THE MENTAL HEALTH OF UNEMPLOYED AND SOCIALLY ISOLATED MIDDLE-AGED MEN IN TIN SHUI WAI, HONG KONG

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Abstract

This study investigates the poor mental health of unemployed middle-aged men (with women as a reference for comparison) in Hong Kong, who were unemployed and isolated socially in what is officially described as a new town, Tin Shui Wai. The study also explores the different aspects of social capital that may improve mental health for middle-aged individuals, drawing on data from ten in-depth interviews with five men and five women, two focus groups with five men and six women and a survey using questionnaires completed by 188 men and 215 women.

The results showed that men in the sample had poorer mental health than women. In particular, levels of depression and alcohol abuse were higher in the men than the women. By contrast, women in the sample manifested more anxiety than the men. The findings also showed that unemployment had more negative effects on men than on women, with the men having more free time but nothing to do, feeling stressed, going out less with family members, drinking more alcohol and so on.

Drawing on theories of social capital (Lin et al. 1985, McKenzie 2006), I argue that the poor mental health among men was associated with weak social capital. The data showed that for both men and women, social

capital could have a positive association with reducing depression and anxiety. In particular, for men, community networks and social support had a positive association with reducing depression and alcohol abuse. For women, group membership, community networks and social cohesion had a positive association with reducing depression and anxiety. Based on these findings, I suggest an approach that focuses on increasing social capital to promote mental health among men and women. The approach argues for the need to introduce policies and strategies to promote social capital at the community and individual level for men, and at the community level for women.

Chapter 1

Social and economic isolation and its mental health costs in Tin Shui Wai

The aim of this study was to examine the poor mental health of unemployed middle-aged men in Tin Shui Wai, a government-established 'new town' of Hong Kong, who were unemployed and isolated socially within their local community. To investigate residents' mental health I conducted ten individual interviews (five men and five women), held two focus groups with eleven people (five men and six women) and designed and distributed a survey questionnaire, completed by 403 respondents (188 men and 215 women). The study used women as a point of comparison. In analysing the data that I collected, I draw on the concept of social capital and its different aspects, arguing that enhanced social capital may contribute to better mental health for middle-aged men, and also women.

Background to the study: sociological approaches to mental health

For many sociologists and other social scientists (Link 2008; Alexopoulos and Bruce 2009; Kendler et al. 2011; Bruce and Raue 2013), mental health is

an important topic. Mental illness may not only bring considerable personal suffering but can also affect many aspects of everyday life, such as interfering with a person's social and occupational functioning. The past one hundred years have seen many studies of the causes and prevention of mental illness (Shorter 1997; Weir 2012). Approaches based in biology or medical science now focus mainly on hypothesized genetic or neuro-chemical processes (Kendler et al.2011; Darby et al. 2016). By contrast, sociological studies (Pearlin 1982, 1989; Pearlin et al. 1999; McKenzie 2006) have focused principally on identifying what social conditions and adversities (stressors) are the causes of stress (stress reactions) and mental illness, on exploring the resources for coping with stressful conditions, and on how the outcomes of stressful circumstances vary across sub-groups in the population.

But what counts as mental health and illness? The World Health Organization (WHO) defines mental health as follows:

> Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal

> stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.[1]

In general, mental health can be divided into two types: positive and negative. An individual is defined as having positive mental health when he or she has a good subjective self-image, possesses positive individual characteristics (such as hope, gratitude, curiosity etc.), enjoys positive experiences and feels self-autonomy, a sense of happiness, life satisfaction, self-worth and self-efficacy (Seligman and Csikszentmihalyi 2000; Seligman et al. 2005). In other words, mental health means having a sense of well-being. On the other hand, negative mental health is equated with mental illness (Offer and Sabshin 1974).

In practice, psychiatrists tend to categorise mental health problems into distinct mental illnesses, differentiating them by their symptoms (Seligman 2000; Compton 2005). According to the recent version of the Diagnostic and Statistical Manual, the DSM-5 (American Psychiatric Association 2013), there are nearly 400 types of mental illness, ranging from various forms of senile dementia, schizophrenia, and mood

[1] Source: http://www.who.int/features/factfiles/mental_health/en/ accessed on 11 May 2017.

disorders, through to substance use disorders, eating disorders and personality disorders.

Many researchers have found that men and women have different prevalence rates for different types of mental illness. Substance-related disorders (such as alcohol dependence) are especially prevalent in men, and depression and anxiety are more common in women (Grant and Weissman 2007; Eaton et al. 2012). Hence the overall gender difference in mental ill-health depends on precisely which conditions are included in its definition and measurement (Busfield 1993). However, in some circumstances, such as unemployment (Artazcoz et al., 2004; Mossakowski 2009; Eriksson et al. 2010) men's rates of depression, as well as alcohol problems, are raised above their usual levels.

Such studies raise questions about mental ill-health in men: what factors cause high levels of mental ill-health in men? In particular, under what conditions do men have relatively high levels of depression and/ or anxiety, as well as alcohol problems? Unemployment has been shown to be a key factor affecting mental health among men. Indeed, studies show that unemployed men may be at higher risk of suffering from mental illness than unemployed women. For example, Suicide Prevention Australia (2008) found that the rate of suicide for men in Australia was four times that of women; they also found that unemployment, which was one

of the main reasons for suicide among men, was commonly preceded by severe mental health problems, such as depression. Additional evidence suggests that the experience of unemployment is a key factor in undermining men's mental health because being unemployed may damage the masculine self-image, given the common social expectation that men will be in full-time paid employment (Artazcoz et al., 2004; Mossakowski 2009; Eriksson et al. 2010).

However, apart from the studies of the impact of unemployment on the men's mental health (Suicide Prevention Australia 2008; Mossakowski 2009; Eriksson et al. 2010), sociological studies of gender and mental health have typically been female-oriented. This is a key reason why I decided to focus on men. I use the concept of social capital (Coleman 1990; Lin 2007) to understand the poor mental health of unemployed and socially isolated middle-aged men in Tin Shui Wai. At the same time, I decided to include women in my study to help to illuminate the situation of the men. Women provide a useful point of comparison, given the fact that depression and anxiety are typically more common in women than men (Grant and Weissman 2007; Eaton et al. 2012).

As I demonstrate in later chapters, the concept of social capital proves useful in understanding the poor mental health of unemployed and socially isolated middle-aged men in Tin Shui Wai, Hong Kong. Social

capital refers to connections among individuals (often called "social networks") and the norms of reciprocity and trustworthiness among people. The evidence indicates that social capital is one of the key elements that can prevent the "progression of life's challenges into mental illness" (McKenzie 2006: 31; Lin 2007; Chan 2009; Hamano 2010; Maulik et al. 2011; Hewitt et al. 2012). As I discuss in later chapters, social capital can be viewed as implicating three continua: structural (hard)/ cognitive (soft) (Coleman 1988; Ibarra 1993), bonding/ bridging (Putnam 2000) and horizontal/ vertical (Colletta and Cullen 2002; Bryant and Norris 2002). In particular, the terms of hard and soft social capital are relevant to my study. According to Ibarra (1993), hard social capital, which develops from instrumental ties that involve the exchange of job-related resources, refers to accumulated task-oriented resources for fulfilling valued career goals. In contrast, soft social capital, which develops from expressive ties involving the exchange of friendship and social support, refers to resources for securing socio-emotional support.

Turning to gender differences in social capital, the evidence suggests that in a wide range of countries men are more effective at creating hard than soft social capital, and that this contributes positively to the development of men's mental health. Traditionally, men have been stereotyped as independent, assertive and ambitious (Wood and Lindorff

2001; Bhattacharya 2011). They are presumed to have more instrumental attitudes than women (i.e. to be more focused on their work or career) and to be less emotionally responsive. With hard social capital, men benefit from creating a clearer sense of identity and having better mental health than those men (and women) who have less hard social capital, even though at the same time they may have weak soft social capital (Wood and Lindorff 2001; Bhattacharya 2011, Olesen et al. 2013). By contrast, women have usually been trained to control soft social capital effectively, since they are viewed as performing expressive roles, in particular in their marital and primary relationships. For example, wives typically perform expressive functions to a greater extent than their husbands. Mostly, husbands "respond to their wives' stress problems with criticism, rejection, passive listening, or dismissal" (Lin et al. 1986: 288). In other words, women are presumed to have less instrumental and more emotionally responsive attitudes than men.

Based on the above discussion, I would hypothesise that lengthy unemployment or underemployment has different meanings for middle-aged men than it has for women, and that it therefore has a different impact on men's mental health. In particular, when a group of middle-aged men is facing the problem of lengthy unemployment or underemployment, both their hard and soft social capital become weak

compared with that of women who are not in paid employment or are underemployed. What is the impact and result of this situation on their mental health? How can we use social capital to understand this situation? This study set out to answer these questions.

Objectives

The aims of this study were:

- to examine and seek to understand the poor mental health of unemployed middle-aged men (using women as a point of comparison) in Hong Kong, who are unemployed and are becoming isolated socially within a community, Tin Shui Wai;
- to explore the different aspects of social capital, including trust, social cohesion, sense of community, group membership, engagement in public affairs, social support, community networks and family social capital, that may contribute to better mental health for middle-aged men who do become unemployed.

Significance of the study

The significance of this study is that it contributes knowledge about the value of social capital to an understanding of the poor mental health of unemployed and socially isolated middle-aged men in Hong Kong. As noted above, sociological studies concerning gender and mental health

have usually focused on women's situation rather than men's. My aim in conducting this research has been to understand the status, problems and difficulties of a group of disadvantaged men. By drawing on data from in-depth interviews, focus groups and a survey, I hoped to give participants a voice and make their problems and perceptions heard. By proposing policy directions and future strategies, I seek to offer practical support to improve their situation.

Outline of thesis

In Chapter two I outline and critically evaluate the relevant theoretical framework and conceptualization used in this study, covering in particular the concepts of mental health, gender and social capital. Chapter three discusses the epistemological and methodological framework that underpins the methods used, describes the characteristics of the samples, and considers the ethical aspects of the study and the study's limitations. In Chapter four, I provide a general description of the fieldwork and target group, including the historical development of the region, its population and community characteristics, and its current and future development. Chapters five, six and seven are the empirical chapters that present the results of my research data. These chapters cover the influence of unemployment on the mental health of men and women (Chapter five), the impact of social capital on the mental health status of

men and women (Chapter six), and the importance of social capital for the mental health of middle-aged men and women (Chapter seven). I analyse the influence of social capital on mental health status, and demonstrate the importance of social capital for the mental health of middle-aged men and women. In Chapter eight, I bring the empirical findings together in a conclusion, and discuss the implications of the study.

Chapter 2

Theoretical framework and conceptualisation

The role of social capital in determining mental and physical health has not been widely researched empirically (Hamano et al. 2010 and Eriksson et al. 2010; Bhattacharya 2011). In particular, middle-aged men are seldom the target for examining the impact of social capital on mental health or illness. In this chapter I examine the relevant concepts, including mental health, gender and social capital, that I use in examining my findings, the theories on which I draw and some of the relevant empirical findings from previous studies.

Theorising mental health

According to the World Health Organization (WHO), health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1948).

In general, as noted in Chapter one, mental health can be divided into two types: positive and negative. An individual is defined as having positive mental health when he or she has a good subjective self-image, possesses positive individual characteristics (such as hope, gratitude,

curiosity etc.), enjoys positive experiences and feels self-autonomy, a sense of happiness, life satisfaction, self-worth and self-efficacy (Seligman and Csikszentmihalyi 2000; Seligman et al. 2005). In other words, mental health means having a sense of well-being. On the other hand, negative mental health is equated with mental illness (Offer and Sabshin 1974).

Mental illness, like physical illness, is however a broad category embracing a range of different types of disorder. The concept has broadened over time and now includes a very wide range conditions such as Alzheimer's, a form of dementia, severe disorders such as schizophrenia, more common disorders such as anxiety and depression, and various substance use disorders such as alcohol abuse, as well as various eating disorders and personality disorders such as psychopathic personality disorder. The focus in this research is on the common mental disorders of anxiety and depression and alcohol abuse.

For many sociologists and other social scientists, mental health is an important topic, not only because it may bring considerable personal suffering, but because it can also affect human life in many different ways (such as affecting people's social and occupational functioning).

In the following paragraphs, I discuss theories relevant to understanding mental ill-health, including Emile Durkheim's (1952 [1897]) classic theory about the causes of suicide, stress theory (Dohrenwend and

Dohrenwend 1969; Pearlin 1982, 1989; Pearlin et al. 1999; McEwen and Wingfield 2003; Dressler et al., 2005; Williams & Mohammed, 2009), and social constructionism (Benedict 1934; Szasz 1961; Foucault 1965, 1973; Coulter 1973; Gaines 1992; Horwitz 2002; Conrad 2007). I have chosen these theories to consider for several reasons. Firstly, Durkheim's classic suicide theory (1952 [1897]) is the first sociological theory to study the social causes of suicide (instead of the psychological causes of suicide), an action that can be viewed as resulting from stress and mental ill-health. However, Durkheim points out that suicide is not just a matter of stress and mental ill-health. Durkheim (1952 [1897]) also suggests that individuals who do not receive social support and are isolated are more vulnerable to suicide (so called "egoistic suicide"). As we shall see, social support is one of key components of social capital at the individual level (Bourdieu 1977, 1980, 1986, 1990; Coleman 1988, 1990) and thus this theory is important for this study as foundation for understanding the importance of social capital on mental health.

Secondly, I consider stress theory, especially Pearlin's stress theory (Pearlin 1982, 1989; Pearlin et al. 1999), which focuses on the influence of problematic life circumstances (such as unemployment) which may generate considerable stress, on mental health. As already noted there is evidence to suggest that the experience of unemployment plays a key role

in undermining men's mental health, because it may damage their masculine self-image and the social expectations that they will be in paid employment (Artazcoz et al. 2004; Mossakowski 2009; Takahashi, Morita and Ishidu 2015). In Pearlin's stress theory, social support also plays an important role in reducing stressors and thus this theory is also relevant for this study in understanding the importance of social capital on mental health, which will be considered further when I discuss work on social capital.

Thirdly, I consider social constructionism. Although theories vary, the core idea of social constructionism (Benedict 1934; Szasz 1961; Foucault 1965, 1973; Coulter 1973; Gaines 1992; Horwitz 2002; Conrad 2007) is to argue that reality is a product of human activity and categories of mental illness are products of human culture and change over time. In this study, men's mental health is also affected by others' expectations (as a male). Therefore, the idea of social constructionism is useful to understand about the influence of collective values on mental health.

Durkheim's Suicide

Durkheim's study, *Suicide* (1952 [1897]), is the first classic sociological theory relevant to mental ill-health. Nowadays, among people with a mental illness suicide is a major cause of death and a suicide attempt may be an early warning sign that a person is developing a mental illness

(Tidemalm et al. 2008; University of Washington 2014). Durkheim argues that suicide is not only an individual act, but also a social fact – that is it is shaped socially and culturally. He notes that suicide occurs in all societies and across all time periods yet, very importantly, its levels differ within and between societies. Nevertheless, he asks how it is that people can be led to commit suicide, given that suicide is viewed as deviant behaviour and is forbidden in most of societies. To answer this, Durkheim suggests using the form and strength of the social integration and moral regulation in a particular society to understand the level of suicide. He differentiates between anomic, egoistic, fatalistic and altruistic suicide.

Anomic suicide, he argues, mostly occurs during the periods of rapid social change (such as sudden gains or losses of wealth), when the existing rules of governing social life do not work anymore and people are left not knowing how to behave, or what is appropriate. There is nearly always a period of anomie for the individual, of greater or shorter length, on the break-up of a long-term neighbourhood relationship, and suicides occur in such situations. In this condition, the important point is that there is an absence of social integration and a lack of moral regulation. People do not know what to do because the old rules seem no longer to apply, and there are no obvious new rules. At the opposite end of the continuum, a set of very powerful and rigid social rules or norms exists in certain societies and

moral regulation is excessive, which may encourage suicide (for example, when an Indian widow might be compelled to throw herself on the funeral pyre of her dead husband). Durkheim calls this fatalistic suicide

Egoistic suicide is a matter of the level of integration. Durkheim argues that people can be integrated into a society in two ways. Firstly, they can be integrated as individuals who are similar to one another, sharing the same sort of ideas with those who are important to them. The typical example is the army. Under these conditions, we find the incidents of what Durkheim called altruistic suicide, putting one's own life at risk to save another. At the other end of the continuum, people can be integrated into society not by sharing common features with others, but through excessive individualism which has low social integration. This is not a fragmentation of society, but it places greater responsibility for social cohesion on the individual. Durkheim argues that in such societies, the individual does not receive collective support and is more vulnerable to isolation and suicide.

In Durkheim's theory, the relative degrees of regulation, normlessness, social integration and the isolation and repression of individuals in society were the primary causes of the varying suicide rates found in different countries. However, Durkheim's concept of integration is rather vague, lacking in concise theoretical definition, but as a general rule, it refers to

the strength of the individual's ties to society and the stability of social relations within that society (Lester 1992; Hassan 2001).

The major contribution and effect of Durkheim's study was that it provided a new perspective from which to look at and understand suicide. Suicide was not just an individual matter but a fact of society with social causes. Although the final structure of Durkheim's theory of suicide is at times unsystematic and inconsistent, his analysis of different levels of suicide between different social groups, using data from official statistics is particularly illuminating and perceptive. The fundamental preoccupation of Durkheim throughout his work is the relationship between the individual and society. Durkheim took the act of suicide, which was by definition an individual action, and showed its social features (Hassan 2001). His analysis I suggest can aid in the understanding of men's mental ill-health in Hong Kong, especially how the society, by affecting men's view on unemployment, may contribute to their poor mental health.

Social circumstances, life events and stress

Stress is a concept that has been widely used by both psychologists and sociologists since the 1950s and 1960s and has been linked to mental ill-health. Pearlin (1989) identifies three fundamental concepts in the study of stress. These are stressors, stress mediators, and stress outcomes. The term stressor refers to "the experiential circumstances that give rise to

stress" (1989: 243). The experiential circumstances can arise from external and internal factors. External factors include environmental or social factors (such as marriage and employment status), and internal factors can be biological or psychological (Pearlin and Lieberman 1978). For example, when people are unemployed or suffer from sudden illness, this may raise their level of stress.

Pearlin (1982, 1989; Pearlin et al. 1999) identifies two types of stressors: life-event stressors and chronic stressors. The term life-event stressors refers to any sudden and unpredicted circumstance that causes a stress response. Pearlin argues that the "sudden and unpredicted" (1989: 244) circumstances are especially important, since change is "a normal and inexorable feature of every level of social life and of aging" (1989: 244). However, only "undesired, unscheduled, non-normative and uncontrolled" change is harmful to human mental health (1989: 244). Two other important factors that influence the effect of an event are "a closure of another stressor" and the "personal view on the event as a problem solving strategy to other stresses" (1989: 244). Pearlin argues that similar life events can cause different levels of stress when considering people's different life trajectories.

Pearlin also contends that there are a wide variety of chronic stressors: status strains, role strains, ambient strains and quotidian strains. Status

strains refer to the stressors arising from the people's position in society (such as being poor, having a particular gender, race, sexuality or religion). Role strains are stressors resulting from conflicts or expectations for an individual's role set, such as difficulties in job, marriage or parenthood. Role strains can be divided into several types, including role overload, interpersonal conflicts within role sets, and inter-role conflict (Pearlin 1989: 245). However, role strains are not totally negative. Having many roles can benefit an individual through providing more functional resources that carry over from one role to another. Ambient strains are stressors that come from an individual's living environment. For example, if people live in an area with a high crime rate, this may increase the feeling of fear towards other residents. Fear may not only impair health directly but also produce stress. The living environment can also affect access to resources. If there are limited basic institutions such as schools, hospitals, fire departments and other public services, the network of social connections will be weak and therefore produce the feeling of stress more easily (Pearlin 1989: 246).

Quotidian strains (also called daily strains) arise out of daily events such as waiting in traffic, fighting for a spot on the underground, or cooking. These strains actually produce the lowest level of stress compared with other strains (Pearlin 1989: 246) and are often excluded from

measures of stress. The effect of these strains can also be minimised through repeated exposure.

Apart from studying life-event stressors and chronic stressors individually, it is important to understand the convergence of life events and chronic stressors. Pearlin (1989) called this "stress proliferation", which means some primary stressors lead to many other secondary stressors. As he (1989: 247) noted, if people have undergone one serious stressor, they will be more likely to undergo another event that triggers chronic stress later as well. For example, unemployment may lead to economic strains; these occupational strains may cause marital strains, and so on. The stressors experienced by an individual usually become problems for others who have interrelated role sets (for example, if a husband is unemployed, his wife will consequently suffer stress as well). This sequence of stressors is sometimes called the "carryover effect" (Pearlin 1989: 247).

Stressors can be reduced by stress mediators, including coping strategies, personal resources and social support, which are social and personal resources that allow people to cope with life event smoothly. Taking into account the impact of stress mediators, different psychological, emotional and physiological outcomes caused by the stressor will be generated, such as weight loss (health outcomes), depression, anxiety,

drug or alcohol abuse (mental health outcomes) and under-performance at work (non-health outcomes). Sociological studies of stress focus principally on how social conditions and life events generate stress for individuals. Such studies examine the different causes of stress, the resources for coping with stress, and on how the outcomes of stress vary across sub-groups in the population.

There is extensive sociological research on the linkage between social conditions and mental ill-health. A classic epidemiological study (Hollingshead and Redlich 1958) based on the collection and analysis of patient statistics found that those in the lowest social class had higher levels of mental illness, and those in the highest social class lower levels when compared with the non-patient population. The data suggested a key role for social factors in leading to mental illness, although the authors did not examine in any detail the factors underpinning the differences while suggesting, drawing on psychodynamic ideas, that childhood experiences could be important. In turn Dohrenwend and Dohrenwend (1969) proposed that social class differences in rates of life-events generate corresponding class differences in rates of psychological impairment. B.S. Dohrenwend (1970, 1973, 1977, 1978) found that group differences in events were limited to selected types of events and specific social attributes. For example, older adults are more likely to encounter the life events of

illness and injury, hospitalisation, and the death of a spouse than young adults and the young adults are more likely to encounter the life events of family conflict and problems with job than older adults (Murrell et al. 1984; 1988). Some studies adopted Kessler's (1979a) technique for examining the relationships between socio-cultural and psychological distress indicators to explore differences in the impact of comparable stressor events and situations on people in different status categories. In one study Kessler (1979b) concluded that differential exposure to life events contributed little to social class, gender, and marital status differences in mental illness, except in the case of non-whites compared to whites. Further, two subsequent reviews concluded that social group differences in overall exposure to life change are minimal (Thoits 1987, Kessler et al. 1985).

