July 2012. Retrieved from https://www.ons.gov.uk

Office for National Statistics. (2012b). Suicide rates in the United Kingdom, 2006 to 2010. Retrieved from https://www.ons.gov.uk

Office for National Statistics. (2013a). A02: Summary of employment, unemployment and economic inactivity for people aged from 16 to 64. Retrieved from https://www.ons.gov.uk

Office for National Statistics. (2013b). Regional labour market statistics, April 2013. Retrieved from https://www.ons.gov.uk

Office for National Statistics. (2013c). Suicides in the United Kingdom, 2011. Retrieved from https://www.ons.gov.uk

O'Leary, V. E., & Donoghue, J. M. (1978). Latitudes of masculinity: Reactions to sex-role deviance in men. *Journal of Social Issues, 34*(1), 17–28. https://doi.org/10.1111/j.1540-4560.1978.tb02538.x

Oliver, I. O., Pearson, N., Coe, N., & Gunnell, D. (2005). Help-seeking behaviour in men and women with common mental health problems: a cross-sectional study. *The British Journal of Psychiatry, 186*(4), 297–301. https://doi.org/10.1192/bjp. 186.4.297

Papyrus. (2013). Prevention of young suicide. Retrieved from http://www.papyrus-uk.org

Parsons, T. (1940). An analytical approach to the theory of social stratification. *The American Journal of Sociology, 45*(6), 841–862. https://doi.org/10.1086/218489

Pieta House. (2013). Preventing suicide and self-harm. Retrieved from https://www.pieta.ie

Public Health England. (2012a). County Durham: Health profile 2012. Retrieved from https://webarchive.nationalarchives.gov.uk/20170106081009/http:/www.apho.org.uk

Public Health England. (2012b). Middlesbrough/Stockton-on-Tees: Health profile 2012. Retrieved from https://webarchive.nationalarchives.gov.uk/20170106081009/http:/www.apho.org.uk

Public Health England. (2012c). Sunderland: Health Profile 2012. Retrieved from https://webarchive.nationalarchives.gov.uk/20170106081009/http:/www.apho.org.uk

Retterstol, N. (1993). *Suicide: A European perspective.* Cambridge: Cambridge University Press.

Rivera-Ramos, Z. A., & Buki, L. P. (2011). I will no longer be a man! Manliness and prostate cancer screening among Latino men. Psychology of *Men and Masculinity, 12*(1), 13–25. https://doi.org/10.1037/a0020624

Samaritans. (2012). Men, suicide and society: why disadvantaged men in mid-life die by suicide. Retrieved from https://www.samaritans.org

Samaritans. (2013). We're In Your Corner: case studies [Moral Support]. Retrieved https://www.samaritans.org

Sanchez, F. J., Bocklandt, S., Vilain, E. (2013). The relationship between help-seeking attitudes and masculine norms among monozygotic males discordant for sexual orientation. *Health Psychology, 32*(1), 52–56. https://doi.org/10.1037/a0029529

Shepherd, C. B., & Rickard, K. M. (2012). Driver for muscularity and help-seeking: The mediational role of gender role conflict, self-stigma and attitudes. *Psychology of Men and Masculinity, 13*(4), 379–392. https://doi.org/10.1037/a0025923

Staples, R. (1978). Masculinity and race: The dual dilemma of black men. *Journal of Social Issues, 34*(1), 169–183. https://doi.org/10.1111/j.1540-4560.1978.tb02547.x

The Scottish Government. (2002). Choose life: A national strategy and action plan to prevent suicide in Scotland. Retrieved from https://www.webarchive.org.uk/wayback/archive/20180514211149/http://www.gov.scot/Publications

Thornicraft, G. (2007). Most people with mental illness are not treated. *The Lancet, 370*(9590), 807–808. https://doi.org/10.1016/s0140-6736(07)61392-0

Welsh Assembly Government. (2009). Talk to me: The National plan to reduce suicide and self-harm in Wales, 2009-2014. Retrieved from https://gov.wales

Wennberg, R. N. (1989). *Terminal choices: Euthanasia, suicide and the right to die.* Michigan: William B. Eerdmans Publishing Company.

Wilson, H. W. (2013). The North-East has the skills to drive economic recovery—if London will let it. *Architect's Journal, 237*(12), 24–27. https://doi.org/10.1111/1468-0319.12006

Windfur, K., & Kapur, N. (2011). Suicide and mental illness: a clinical review of 15 years findings from the UK National Confidential Inquiry into Suicide. *British Medical Bulletin, 100*(1), 101–102. ttps://doi.org/10.1093/bmb/ldr042

World Health Organization. (2010). Mental health: strengthening our response: Factsheet No: 220 [Information]. Retrieved from https://www.who.int

World Health Organization. (2011). 10 facts on mental health [Information]. Retrieved from https://www.who.int

World Health Organization. (2012a). Mental Health: Country reports and charts [Information]. Retrieved from https://www.who.int

World Health Organization. (2012b). Suicide [Information]. Retrieved from https://www.who.int

World Health Organization. (2012c). World Suicide Prevention Day: 10th September 2013 [Information]. Retrieved from https://www.who.int