However, the most critical issue concerning the validity of such conclusions is whether events have been selected appropriately from the universe of all possible events and circumstances. Life-event checklists have suffered from a number of methodological deficiencies enumerated comprehensively elsewhere (e.g. Dohrenwend et al. 1978; Thoits 1982). The most important concern is whether event inventories adequately represent the entire spectrum of life events, given that no finite measure can count all possible events (Tausig 1982). Dohrenwend and associates (1978) stated this problem as defining the 'population' of events from which a 'sample'

of events is selected. Events should be selected with probabilities proportional to a meaningful criterion. In practice, events usually are selected in an arbitrary manner.

Liem and Liem (1978) also criticised the conclusion that life events did not account for social class differences in mental health for failing to consider the impact of chronic stressors among lower social classes, such as lengthy unemployment among working- class men (Thoits 1987, Kessler et al. 1985). Reliance upon the deceptively simple measurement strategy of event inventories has been described as a methodological expedient: chronic stressors are more difficult to assess because such problems often are subjective in nature (Eckenrode 1984, Kessler et al. 1985, Pearlin 1989).

It is clear that life-event change illuminates only one corner of the universe of social stressors; omitted are problematic life circumstances that recur or persist. However, Pearlin (Pearlin 1982, 1989; Pearlin et al. 1999) argues that the major precursors of distress are more likely to occur in the conflicts and frustrations experienced by ordinary people doing ordinary things than in exotic, ephemeral, or once-in-a-lifetime events. Cross-sectional data from the Spanish Health Survey for the years 2006 and 2011–2012 (Urbanos-Garrido and Lopez-Valcarcel 2015), which estimate the average treatment effect of unemployment on self-assessed health (SAH), and mental problems, found that unemployment had a significant

negative impact on both SAH and mental ill-health. This impact was particularly high for the long-term unemployed. With respect to the impact on mental ill-health, negative effects significantly worsened with the economic crisis. For the full model, the changes in the effects of long-term unemployment on mental problems and mental health risk were, respectively, 0.35 (CI 0.19–0.50) and 0.20 (CI 0.07–0.34). In addition, a population-based study in Netherlands on the influence of unemployment on mental health found that job loss increased the risk of any mental disorder, including mental disorders, mood disorders, anxiety and substance use disorder, significantly among men (Barbaglia et al. 2015). Besides, a cross-sectional study conducted in 16 North Carolina counties found that people living in poor housing because of poverty, which was a kind of chronic stressors, affected mental health (Quandt et al. 2016). The study found that there were links between poor housing and mental health. For example, the respondents with 5+ persons sleeping per room were more likely to have depression (Center for Epidemiologic Studies Depression Scale, CES-D) score ≥10 (31.5% vs. 13–14%, $P = .01$) and anxiety (Personality Assessment Inventory, PAI) scores ≥27 (19.6% vs. 5–9%, $P = .02$) than those without 5+ persons sleeping per room. Those who did not feel they or their belongings were secure were more likely to have depression CES-D score ≥10 than those who felt they or their belongings

were secure (19.4% vs. 9.1%, *P* = .01). Those without a key were more likely to have an anxiety PAI score ≥27 than those with one (11.5% vs. 5.1%, *P* = .04).

There are two arguments to explain why chronic stressors and life events often produce feelings of stress. First, any society has a set of social norms governing people's behavior. People who depart from these social norms for whatever reason can experience pressure and stress. For example, according to the social norms of most societies, men should go out to work (Kuczynski and Parkin 2007; Bukowski et al. 2007). Hence if men are unemployed, this may increase their likelihood of experiencing stress. According to a study on the mental health of unemployed middle-aged Chinese men in Hong Kong (Chiu and Ho 2006), a high prevalence (73%) of common mental disturbances as defined by General Health Questionnaire (GHO) caseness was evident among unemployed middle-aged men. This rate was much higher than among unemployed females (54%) (Lai et al. 1997) and adults aged 60 or above (25%) in Hong Kong (Lam and Boey 2005). In addition, according to the European Social Survey (Van der Meer 2014), the distressing effect of unemployment was more severe for men than for women. Unemployed men were reported to be 0.4 points less well off than unemployed women, which was almost seven per cent less. One of reasons for this difference was that, based on family

values and the centrality of the family, men found that it was important for them to provide a large part of the household income, whereas doing household work decreased their subjective well-being.

Second, certain sequences of chronic stressors and life events generate practical and social obstacles for people and these can cause stress. For instance, a divorced man with a child or children may face obstacles in continuing to participate in family life due to part-time work and unemployment; however, whether this circumstance becomes a stressor for him depends on other factors (such as whether he views working part-time, or unemployment, as a violation of social norms) (Cohen-Israeli and Remennick 2015). In particular, as I have already emphasized, unemployment has been widely regarded as a major risk factor for men's mental health problems (Artazcoz et al. 2004; Mossakowski 2009).

The second stage in the stress process involves moderators or mediators. In terms of stress mediators, Pearlin et al. (1981) argue that stress mediators are social and personal resources that can reduce the effects of stressors and allow people to face and adjust to change relatively smoothly. In other words, stress mediators can influence the stress outcome. Pearlin et al. (1981) and Pearlin (1989) suggest three types of stress mediator: coping strategies, personal resources and social support.

Coping strategies consist of behaviour that people engage in when responding to the stressors they encounter, and can be divided into different types: (1) behaviour to change the stressors (such as finding a new job after being fired); (2) behaviour to try to prevent a stressor occurring (such as receiving marriage counseling to prevent divorce); (3) behaviour to reinterpret the stress in a different way (such as viewing the increasing workload as an opportunity rather than a burden); (4) behaviour to manage the stress outcome (such as exercising regularly when facing pressure in daily life) (Pearlin 1989: 250).

In addition, personal resources include both a sense of mastery and self-esteem which have been shown to reduce the severity and prevalence of stress outcomes directly. Mastery refers to "the extent to which people see themselves as being in control of the forces that importantly affect their lives" (Pearlin et al. 1981: 340). Self-esteem "involves the judgments one makes about one's own self-worth" (*ibid*). The interactive effects of these personal resources with coping strategies and social support are still unclear.

However, social support, which is one dimension of social capital and is accessed by people through their social network (Bourdieu 1977, 1980, 1986, 1990; Coleman 1988, 1990), has been widely studied and the evidence indicates that there is a strong and significant effect on managing stress

outcomes (Pearlin 1989; Lin et al. 1979; LaRocco et al. 1980; Bhattacharya 2011). Social support can be defined as instrumental assistance, informational assistance or emotional assistance from others. Social support, especially socio-emotional support, is related inversely to diverse forms of psychological disorder (Kessler and McLeod 1985; Choenarom et al. 2005; Hewitt et al. 2012). Longitudinal studies demonstrate reciprocal relationships: causal influence goes from support to mental health and vice versa (Turner 1983, Aneshensel and Huba 1984). A major issue concerns whether social support acts as a stress-buffer, ameliorating the deleterious effects of stress (Lin et al. 1985; Thoits 1982; Kingori et al. 2015). In reviewing this contradictory literature, Kessler and McLeod (1985) concluded that the mental health impact of stress is buffered by perceived social support, a dimension of social capital that is particularly relevant to my study, but not by membership in social networks. Similar findings (Gilbar 2005; Lee et al. 2012) and the evidence indicates this is still the case.

Turning to stress outcomes, these are usually viewed as psychological, emotional or physiological conditions caused by stressors after the intervention of mediators. Apart from general studies of single mental illnesses (such as depression, anxiety or drug and alcohol abuse), stress outcomes can involve the co-morbidity of multiple physical and mental ill-health outcomes or non-health outcomes (such as underperformance at

work). As Pearlin argue, multiple outcomes are found since people with different social and economic characteristics may have different modes of manifesting stress. Therefore, it is risky to "judge effects only on the basis of a single outcome" (Pearlin 1989: 253).

Pearlin's conceptualisation of stressors as rooted in the social and economic structures of daily life is compatible with the view of social relations underlying network theory (e.g. Burt 1992; Granovetter 1973; 185). However, Lennon (1989) argues that on the level of analysis of individuals embedded in social relationships, it is misleading to relegate 'social support' to a mediating role because both support and stressor often reside in the same sets of interactions (Atkinson, Liem, and Liem 1986; Eckenrode and Gore 1981; Thoits 1982) and cannot be understood apart from this relational context. Thus, for example, even though marital strain often entails the loss or disruption of an important supportive relationship, an ongoing marriage can provide 'stability, economic security, and a sense of identity' (Lennon 1989: 262). Lennon (1989) also argues that another important macro-level factor that affects network relations is the social structuring of power and dependency. Because power and inequality are embodied in social relations, exposure to stressors and access to support are influenced by positions in the hierarchy of social stratification. In fact, a number of studies have investigated the impact of relative power in social

relationships on psychological distress (Horwitz 1982; Mirowsky 1985; Rosenfield 1980). For example, if the power of husband and wife is unequal, as when the wife has to depend on her husband for financial support, the relatively powerless one may not seek help and feel stressed, as when she is experiencing domestic violence (Antai 2011).

Social constructionism

Many contemporary sociologists engaged in 'stress research' use theoretical frameworks that differ from structural functionalism (Merton 1968). One framework is that of social constructionism (Coulter 1973; Gaines 1992; Szasz 1961; Horwitz 2002; Conrad 2007). Social constructionism has made significant contributions to understanding of the social dimensions of illness. It is a conceptual framework that emphasises the cultural and historical aspects of phenomena widely thought to be exclusively natural. The emphasis is on how meanings of phenomena do not necessarily inhere in the phenomena themselves but develop through interaction in a social context (Conrad and Barker 2010). In particular, the social constructionist approach to mental illness argues that categories of mental illnesses are produced by people within their different cultural backgrounds and thus what constitutes mental illness may be different in different societies and vary over time. Social constructionists emphasise how the meanings and experiences of mental

illness are shaped by cultural and social systems (Coulter 1973; Gaines 1992; Szasz 1961; Horwitz 2002). One of the most important intellectual foundations of social constructionism is social problems theory. Different from positivist interpretations, scholars in the social problems theory asserted (Becker 1963; Gusfield 1967, 1975; Spector and Kitsuse 1977) that deviant behaviour or a social problem is not given, but is conferred within a particular social context and in response to claims-making and moral entrepreneurialism by social groups. Such scholars also argue that the construction of a category of deviant behaviour or a social problem and their application involve processes of social control (i.e. behaviour or occurrences are defined as deviant or problematic in an effort to regulated how particular groups of people should behave).

Durkheim (1966 [1895]), whose ideas I outlined above, was arguably the first sociologist to use a social constructionist view to study mental illness. Unlike his argument in *Suicide* (1952 [1897]), Durkheim in his *The Rules of Sociological Method* (1966 [1895]) sees all deviant behaviour as the violation of social rules. He argues that crime (and by implication, mental illness) is not defined in terms of individual behaviour, but rather that it is the collective value that defines what is appropriate and inappropriate behaviour. The same behaviour can be defined either as deviant or as normal behaviour in different circumstances. This shifts the focus of

analysis from the study of individual behaviour to the study of the cultural context of behaviour.

The anthropologist Ruth Benedict (1934) supported Durkheim's argument. She argued that some sorts of behaviour defined as deviance in Western society (such as paranoia, seizures and trances) are often considered normal in other cultures. For example, among Shasta Indians in California or native peoples in Siberia, seizures are not viewed as a dreaded illness but as a special connection to a supernatural power.

Symbolic interactionism also contributed significantly to a social constructionist approach to mental illness. According to Goffman (1961, 1963) and other symbolic interactionists (Blumer 1969; Charmaz 1991; Glaser and Strauss 1965), individuals actively take part in the construction of their own social worlds through daily social interaction. Researchers (Charmaz 1991; Glaser and Strauss 1965) thus use the principle of symbolic interactionism to explore illness as experienced within the context of daily social interactions, and how it changes the individual's behaviour. For example, medical sociologists have adopted this approach to study how people make sense of their illness, how they cope with restrictions, and how they divert self-erosion which means people lose their self, in the face of the restrictions (Burt 1992).

Another important scholar affecting the groundwork of social constructionism is Eliot Freidson. Freidson (1970) argues that illness can be independent from any biological effects. As he said, 'when a physician diagnoses a human's condition as illness, he changes the man's behavior by diagnosis; a social state is added to a biophysiological state by assigning the meaning of illness to disease. It is in this sense that the physicians creates illness . . . and that illness is . . . analytically and empirically distinct from mere disease' (p. 223). Freidson also argues that illness and disease, like deviance, are social constructions (i.e., illness is categorised based on social ideas about what is not acceptable in the society).

Foucault (1965, 1973) extended the Durkheimian view into a critical analysis of the history of mental illness in Western civilization. He also emphasises the importance of the scrutiny of medical knowledge. Foucault regards knowledge as a form of power and argues that professional knowledge about human normality and abnormality is a form of power in modern societies. Foucault argues that medical discourse constructs knowledge about the body, including disease. In return, medical discourse not only can affect human's behaviors and their subjective experiences of embodiment, but also can shape human's identities and legitimate medical interventions (Foucault 1973, 1977).

Based on the above examination, it is clear that the main idea of social constructionism is to argue that reality is a product of human activity. Categories of mental illness are products of human culture and change over time. A social constructionist approach to illness is rooted in the widely recognized conceptual distinction between disease (the biological condition) and illness (the social meaning of the condition) (Eisenberg 1977). However, Timmermans and Haas (2008) argue that there are criticisms and limitations of this distinction. A social constructionist approach emphasises how the meaning and experience of illness are shaped by cultural and social systems, but excludes the importance of biological and pathological factors. Social constructionists often study "health and illness holistically rather than with a narrow focus on biological factors but an aversion to taking the 'disease aspects of medicine into consideration results in gaping analytical holes'" (Timmermans and Haas 2008: 662). Nevertheless, Conrad and Barker (2016) argue that social constructionism is still an exceedingly useful conceptual framework. In contrast to the medical approach, which assumes that diseases are general and unchangeable over time or place, social constructionists focus on how the meaning and experience of illness are affected by cultural and social systems.

Mental health, unemployment, poverty and deprivation

Mental health conditions, particularly depression and anxiety, represent a high burden of disease worldwide (Whiteford et al. 2013) and are, as I have already suggested, strongly associated with unemployment (Madianos et al. 2011; Liwowsky et al. 2009; Comino et al. 2000; Chen et al. 2012; Eurostat 2015). Unemployed people generally experience three major types of distress. The first is financial distress. They may have to face financial difficulties or even financial ruin, and many begin to lose their lifetime savings and even their homes (Janlert 2009) if the unemployment continues. The second is physical ill-health. Medical symptoms such as diabetes, hypertension, and coronary heart disease are associated with unemployment (Bartley et al. 2004). The third is mental ill-health. Poor mental health is common among the unemployed (McKee-Ryan et al. 2005; Butterworth et al. 2012), and unemployment is associated with higher levels of depression (Madianos et al. 2011; Liwowsky et al. 2009), suicide (Classen and Dunn 2012) anxiety (Comino et al. 2000; Chen et al. 2012) and alcohol problems (Backhams et al. 2016).

In fact, as noted above, unemployment is a highly stressful life circumstance, associated with negative mental health outcomes. The relationship between unemployment and mental health is generally believed to be dependent on self-worth, cultural perceptions, gender

identity and participants' functional role in the family (Artazcoz et al. 2004; McKee-Ryan et al. 2005), as well as social capital, in particular hard social capital, as I discuss below. In relation to personal self-worth, unemployed people usually feel fear, anxiety and worry when they fail to fulfill a significant obligation (i.e. having a job) (Higgins 1987). Also, different cultural perceptions of the importance of work across gender groups may result in different level of the impact of unemployment across different genders (McKee-Ryan et al. 2005). For example, evidence suggests that the experience of unemployment is a key factor in undermining men's mental health because being unemployed may damage the masculine self-image, given the common social expectation that men will be in paid employment (Artazcoz et al., 2004; Mossakowski 2009; Eriksson et al. 2010). Studies in a Chinese community also found that Chinese men were more likely to have experienced mental distress during unemployment because of their predominant role as family provider (Shek 2001; Yip and Ng 2002).

The negative impact of unemployment on mental health is associated with poverty that results from low perceived self-efficacy and mounting economic pressure. According to the WHO (2005), unemployment is positively associated with poverty, that is, if someone is unemployed, he/she is likely to be in poverty. In *When Work Disappears*, William Julius Wilson (1997) made a connection between urban poverty and mental ill-

health when he asserted that unstable work and low income decrease one's perceived self-efficacy. A meta-analysis showed that indebtedness caused by unemployment is one mediating factor between poverty and poor mental health (Fitch et al. 2011). Another study carried out in Philadelphia supported these findings by revealing the adverse effects of economic pressure on mental health and parental behaviour (Elder et al. 1995). The research revealed that mounting economic pressure, caused by unstable work and low income, created feelings of emotional distress. In other words, it suggested that unemployment not only affected the mental health of the unemployed persons themselves, but also their family members.

In addition, unemployment was found not only to be associated with poverty but also with hopelessness, apathy, diminished activity, a disrupted sense of time and overall breakdown of social life (Jahoda 1982). Jahoda's latent deprivation model of unemployment contends that, aside from the loss of income, individuals are deprived of five latent functions once they lose a job. The deprivation of the five latent functions includes 'loss of time structure, social contact, collective purpose, social identity/status, and activity' (Jahoda 1982: 188). In other words, without work, people face higher risks of economic and social deprivation, which is

associated with poorer well-being (McKee-Ryan et al. 2005; Paul and Moser 2009).

Poverty and deprivation, one component of the broader construct of socio-economic status (SES) (Baker 2014), have also independently been associated in longitudinal research with the onset of mental health problems (Kiely et al, 2015). In Canada (as elsewhere), children, women, unattached people, the elderly and Aboriginal people are disproportionately impacted by poverty (Collin and Jensen 2009) and deprivation (Franks 2013; Wong et al. 2015; Gunnarsdottir et al. 2016). Traditionally, 'absolute poverty' refers to a fixed income level necessary for survival and 'relative poverty' refers to the level of income in relation to the mean or median income of income in relation to the mean or median income of a population (Toye and Infanti 2004). Relative poverty can be identified by comparing the income received with a threshold (or poverty line) that reflects a judgment about how much is required to meet existing needs, or by observing what people are able to obtain given their available resources and comparing this with existing views on whether or not this is consistent with an acceptable standard of living. The first approach seeks to identify income poverty while the latter focuses on identifying deprivation, and they differ in important ways in how the underlying concepts are conceived and operationalised (Saunders et al. 2014). The

subsequent development of the term 'multiple deprivations' has come to refer to a range of indicators of social and economic deprivation and exclusion in poverty studies (Barnes et al. 2007; Toye and Infanti 2004).

Notwithstanding the above differences, poverty and deprivation are closely related concepts and are also important factors affecting mental ill-health; indeed the negative association between poverty and deprivation and mental health has been increasingly documented (Lund et al. 2010; Adjaye-Gbewonyo and Kawachi 2012; Kawachi et al. 2004; Wilkinson and Pickett 2007, 2009; Walker and Smith 2001; Wilkinson 1996).

The relative deprivation hypothesis (also known as the relative income hypothesis or the income inequality hypothesis) (Mishra and Carleton 2015) offers an explanation of the individual-level mechanisms underlying the relationship between inequality and negative outcomes at the aggregate level (e.g. Adjaye-Gbewonyo and Kawachi 2012; Kawachi et al. 2004; Wilkinson and Pickett 2007, 2009). This hypothesis states that inequality manifests itself through various forms of socioeconomic comparison (especially income inequality). These various forms of socioeconomic comparison in turn undermine social cohesion, social capital, trust, and well-being more generally, eventually leading to negative mental health outcome (Walker and Smith 2001; Wilkinson 1996).

Poverty can be both a cause and effect of mental disorders (WHO 2005). The relationship between poverty and mental health is bidirectional, with poverty often leading to mental illness and mental illness regularly reinforcing poverty (Anakwenze and Zuberi 2013). According to the social causation hypothesis, conditions of poverty increase the risk of mental illness through heightened stress, social exclusion, and decreased social capital (Patel and Kleinman 2003; Lund et al. 2010). Conversely, according to the social selection or social drift hypothesis, people with mental illness are at increased risk of drifting into or remaining in poverty through reduced productivity, loss of employment and associated earnings (Saraceno et al. 2005). However, some epidemiologists (Muntaner et al. 2004; Saraceno et al. 2005) have found specific patterns in the relationship between poverty and particular mental illness. The consensus among epidemiologists suggests that the social causation hypothesis (poverty → poor mental health) is more plausible for explaining the high-prevalence mental disorders, such as depression and anxiety disorders, whilst the social selection hypothesis (poor mental health → poverty) is probably more relevant for low-prevalence mental disorders like schizophrenia (Muntaner et al. 2004; Saraceno et al. 2005).

Perceived social support, which is one dimension of social capital s and is accessed by people through their social network, is viewed as

playing an important role in maximizing resilience and maintaining mental health in the face of the above deprivation challenges (Asakura 2011; Teti et al. 2012). Resilience typically refers to 'good outcomes in spite of serious threats to adaptation or development', (Masten 2001: 228). As mentioned before, according to Jahoda's (1982: 188) latent deprivation model of unemployment, aside from the loss of income, individuals are deprived of time structure, social contact, collective purpose, social identity/status, and activity once they lose a job. Many studies (Creed and Macintyre, 2001, Creed and Reynolds, 2001) show that this deprivation (particularly social loneliness) affects wellbeing among unemployed persons, and that their detrimental effects may actually be greater than loss of income (Paul and Batinic, 2010). According to a longitudinal and nationally representative study of 3,190 people who had experienced both unemployment and employment (Milner et al. 2016), high social support (11.58, 95%, 95% CI 10.81 to 12.36, $p < 0.001$) was associated with a large increase in mental health (measured on an 100 point scale, with higher scores representing better mental health), compared to when a person reported low social support. When a person was unemployed but had high levels of social support, their mental health was 2.89 points (95% CI 1.67 to 4.11, $p < 0.001$) higher than when they were employed but had

lower social support. The buffering effect of social support was confirmed in stratified analysis.

The gendered landscape of mental health and illness

Sex and gender

Before discussing gender differences in mental health, we must first clearly define the terms "sex" and "gender". Sex refers to the biological differences of the body, such as anatomy (e.g. body size and shape) and physiology (e.g. hormonal activity or functioning of organs) between males and females. In contrast, according to Torgrimson and Minson (2005), gender not only refers to the social expectations of being a man or a woman in society, but also to the relationship between them. Every society attaches different social expectations to females and males. Gender operates in shaping how to interact with others and how to think people think about themselves. In particular, gender has usually involved a hierarchy that gives men and women different levels of roles, responsibilities, opportunities, and access to resources and benefits (Galdas et al. 2010).

Many social scientists explore whether the main reasons for the differences in the behaviour of men and women arise from sex differences (nature) and/ or gender differences (nurture). Some scholars (Udry 2000;

Kendler et al. 2006) argue that innate differences in behaviour between men and women are found in all cultures. For example, they argue that men have greater involvement in economic, social and political activities than women in most societies, while women are more likely to take care of children, their husbands and their family members at home. Scholars (Somerset et al. 2007; Lester et al. 2014) also suggest that men tend biologically to be more aggressive than women, and it is argued that this is because of the influence of the male sex hormone.

Nevertheless, some scholars (Kuczynski and Parkin 2007; Bukowski et al. 2007) contend that differences in the behaviour of men and women are largely the product of culture. For example, women are expected and trained to be more passive or gentle in some cultures than in others, and it is argued that this is because they are expected to spend a significant part of their lives caring for children and so can less readily take part in economic activities and as a result have less power. This training process is called "gender socialisation" and is associated with concepts of masculinity and femininity (Kuczynski and Parkin 2007; Bukowski et al. 2007).

Those who argue that differences in behaviour between men and women are the result of gender socialisation (Kuczynski and Parkin 2007; Bukowski et al. 2007) contend that the learning of gender roles operates

through many social institutions, such as the family, school and the media. Many studies (Kuczynski and Parkin 2007; Bukowski et al. 2007) have found that even when parents believe that their treatment of boys and girls should be the same, mother–infant interaction actually shows differences in treatment. For example, systematic differences in dress, hairstyle and so on can also have a significant impact on the learning of gender roles (Kuczynski and Parkin 2007).

Second, the education system also contributes to gender socialisation. In school, children learn gender roles through textbooks and daily learning activities. For example, in textbooks, children are often taught that mothers are housewives and are more likely to stay at home to care for their children and their husbands, while fathers are responsible for going out to work and are depicted as policemen, doctors and so on. Of course, such socialisation varies across time and place. However, whatever the precise expectations, socialisation creates differences in behaviour between boys and girls (Bukowski et al. 2007).

The mass media also influence the learning of gender roles. Many studies show that in cartoons and commercial TV shows, most of the leading figures have been male, and that males typically dominate active pursuits. Under the influence of socialisation, clear gender roles and expectations for men and women are formed and the differences in

behaviour between men and women are generated (Wentzel and Looney 2007).

However, some scholars argue that sex and gender interact and mutually affect each other in the development of individual bodies, cognitive abilities, disease patterns and so on (Nowatzki and Grant 2011; Fausto-Sterling 2012; Springer et al. 2012). For example, pain not only has biological aspects (i.e. sex differences in pain signalling), but also cultural aspects (i.e. gender differences in how men or women report pain) (Leopold et al. 2014). Therefore, differences of sex and gender can interact to produce different health outcomes.

Sex and gender are also both binary categories, and that there is now a growing interest in the overlap between the categories and overlap in the behavior of men and women, so that binary distinctions/ assumptions are breaking down to some extent. In particular, there is a complex interdependency of sex and gender is throughout the human life cycle (Regitz-Zagrosek, 2012). Integrating sex and gender analysis into a life course approach can reveal how sex and gender-related factors interact to influence the development of non-communicable diseases (Brands et al. 2002). For example, sex-specific biological factors determine responses to particular diets that make women and men more vulnerable to certain types of fat dispersions, and gender-related behaviors result in different

levels of accumulated risk for raised blood pressure, obesity, hyperglycemia, and hyperlipidemia (WHO 2011).

Gender and inequality

Males and females are undoubtedly treated unequally in some areas. Inequality is defined as a difference in social status, wealth or opportunity between people or groups in both less and more developed countries or societies (Simon and Nath 2004; Permanyer 2013). Men and women from similar social backgrounds may be treated differently because of cultural and social influences. Gender inequality can be found in many areas, including education, occupation, and income. In the following paragraphs, I discuss different aspects of gender inequality.

First, obtaining a high level of education is an important way to achieve upward social mobility. However, higher education has never been equally provided for all people, even in developed countries. According to a study by Andres and Adamuti-Trache (2007), even though gender integration has occurred since 1979 in all subfields of health sciences in Canada, most subfields within the social sciences have maintained a pattern of steady gender polarisation (i.e. women are dominant in the field of social sciences, such as social work). In Hong Kong, the same situation occurs (Census and Statistics Department 2011).

This difference between men and women leads to different economic and social rewards for men and women after graduation from university.

Second, although more women are now employed in the paid workforce worldwide, women still have relatively lower income and less prestigious jobs, such as those of secretary and receptionist. In many countries the better occupations (such as those of doctor, lawyer or manager) are still dominated by men, especially at the top (Huffman and Cohen 2004; Gauchat et al. 2012). In Hong Kong, the proportion of men (43%) working as managers and administrators, professionals and associate professionals is higher than women (36%) (Census and Statistics Department 2012).

Third, many sociological studies show that not only are income levels influenced by the competitive force of supply and demand in the market, but that women earn less than men for doing the same job, so that women have to work longer hours to get the same income as that of men (Platt 2011). This is also the case in Hong Kong (Census and Statistics Department 2011). At the same time, the gendered domestic division of labour means that even if women have a paid job, they still tend to do more of the childcare and household chores (Mert 2017). This situation is also found in Hong Kong (Groves and Lui 2012).

Gender and mental health

Apart from gender inequalities in social status, wealth or opportunity over the past decades, many studies have also identified gender differences in mental ill-health. The most typical finding, as noted earlier, is that females are more likely to be depressed than males (Inabe et al. 2005; Eaton et al. 2012). This difference is also found in community samples, in those seeking help for emotional problems in psychiatric outpatient clinics, and in mental hospital populations (Ensel 1986; Eaton et al. 2012). In general, women are more likely to suffer from mood disorders (however, this does not include mania) and anxiety disorders than men. In particular, it is well-documented that women are more susceptible to anxiety and depression than men (National Institute of Mental Health 2001; Nolen-Hoeksema and Keita 2003; Eaton et al. 2012). On the other hand, men are more likely than women to have substance use disorders and antisocial personality disorder (Rosenfield 1999; Grella et al. 2009). This means as noted earlier that whether mental illness overall is more common in women than men depends on how its boundaries are drawn (i.e. what is placed in the category). For example, the Epidemiologic Catchment Area Study (Regier et al. 1988), which was conducted between 1980 and 1985 across five United States sites with a sample 18,571 persons aged 18 or above living in households, and a sample of 2,290 persons aged 18 or

above in institutions, found that women were more likely to suffer from both affective and anxiety disorders than men (the two to one ratio is common). On the contrary, men were more likely to suffer from substance-use and antisocial personality disorders. Nevertheless, no significant gender differences were found for schizophrenic disorder or cognitive impairment (see Table 2.1). As Busfield (2011) has pointed out, such gender differences have also been found in a wide range of studies across a wide range of countries (WHO 2010).

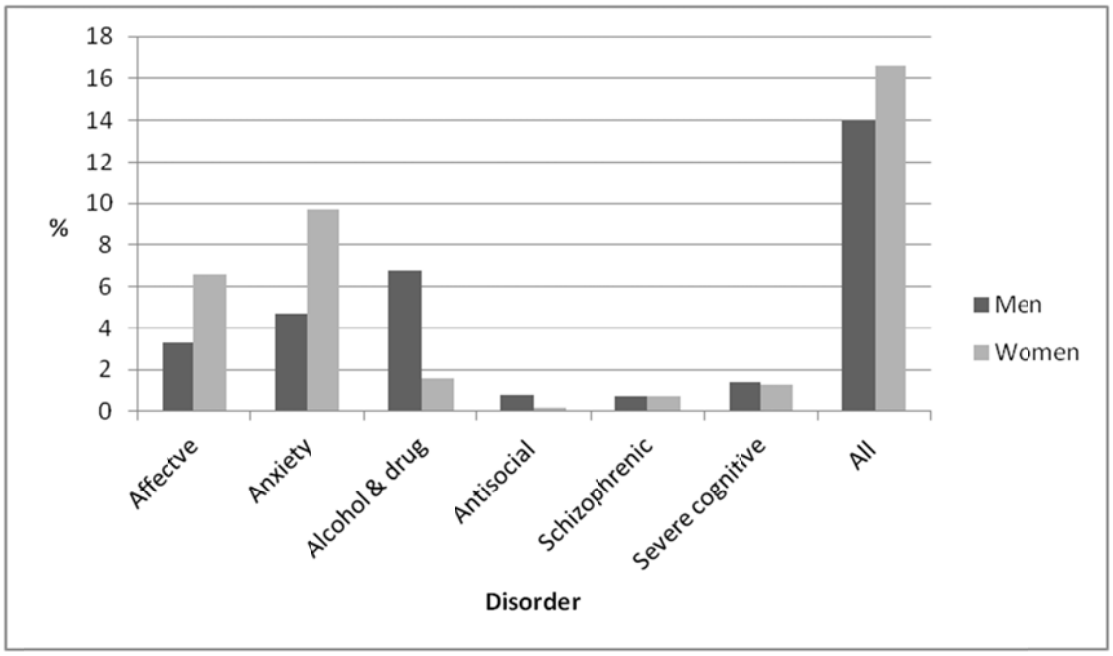

Table 2. 1: 1-month prevalence rates by type of disorder and gender, ECA, 1980-1984

Source: data from Regier et al. (1988) and table from Busfield (2011)

In the following discussion, in order to understand the gender difference in mental health in more detail, I mainly focus on the sociological

relationship between gender and mental health (i.e. how the social expectations and gender socialization of being a man or women affects the mental health of men and women). Although as discussed in the previous section of "sex and gender", the terms "sex" and "gender" can be defined in different aspects, including biological analysis ("sex") (Somerset et al. 2007; Lester et al. 2014), sociological analysis ("gender") (Torgrimson and Minson 2005; Galdas et al. 2010) and integrating sex and gender analysis (Nowatzki and Grant 2011; Fausto-Sterling 2012; Springer et al. 2012), I will only focus on sociological analysis ("gender").

The gender differences in mental health as discussed above have not only led to speculation that women may be more likely to be at risk than men from certain stressful conditions, such as network losses through end of friendship and divorce etc., but also that this gender difference may be caused by other processes, for instance, men may be more likely to use other ways (such as excessive drinking) in the face of stressful circumstances. Rosenfield et al. argued that under the influence of socialisation adolescent boys are more likely to use self-salience which refers to "the relative importance of the self versus the collective in social relations" (2005: 323) than adolescent girls when facing stressful circumstances.

In addition, some studies (Gove 1984; Rogers and Pilgrim 2005) have examined the relationship between psychiatric morbidity and marital status. These studies have found that generally the married have lower rates of psychiatric morbidity than those who are single or divorced, and that married women are more likely to have a high level of mental distress than married men. Gove (1984) argues that this difference is mainly caused by their different social roles in which the roles of men tend to be more structured or 'fixed' than the roles of women, while women are more likely to occupy nurturing roles than men. Gove argued that highly structured or 'fixed' roles tend to be causally related to good mental health and low rates of morbidity. In contrast, nurturing roles tend to impose a strain and to impair one's ability to effectively adopt a sick role and as a consequence nurturing roles are linked to poor mental health and the higher rates of morbidity.

One area of particular interest in relation to gender and mental health has been that of domestic and sexual violence. Although women as perpetrators of domestic violence are nearly as common as men in developed countries, such as the United Kingdom (Rogers and Pilgrim 2003), the level of child abuse, spouse/ cohabitant battering and sexual violence is still higher for female victims. For example, the rate of post-traumatic symptoms following victimisation of female victims is always

higher than for males (Rogers and Pilgrim 2003). The World Health Organization (2013) estimated that, worldwide, about 73 million (7%) boys and 150 million (14%) girls under the age of 18 are sexually abused every year. In addition, secondary analysis of cross-sectional data previously collected at random from the general population to assess the prevalence of interpersonal violence in Sweden also found that in the female population sample, victims reporting all three forms of violence, including emotional, physical and sexual, were four times more likely to report many symptoms of psychological ill-health compared to those reporting only one form of violence (adj OR: 3.8, 95 % CI 1.6-8.8) (Simmons et al. 2015). The same situation is found in Hong Kong[2]. But the finding, that the level of child abuse, spouse/ cohabitant battering and sexual violence is still higher for female victims, may be an overestimate, since there is a gender difference in seeking help from services that may also help us to explain the over-representation of women in mental ill-health statistics (Rogers and Pilgrim 2005). If a person experiences symptoms, he or she may decide not to seek help from a medical practitioner immediately. Seeking help and how to seek help depends on one's personal experience

[2] Source: website of the Social Welfare Department, HKSAR, http://www.swd.gov.hk/vs/english/stat.html

of the difficulties and one's personal networks (such as help with referral) (Rogers et al. 1993; Kilmartin 2005).

Importantly, seeking help for mental health problems requires that individuals self-report their difficulties or emotional struggles. In other words, people have to label or view themselves as having problems that require help as, though this may be prompted by comments from family or friends. Both self-reporting and help-seeking processes may be affected by gender differences in attitudes, norms, values and expectations (Dohrenwend and Dohrenwend 1977; Rogers and Pilgrim 2005; Kilmartin 2005). For example, endorsement of traditional hegemonic masculinity norms, such as being strong and invulnerable, not expressing emotions, being resilient, and being independent, is a key influence upon psychological help-seeking among men (O'Brien et al. 2005; Noone and Stephens 2008; McCusker and Galupon 2011). Jeffries and Grogan (2012) found that embarrassment and anxiety about seeking help could result when men believed that they should tolerate the pain or solve the problem by themselves because they were men. As Dohrenwend and Dohrenwend argued, "sex differences in the seeking of help correspond to attitudinal differences: women are more likely to admit distress … to define their problems in mental-health terms … and to have favourable attitudes towards psychiatric treatment" (1977: 1338). In addition, Rosenfield (1989)

argued that both the level of demands and the level of relative power, which are structural elements of network relationships that are formed by gender inequalities, contribute to gender differences in psychological distress.

The sociology of emotions as developed by Hochschild (1979, 1983) provides a complementary framework for understanding gender differences in distress in its attention to socialisation processes that give rise to different norms and obligations governing the expression of emotions for women and for men. From this perspective, the development of depressive symptoms in women and acting-out behaviours in men is consistent with gender-specific emotion. Some of the more recent work in this field argues that women typically internalise their feelings, resulting in higher levels of depression, whereas men tend to externalize them resulting in higher levels of substance abuse and violence (Rosenfeld et al 2005). Hochschild (1979) also discussed the impact of social class on emotional socialisation, noting that middle-class individuals are taught to value emotion management to a greater extent than are working-class persons. The importance of this socialisation on mental health is that mental illnesses are produced by people within their own specific cultural backgrounds.

Gender differences in seeking professional help are encouraged by the fact that women are more likely than men to view their problem as mental illness, and that men are less likely to recognise and label their problems as needing professional help. It is argued that this is because women generally are more willing to talk about their emotional problems with others than men (Crowe 2006). For example, Oliver et al (2005) carried out a questionnaire survey (n=15 222) of the population of Somerset (Oliver et al. 2005), with a total of 10 302 (95.0%) respondents answered questions regarding their attitudes to seeking help for mental health problems. Of these, 8368 (81.2%) said that they would seek some form of help if they thought their health was suffering as a result of stress or strain. However, men (84.79%) were significantly less likely than women (86.6%) to say that they would seek help from general practitioner (OR=0.78, 95% CI 0.72–0.88, P<0.001). Research in several countries also shows in particular that men are less likely than women to consult with the relevant professionals (Moller-Leimkuhler 2002; Galdas et al. 2005; Harmony House Hong Kong 2014; Juvrud and Rennels 2017). As a result, women are more likely than men to obtain professional help.

Because of these influences, the number of men with mental disorders may be underestimated, which may cause many problems for men, such as increasing the risks of suicide, alcohol abuse and stress (Goldbery

1976/1977; Massey et al. 1993; Lindstrom 2005; Centers for Disease Control and Prevention 2010). In particular, it is common for men to consume alcohol and/ or smoke cigarettes as a socially acceptable way of managing anxiety and depressive feelings – alcohol abuse in itself constituting a mental disorder (Goldbery 1976/1977; Census and Statistics Department 2013).

As mentioned in the Introduction and earlier in the chapter, unemployed men may also have a higher risk of suffering from mental illness than unemployed women. The National Alliance on Mental Illness and Mental Health America (2009) found that unemployed people were four times more likely than employed people to have mental health problems, such as depression. There is evidence to suggest that the experience of unemployment is key in undermining men's mental health, because it may damage the masculine self-image and social expectations of being in full-time paid employment (Artazcoz et al. 2004; Mossakowski 2009).

Men, masculinity and mental health

Traditionally, men's mental health has not been a major research topic or clinical interest in its own right (Addis and Cohane 2005). Much of the research on men's mental ill-health comes from the studies focusing on gender differences in mental ill-health. These studies mainly focus on

either the structural determinants of gender differences in mental health, such as low self-reporting and help-seeking rate among men under the influence of gender socialisation or the limitations of research design seeing the differences as "an artefact of the construction of epidemiological research"[3] (Rogers and Pilgrim 2005: 67). Only in recent years, has the influence of gender on men's mental health practices become a focus in both men's health and social science studies (Mckenzie et al. 2016).

The view that the male gender role is associated with predictable mental health risks is not new. Goldberg (1976/1977) popularised the concept of the 'male harness' 40 years ago. The male harness refers to the social and cultural imperative in Western societies that men be emotionally controlled, competitive, independent, and successful. Up until now men are also expected to be strong, dominant, tough, and unemotional (O'Neil et al. 1986; Chan 2009b; Kimmel 2011). As a result adult men often do not cultivate intimate friendships with other men outside of the workplace and reply on their spouse or partner for interpersonal support. It is also common for men to consume alcohol as a standard routine of social interaction, and as a socially acceptable way of managing anxiety and

[3] Rogers and Pilgrim (2005) argue that the studies related to gender differences and mental health mostly focus on married women and married men. These studies seldom examine other variations in marital relationships such as divorce and thus underestimate the problem of mental health among men.

depressive feelings. Goldberg (1976/1977) observed that men in the harness are at highest risk for mental health problems following stressful life events such as illness, divorce, unemployment, retirement, or other threats to the masculine ideal.

Subsequent perspectives on men's mental health have evolved beyond a focus on men who conform to traditional masculinity expectations, which arise due to gender socialisation processes throughout childhood and into later life (Levant 1990; O'Neil 1981), and recognise that increasing numbers of men in contemporary Western societies neither espouse traditional masculine values nor engage in behaviours rigidly adherent to the traditional male role (Lee and Owens 2002). Contemporary men's studies include an interest in the extent to which there is societal support and acceptance for some of these changes, as well as critical analysis of the social sanctions against men who either choose to disregard gender norms or are unable to fit the idealised male image due to race, sexual orientation or other differences at variance with the dominant culture (Gerald and Rosalind 2006).

Some have argued that endorsement of traditional hegemonic masculinity norms in the West and in Asia (e.g., being strong and invulnerable, not expressing emotions, being resilient, and being independent) is a key influence on psychological help-seeking among men

(O'Brien, Hunt and Hart 2005; Noone and Stephens 2008; McCusker and Galupo 2011; Leung and Chan 2014; Harmony House Hong Kong 2014; Juvrud and Rennels 2017). For example, embarrassment and anxiety about seeking help might result when men believe that they should tolerate the pain or solve the problem by themselves because they are men (Jeffries and Grogan 2012). The cognitive conflict and the negative emotions that result from defying, or wanting to defy, these masculine norms (e.g. by seeking help) has been termed gender role conflict. Studies suggest that this conflict is associated with low help-seeking, possibly because men who experience a gender role conflict usually subscribe highly to traditional male norms, while also appreciating the value of seeking help (Good and Wood 1995; Blazina and Watkins 1996). A similar situation was found in Hong Kong. A study of men in Hong Kong found that when they faced problems, most of them, in particular those with a low-income, low levels of education and middle-aged, tried to solve the problems themselves, and did not seek help formally or informally (Chan 2009b). Another study (Hong Kong Council of Social Service 2004) found that the main reasons that men did not seek help included being unwilling to talk about their problems with others and thinking that they had the ability to solve problem themselves. For those who did seek help, most of them sought it from their friends and from family members. Few were willing to seek

help from professional organisations. This is supported by data from Harmony House Hong Kong, which reported that in the financial year of 2013-14 there were 15,304 cases of women seeking help by phone, but only 4,800 cases of men seeking it in the same period.[4]

Social capital

Social capital refers to connections among individuals (often called "social networks") and the norms of reciprocity and trustworthiness among people (Putnam 2000). Social networks are increasingly regarded as important sources of social capital and allow people to access social support. In Chinese society, social capital is termed "*guanxi*" (Coleman 1990; Lin 2007). Social capital covers the stock of active connections among people. Under the process of active connection, trust, mutual understanding, shared values and behaviour among people are formed. Social capital is "the value of those assets of social structures to actors, as resources that can be used by the actors to realize their interest" (Coleman 1990: 305).

Social capital can be viewed as implicating three continuua: structural/cognitive, bonding/bridging and horizontal/vertical. As

[4] Source: http://harmonyhousehk.org/chi/statimage/stat_chi.htm accessed on 18 September 2015.

Coleman (1988) has argued, structural social capital refers to relationships, networks, associations, and institutions that link people and groups. Structural social capital can be measured by the analysis of linkages and network density. For example, the numbers of church groups, volunteer groups and interest societies may be considered an indicator of structural social capital. At an individual level, the membership of groups outside the work environment can be measured. Cognitive social capital, which is sometimes called a collective moral resource, includes values, norms, reciprocity altruism and civic responsibility. Different from structural social capital, cognitive social capital relates to beliefs and perceptions. This can be measured by conducting surveys of the level of trust amongst neighbours, and civil identity (such as whether you feel that you are a member of society) and comparing the rates of trust in different areas. At an individual level, the perceptions of community, such as the sense of belonging and trust, can be measured.

Similar concepts of structural and cognitive social capital are also discussed in Ibarra's theory of hard and soft social capital mentioned in the previous chapter (Ibarra 1993). According to Ibarra, hard social capital refers to accumulated task-oriented resources developed from instrumental ties for fulfilling valued career goals. Soft social capital refers

to emotional support resources. Soft social capital is particularly characterised by high levels of closeness and trust.

Bonding social capital is an intra-group phenomenon and relies on strong ties between individuals. This can be reflected in homogeneity, strong norms, loyalty and exclusivity. A typical example is the family unit found in small close-knit migrant groups that depend on mutual support (Putnam 2000; Onyx and Bullen 2001). Bridging social capital, on the other hand, is outward facing and links different groups in society. Compared with bonding social capital, the ties among people are weaker and are sometimes fragile (Putnam 2000).

The final dimension is horizontal and vertical social capital. Horizontal social capital is the social capital that arises among people in similar strata of society. This dimension of social capital can be viewed as "bonding and bridging social capital" and "structural and cognitive social capital". By contrast, vertical social capital is the social capital that provides integration among people in the different strata of society. This can be considered the degree of integration of groups in which people link together across different societal levels. The extent to which those who do not have power in society can connect and leverage resources and information from those who have power can affect policy-making and resource allocation. This can be seen as a type of bridging social capital, with structural components

referring to the organisational integrity, penetration and effectiveness of the state, and cognitive elements reflecting group identity (Colletta and Cullen 2002, Bryant and Norris 2002).

Theorising social capital

The concept of social capital draws attention to the effects and consequences of human sociability and connectedness and their relations to the individual and social structure. The concept of social capital is not new. While earlier scholars (Loury 1977, 1987; Ben-Porath 1980) pointed to the phenomenon of resources or capital arising through social relations or even employed the term social capital, it is only since the 1980s, when several sociologists, including Bourdieu (1977, 1980, 1986, 1990), Coleman (1988, 1990) and Putnam (1993a, 1995, 2000), independently explored the concept in more detail, that it caught the attention of the research community.

In the following paragraphs, Bourdieu, Coleman and Putnam's theories are discussed in more detail for several reasons. Firstly, in this study, apart from social networks and support, the other aspects of social capital (including trust, social cohesion, a sense of community, group membership, engagement in public affairs, and family social capital) are examined. As Lin (2001) and Kawachi (2006) have argued, social capital is a property of individuals and of collectives. At the individual level, social

capital is often measured through questions about social connections and social support. This level focuses on how individuals gain returns through access to social networks, e.g. in terms of job opportunities, emotional support and good health. Bourdieu (1977, 1980, 1986, 1990) and Coleman (1988, 1990) are popular scholars using this approach. In addition, the discussion of social capital has expanded to include elements at a more collective level, such as generalised social trust (Putnam 1993a, 1993b, 1995, 2000). The focus of such studies is to explore how networks, norms and trust are vital in the creation and maintenance of the collective assets. This approach is mainly based on the ideas of Pierre Bourdieu (1977, 1980, 1986, 1990). Secondly, this research also seeks to understand the importance of different aspects of social capital in contributing to better mental health in middle-aged men who are unemployed. I thus use Bourdieu's theories to understand more about the inequalities in the dynamics of social class relations (i.e. social capital) (Bourdieu 1986; Bourdieu and Wacquant 1992).

Social capital in Bourdieu's theory

Pierre Bourdieu's (1977, 1980, 1986, 1990) main focus was on the ways in which society is reproduced, and how the dominant classes maintain their positions. For Bourdieu, class reproduction could not only be explained by economics, but also by using cultural knowledge (i.e. cultural capital) in the dynamics of social class relations (i.e. social capital) (Bourdieu 1986;

Bourdieu and Wacquant 1992). According to Bourdieu, social capital is defined as 'the aggregate of the actual potential resource which linked to possession of durable network of more of less institutionalized relationships of mutual acquaintance or recognition' (1986: 248). Social capital for Bourdieu is related to the size of the network and the volume of past accumulated social capital commanded by the agent (Bourdieu 1986: 249). The volume of the social capital possessed by a given agent depends on the size of the network of connections that people can effectively mobilize and on the volume of the capital (economic or cultural) possessed in their own right by each of those to whom they are connected (Bourdieu 1986). Bourdieu (1977, 1980, 1986, 1990) argued that different socioeconomic groups possess different forms of cultural capital, which affect the group's social capital development and reproduce social inequality in the society. In *Distinction* (1984) Bourdieu argued that the different distribution of cultural capital among different kinds of people is linked to class distinctions. Taste, which is certain personal preferences developed as a social product, is one example of a deeply ideological category that functions as a marker of class. Taste can be an indicator for class classification. Bourdieu argued that taste actually contains the constellations of taste, consumption preferences and lifestyle practices. The whole process of presenting taste is an exercise in power. For example, he

claimed that there are three levels of taste or cultural capital, including pure or legitimate taste, average (or middlebrow) taste, and popular or vulgar taste. Pure or legitimate taste is often found in the dominant class that has the greatest educational capital. Examples are classical music and painting. Average (or middlebrow) taste is about less valuable and more common objects which are used by people in general. Popular or vulgar taste is mostly labelled as a non-cultured practice. These classifications actually contain the means of power and are the instruments of domination by the dominant class. The dominant class labels itself as a pure or legitimate group through categorizing different kinds of taste. In particular, education is an important means for the reproduction of differentiated cultural patterns.

Both Bourdieu (1977, 1980, 1986 [1983], 1990) and Crook (1997) have pointed out that education can affect cultural practices. For example, people who go to some universities may have more chance to study classical music. Also, education can be obtained by informal means. For instance, the dominant class passes its cultural capital (such as high class manners and lifestyle) to its children as a way of securing its own social reproduction. This informal education does not occur equally for everyone because of different levels of cultural capital by parents and thus is used for maintaining the power of the dominant class. With different habits,

lifestyles, values, and dispositions, people can have their own subjective ways of understanding and perceiving the world based on their social classes. These subjective views can become the expectations of particular social classes that in turn govern group members' behavior and thus lead the group members to ensure that the wrong kind of people do not enter their circles (Bourdieu 1986, Bourdieu and Wacquant 1992). In other words, with different cultural capital, people in the same class will be bound together to secure the profits of membership, including material profits (such as all the types of services accruing from useful relationships), and symbolic profits (such as those derived from association with a rare, prestigious group). Bourdieu argued that these class classifications actually contain the means of power and are the instruments of domination by the dominant class, since this class labels itself as a pure or legitimate group through categorizing different kinds of taste. In other words, the tastes and preferences of different social classes can be useful means for the members of social classes to identify themselves and demonstrate their difference from other social classes; and in this way social inequality is reproduced in the society.

However, some scholars (Alexander 1996; Jenkins 1992) have argued that Bourdieu's theory is reductionist in its privileging of economic capital as the last source and eventual exchange form of all other capitals. In

addition, similar to human capital and rational action theorists (Goldthorpe 1996), Bourdieu can be faulted for attributing an interest-bound, utility-orientation in all human action (Swartz 1997: 78). According to Bourdieu's argument, social capital becomes highly context-specific as a direct consequence of the relativity among the social, cultural, economic and symbolic fields (Adam and Roncevic 2003: 161; Savage, Warde and Devine 2005). This makes any automatic aggregation of social capital problematic (Schuller 2001:12). Especially, social capital is problematic as a feature of social classes which contain a wide variety of people under the social, cultural, economic and symbolic fields.

Social capital in Coleman's theory

Like Bourdieu, Coleman (1988, 1990) also views social capital as an individual asset. However, unlike Bourdieu, for Coleman, social capital consists of two roles: it is an aspect of a social structure, and it facilitates certain actions of individuals within the structure (1990: 302). Social capital is not fungible across individuals or activities. Social capital is the resources, real or potential, gained from relationships. In his scheme of social action, Coleman (1990) delineates how actors exercise control over resources in which they have an interest, and how they are also interested in events (or the outcome of events) that are at least partially controlled by other actors. Thus, in order for their interests to gain from the outcome of

an event, actors engage in exchanges and transfers of resources. These social relationships serve important functions in facilitating the actions of individual actors; they form the basis of social capital.

For Coleman, social capital is productive, i.e. social capital has a clear instrumental purpose and is used so that actors can achieve particular ends that would have been impossible without it. Like Bourdieu, Coleman defines social capital as a collective resource which can be used by actors who are goal-oriented. Social capital needs an element of embeddedness in social structure. In addition, like Bourdieu, Coleman sees social capital as crucially inhabiting in the social structure of relationships among people. This is different from both financial and human capital. However, unlike Bourdieu, Coleman argues that social capital is as a bonding mechanism which is used to the integration of social structure (Coleman 1988, 1990).

Another main difference between Bourdieu and Coleman is that for Coleman, social capital is viewed as a public good. Direct contributions by actors will benefit the whole. Strong families or communities accrue from strong social bonding among members (Coleman 1988, 1990). However, Bourdieu views social capital as a scarce resource. It is used for class reproduction that perpetuates structured inequality (Bourdieu 1986, Bourdieu and Wacquant 1992). As many scholars (Fraser and Lacey 1993; Molyneux 2002; Tonkiss 2000) have argued, Coleman can be faulted for

paying little attention to structural inequalities and power relationships in general.

Social capital in Putnam's theory

All the theoretical principles suggested by Coleman have been adopted by Putnam (1993a, 1995, 2000). For Putnam, social capital refers to 'features of social organisation, such as networks, norms and trust that facilitate action and cooperation for mutual benefit' (1993a: 35). Putnam argues that social capital is a quality that can be a facilitator of interpersonal cooperation. Putnam's work on participation in voluntary associations in democratic societies such as the United States strongly reflects the use of this perspective. He argues that such social associations and the degree of participation indicate the extent of social capital in a society. These associations and participation promote and enhance collective norms and trust, which are central to the production and maintenance of the collective well-being (Putnam 1993a, 1995).

According to Putnam's argument, social capital, essentially the amount of 'trust' available, is viewed as the main stock characterising the political culture of modern societies (1993a, 1995). For Putnam, voluntary associations enable a horizontal linking of people, and produce trust, the norm that causes interpersonal bonding. Putnam argued that trust creates the basis for reciprocity, and social networks and voluntary associations

that are not means for realizing the short-term interests of any specific groups. There is a circle among trust, reciprocity and voluntary associations: trust creates reciprocity and voluntary associations; reciprocity and voluntary associations strengthen and produce trust (Putnam 1993b:163-185). This is also the celebrated norm-producing feature of networks in Coleman's formulation. However, Putnam specifically connects trust and its concomitant reciprocity to civil engagement as an index of the strength of civil society. In short, social capital is associated with political involvement, especially through voluntary associations. Therefore, Putnam argues that social capital amounts to a direct assessment of the democratic strength of American society and becomes a collective trait functioning at the aggregate level and can be a tool for reflecting societal, political and economic prosperity (1993a, 1995, 2000). However, some scholars (Portes 1998; Brucker 1999; Foley and Edwards 1999; Swain 2003) argue that the direction of causation between social capital and, societal, political and economic prosperity is never convincingly made clear. Besides, for the conflict and power side of social capital as represented by Bourdieu, to some extent, Putnam leaves untouched (Siisiäinen 2002). For example, Putnam does not discuss conflicts and internal power structures among different parties and

voluntary associations, and conflicts between civil society and the political society (and the state).

The difference between men and women in their use of social capital

In the previous paragraphs, I have discussed different gender expectations that may lead men to have less depression but more substance use problems (such as alcohol and drug abuse) than women. In addition, gender stereotypes and expectations can lead to differences in the use of social capital between men and women. In general, women are more likely than men to be socialised into expressive roles and to provide emotional support for both sexes (Lin et al. 1986; Rogers and Pilgrim 2005). Men are more likely to be socialised into instrumental roles (Emmerik 2006) which emphasise personal achievement and accomplishment (Wood and Lindorff 2001; Bhattacharya 2011). With different gender stereotypes, there is a difference between men and women in their use of social capital. The evidence suggests that men are more effective in creating 'hard' social capital than women (Emmerik 2006). With hard social capital, men benefit from creating a sense of identity, which may in turn produce good mental health, even though men may have less 'soft' social capital (such as support from friends) (Wood and Lindorff 2001).

In contrast, women have usually been trained to use soft social capital effectively, since they are viewed as performing expressive roles, in

particular in their marital and primary relationships. In terms of marital relationships, wives typically perform expressive functions more than their husbands (Lin et al. 1986). In particular, wives usually consistently provide expressive support to husbands if they do become unhappy and experience depression (Choenarom et al. 2005).

To conclude, social capital is a property of individuals and collectives. The individual level, emphasised by Bourdieu and Coleman, focuses on the characteristics of individuals to measure the social capital (such as social networks and support). In contrast, the collective level, examined by Putnam, focuses on the characteristics of collectives as members in a place (such as country and community) to measure social capital (such as trust, social cohesion, a sense of community, group membership, engagement in public affairs). In the following paragraphs, the relationship of mental health and social capital at individual and collective levels will be examined.

The relationship of mental health and social capital

How does social capital promote mental health?

Social capital is viewed as one of the key elements in promoting mental health. Lin (1986, 1990, 1992, 2007) argues that there are two types of expected returns on creating social capital, namely returns on

instrumental action[5] and returns on expressive action. Among these, returns on expressive action are viewed as a key element to promoting mental health. With regard to expressive action, social capital is used for preserving and protecting existing resources (Lin 1986, 1990, 2007). To achieve this, people who have common interests and control similar resources tend to be accessed and mobilise together. In this process, alters are willing to share their resources with ego since "the preservation of ego and its resources enhance[s] and reinforce[s] the legitimacy of alters' claim to like resources" (Lin 2007: 244). In turn, physical health, mental health and life satisfaction can be promoted (Lin et al. 1986; Lin 2007).

Mental health can also be promoted through enforcing expressive action based on a "homophily principle" (Lin 2007). Under this principle, people with similar characteristics, attitudes and lifestyles are more likely

[5] For instrumental action, the three possible returns are economic, political, and social. Economic return is simply shown in terms of wealth (such as earning, assets and so on). Political return is reflected by "hierarchical position in a collective" (Lin 2007: 244). Social return is reputation, which can be defined as "the extent of favourable/unfavourable opinions about an individual in a collective" (Lin 2007: 244). Reputation is one form of social capital. High and low reputation can become a credit and debt respectively to the ego, in using a network and gaining social resources. As Lin contends, "the greater the debt, the larger the network, and the stronger the need for ego and alter to maintain the relationship; the greater the propensity to spread the word in the network, the greater the reputation gained by alter" (2007: 244). Through this process, the alter is gratified by the reputation, which along with material resources (such as wealth) and hierarchical position (such as power), constitutes one of the three fundamental returns in instrumental actions.

to live, meet and work in similar environments that encourage interactions and associations. Likewise, the frequency and intensity of interactions lead to the spread of similar attitudes and lifestyles. Based on this principle, we can predict that the maintenance of health status needs sharing and confiding among intimates who can understand and respond to the problem involved (Lin 2007: 245).

Apart from Lin et al. (2001), McKenzie (2006) has also studied the importance of "bonding and bridging social capital" and "bridging social capital trust and cognitive social capital" in the promotion of mental health. He (2006) has suggested, that both bonding and bridging social capital can be useful for promoting mental health. Through bonding social capital, individuals and families meet each other within a group and this allows individuals not only to receive mutual help but also to develop identity and enhance social status in society or certain kinds of groups. Furthermore, with bridging social capital, individuals are thus not isolated in the community since they have more chances to extend their social networks with different social backgrounds and/or classes through engaging into community activities or affairs. Studies (Burt 1992, 1997) find that this bridging social capital is good resource to manage conflicts in the community since there are some benefits for individuals with different social circles. These are: 1) accessing information uniquely and in a timely

manner; 2) having greater bargaining power for controlling resources and outcomes.

Scholars such as McKenzie (2006) also argue that bonding and bridging social capital are not only important in promoting mental health at the individual level (i.e. mutual help among individuals within group), but also at the community level (i.e. using collective power to promote mental health). At the individual level, personal interaction affects the mental health of individuals. McKenzie (2006) argues that the ties among individuals in an area can be useful for transmitting knowledge. In an area with a higher level of bonding and bridging social capital, communication is easier. Positive health messages may thus be more easily promoted. Further, if these bonded and bridged groups have a higher level of social control, then the promotion of health norms and the correction of deviant health behaviour, such as smoking and drug misuse, are more easily facilitated (McKenzie 2006). Similarly, strong and similar ties are expected to encourage resource-sharing among people and therefore enrich life satisfaction. This life satisfaction can be demonstrated by "optimism and satisfaction with various life domains such as family, marriage, work, and community and neighbourhood environment" (Lin 2007: 245).

As well as social support from marital relationships producing a positive impact on mental health as I discussed previously (Lin et al. 1986;

Choenarom et al. 2005; Hewitt et al. 2012), social support from friends can also foster mental health. Friendship relationships have positive therapeutic value for people (Maulik et al. 2011). However, as Booth (1972) and Chan (2009b) contend, the quality of men's friendships is usually weaker than women's because of different early training in socio-emotional roles. This implies that the social support men receive from friendship is relatively less than that received by women. In other words, men may have higher risk of mental illness, during stressful life events because of weaker social support from their friends. Although some studies (Markiewicz et al. 2000; Morrison 2009) find that the quality of men's close friendships from work is stronger than women's, the benefit of this men's friendship from work mainly focuses on career success and job satisfaction (i.e. job oriented outcome), rather than emotional support.

At the community level, the evidence (McKenzie 2006) shows that if there is a high level of bonding and bridging social capital in the community, structural social capital (such as social and health services) is easy to protect, for example by organising social actions and forming social organisations to fight for the budget cuts to a school or hospital. However, if there is a low level of bonding and bridging social capital in the community, societal safety nets may be insufficient because of a low level of social participation. In turn, people in the community will have fewer

opportunities to receive the social support that is a key element in preventing the "progression of life's challenges into mental illness" and in releasing pressure on the families and carers of people with mental illness (McKenzie 2006: 31). Nevertheless, one of the important elements to strengthen this positive impact of developing bonding and bridging social capital is whether perceived social support exists in the social networks, instead of whether being a member in the social actions and/ or social organisations, i.e. membership only. As noted before, Kessler and McLeod (1985) and other scholars (Gilbar 2005; Lee et al. 2012) also argued that the mental health impact of stress is not buffered by actual membership in social network, but rather by perceived social support.

McKenzie (2006) has also suggested that bridging social capital and cognitive social capital are useful for promoting mental health. Both can be measured not only by the level of trust in neighbours and the rates of trust, but also by civic identity. For instance, if a person becomes a member of local organisation in the community, he/she will gain a civic identity in organisations and the community, and thus develop civic trust later. In particular, this cognitive social capital consists of certain principal characteristics, including normative values, reciprocity altruism and civic responsibility.

The development of ties can be facilitated by the ties linked with the community and this promotes health. For example, membership of small close-knit migrant groups and trust are highly related. Studies show that increased trust can reduce the death rates from coronary heart disease, malignant neoplasm and infant mortality (Cullen and Whiteford 2001; Dinesen 2013).

A community with a low level of trust not only correlates with physical problems, but also mental problems. As Lin (2007) and Hamano et al. (2010) argue, if people live in a mistrustful area, it will increase the chances of high anxiety and high vigilance towards society and neighbours. Therefore, the chance of staying at home will increase, and the chance of keeping contact with close friends, family and the community, and of receiving social help from others, will be reduced. In particular, men often have a lower level of trust towards the community in which they live than women because of gender socialisation processes during adolescence (Lindstrom 2005). In turn, this adversely affects men's mental health, and leads to problems such as alcohol abuse. It contributes to social disorder (such as graffiti and public drinking) and affects the mental health status of men (Massey and Denton 1993; Lindstrom 2005). Lin et al. (1986) and Lin (2007) also argue that the lack of social support is one of key factors in causing the problem of depression for both women and men.

Moreover, joining groups in the community can consolidate the shared values of its members and maintains more effective social control, which can prevent suicide, crime, substance abuse and domestic violence. This can decrease the incidence of mental illness in the community (Carpiano 2006; Moore et al. 2009).

Nevertheless, not all social capital is good for mental health. For example, if the community is highly bonded, it may decrease the level of tolerance towards people with psychological difficulties. The community may even try to exclude such people instead of helping them, because of a belief that people with mental problems may produce negative health norms and increase the social burden on society (McKenzie et al. 2002; Whitley and McKenzie 2005). As Durkheim argued in *Suicide* (1952 [1897]), altruistic suicide is encouraged when people who are similar to each other as individuals are integrated, sharing the same sort of ideas with those who are important to them.

Based on the above review, I conclude that social capital can produce returns on both instrumental action and expressive action. In particular, returns on expressive action are useful in promoting mental health. However, the returns on instrumental action and returns on expressive action not only exist separately, but often reinforce each other. Physical health gives people the ability to work and to accept the responsibility for

attaining economic, political and social status. Economic, political and social status provides people with the resources to preserve physical health, mental health and life satisfaction. Nevertheless, the level of instrumental and expressive returns that an individual gains is uneven, since it depends on the density and openness of the social network. If a network is denser with more intimate and reciprocal relations among members, this may increase the likelihood of mobilising others with shared interests and resources to preserve and protect the existing resource or expressive returns. External factors, such as "community and institutional arrangements and prescriptive versus competitive incentives" (Lin 2001: 245), may also affect the density and openness of networks and relations and the success of instrumental or expressive actions.

To conclude, in this section, the relationship of mental health and social capital has been examined. Social capital is a very useful resource in promoting human mental health. Different types of social capital can strengthen mental health at both the individual and community levels. In relation to gender differences, we find that under the influence of gender stereotypes men usually obtain more social capital from their career and women usually gain more social capital from the emotional support of family, friends and community. These gender differences also contribute to the positive development of mental health for men and women.

Conclusion

Because of marked differences in gender expectations, differences in the use of social capital by men and women have different effects on the development of their mental health. Men are typically viewed as independent, assertive and ambitious, and tend to control more social capital from instrumental ties involving the exchange of job-related resources for fulfilling valued career goals than women. This hard social capital actually becomes the main source preventing men's mental illness (Bhattacharya 2011; Olesen et al. 2013). In contrast, women have relatively rich social capital from family, friends and community. Nevertheless, until now, there has been limited study of the value of using different types or dimensions of social capital in preventing mental illness. As McKenzie (2006) has noted, possible mechanisms through which social capital is considered to have an impact on the rates of mental illness have not been well researched. Additionally, in terms of gender studies, middle-aged men are seldom the subject of examinations of the impact of social capital on mental health or mental illness. Therefore, this research seeks to understand the status and relationship of mental health and social capital among middle-aged men who are unemployed, and the importance of different aspects of social capital (including trust, social cohesion, a sense of community, group membership, engagement in public affairs, social

support, community networks and family social capital) in contributing to better mental health in middle-aged men who are unemployed.

Chapter 3

Research methods

Methods of data collection

The aim of this study, as indicated previously, was to examine and seek to understand the mental health of unemployed middle-aged men in Tin Shui Wai, a new town of Hong Kong, who were unemployed and were becoming isolated socially within their local community. The location of fieldwork was Tin Shui Wai, a high-rise new town in the north-western part of the New Territories, Hong Kong, built largely on reclaimed land. I chose this locality because Tin Shui Wai had many characteristics of interest to my study. Tin Shui Wai is one of the poorest districts in Hong Kong and is located 25 kilometers from the Central district of Hong Kong. Many residents face employment problems (see Chapter four).

The study used both quantitative and qualitative research methods to explore and compare the mental health of both men and women living in this community. The two research methods had different purposes. A quantitative approach involving a questionnaire survey was used to investigate the status and relation of mental health and social capital among middle-aged persons in Tin Shui Wai, and the importance of

different aspects of social capital in contributing to better mental health. A qualitative approach involving interviews and focus groups was used to explore in detail the different aspects of the participants' situations, their connections to their communities and their self-perceptions of their mental health.

The questionnaire for the quantitative component of the research included questions to measure the respondents' mental health status and social capital, as well as background information, such as employment status, age, sex and so on. The level of anxiety and depression and the abuse of alcohol were measured separately in the questionnaire using two specific scales, namely the Hospital Anxiety and Depression Scale (HADS) for the measurement of anxiety and depression and the Alcohol Use Disorders Identification Test (AUDIT) for the measurement of alcohol abuse. The total number of valid questionnaires obtained was 403. Among 403 respondents, 224 respondents were from non-government organisations (NGOs) and 179 were from the community. The questionnaire is included as appendix A. Besides, I invited the respondents who responded to the questions in the questionnaire, to speak more qualitatively to ensure that I could understand their viewpoint and situation related to their mental status, employment status and feelings about current employment status in more detail.

Individual interviews and focus groups provided the qualitative component of the research. I chose interviews as a method since I wanted to collect some personal data, including more information about the interviewee's mental status, employment status and feelings about their current employment status. Focus groups were primarily used for collecting information from the residents in Tin Shui Wai about their views of the community and their own mental and employment status. Respondents in the focus group were invited through a service unit which was connected with my former work organisation. All interviewees and participants in focus groups were also invited to respond to the questions in the questionnaire, to speak more openly and qualitatively to help to ensure that I could understand their viewpoint and situation related to their mental status, and their current employment status and feelings about it in more detail. The interview and focus group guidelines are given in Appendices B and C.

As a pilot study, before conducting the research formally, I invited ten people, including four social workers, one Associate Professor in social work in Hong Kong and five residents in Tin Shui Wai, to try to answer the planned interview and focus group questions and give their comments as to how they could be improved. However, for the questionnaire, no pilot study was undertaken to test its reliability and validity formally since

only three NGOs were willing to be involved in this study voluntarily, and given their limited manpower, they could only collect the data one time. . However, to ensure the questions were relevant to my research focus, I, referred to other scholars' definition of social capital (Caughy et al. 2003, De Silva 2006, Desai et al. 2005, Drukker et al. 2003, 2004, Greiner et al. 2004, Lindstrom 2004, O'Brien et al. 1996, Pevalin 2004, Pevalin and Rose 2003, Pollack and von dem Kneseback 2004, Saluja et al. 2003, Steptoe and Feldman 2001, Stevenson 1998, Sundquist et al. 2004, Van der Linden et al. 2003, Veenstra 2005, Ziersch and Baum 2004, Ziersch et al. 2005) (see 'Questionnaire design' later in this chapter) and also used existing validated questionnaires related to social capital, such as the Lubben Social Network Scale (Lubben 1988), Social Network Index (Cohen et al. 1997), Multidimensional Scale of Perceived Social Support (Zimet et al. 1988) and Social Capital Assessment Tool (SOCAT) (Krishna and Shrader 1999)], to design the social capital questions for survey, as well as the interview questions and focus group questions on social capital. I did not totally simply copy these questionnaires to design my own questionnaires and questions for the interviews and focus group. Rather I selected relevant questions based on certain criteria, 1) the questions should be at the individual level; 2) the questions should be able to apply in an urban area.

After selection, I translated the questions into Chinese and rearranged their order to make it easier for respondents' to answer them easily.

The data collection was conducted from October 2009 to April 2010.

Choosing the samples

I chose to focus my research on middle-aged respondents between 30 to 60 years-old. The age range was chosen for two reasons. First, I chose 30 years as the minimum age since the number of unemployed persons over 30 has been increasing in Hong Kong. According to the 2011 population census in Hong Kong (Census and Statistics Department 2011), the number of unemployed persons decreased by 17.6% from 20-24 to 25-29. However, the number of unemployed persons increased by 4.4% from 30-34 to 35-39. This pattern of increases applies to other age ranges up to 50-54. Second, I set 60 as the maximum age for the sample since 60 is the common retirement age in Hong Kong although there is currently no mandatory retirement age. Employees and employers are free to negotiate on a mutually agreed basis for a suitable retirement age, as with other terms and conditions of employment, when they enter into an

employment contract. However, for civil servants and registered teachers, the retirement age is 60 years[6].

A second decision I made was to include both women and men in my sample. This was because, as already suggested, I wanted to use women as a point of comparison in the study.

Having decided to focus on men and women aged 30 to 60 I proceeded to find the samples for my research – for the questionnaire survey, and the individual interviews and focus groups – with some assistance.

For the questionnaire survey, I invited respondents in the NGOs and in the community respectively since I wanted to find social service users and non-social service users who had received formal help and had not received formal help respectively, to participate in my study. For the samples from the NGOs, I conducted part of the questionnaire survey at an NGO in which I had previously worked and provides community services for local residents and social services for middle-aged men in Tin Shui Wai. In addition, I also conducted part of the questionnaire survey at two NGOs, which provided integrated family service in Tin Shui Wai. The NGOs were financially supported by the Hong Kong government. The

[6] Source: http://www.info.gov.hk/gia/general/201406/25/P201406250550.htm accessed on 21 November 2016.

questionnaires were completed by the respondents themselves. There was no random sampling, since it was too costly for me to use this method (such as telephone and mail survey) to contact the target group. For the samples from the community, I went to locations in the community (such as public parks and bus stations) and invited residents directly to answer the questionnaire survey using convenience sampling. This was different from the survey conducted in the NGOs, where the questionnaires were completed by the respondents themselves. In the community setting I asked the questions and wrote down the answers from respondents since it was not convenient for the respondents to fill in their answers to the questions in places such as public parks and bus stations. In addition, to ensure that I could understand the respondents' viewpoint and situation in more detail, I also asked them some less-structured open-ended questions and this generated useful data. When I collected useful qualitative data from the survey, I wrote down the answers on the questionnaire. After that, I created a variable of "others" in each case in SPSS (Statistical Product and Service Solutions) for inputting the related qualitative answer for analysis. When I ran the related data for analysis, I also extracted the qualitative answers to have a better understanding of the findings. No formal figure was obtained for the response rate or could be provided for the survey in both the NGOs and in the community, since the staff of NGOs was not

willing to keep a record of the number refusals because their manpower was limited and they participated voluntarily. In the community, some places (such as bus stations) used for inviting people to answer the questionnaires, make it difficult to keep adequate data to allow for the calculation of a response rate because most passengers, who were my potential respondents, got off the bus in a very short period of time. When I indicated my intention to invite them to answer the questionnaire, most of them would refuse my invitation or leave as soon as they could. Therefore, it was difficult to me to count correctly the number who refused.

For individual interviews and focus groups, all respondents were service users in the agency and took part in the study voluntarily and I obtained their consent to participate. As noted, all respondents were invited by the staff of the related NGOs through convenience sampling. Ten individual interviews (five with men, five with women) and two focus groups, with 11 people (five men and six women) were carried out. Hence, a total of 21 participants were involved in the qualitative component of the research.

The NGO staff approached people for survey through daily activities without considering their background since the questionnaire was intended to investigate the general status of mental health and social capital of the respondents. When the NGO staff approached the service

users for survey, the staff would first ask the service user whether they were willing to participate in a study about the relationship between mental health and social capital among middle-aged people who are unemployed and are becoming isolated socially in Tin Shui Wai. If they were willing to answer the questions, the staff member showed them the "Participant Information Sheet" and explained in detail the content of the research. However, for the interviews and focus groups, the staff approached individuals taking account of their background (for example, they were looking for individuals who had poor mental health or physical health or who were unemployed and/ or whose spouse was unemployed) since the questions in the interviews and focus groups included self-perceptions and self-assessments of their mental health and of different aspects of their situations. Similar to the process for the recruitment of survey, the NGO staff would first ask the service users whether they were willing to participate the study. If they were willing to do so, the staff showed them the "Participant Information Sheet" and explained in detail the content of the research.

Ethical aspects of the study

Because this study involved human participants, I sought and gained ethical approval in October 2009 from the University of Essex before data collection was undertaken. In addition, I obtained participants' oral

consent to be involved in my study. I did not obtain their consent in writing since it was difficult to request the participants to sign any consent form in the street. For the survey, interviews and focus groups, no signed consent for the NGO sample was collected since the service users resisted signing the consent form. Moreover, their agreement to answer my questions itself constituted consent. In addition, I designed a participant information sheet (Appendix D). I showed this information sheet to all respondents who were invited by the NGOs. For respondents who were invited by the NGOs where I had formerly been employed and for respondents approached in public areas, I informed them orally of the content of the information sheet.

To ensure confidentiality and anonymity, I did not collect participants' names or any other personal information (such as identity card numbers). However, I collected a range of socio-demographic information including their age, sex, marital status, number of year(s) living in Hong Kong and in Tin Shui Wai, household composition, education level, nationality, occupation and income. All the data collected from the participants was used only by me. In addition, for the qualitative research, I gained approval from the participants to audio-record the interviews and focus groups. If participants did not want to be audio-recorded, I recorded the content on paper. In total, three male and two female in-depth

interviewees and all respondents in focus groups were willing to be audio-recorded. I was the only person to listen to the audio-recording in the process of transcribing and analyzing the data. All the data and information collected were entered into and saved on my private computer which has been used and accessed only by me.

Risk management procedures were put in place to minimize any risks that the respondents or I might experience as a result of participating in the study. Respondents who felt disturbed or upset by participating had the option to terminate their participation immediately. None of respondents in this study reported that they felt disturbed or upset. For participants invited to participate by the agency who had formerly employed me, and for respondents in public areas, I offered follow-up referral to my former agency in which there were social workers who could provide counselling if the respondents felt disturbed or upset. In addition, for those invited by other local agencies to participate in the survey, I reminded agency employees that if the respondents felt disturbed or upset, the survey should be terminated and their social workers should provide support. In addition, to minimise risks to me if I met respondents who had mental health problems associated with drinking, I only approached people when the out-reach team was nearby.

Questionnaire design

For the survey, a questionnaire measuring respondents' social capital and mental health, including alcohol use, and collecting background information on respondents, such as their employment status, age, sex and so on was designed. There was also a follow-up question about their employment status. I added a question related to the positive and negative effects of unemployment / absence of paid work for the respondents, who were unemployed, a housewife, or retired, to answer. The aim of this question was to understand more about the general effects of unemployment for these individuals. In particular, the negative effects of unemployment/ absence of paid work were not aimed at finding the symptoms and/ or diagnosis of mental illness under the influence of unemployment/ lack of a paid job.

Measuring social capital

As mentioned in Chapter two, there is a lack of a single consensual and established definition of social capital (Brunie 2009). One of main reasons is that there is disagreement about whether social capital is an individual asset or a collective resource (Kawachi et al. 2004). While some scholars argue (Bourdieu 1986; Loury 1977; Portes 1998) that social capital is an individual asset, others (Putnam 2000) argue that social capital is a collective property. However, many scholars agree that social capital can

have both individual and collective characteristics (Ferlander and Makinen 2009; Habibov and Afandi 2011; Kawachi 2006).

The term social capital was first introduced at individual level (Bourdieu 1986; Loury 1977; Portes 1998). Social capital at this level is seen as a resource embedded in network (such as social support) that can be accumulated over time and has a potential capacity to achieve an end, such as having job opportunities and good health (Lin 2001; Kawachi 2006). Koput (2010) identified four characteristics of social capital at the individual level. Social capital is 1) a productive resource for value creation, 2) an investment which brings gain or loss in the future, 3) inherent in relationships, and 4) fungible - that is, it can be used for other purposes.

The concept of social capital later evolved to also denote social connectedness in communities. Described by Robert Putnam, social capital at community level refers to the features of social organisation (Putnam 1995). It is the resources embedded in a society that can be increased. The more the social capital, the better the community. Putnam expanded the definition to include the shared norms, values and mutual trust which facilitate coordination and cooperation for mutual benefit. He also introduced a conceptual twist by arguing that social networks not only have a value to the people within the social network (compositional

effects), but also to people outside the network (contextual effects). Social capital thus defined is the value of social relationships to groups (including communities, states and countries), as well as to individuals. This has led to significant debate as to whether social capital should be considered a property of groups of people (an ecological construct) or of individuals. However, Portes highlighted a potential risk of directly transplanting the concept from individual level to community level – logical circularity. He expounded that, 'as a property of communities and nations rather than individuals, social capital is simultaneously a cause and an effect. It leads to positive outcomes, such as economic development and less crime, and its existence is inferred from the same outcome' (1998: 19). This circular reasoning is one of the logical fallacies, in which the justifications and elaborations loop the result back to where the proposition starts.

In my study, I used a compositional approach (characteristics of individuals) to measure the concept of social capital, instead of a contextual approach (characteristics of place) since I wanted to explore how the different aspects of social capital that middle-aged men control 'individually' (not the social capital of community), might contribute to better mental health for them, instead of a collective outcome, such as lower depression rate in the community as a whole.

Currently, there is no standard measurement of social capital. According to Wall et al.'s findings (1998), there are eleven different dimensions of social capital commonly used in measurement: trust, social cohesion, a sense of community, group membership, engagement in public affairs, social support, community networks, family social capital, neighbourhood problems, workplace social capital, and healthcare social capital. Eight of these eleven dimensions reflect the common definitions of social capital and were used for analysis in this study[7] (see Chapters six and seven). Three of the eight dimensions (trust, social cohesion and sense of community) relate to the cognitive measures of social capital (Harpham et al. 2002). Four dimensions (group membership, engagement in public affairs, social support and community networks) relate to structural social capital, and one relates to Coleman's (1988) definition of family social capital. The other three, which I decided not to use in this study—neighbourhood problems, workplace social capital, and healthcare social capital—relate to problem-solving by neighbourhoods and social capital in workplaces and healthcare (McKenzie and Harpham 2006: 44-47), but they are not highly relevant to my study since I wanted to use a

[7] In this study, eight of these eleven dimensions are for analysis. However, one of dimensions (i.e. family social capital) is brought into the other seven dimensions for analysis because of the similarity in their content.

compositional approach (characteristics of individuals) to measure the social capital and to explore the different aspects that middle-aged men control 'individually'.

In terms of the cognitive measure of social capital, researchers have measured people's trust and attitudes towards other community members. Based on existing research on social capital (Veenstra 2005, Desai et al. 2005, Ziersch et al. 2005, Pollack and von dem Kneseback 2004, Lindstrom 2004), De Silva concludes that "trust" can be measured as "generalized (thin) trust", "trust in institutions (such as politicians, community leaders, government and so on)", "thick trust" (such as trusting people in specific tasks), and "security of employment contract[s]" (2006: 46). In addition, social cohesion can be defined as "social harmony", such as "getting along with neighbours, close neighbourhood, people know each other, degree to which neighbours are aware and supportive of actions" (De Silva. 2006: 46, Stevenson 1998, Van der Linden et al. 2003, Drukker et al. 2004, 2003, Steptoe and Feldman 2001). Lastly, in terms of a sense of community, the dimensions usually measured are "feeling at home in neighbourhood, rating community as a place to live, neighbourhood attachment, and community integration" (De Silva. 2006: 46, Caughy et al. 2003, Greiner et al. 2004, Saluja et al. 2003, Pevalin 2004, Pevalin and Rose 2003, O'Brien et al. 1996).

For the dimension of structural social capital, the associational activity and the extent of networks within the community are the main focus. The main indicators are usually group membership, engagement in public affairs, social support, and community networks. In terms of group membership, "participation in voluntary or local organisation (especially frequency measured occasionally)" is measured (De Silva 2006: 45, Veenstra 2005, Desai et al. 2005, Ziersch et al. 2005, Pollack and von dem Kneseback 2004, Lindstrom 2004). Engagement in public affairs is defined as "citizenship—involvement in local civic action", and "informal social control—willingness to intervene in hypothetical neighbourhood-threatening situations" (De Silva 2006: 45, Greiner et al. 2004, Saluja et al. 2003, Pevalin and Rose 2003, O'Brien et al. 1996). In addition to these, social support is the "actual social support" which means "the extent of help received from neighbours for different needs", "the perceptions of social support" which means "neighbours willing to help in theoretical situations", and "reciprocity" (De Silva 2006: 45, Stevenson 1998, Van der Linden et al. 2003, Drukker et al. 2003, 2004, Steptoe and Feldman 2001). Finally, community networks include informal social contacts with neighbours, bridging social ties with people with different backgrounds, connections with friends and family (De Silva 2006, Sundquist et al. 2004, Ziersch and Baum 2004).

In relation to family social capital, measurement includes "family structure, such as single-parent family, number of children" and "family characteristics, such as work patterns of mother, emotional support from parents to children" (De Silva 2006: 46, Runyan et al. 1998, Parcel and Menaghan 1993, Furstenbery and Hughes 1995).

For this study, I designed my own questions to measure social capital. These questions covered perceptions of trust, social cohesion, sense of community, group membership, engagement in public affairs, social support, community networks and family social capital. I designed my own questions for two reasons. First, the existing scales of social capital that I mentioned earlier, such as the Lubben Social Network Scale (Lubben 1988), the Social Network Index (Cohen et al. 1997), the Multidimensional Scale of Perceived Social Support (Zimet et al. 1988) and the Social Capital Assessment Tool (SOCAT) (Krishna and Shrader 1999)], do not include all aspects of social capital that I particularly wanted to measure - (such as trust, social cohesion, sense of community, group membership, engagement in public affairs, social support, community networks and family social capital). Second, some scales (such as the Social Capital Assessment Tool (SOCAT) (Krishna and Shrader 1999) include both community and individual level measures and have been applied in rural communities. However, in my study, only social capital at an individual

level was measured. Also, Tin Shui Wai is a relatively new urban area in Hong Kong. A tool designed for measuring social capital in rural communities was not therefore suitable. My questions drew on four existing scales: the Lubben Social Network Scale, Social Network Index, Multidimensional Scale of Perceived Social Support, and Social Capital Assessment Tool (SOCAT).

The scale used in this study was designed as a self-report measure. It contained 16 items related to social capital. However, only 14 items were used for scoring and two questions (i.e. item 1 and item 5) were for guiding the respondents to skip the questions that were not relevant to them. The scale was scored by adding each of the 14 items with 25 questions in total[8] to measure seven areas, as follows:

- items 2, 3, 4, 6 and 7 measured the level of social support
- items 8 and 9 measured the level of group membership
- item 10 measured the level of engagement in public affairs
- items 11 and 12 measured the level of trust
- items 13 and 14 measured the level of a sense of community

[8] 14 items included 25 questions since some items contained more than one question, for example, items 10, 12, 15 and 16 contained 3, 4, 4, and 4 questions respectively.

- item 15 measured the level of community networks
- item 16 measured the level of social cohesion.

The method of scoring is set out in Table 3.1.

Items	Scoring
2, 6, 9, 11, 12, 13, 14, 15, 16 (four-point scales)	0–3
3,4,7,8,10 (two-point scales)	0 or 3

Table 3. 1: The method of scoring of the self-designed scale

In terms of the reliability of the self-designed scale, the item-total correlation of each question was between .459 and .895. In addition, the Cronbach's alpha of this self-designed scale was .802. The Cronbach's alpha of each area is given in Table 3.2.

Measurement area	Number of questions and related Cronbach's alpha
Social support	5 questions, .700
Group membership	2 questions, .595
Engagement in public affairs	3 questions, .719
Trust	5 questions, .726
A sense of community	2 questions, .686
Community networks	4 questions, .459
Social cohesion	4 questions, .895
Overall: Social capital	25 questions. 802

Table 3. 2: Cronbach's alpha of the self-designed scale

Various assessments of the validity of this self-designed scale were carried out using SPSS.

1. Face validity: The whole scale contained seven areas with 14 items that were designed based on existing professional scales of social capital.

2. Construct validity: As well as drawing on existing studies of social capital, the questions were based on cultural features of Hong Kong society, for example the type of institutions (such as school, government departments and NGOs) from which Hong Kong people mostly seek help. Furthermore, apart from the Pearson correlation of "trust" toward the areas of "group membership", "engagement in public affairs" and "social cohesion", the Pearson correlation among the seven areas was significant between .128 and .459. This not only showed convergent validity, but also implied that the dimensions of each area were related and consistent. The non-significant correlations between "trust" and the areas of "group membership", "engagement in public affairs" and "social cohesion" might be due to the fact that there were many "unusual" incidents that occurred with the police force during the research period. These included a policeman raping many women inside the police station, and police using private cars to stop illegal car racing without the agreement of the owners of the private cars. Incidents like these might have affected the trust of respondents

towards the police force (Q12.2) and thus might have affected the validity of the questions.

3. Structure validity: Apart from conducting a reliability test, factor analysis was also conducted to examine the internal validity of the scale. The 14 items were subjected to principal component analysis (PCA). The suitability of performing PCA was assessed by SPSS before carrying it out. The results of Kaiser-Meyer-Olkin (KMO) and Bartlett's tests are shown in Table 3.3. The KMO value of each of the seven areas was from 0.526 to 0.784. These values were between 0.5 and 0.7, and between 0.7 and 0.8 which are mediocre and good respectively (Kaiser 1974) and all the P values of Bartlett's test are smaller than 0.001. The results indicated that the database was suitable for factor analysis. PAC revealed the presence of seven areas with eigenvalues exceeding 1, explaining 22.1%, 8.2%, 5.5%, 4.9%, 4.4%, 3.9%, and 3.5% of the variance respectively, and a total of about 52.5%.

Measurement area	KMO value	X^2 of Bartlett's test	P
Social support	0.668	1502.089	<0.001
Group membership	0.588	279.7728	<0.001
Engagement in public affairs	0.606	81.300	<0.001
Trust	0.763	480.082	<0.001
A sense of community	0.566	128.922	<0.001
Community networks	0.526	158.354	<0.001
Social cohesion	0.784	976.723	<0.001
Overall: Social capital	0.687	4758.638	<0.001

Table 3. 3: Kaiser-Meyer-Olkin and Bartlett's test

Nevertheless, because of limited resources, inter-rater reliability and test-retest reliability were not carried out in this study.

Measuring mental health and alcohol use

In general, instruments for measuring mental illness in community settings can be divided into two types: dimensional and diagnostic. Dimensional instruments, which are also called screening instruments or symptom inventories, are designed for interviewers to employ in research contexts to provide information about an individual's relative symptom level rather than a discrete diagnosis and may, depending on their content, assess general mental health or specific symptom areas such as depression. These instruments include the General Health Questionnaire (GHQ) (Goldberg 1978), the Hopkins Symptom Checklist (HSCL) (Parloff et al. 1954), the Depressive Scale (CES-D) (Center for Epidemiologic Studies Short Depression Scale) (Radloff 1977), Beck's Depression Inventory (BDI) (Beck et al., 1961), Hopkins' Symptom Check List (HSCL) (Derogatis et al. 1974), and the Symptom Check List (SCL-90) (Derogatis and Cleary 1977) etc. They can be fully structured for lay interviews, semi-structured for clinician interviews, or used as a self-administered questionnaire (Switzer, Dew, and Bromet 1999; Widiger and Samuel 2005).

On the other hand, there are diagnostic instruments or schedules, which are used by clinicians for making diagnostic judgments (such as Present State Examination (PSE)) or for both diagnostic judgments by clinicians and for epidemiological research (such as the Diagnostic Interview Schedule (DIS) and the Structured Clinical Interview for the DSM-III-R (SCID)). These instruments are based very closely on the specific symptoms described by the some version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) or of the ICD-10-CM (International Classification of Diseases-10-Clinical Modification). One of the main purposes for developing diagnostic instruments is to allow non-clinicians to do structured or semi-structured interviews in which individuals can be categorized into a set of dichotomous outcomes (e.g. whether they meet the criteria for major depression or not). This is different from the dimensional instruments which place individuals along a continuum of symptom severity (e.g. more or less depressed) (Switzer, Dew and Bromet 1999, Widiger and Samuel 2005, Busfield 2011).

In my study, as indicated above, I used the Hospital Anxiety and Depression Scale (HADS), a dimensional instrument to measure the mental health of respondents. I chose this instrument because it has been widely used and validated in adult populations (Mykletun et al. 2001; Wang et al. 2006; Arving et al. 2008). In addition, depression and anxiety

are important in sociological research on mental health since they are the most prevalent disorders (especially for adult women). HADS, which contains 14 questions, is a self-assessment scale. Responses to each item are indicated on a four-level response scale based on the frequency symptoms have been experienced in the past week, from zero (none of the time) to three (most of the time). Seven questions are intended to measure the level of anxiety and depression respectively. Thus, the HADS score for each person ranges from 0 to 21 points, where zero means experiencing anxiety and depression none of the time through to 21, which means symptoms are experienced all of the time. The scores are then grouped according to the criteria developed by Zigmond and Snaith (1983) into three levels of anxiety and depression: normal (0–7); borderline abnormal (8–10); and abnormal (11–21). The last category is intended to represent the portion of the population previously found to meet diagnostic criteria for clinical depression and anxiety requiring professional help. The scale was designed to provide a simple yet reliable tool for use in medical practice. Initially, as the title indicates, it was only considered valid in a hospital setting. However, many studies have confirmed that the scale is also valid in community settings and in primary care medical practice (Zigmond and Snaith 1983). Further validation studies of the Chinese language translations of the HADS have been undertaken (Leung et al. 1993).

I also, as noted above, used an instrument to probe alcohol abuse: the Alcohol Use Disorders Identification Test (AUDIT). I wanted to include an instrument measuring alcohol use since substance-related disorders (such as alcohol dependence) are very prevalent, especially among men, and seem to provide a key way in which men handle their problems and difficulties (Adinoff et al. 2017). Many sociologists have a special interest in this subset of disorders (Grant and Weissman 2007; Eaton et al. 2012). I also chose this instrument because it is among the most frequently used in the study of alcohol abuse. AUDIT, a ten-item screening instrument developed in a WHO collaborative study (Saunders et al. 1993), is designed to screen for a range of drinking problems (especially information about hazardous, harmful use, abuse and dependence). The AUDIT is scored by summing up all 10 items. Items 1 to 8 and items 9 to10 are scored on a 0–4 scale and a 0, 2 and 4 scale respectively. This is because items 1 to 8 were designed as five-point scales (i.e. 0, 1, 2, 3, 4) and items 9 to 10 were designed as a three-point scale (i.e. 0, 2, 4) and the full score for each item (i.e. four score for 1 to 10 items) can ensure the scoring for all items is consistent. A score of eight or above indicates the presence of alcohol problems (harmful or hazardous drinking). A score of 13 or more indicates alcohol dependence. This scale was designed as a self-report measure for use in primary health care settings and has been used in a

number of different countries (such as Australia, Kenya, Bulgaria, Norway, Mexico and the USA) and with diverse cultural groups (Dawe et al. 2002).

Analysis of the quantitative and qualitative data

For the quantitative data analysis, I used SPSS. All the survey data were analysed using the following procedures. Step1: A code list was designed for the variables from all questions. Step 2: All variables were defined onto the 'variable view' sheet in SPSS. Step 3: All the data were then entered into SPSS based on the code list I had designed. Step 4: Data cleaning was performed through the method of possible-code cleaning and contingency cleaning (Babbie 2001). Step 5: The analysis, such as descriptives, correlation, linear regression models and MANOVA etc., was started based on the research questions.

For the qualitative data analysis, I did not use any software. All qualitative interview and focus group data were analysed using the following procedures. Step 1: All qualitative interview and focus group content were typed as transcripts directly and immediately into Excel files Step 2: The background information on each respondent (such as sex, age, employment status and so on) was recorded in a new column. Step 3: The various responses of different individuals to one particular question were examined and then specific words, ideas or expressions that were used frequently were listed. In addition, if some new point or comments that I

did not expect to hear emerged, these specific words, ideas or expressions were also listed. For example, in the focus group, I found unexpectedly that women named their current occupational status flexibly. In general, when they were employed, they described themselves as an employee. In contrast, when they were unemployed, they described themselves as a housewife. Step 4: Specific words, ideas or expressions, that were listed in Step 3, were organized into categories which were marked as standard terms. For example, using 'negative effects of unemployment' as a category for any related words, ideas or expressions (such as 'feel stressed' and 'don't want to make contact with relatives and friends' after unemployment). Step 5: each of the response categories were matched with themes that related to my study questions. Step 6: Possible and plausible explanations of the findings were explored through going back to the literature reviewed in the thesis.

Characteristics of the survey sample

The total number of respondents in the survey was 403. In the following paragraphs, I not only describe the characteristics of the sample in the survey, but also explore the representativeness of the samples by comparing the sample to the Tin Shui Wai population and that of Hong Kong overall (Census and Statistics Department 2011).

Age

The average age of male respondents in the survey sample was 46.9 years; for females it was 41.0 years. For both male and female respondents, the minimum age was 30 and the maximum age 60 (see Table 3.4). In Hong Kong there is no official data about the average age of middle-aged individuals in Tin Shui Wai and Hong Kong as a whole. However, the age range for all respondents' was in 30-60 – the targeted aged range for the study.

	Men (N=181)	Women (N=203)	Overall (N=384)
Average	46.9 years	41.00years	43.8 years
Max.	60 years	60 years	60 years
Min.	30 years	30 years	30 years

Table 3. 4: Age in the survey sample

Sex

Table 3.5 shows the distribution by sex: 188 (46.7%) were men; 215 (53.3%) respondents were women. Compared with the population in Tin Shui Wai, the proportion of male and female in the survey sample was quite similar to that of Tin Shui Wai (men: 45.1%; women: 54.9%).

	Research samples	Tin Shui Wai	Hong Kong
Male	188 (46.7%)	62,807 (45.1%)	1,564,891 (44.9%)
Female	215 (53.3%)	76,437 (54.9%)	1,922,898 (55.1%)
Total	403 (100%)	139,244 (100%)	3,487,789 (100%)

Table 3. 5: Sex of middle-aged population in the survey sample (aged 30-60), Tin Shui Wai (aged 30-59) and Hong Kong as a whole (aged 30-59)

Marital status

Most of survey respondents were married - 144 (78.3%) of the men and 148 (68.8%)] of the women. Thirty (16.3%) of the men and 34 (15.8%) of the women were single. Twenty-five (11.6%) of the women and 10 (5.4%) of the men were divorced (see Table 3.6). The marital status in the survey sample was slightly different from that in Tin Shui Wai and Hong Kong as a whole. For example, the percentage of married middle-aged population in Tin Shui Wai and single middle-aged population in Hong Kong as a whole was higher than the percentage of marriage respondents and single respondents respectively. However, the pattern of distribution of marital status, was to large extent similar with Tin Shui Wai and Hong Kong as a whole (see Table 3.7-3.8). For example, most of the survey respondents were married or single.

	Men	Women	Overall
Single	30 (16.3%)	34 (15.8%)	64 (16.0%)
Married	144 (78.3%)	148 (68.8%)	292 (73.2%)
Divorced	10 (5.4%)	25 (11.6%)	35 (8.8%)
Widowed	--	8 (3.7%)	8 (2.0%)
Total	184 (100%)	215 (100%)	399 (100%)

Table 3. 6: Marital status in the survey sample

	Men	Women	Overall
Single	8,236 (13.1%)	8,873 (11.6%)	17,109 (12.3%)
Married	51,449 (81.9%)	56,534 (74.0%)	107,983 (77.5%)
Divorced	2,476 (3.9%)	8,086 (10.6%)	10,544 (7.6%)
Widowed	292 (0.5%)	2,395 (3.1%)	2,687 (1.9%)
Others	354 (0.6%)	567 (0.7%)	921 (0.7%)
Total	62,807 (100%)	76,455 (100%)	139,244 (100%)

Table 3. 7: Marital status of middle-aged population aged 30-59 in Tin Shui Wai

	Men	Women	Overall
Single	314,869 (20.1%)	352,741 (18.3%)	667,610 (19.1%)
Married	1,178,581 (75.3%)	1,365,771 (71.0%)	2,544,352 (73.0%)
Divorced	55,379 (3.5%)	135,586 (7.1%)	190,965 (5.5%)
Widowed	7,653 (0.5%)	54,266 (2.8%)	61,919 (1.8%)
Others	8,409 (0.5%)	14,534 (0.8%)	22,943 (0.7%)
Total	1,564,891 (100%)	1,922,898 (100%)	3,487,789 (100%)

Table 3. 8: Marital status of middle-aged population aged 30-59 in Hong Kong as a whole

Length of time living in Hong Kong

Sixty-three (34.4%) of the male and 84 (40.4%) of the female survey sample respondents were born outside Hong Kong (mainly in Mainland China) (see Table 3.9). Compared with the population in Tin Shui Wai and Hong Kong as a whole, the proportion of male and female respondents born outside Hong Kong (mostly in Mainland China) in the survey sample was similar to that in Tin Shui Wai (men: 31.9%; women: 41.4%) and Hong Kong as a whole (men: 30.1%; women: 38.8%) (see Table 3.10-3.11). The average length of time living in Hong Kong was 36.4 and 16.8 years for men and women respectively (see Table 3.12)[9]. However, no related official district (i.e. Tin Shui Wai) and regional (i.e. Hong Kong as a whole) data were found for comparison.

[9] The difference in the average length of time living in Hong Kong between men and women was marked because most male respondents migrated to Hong Kong with their parents in the 1970s when they were children, but most female respondents migrated to Hong Kong in 1990s for marriage when they were adult. It was common in the 1990s for many women from Mainland China to marry Hong Kong men (Census and Statistics Department 1999).

	Men	Women	Overall
Lived in HK since birth	120 (65.6%)	124 (59.6%)	183 (46.8%)
Born outside H K	63 (34.4%)	84 (40.4%)	208 (53.2%)
Total	183 (100%)	208 (100%)	391 (100%)

Table 3. 9: Place of birth in the survey sample

	Men	Women	Overall
Lived in HK since birth	88,405 (68.1%)	87,191 (58.6%)	175,596 (63.0%)
Born outside H K	41,397 (31.9%)	61,534 (41.4%)	102,931 (37.0%)
Total	129,802 (100%)	148,725 (100%)	278,527 (100%)

Table 3. 10: Place of birth for the middle-aged population aged 30-59 in Yuen Long

	Men	Women	Overall
Lived in HK since birth	1,092,765 (69.9%)	1,074,825 (61.2%)	2,167,590 (65.3%)
Born outside H K	469,673 (30.1%)	680,002 (38.8%)	1,149,675 (34.7%)
Total	1,562,438 (100%)	1,754,827 (100%)	3,317,265 (100%)

Table 3. 11: Place of birth for the middle-aged population aged 30-59 in Hong Kong as a whole

	Men (N=63)	Women (N=84)	Overall (N=208)
Average	36.4 years	16.8 years	25.3 years
Max.	60 years	60 years	60 years
Min.	10 years	1 years	1 years

Table 3. 12: Length of time living in Hong Kong for those born outside Hong Kong in the survey sample

Length of time living in Tin Shui Wai

The average length of time living in Tin Shui Wai in the survey sample was 8.9 and 8.4 years for men and women respectively (see Table 3.13). There were no related official district (i.e. Tin Shui Wai) and regional (i.e. Hong Kong as a whole) data for comparison.

	Men (N=181)	Women (N=209)	Overall (N=390)
Average	8.9 years	8.4 years	8.6 years
Max.	17 years	18 years	18 years
Min.	1 years	0.3 years	0.3 year

Table 3. 13: Length of time living in Tin Shui Wai in the survey sample

Household composition

Most of the respondents in the survey sample were living with their spouse [men: 139 (76.4%); women: 146 (67.9%)], their sons and/ or daughters [men: 126 (69.2%); women: 146 (67.9%)], mothers [men: 24 (13.2%); women: 44 (20.5%)], and fathers [men: 14 (7.7%); women: 22 (19.2%)] (see Table 3.14). In Hong Kong, there are no official regional (i.e. Tin Shui Wai) and overall (Hong Kong as a whole) data for comparison. However, according to the 2011 population census in Hong Kong (Census and Statistics Department 2011), most people were living as a couple with unmarried children (Tin Shui Wai: 48.2%; Hong Kong as a whole: 39.4%), lone parent with unmarried children (Tin Shui Wai: 14.5%; Hong Kong as a whole: 11.9%), or as a couple (Tin Shui Wai: 10.1%; Hong Kong as a whole: 15.0%) (see Table 3.15). This indicates that most households were nuclear families in Hong Kong and this situation was similar to the survey sample.

	Men (N=182)	Women (N=215)	Overall (N=397)
Live alone	8 (4.4%)	4 (1.9%)	12 (3.0%)
Wife/ Husband	139 (76.4%)	146 (67.9%)	285 (71.8%)
Son (s) and/or Daughter (s)	126 (69.2%) How many: [Average: 1.88; Min.: 0; Max.:4]	146 (67.9%) How many: [Average: 1.75; Min.: 0; Max.:6]	272 (68.5%) How many: [Average: 1.81; Min.: 0; Max.:6]
Father	14 (7.7%)	22 (19.2%)	36 (9.1%)
Mother	24 (13.2%)	44 (20.5%)	68 (17.1%)
Grandfather(s) and/or Grandmother(s)	--	2 (0.9%)	2 (0.5%)
Grandson(s) and/or Granddaughter(s)	1 (0.5%)	10 (4.7%)	11 (2.8%)
Brother(s) and/or sister(s)	9 (4.9%)	24 (11.2%)	33 (8.3%)
Others	4 (2.2%)	8 (3.7%)	12 (3.0%)

Table 3. 14: Household composition in the survey sample

* Remarks: The respondents could select more than one choice and thus there was no figure in total.

	Tin Shui Wai	Hong Kong as a whole
Couple	9,395 (10.1%)	354,349 (15.0%)
Couple and unmarried children	44,642 (48.2%)	934,115 (39.4%)
Lone parent and unmarried children	13,402 (14.5%)	282,621 (11.9%)
Couple and at least one of their parents	734 (0.8%)	27,033 (1.1%)
Couple, at least one of their parents and their unmarried children	2,389 (2.6%)	88,478 (3.7%)
Relative households	7,731 (8.3%)	227,098 (9.6%)
One-person households	13,750 (14.8%)	403,994 (17.1%)
Non-relative households	649 (0.7%)	50,674 (2.1%)
Total	92,692 (100%)	2,368,362 (100%)

Table 3. 15: Household composition in Tin Shui Wai and Hong Kong as a whole

Education level

Most male [68 (37.6%)] and female [107 (50.2%)] respondents were educated to secondary school level (see Table 3.16), though the figure was

somewhat higher for women than men. The proportion of male and female respondents educated to secondary school level in the survey sample is slightly different from that for Tin Shui Wai (men: 51.1%; women: 52.9%) and Hong Kong as a whole (men: 48.3%; women: 51.2%) (see Table 3.17 and Table 3.18). In particular, the percentage of male respondents who were educated to secondary school level or beyond in the survey sample is lower than in the population in Tin Shui Wai and Hong Kong as a whole. This difference suggests, importantly, that the male respondents in the survey sample were less educated when compared with the population in Tin Shui Wai and Hong Kong overall.

	Men	Women	Overall
No education (including without formal or with informal education)	4 (2.2%)	4 (1.9%)	8 (2.0%)
Private tutorial	2 (1.1%)	2 (0.9%)	4 (1.0%)
Primary school	60 (33.1%)	44 (20.7%)	104 (26.4%)
Secondary school	68(37.6%)	107 (50.2%)	175 (44.4%)
Post-secondary or above	47 (26.0%)	56 (26.3%)	103 (26.1%)
Total	181 (100%)	213 (100%)	394 (100%)

Table 3. 16: Education level in the survey sample

	Men	Women	Overall
No education	6,370 (10.1%)	9,560 (12.5%)	15,930 (11.4%)
Private tutorial			
Primary school	15,239 (24.3%)	17,252 (22.6%)	32,491 (23.3%)
Secondary school	32,068 (51.1%)	40,394 (52.9%)	72,462 (52.0%)
Post-secondary or above	9,130 (14.5%)	9,231 (12.1%)	18,361 (13.2%)
Total	62,807 (100%)	76,437 (100%)	139,244 (100%)

Table 3. 17: Education level of middle-aged population aged 30-59 in Tin Shui Wai

	Men	Women	Overall
No education	92,393 (5.9%)	159,079 (8.3%)	251,472 (7.2%)
Private tutorial			
Primary school	252,352 (16.1%)	315,419 (16.4%)	567,771 (16.3%)
Secondary school	754,670 (48.3%)	985,221 (51.2%)	1,739,891 (49.9%)
Post-secondary or above	465,476 (29.7%)	463,179 (24.1%)	928,655 (26.6%)
Total	1,564,891 (100%)	1,922,898 (100%)	3,487,789 (100%)

Table 3. 18: Education level of middle-aged population aged 30-59 in Hong Kong

Employment status

87 (46.3%) of the male and 73 (34.0%) of the female respondents in the survey sample were in full-time employment, while 54 (28.7%) of the male and 15 (7%) of the female respondents said they were unemployed (see Table 3.19).

	Men	Women	Overall
Self-employed	4 (2.1%)	4 (1.9%)	8 (2.0%)
Full-time	87 (46.3%)	73 (34.0%)	160 (39.7%)
Part-time	8 (4.3%)	21 (9.8%)	29 (7.2%)
Retired	35 (18.6%)	2 (0.9%)	37 (9.2%)
Housewife	--	100 (46.5%)	100 (24.8%)
Unemployed	54 (28.7%)	15 (7.0%)	69 (17.1%)
Total	188 (100%)	215 (100%)	403 (100%)

Table 3. 19: Employment status in the survey sample

There are no official data about the employment status of individuals in Tin Shui Wai. There are only data related to the 18 districts of Hong Kong. Therefore, the comparison is based only on the data for Hong Kong overall and the Yuen Long District to reflect the Tin Shui Wai situation.

In 2001, the unemployment rate for all adults aged 15 or over in Yuen Long was 8.4%, while that in Hong Kong it was 6.9%. In 2009 when unemployment was falling across Hong Kong, the unemployment rate of Yuen Long was 6.8%, while that in Hong Kong dropped to 5.4%. Among people aged 40-59, the age group, which is the closest to my study focuses, the unemployment rate was 4.1% in January-March 2010 in Hong Kong. For men in Hong Kong aged 40-59 the unemployment rate was higher (4.9%) than for women (3.2%) (Census and Statistics Department 2010). However, there are no official data about the employment status of middle-aged individuals in Tin Shui Wai and Yuen Long in this period of time. The available data do, however, suggest that the unemployment rate of my survey sample was generally higher than the situation in Yuen Long and Hong Kong as a whole. This is because I and the NGOs particularly looked for those who were unemployed. However, for the analysis of the specific relationship between unemployment and mental health, this sample size (i.e. n=54 of the men and n=15 of the women reported being unemployed) was rather small. This is also one of limitations of my study which I discuss later in this chapter.

For the unemployed respondents, the average length of time unemployed was 3.5 and 4.9 years for men and women respectively (see Table 3.20). All male and female unemployed respondents said that their

family member(s) knew they were unemployed (see Table 3.21). 62.5% and 73.3% male and female unemployed respondents said that they had not sought any help to find a job (see Table 3.22).

	Men (N=46)	Women (N=15)	Overall (N=61)
Average	3.5	4.9	3.8
Max.	10	13	13
Min.	0.4	0.5	0.4

Table 3. 20: Length of time (years) unemployed in the survey sample

	Men (N=56)	Women (N=15)	Overall (N=71)
Yes	56 (100%)	15 (100%)	71 (100%)
No	0 (0%)	0 (0%)	0 (0%)
Total	56 (100%)	15 (100%)	71 (100%)

Table 3. 21: Whether the respondent's family member(s) knows about their employment status

Did you seek help to find a job?	Men	Women	Overall
Yes	21 (37.5%)	4 (26.7%)	25 (35.2%)
No	35 (62.5%)	11 (73.3%)	46 (64.8%)
Total	56 (100%)	15 (100%)	71 (100%)

Table 3. 22: Seeking help to find a job in the survey sample

There are no comparable data for Hong Kong as a whole.

Focus groups and in-depth interviews

As noted earlier, two focus groups were conducted, involving 11 participants in total. All participants were service users in an NGO and all of them also completed the questionnaire. The average duration of each focus group was around 60 to 90 minutes.

The first focus group consisted of six women. The age range of this group was from 38 to 49. All the women were full-time housewives, but all

of them were at the time looking for a part-time or full-time job. All of them had between one and three children.

The second focus group consisted of five men. In my initial plan, I had planned to recruit six men as participants. However, one of participants was absent because of a personal reason. The age range of this group was from 36 to 60. Four of them were unemployed and had been looking for full-time employment for a long time. One of the five participants had retired after having been unemployed since 2005. The youngest participant (36 years old) was single and suffered from a permanent disability. The other members of this focus group were married and had one to three children.

For the in-depth interviews, ten people were interviewed, five men and five women. The interviewees were service users in NGOs and all of them also completed the questionnaire. Each interview lasted about one hour. The demographic characteristics of the male and female interviewees in the in-depth interviews are shown in Table 3.23.

	Men (N=5)	Women (N=5)
Age range	31-60	38-55
Employment status	Employed (Full-time): 3 Employed (Part-time): 1 Unemployed: 1 Retired: 0	Employed (Full-time): 1 Employed (Part-time): 0 Unemployed: 1 Retired: 1 Housewife: 2
Marital status	Married: 4 (two have two to three children) Single: 1 Divorced: 0	Married: 4 (two have two to three children and one has one child) Single: 1 Divorced: 1

Table 3. 23: Demographic characteristics of male and female interviewees

Difficulties encountered and limitations of the study

The most difficult aspect of the study was the recruitment of non-service users as respondents to talk about their mental and unemployment status and their feelings about their status. To find non-social service users to participate, I approached people in public parks and bus stations. I would first tell them I was a researcher and conducting a study about the relationship between mental health and social capital among middle-aged people who are unemployed and are becoming isolated socially in Tin Shui Wai. If they were willing to answer the questions, I showed them the "Participant Information Sheet" and explained in detail the content of the research. Of course, many residents refused my invitation or left as soon as I introduced myself. It took several attempts to find willing participants. If a respondent was willing to be interviewed, I would ask him or her to introduce his or her friends, family members and relatives to me as possible respondents. This snowballing method was an effective way to

recruit further respondents. However, the limitation of this method was that the background of respondents might be similar. For this reason, I mostly encouraged the respondents to introduce their friends as possible next respondents instead of their family members and relatives, though friends are likely to be of a similar social status.

A second difficulty I encountered was how best to encourage the respondents to share information about their personal life, such as their mental health and unemployment status, and their feelings about their status. To encourage respondents to say more, I would first talk with them about their general view of the community and its residents. I would also tell them I was a student and that I would like to know more about the difficulties encountered by middle-aged people. Using these strategies I found that most respondents were willing to talk about their personal experiences.

A final and very important difficulty was the limited number of respondents in the focus groups, the in-depth interviews and completed questionnaires in this study, and in particular the small number of unemployed men who were interviewed (there were several in the men's focus group). This was due largely to my limited resources. As explained before, only three NGOs were willing to help me to collect data and invite their service users to participate in focus groups and individual interviews.

With limited manpower, they tried their best to invite their service users to participate in this study but were not able to find many volunteers. The total number of individual interviews was ten and there were only two focus groups with eleven people in total. In particular, the sample of unemployed middle-aged men (N=1 in individual interview; N=5 in focus group) and women (N=1 in individual interview; N=0 in focus group) was small. For the quantitative research, the total number of valid questionnaires was 403. In particular, as I have noted before, the sample of unemployed middle-aged men (N=54, 28.7% of the men) and women (N=15, 7% of the women) was small. This limited number of respondents and completed questionnaires affected the representativeness of the study since the analysis of the relationship between unemployment and mental health draws on a small sub-sample.

However, I would argue that this study can still provide a picture of the status of social capital and mental health between male and female middle-aged persons. First, I invited different kinds of residents to participate in the study, including both employed and unemployed people, and social service and non-social service users. For example, the respondents mainly came from existing social welfare service centres and from the local area. Different participant voices were thus included. Second, as I said earlier in this chapter, some of survey respondents were

recruited by me in the community. Apart from asking them to respond to the questions in the questionnaire, I also spoke more qualitatively with the male and female respondents to ensure that I could understand their viewpoint and situation in more detail, and this further questioning generated useful data and reflect the situation of male and female respondents, including those who were unemployed. In general, their viewpoints and situation were similar to the male and female respondents in the focus groups and in-depth interviews. Third, there is the interesting finding, discussed in detail in Chapter five, that women name their current occupational status flexibly. In general, when they are employed, they describe themselves as an employee. In contrast, when they are unemployed, they describe themselves as a housewife. For this reason, I also analysed qualitatively the information collected from housewife respondents in the focus group (N=6) and in-depth interviews (N=2), who self-defined as housewife, but actually made it clear that they regarded themselves as unemployed and would choose to have a job were one available, to reflect the situation of unemployed female respondents.

In addition, for the unemployed male respondents, apart from speaking more qualitatively with them in survey, as I have already mentioned, I also conducted a follow-up study with two unemployed men, who still participated in activities in my former work organization. They

were invited by the staff to take part in my follow-up study, one year after the initial study since I wanted to understand any changes in their lives that reflected the situation of unemployed male respondents. This involved a face-to-face discussion. The conversation was informal and was not structured (questions were not designed in advance), although I had thought about the issues that I wanted to raise.

In the next chapter, I turn to provide a general description of the fieldwork location and target group, including the historical development of the region, its population and community characteristics and its current and future development.

Chapter 4

Description of the fieldwork site and samples

My fieldwork location, Tin Shui Wai, was in the north-western part of the New Territories, Hong Kong. Tin Shui Wai has been developed as what was officially described as a new town since the 1980s. There are 18 districts in Hong Kong; Tin Shui Wai is part of the Yuen Long District.[10] The total area of Tin Shui Wai is 488 hectares. (See Figure 1 below for a map of Tin Shui Wai, Yuen Long)

[10] Yuen Long is situated in the northwestern of New Territories, Hong Kong and covers Ping Shan Heung, Ha Tsuen Heung, Kam Tin Heung, San Tin Heung, Shap Pat Heung, Yuen Long Town, and Tin Shui Wai.

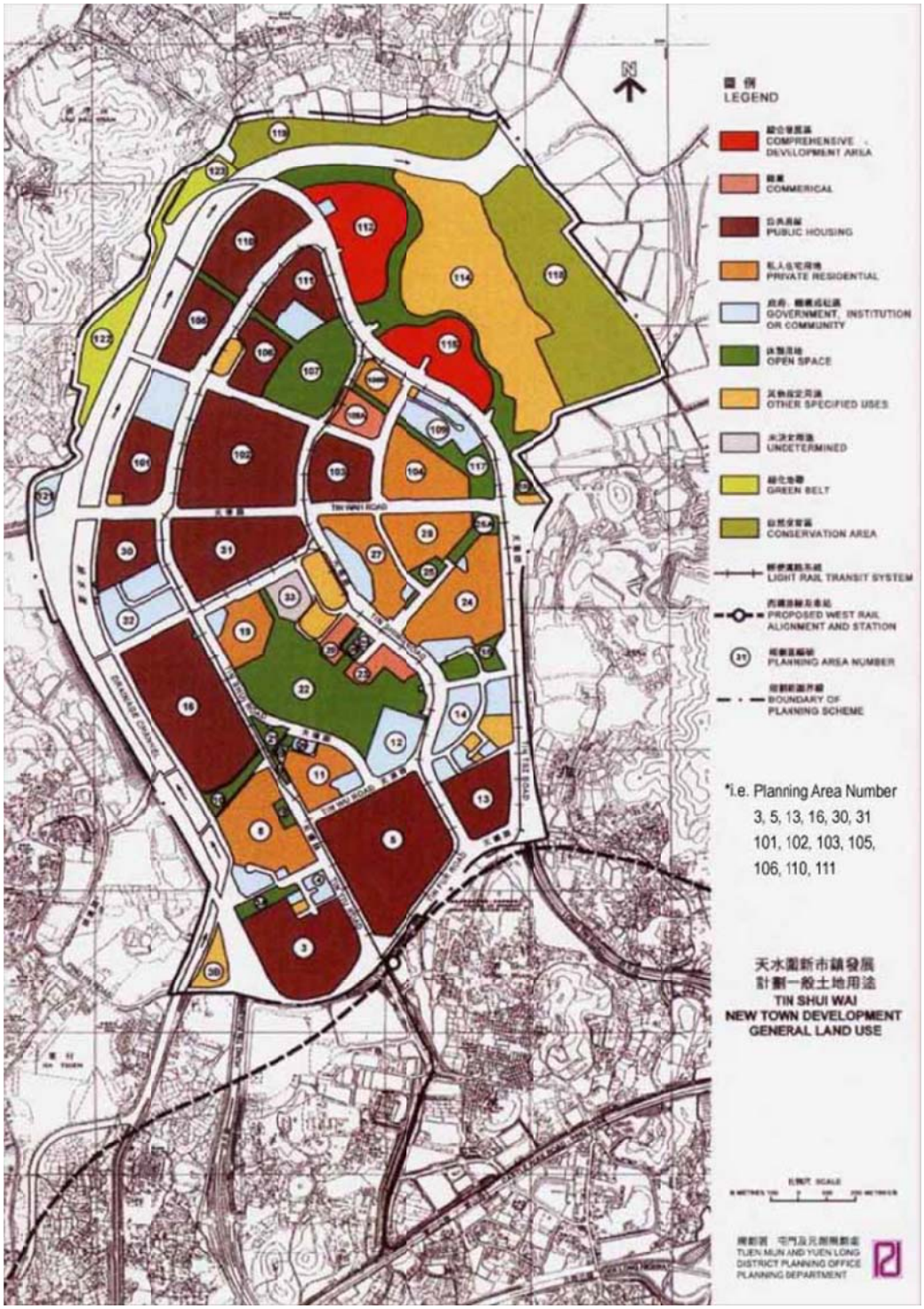

Figure 1: A map of Tin Shui Wai, Yuen Long, Hong Kong

The historical development of Tin Shui Wai

In the 1980s, Tin Shui Wai was planned to be developed as a new town for residential use with private and public housing to help to meet the needs of rapid population growth in Hong Kong. Before the plan for its development as a new town, Tin Shui Wai did not exist. The area was a fishpond area, which was reclaimed for the development of Tin Shui Wai New Town.

In the late 1970s, the Tin Shui Wai new town development land was owned by private property companies: 51% by China Resource and 49% by Cheung Kong Holdings. In the early 1980s, the British Colonial Government announced its purchase of the rights to the development of Tin Shui Wai from these companies to solve the problem of rapid population growth and the private property companies made a significant profit on the sale. Later in the 1980s, the British Colonial Government started building the new town and allowed private company development as well.

In 1992 the first public housing estate, called Tin Yiu Estate, was completed. From 1991 to 1998, much private housing owned by Cheung Kong Holdings was built and sold under government-planned land use. Transportation (bus and light rail only) linking Tin Shui Wai and the urban

areas was finished in early 1998. The development of the southern part of Tin Shui Wai was also completed at this time.

In 1998, when the development of the northern part of Tin Shui Wai was taking place, the Asian financial crisis occurred. In Hong Kong many private housing projects ceased, including in Tin Shui Wai. To prevent a continuing decline in house prices in Hong Kong as a whole, the Housing Authority accepted the Hong Kong Special Administrative Region (HKSAR) government's recommendation for the long-term cessation of construction and sale of home ownership scheme flats[11] from 2003 onwards. All home ownership scheme flats thus became public housing for low income families, owned by the HKSAR government. The HKSAR government then invited low-income families[12] to apply for the public flats

[11] The Home Ownership Scheme (HOS) is designed to assist residents to buy their own home. HOS flats are subsidized public housing, and the buying, selling and mortgage of these flats is subject to certain restrictions.

[12] Most of these low income families included new immigrant family members from Mainland China, usually the mother or wife of the applicant. In Hong Kong, many Hong Kong males marry mainland Chinese women. After marriage, the wife and children born in Mainland China can apply for a One-way Permit (OWP) to enter Hong Kong for settlement. However, to prevent a large number of Mainland women and children from entering Hong Kong in a short period of time, "the daily quota is 150 with priority given to eligible children and spouses whose father and husband is a Hong Kong resident whereby 1) a daily sub-quota of 60 children of all ages who are eligible for right of abode in Hong Kong under Article 24(2)(3) of the Basic Law; 2) a sub-quota of 30 for long-separated spouses; 3) an unspecified sub-quota of 60 for other OWP applicants allocated to the following categories of persons: separated spouses irrespective of the length of separation, dependent children coming to Hong Kong to join their relatives,

in Tin Shui Wai, giving them a fast-pass to secure them quickly.[13] At the same time, the HKSAR government introduced a policy which specified that at least 80,000 new houses (including public and private housing) be built each year, so that 70% of the Hong Kong population could have their own flats within 10 years. This not only led to a poorly balanced distribution of public and private housing, but also meant that the height and density of housing in the northern part of Tin Shui Wai would be greater than in the southern part (see photos E1 and E2) (Chow and Tsang 2004). For example, there are only five public estates of 26 blocks and fewer than 30 stories per block in the southern part, but eight public estates of 68 blocks and more than 30 stories per block in the northern. As a result, in the northern part of Tin Shui Wai, most residents, who are from low-income groups with or without new immigrant family member(s), are now living in crowded public housing (see Photo E2). For example, in Tin Shui Wai, amongst the 90,000 households, nearly 60% live in public

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persons coming to Hong Kong to take care of their dependent parents, dependent elderly people coming to Hong Kong to join their relatives and those entering Hong Kong for inheritance of property" (Immigrant Department 2016)

[13] The Hong Kong Housing Authority (HKHA) introduced an Express Flat Allocation Scheme (EFAS) for Public Rental Housing (PRH) applicants to have a chance to be allocated PRH units more quickly. The scheme's operation is dependent on the availability of housing resources. Flats included for selection are less desirable. For example, some flats may have involved in unpleasant incidents [such as suicide], may be in lower floor level, or may be relatively poor internal layout (such as small toilet).

housing. Compared with the increasing population who are new immigrants[14] in Hong Kong (from 11.5% in 2006 to 12.2% in 2011), the percentage of new immigrants in Tin Shui Wai decreased from 14.1% in 2006 to 9.5% in 2011. This was mainly because 1) many residents, who were new immigrants in 1990s and 2000s, became permanent residents[15] in Hong Kong in 2010s; 2) most Tin Shui Wai residents live in public housing, most of which is occupied by long-term residents who seldom leave the area. Thus population movement generally, and of new immigrants (including Chinese and non-Chinese) in particular, has been relatively lower in the Tin Shui Wai population than in Hong Kong overall now (Census and Statistics Department 2006a, 2011). Compared with the increasing population who are non-Chinese in Hong Kong, which grew from 5% in 2006 to 6.4% in 2011, the percentage of non-Chinese in Tin Shui Wai is relatively small and only increased slowly (from 1.9% in 2006 to 2.7% in 2011). This was mainly because traditionally most non-Chinese live in certain districts in Hong Kong. They seldom move to other districts. For

[14] The definition of a 'new immigrant' is a person who has been living in Hong Kong for less than seven years. Only a person who has lived in Hong Kong for more than seven years is eligible to become a permanent Hong Kong citizen.

[15] If new immigrants have ordinarily resided in Hong Kong for a continuous period of not less than seven years, they will become permanent residents. (Source: http://www.immd.gov.hk/eng/services/right-of-abode-in-hksar/apply.html#coe accessed on 15 May 2017.)

example, people from South Asia, such as those from India, Pakistan and Nepal, traditionally live in Sham Shui Po, Kung Tang etc., Europeans and Americans live in southern Hong Kong Island, and Japanese live in western Hong Kong Island (Census and Statistics Department 2006a, 2011).

Photo E1 The high density urban landscape of Tin Shui Wai

Photo E2 Crowded high density living conditions in Tin Shui Wai

As the southern part of Tin Shui Wai was developed at an earlier stage than the northern, its appearance is comparatively less congested—it has a park, a sports ground, and areas of commercial activities etc. Public and social amenities include a small library, an indoor recreation centre and some shopping centres. By contrast, the northern part of Tin Shui Wai was developed later and has been affected to a greater extent by the change in housing policy in the 1990s. Public or recreational facilities such as playgrounds are rare, and there are no libraries, football fields, or swimming pools. This has led to a very unbalanced distribution of land use in the northern part of Tin Shui Wai (Chow and Tsang 2004).

Lastly, because Tin Shui Wai was developed as a residential zone, job opportunities are rare inside the region. This contributes to a relatively high unemployment rate. The detailed situation about unemployment will be described later in this chapter.

Population and community characteristics

In the section that follows a provide a range of data about the population and community characteristics of residents of Tin Shui Wai comparing them with that of Hong Kong as a whole. The data differs from that given in Chapter three: there the focus was on the characteristics of the survey sample in comparison with those of a similar age in Tin Shui Wai and Hong Kong overall in order to make some assessment of the representativeness of the sample. Here the aim is to outline the characteristics of those living in Tin Shui Wai when compared with Hong Kong as a whole so all persons are included.

Population

According to the 2011 population census of Hong Kong (Census and Statistics Department 2011), the total size of the population was 7,071,576 persons. There were 578,529 people living in Yuen Long District as a whole and 287,901 in Tin Shui Wai. In other words, the Tin Shui Wai

population is about 4% of the total population of Hong Kong and 49.8% of the total population of Yuen Long District.

Age

Table 4.1 shows the age distribution in Hong Kong overall and in Tin Shui Wai. The average age in Hong Kong is 41.7 years. Hong Kong is now facing the problem of an ageing population. About 49.3% of the population is 30–59 years old. At the same time, the population of children (0–14 years old, 11.6%) is less than the population of the elderly (60 years old or above, 19.1%) (see Table 4.1).

In Tin Shui Wai, the population is a little younger than in Hong Kong's overall population. The average age is 38.6 years in Tin Shui Wai. This difference is due to two factors: 1) many young residents, who are permanent resident in Hong Kong now, but were not born in Hong Kong and migrated to Hong Kong in the 1990s and 2000s, live in the region; 2) compared with local Hong Kong people who were born in Hong Kong, most of those young residents are more willing to have a child soon after marrying.[16] In 2011 14.5% of the Tin Shui Wai population were children (0–

[16] In Hong Kong as a whole, most local residents are not willing to have a child. The total fertility rate (TFR) rate for 2006 was 0.966. Because of the low TFR, the HKSAR government has been encouraging Hong Kong residents to have babies. For example, in 2007 during a public speech, Chief Executive Donald Tsang Yam

14) compared with 11.6% in Hong Kong as a whole. Also, compared with the Hong Kong population in general, the population aged 30–59 in Tin Shui Wai (48.4%) was a little lower (49.3%) (see Table 4.1).

Age	Hong Kong		Tin Shui Wai	
	N	%	N	%
0-14	823,560	11.6%	41,694	14.5%
15-29	1,409,349	19.9%	72,869	25.3%
30-44	1,685,290	23.8%	63,339	22.0%
45-59	1,802,499	25.5%	75,905	26.4%
60-74	874,306	12.4%	24,917	8.7%
75 or above	476,572	6.7%	9,177	3.2%
Total	7,071,576	100%	287,901	100%

Table 4. 1: Age distribution of the Hong Kong population and of Tin Shui Wai
Source: Census and Statistics Department (2011)

Sex

In 2011, the total number of Hong Kong males was less than that of Hong Kong females, a somewhat different pattern from elsewhere in Asia-Pacific region where males outnumber females.[17] In Hong Kong overall the sex ratio is 87.6 males: 100 females; 47.4% and 51.1% respectively are males and females aged 30–59 (Census and Statistics Department 2011) (see Table 4.2 and Table 4.3). This higher proportion of females is mainly because most of the foreign domestic helpers included in the Hong Kong

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Kuen encouraged each Hong Kong couple to have three children [source: *Sing Tao Daily* (newspaper). "Chief Executive Donald Tsang Yam Kuen encouraged each family to have 3 children: total fertility rate in Hong Kong drops to 0.966 which is the lowest in the world" 22 February 2007 (in Chinese)].

[17] On average, the sex ratio is 110 males: 100 females in the Asia-Pacific region (United Nations, 2010).

population are women. In addition, Hong Kong is an ageing city, and men's average life expectancy is less than women's.

Age	Hong Kong		Tin Shui Wai	
	N	%	N	%
0-14	426,248	12.9%	21,612	15.6%
15-29	668,473	20.2%	36,177	26.2%
30-44	702,900	21.3%	25,470	18.4%
45-59	861,991	26.1%	37,337	27.0%
60-74	443,402	13.4%	13,562	9.8%
75 or above	200,001	6.1%	3,975	2.9%
Total	3,303,015	100%	138,133	100%

Table 4. 2: Age distribution of all men in Hong Kong and Tin Shui Wai
Source: Census and Statistics Department (2011)

Age	Hong Kong		Tin Shui Wai	
	N	%	N	%
0-14	397,312	10.5%	20,082	13.4%
15-29	740,876	19.7%	36,692	24.5%
30-44	982,390	26.1%	37,869	25.3%
45-59	940,508	25.0%	38,568	25.8%
60-74	430,904	11.4%	11,355	7.6%
75 or above	276,571	7.3%	5,202	3.5%
Total	3,768,561	100%	149,768	100%

Table 4. 3: Age distribution of all women in Hong Kong and Tin Shui Wai
Source: Census and Statistics Department (2011)

In Tin Shui Wai, a similar situation also exists with more women than men. However, the uneven gender distribution is relatively smaller than in Hong Kong overall. The sex ratio is 92.2 males: 100 females (Census and Statistics Department 2011). In terms of gender differences, 45.4% and 51.1% respectively of the Tin Shui Wai population are males and females aged 30–59. Furthermore, as we might expect, the elderly population aged 60 or above in Tin Shui Wai (11.9%) is less than in Hong Kong overall

(19.1%) and both the male or female populations in this age range are higher in Hong Kong than in Tin Shui Wai (see Table 4.2 and Table 4.3.)

Marital status

Tables 4.4 to 4.6 show the marital status of the population in Hong Kong as a whole (including children) and in Tin Shui Wai.

Marital status	Hong Kong		Tin Shui Wai	
	N	%	N	%
Single	2,797,110	39.6%	125,286	43.5%
Now married	3,608,078	51.0%	139,296	48.4%
Widowed	388,331	5.5%	9,419	3.3%
Divorced	243,946	3.4%	12,571	4.4%
Separated	34,111	0.5%	1,329	0.5%
Total	7,071,576	100%	287,901	100%

Table 4. 4: Marital status of all persons in Hong Kong and Tin Shui Wai
Source: Census and Statistics Department (2011)

Marital status	Hong Kong		Tin Shui Wai	
	N	%	N	%
Single	1,390,987	42.1%	63,979	46.3%
Now married	1,760,524	53.3%	69,079	50.0%
Widowed	60,449	1.8%	1,178	0.9%
Divorced	78,160	2.4%	3,332	2.4%
Separated	12,895	0.4%	565	0.4%
Total	3,303,015	100%	138,133	100%

Table 4. 5: Marital status of all men in Hong Kong and Tin Shui Wai
Source: Census and Statistics Department (2011)

Marital status	Hong Kong		Tin Shui Wai	
	N	%	N	%
Single	1,406,123	37.3%	61,307	40.9%
Now married	1,847,554	49.0%	70,217	46.9%
Widowed	327,882	8.7%	8,241	5.5%
Divorced	165,786	4.4%	9,239	6.2%
Separated	21,216	0.6%	764	0.5%
Total	3,768,561	100%	149,768	100%

Table 4. 6: Marital status of all women in Hong Kong overall and in Tin Shui Wai
Source: Census and Statistics Department (2011)

In Hong Kong, 51% of the population is "now married" and 39.6% "never married". Men are more likely to be "now married" (53.3%) and "never married" (42.1%) than women - 49.0% for "now married" and 37.3% "never married". The above situation is also found in Tin Shui Wai. 48.4% and 43.5% population are "now married" and "never married" respectively. Analysed by gender, in Tin Shui Wai men are more likely to be "now married" (50%) and "never married" (46.3%) than women (46.9% for "now married" and 40.9% for "never married"). (See Table 4.5 to Table 4.6)

Education level

Table 4.7 shows the education levels of all persons resident in Hong Kong as a whole and specifically in Tin Shui Wai.

	Hong Kong			Tin Shui Wai		
Education level	Male	Female	Total	Male	Female	Total
No school/ Pre-primary	646,512 (19.6%)	861,383 (22.9%)	1,507,895 (21.3%)	28304 (20.5%)	33,467 (22.3%)	61,771 (21.5%)
Primary	554,018 (16.8%)	596,680 (15.8%)	1,150,698 (16.3%)	29,518 (21.4%)	28,642 (19.1%)	58,160 (20.2%)
Lower secondary	558,617 (16.9%)	592,282 (15.7%)	1,150,899 (16.3%)	28,348 (20.5%)	30,124 (20.1%)	58,472 (20.3%)
Upper secondary (including craft level)	804,850 (24.4%)	970,338 (25.7%)	1,775,188 (25.1%)	34,636 (25.1%)	38,689 (25.8%)	73,325 (25.5%)
Post-secondary – Diploma/ Certificate	136,943 (4.1%)	166,608 (4.4%)	303,551 (4.3%)	4,930 (3.6%)	5,858 (3.9%)	10,788 (3.7%)
Sub-degree course	99,733 (3%)	97,707 (2.6%)	197,440 (2.8%)	3,175 (2.3%)	2,947 (2.0%)	6,122 (2.1%)
Degree course or above	502,342 (15.2%)	483,563 (12.8%)	985,905 (13.9%)	9,222 (6.7%)	10,041 (6.7%)	19,263 (6.7%)
Total	3,303,015	3,768,561	7,071,576	138,133	149,768	287,901

Table 4. 7: Education levels in Hong Kong and Tin Shui Wai
Source: Census and Statistics Department (2011)

According to the 2011 population census in Hong Kong (Census and Statistics Department 2011), 13.9% of the population fall in the category "degree or above", while 79.0% of the population only have education up to the upper secondary level (including craft level) or below (see Table 4.7). In terms of gender differences, overall men in Hong Kong have higher education levels than women. For example, 15.2% of men and 12.8% of women have a degree or above (see Table 4.7).

In Tin Shui Wai the population is somewhat less well-educated. Only 6.7% fall in the category "degree or above" and 87.5% of are in the upper secondary level (including craft level) category or below. Further, men in Tin Shui Wai have rather similar education levels to women. For example, 6.7% of men and 6.7% of women have a "degree or above" (see Table 4.7).

It is clear however, that as we might expect education levels are increasing. This is visible if we compare the education of those aged 30 to 59 with that of young adults (20-29). The data are given in Tables 4.8 and 4.9 below.

	Young adults in Hong Kong			Middle-aged adults in Hong Kong		
Education level	Male	Female	Total	Male	Female	Total
No school/ Pre-primary	1,808 (0.4%)	4,445 (0.8%)	6,253 (0.6%)	92,393 (5.9%)	159,079 (8.3%)	251,472 (7.2%)
Primary	12,223 (2.7%)	18,221 (3.4%)	30,444 (3.1%)	252,352 (16.1%)	315,419 (16.4%)	567,771 (16.3%)
Lower secondary	49,921 (11.1%)	63,162 (11.8%)	113,083 (11.5%)	310,970 (19.9%)	369,666 (19.2%)	680,636 (19.5%)
Upper secondary (including craft level)	196,366 (43.5%)	218,333 (40.9%)	414,699 (42.1%)	443,700 (28.4%)	615,555 (32.0%)	1,059,255 (30.4%)
Post-secondary – Diploma/ Certificate	40,175 (8.9%)	50,372 (9.4%)	90,547 (9.2%)	69,506 (4.4%)	91,516 (4.8%)	161,022 (4.6%)
Sub-degree course	31,509 (7.0%)	36,445 (6.8%)	67,954 (6.9%)	60,379 (3.9%)	55,945 (2.9%)	116,324 (3.3%)
Degree course or above	119,209 (26.4%)	143,467 (26.8%)	262,676 (26.6%)	335,591 (21.4%)	315,718 (16.4%)	651,309 (18.7%)
Total	451,211	534,445	985,656	1,564,891	1,922,898	3,487,789

Table 4. 8: Education levels of middle-aged and young adults in Hong Kong
Source: Census and Statistics Department (2011)

As we would expect from the data in Table 4.8, if we look at the middle-aged population (30–59) in Hong Kong, men also have higher education levels than women (21.4% against 16.4% have a degree course or above) (see Table 4.8). However, for young adults (20–29) in Hong Kong, 26.4% and 26.8% of young men and women hold a degree or higher qualification (see Table 4.8). This indicates that the gender difference is larger for the older generation than for the younger one.

	Young adults in Tin Shui Wai			Middle-aged adults in Tin Shui Wai		
Education level	Male	Female	Total	Male	Female	Total
No school/ Pre-primary	103 (0.5%)	179 (0.8%)	282 (0.6%)	6,370 (10.1%)	9,560 (12.5%)	15,930 (11.4%)
Primary	998 (4.5%)	789 (3.4%)	1,787 (3.9%)	15,239 (24.3%)	17,252 (22.6%)	32,491 (23.3%)
Lower secondary	3,247 (14.7%)	2,777 (11.8%)	6,024 (13.2%)	15,518 (24.7%)	19,335 (25.3%)	34,853 (25.0%)
Upper secondary (including craft level)	11,566 (52.4%)	12,057 (51.4%)	23,623 (51.9%)	16,550 (26.4%)	21,059 (27.6%)	37,609 (27.0%)
Post-secondary – Diploma/ Certificate	2,041 (9.3%)	2,550 (10.9%)	4,591 (10.1%)	1,880 (3.0%)	2,277 (3.0%)	4,157 (3.0%)
Sub-degree course	1,189 (5.4%)	1,530 (6.5%)	2,719 (6.0%)	1,827 (2.9%)	1,289 (1.7%)	3,116 (2.2%)
Degree course or above	2,913 (13.2%)	3,595 (15.3%)	6,508 (14.3%)	5,423 (8.6%)	5,665 (7.4%)	11,088 (8.0%)
Total	22,057	23,477	45,534	62,807	76,437	139,244

Table 4. 9: Education levels of middle-aged and young adults in Tin Shui Wai
Source: Census and Statistics Department (2011)

For the middle-aged population (30–59) in Tin Shui Wai, 8.6% of men and 7.4% of women are in the degree or above category (see Table 4.9). For young adults (20–29) in Tin Shui Wai, again the gender difference is quite small, but women are more likely to have a degree (15.3%) than men (13.2%) This indicates that the gender difference is not large for both middle-aged and younger generations in Tin Shui Wai. However, the middle-aged adults are less well-educated than the young people (Census and Statistics Department 2011).

Income [18]

Tin Shui Wai is one of the poorest districts in Hong Kong. In 2011, 21.1% (122,070 people) of the population was living in poverty in Yuen Long, the third highest proportion of the 18 districts (Census and Statistics Department 2011). According to the 2011 population census in Hong Kong (Census and Statistics Department 2011), in Hong Kong overall, the average monthly income is around US$1410 per person.[19] In Yuen Long, the average monthly income is around US$1282 per person. Household monthly income is around US$2628 in Hong Kong and US$2307 in Yuen Long. Hence, on average, the income for individuals and households is less in Yuen Long than for the general Hong Kong population.

Furthermore, according to data from the Social Welfare Department in Hong Kong, 48% of families in Tin Shui Wai are recipients of Comprehensive Social Security Assistance (CSSA) Scheme—the social security safety net in Hong Kong - the proportion in Hong Kong as a

[18] In Hong Kong, there is an absence of official data about the average income of individuals in individual regions (including Tin Shui Wai). There is only data related to the 18 districts. Therefore, data analysis in this part will only be based on the data for the Yuen Long District to give a guide to the Tin Shui Wai situation.

[19] The exchange rate is HK$7.8: US$1 under official fixed exchange rate policy in Hong Kong.

whole is 9.5%.[20] The financial situation of the remaining 52% of families is also usually not very good. Among those who did not apply for CSSA, some are poor, yet are still not willing to apply, as they want to live by their own efforts even though their financial and living conditions are inadequate. Also, some residents have no knowledge about social welfare in Hong Kong and do not know that they can apply for CSSA.

Employment

In Chapter three, I outlined the situation in relation to employment status in Hong Kong and Yuen Long district which includes Tin Shui Wai (there are no separate data for Tin Shui Wai) and I will not repeat it in detail here. The key point is that in 2001 overall the unemployment rate in Yuen Long district was higher than in Hong Kong (8.4% against 6.9%), and when unemployment declined overall in Hong Kong in 2009, the unemployment rate in Yuen Long was still higher than in Hong Kong (6.8% against 5.4%).

Based on my working experience as a research officer for four years in Tin Shui Wai, it is clear that many middle-aged men face the problem of unemployment or underemployment due to the lack of job opportunities in residential zones. Even though there are some low-skill jobs (such as

[20] The CSSA Scheme provides a safety net for individuals or families who cannot support themselves financially in Hong Kong. It is designed to bring their income up to a prescribed level to meet their basic needs.

cleaning and security) within the region, employers mostly prefer to employ women and young people rather than middle-aged men. Employers prefer to employ the women to do cleaning jobs since because of gender stereotypes they think that the women are specialized in cleaning. Also, the employers prefer to employ young people to do security jobs since they think that the young people have more energy to do night shifts than middle-aged men. Most middle-aged men are employed temporarily when employers do not have enough staff in peak seasons, such as public holidays. Also, if residents have to go to the urban area for employment, they need to spend at least two hours each day travelling and afford expensive travel costs[21]. As a result, many less-educated men cannot afford to go outside Tin Shui Wai for work or to find a job (Headline (newspaper) 2008) (see photos E3, E4, E5 and E6) and thus they are unemployed or underemployed.

[21] The transportation cost is around US$3.80 to $5.10 per round trip. The average transportation cost for a week (six working days per week) is round US$22.8 to US$30.6. However, the average weekly salary for an individual is around US $304.5 (the monthly salary is around US$1,218 as noted earlier).

Photo E3 Bus transportation linking Tin Shui Wai with outside areas and within Tin Shui Wai

Photo E4: Light rail transportation linking Tin Shui Wai with outside areas and within Tin Shui Wai

Photo E5 Bicycle transport in Tin Shui Wai

Photo E6 Cycle parking area in Tin Shui Wai

Because middle-aged men have difficulty finding a job in Tin Shui Wai, many of them stay at home without paid work and their wives work in part-time jobs to support the household. For the most part these jobs are low-paid and low-skilled (such as cleaning work and domestic help) whether inside or outside Tin Shui Wai. The salary for such work is around US$1.90 to $2.80 per hour.[22] Under these circumstances, many couples in Tin Shui Wai experience domestic conflict. For example, some working wives are angry because they think that their husbands do not try their best to find a job (even a low-paid job). Some unemployed middle-aged men suspect that their wives have a lover because their wives always work long hours and come home late (Yip 2009). I discuss these matters more fully below.

In Tin Shui Wai, as I showed in Chapter three, a rather higher proportion of households are nuclear families (48.2%) (see Table 3.15 on page 117). The average number of family members is three persons per household (Census and Statistics Department 2011). The higher percentage of nuclear families in Tin Shu Wai suggests that family support is a little more limited. Because of its remote location, many residents live far away from their parents and relatives and find it harder to seek help from

[22] Source: Headline (newspaper). '25% Tin Shui Wai Residents are not working in a full-time job', 15 October 2008. (in Chinese).

extended family members when they face urgent problems (Chow and Tsang 2004).

Neighbourhood relationships and social support

Community relationships among residents are weak in Tin Shui Wai. This is because almost all residents have moved from other regions or are new immigrants to Hong Kong. Before moving to Tin Shui Wai, they had little knowledge of the community. As a result, they are not familiar with it, and usually do not have any established social networks with their neighbours. (Chow and Tsang 2004)

Weak community relationships generate alienation amongst the residents, especially since they seldom leave Tin Shui Wai to visit their friends and relatives because of high travel costs (Chow and Tsang 2004). Under these circumstances, many residents in Tin Shui Wai are isolated. For example, according to conversation with respondents in my in-depth interviews and survey, many middle-aged men sit in public parks without particular purpose, just waiting for people to go by, doing some exercise and/or taking a rest (see photos E7, E8, E9, E10). Even though some of them talk to others, their talk only focuses on general issues, such as daily news). Some men spend the time gambling in the public parks (photos E11 and E12). If they gamble they appear less isolated, but there is no evidence that the groups become friendship networks since they mostly leave

immediately once the gambling ends. When they have a problem, they do not usually have any network that they consider they can seek help from.

Photo E7 Men passing time in the local park

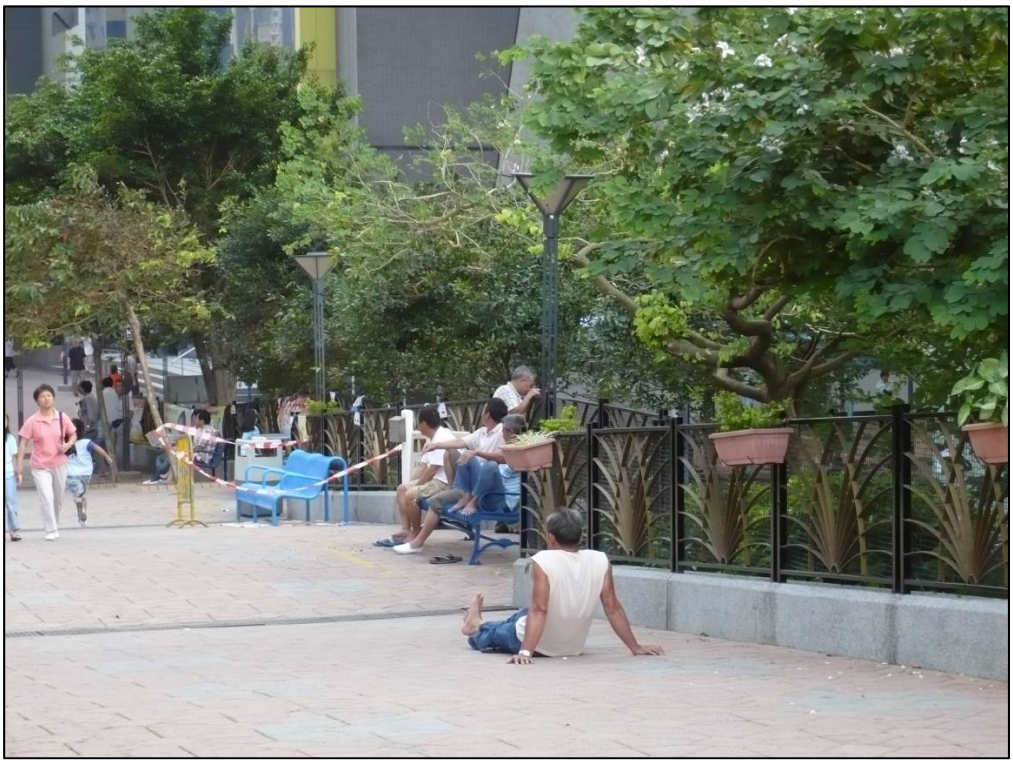

Photo E8 Men passing time in the local park

Photo E9 Men passing time in the local park

Photo E10 Men passing time in the local park

Photo E11 Men gambling in the park

Photo E12 Men gambling in the park

In Chinese society, men tend seldom to talk to others (even nuclear or extended family members, friends and colleagues) about their problems or private matters, even though they may talk to others about the general issues (such as news) which is almost certainly better than having no interaction at all. According to a study of men in Hong Kong (Hong Kong Council of Social Service 2004), only 61.2% of men seek help from their family members, friends or colleagues when they are facing a problem. At the same time, only 13.1% of men seek help by attending related activities or seminars when they are facing a problem, and only 4.2% from social workers. According to another study of men and women conducted by the Department of Health (2005), interviewees claimed that they could not count on anyone for emotional support (16.8% of men and 13.6% of women) and financial support (18.9% of men and 18.6% of women). Analysed by age, middle-aged people (52.7% of those aged 35–64) reported that they could not count on someone for emotional support when they needed help, compared with the younger (18.0% of those aged 15–34) and the older groups (39.4% of those aged 65 or above). Middle-aged people (67.0% of those aged 35-64) were also more likely to report that they could not count on someone for financial support when they needed it, than people in the younger (22.8% of those aged 15–34) and the older groups (40.2% of those aged 65 or above). This means that middle-age people

have weaker support networks than those younger or older when they face problems.

Service provision

In Tin Shui Wai, public facilities for the 287,901 population include two libraries, one health centre, one general outpatient clinic, one maternal and child health centre, four community centres, a swimming pool, a stadium, three gymnasiums, two post offices and many playgrounds within each estate (photos E13 and E14). In addition, the social services for Tin Shui Wai residents include 38 services related to family and child welfare (such as the child care centre service, extended hours child care service, integrated family service centre, neigbourhood support child care project, and small group homes for children from 4 to under 18 years of age who cannot be adequately cared for by their families for various reasons such as behavioural, emotional or relationship problems, or family crises arising from illness, death and desertion etc.). There are also five services related to social security (such as an integrated employment assistance programme for self-reliance, social security services etc.), ten services for the elderly (such as a day care centre/ unit for the elderly, a district elderly community centre, enhanced home and community care services for the elderly, a neigbourhood elderly centre etc.), as well as 34 rehabilitation and medical social services (such as a care & attention home for severely

disabled persons, a day respite service, a district support centre for persons with disabilities etc.), twenty services for young people (such as an after school care programme, an integrated children and youth service centre, district youth outreaching social work teams etc.), but no service related to community development up to September 2015[23]. Even though the government seems to provide many services and facilities in Tin Shui Wai, these public and social services are not enough to meet the community's service needs since the level of services provided is based on the proportion of population, not the composition of the population or the problems it faces (Chow and Tsang 2004). Therefore, many residents complain that the service and facilities are insufficient in Tin Shui Wai and they have to wait for long time to receive a service and/ or use facilities. This is because many residents are applying for the service and/ or using the facilities in Tin Shui Wai. For example, the bookcases are always empty in the public library. Photos E15, E16, E17 and E18 show some of the facilities available for residents.

[23] Source: http://www.swd.gov.hk/tc/index/site_pubsvc/ accessed on 18 September 2015.

Photo E13 A playground for children

Photo E14 A playground for children

Photo E15 Public services: the local branch of the library

Photo E16 Public services: An integrated family service centre

Photo E17 Public services: a local church

Photo E18 Public services: a local facilities block for providing social services

For Tin Shui Wai residents, these public and social services are not enough to meet their service needs because of the failures of town planning to take account of needs. As Chow and Tsang have argued "the poorly balanced distribution of public and private housing has very much affected the population profile in Tin Shui Wai" (2004: 9). In 2011, as noted, the total population of Tin Shui Wai was 287,901, with 58.5% and 21.8% living in public housing estates and Home Ownership Scheme Housing, respectively. Moreover the number of persons living in public housing in Tin Shui Wai (North) was 89,206, representing 86% of the total population in that area. The high proportion in public housing would not matter if there were employment opportunities in the locality or good access to jobs in Hong Kong city at a reasonable cost. Due to its remote location and high travel costs, many Tin Shui Wai residents have the impression that Tin Shui Wai is a boring and isolated community. As a result, there has been an increasing demand for public facilities and social services to meet the needs of the residents in this remote, newly developed area.

In Hong Kong, as noted earlier, the level of services provided is based on the proportion of population, not the composition of the population or the problems it faces. For example, if the population is less than 30,000 in number, no independent integrated family service centre, to support and strengthen individuals and families by delivering services that are 'child-

centred, family-focused and community-based', will be provided within the region. For this reason, there is currently no hospital in Tin Shui Wai. Instead, Tin Shui Wai residents have to spend half an hour to an hour and around US$2.60 in travel costs to go to the hospital in Yuen Long Central in an emergency. For general illness which does not require hospital care, Tin Shui Wai residents mostly go to private clinics within the community, or they may even not seek any professional help at all because private clinics are costly (see photo E19).

Photo E19 A private medical clinic, too costly for many Tin Shui Wai residents

Because of insufficient public and social services, many residents and families do not have access to the services they need in Tin Shui Wai. This leads to late intervention (Chow and Tsang 2004). An unfortunate result is

that since 2003, many family tensions, domestic violence, and spouse, child and elderly abuse cases have been reported[24] which drew the public's attention to Tin Shui Wai community. For example, in 2003, the husband of a new immigrant woman from the mainland killed his twin daughters and then committed suicide. The man had previously sought and received help from a social service organisation and a police station. In April 2004, a man killed himself after stabbing to death his 31-year-old new immigrant wife from the mainland and their two teenage daughters in their flat in Tin Shui Wai. In October 2007, a 36-year-old woman suffering from mental illness tied the hands and feet of her 12-year-old daughter and 9-year-old son, and flung them out of a window from the 24th floor flat and then jumped to her death. Her husband, who also had a history of mental illness, was at the time hospitalized with terminal cancer. After a series of reported cases, Tin Shui Wai was labelled the "City of Misery".[25]

[24] In terms of the whole situation in Hong Kong, 12.5%, 12.5% and 9.4% of child abuse cases, spouse abuse cases and elderly abuse cases are from Yuen Long District. Among 18 districts in Hong Kong, the Yuen Long District ranked 1st, 1st and 3rd for the number of child, spouse and elderly abuse cases respectively to June 2015 (Source: http://www.swd.gov.hk/vs/english/stat.html accessed on 21 November 2016).

[25] In July 2006, the Director of Social Welfare called Tin Shui Wai a "City of Misery". However, her comment was criticised because the government had done nothing to solve the social problems in Tin Shui Wai.

Tin Shui Wai now and in the future

After a series of tragedies in Tin Shui Wai, in 2005 the HKSAR government introduced many policies to increase support to residents. In the following section, I describe the major policies that have been announced by HKSAR government in policy addresses by Chief Executive or budget plans since 2005.[26]

Policy and planning, 2005-06 to 2009-10

For the five years from 2005, the HKSAR government announced different policies in the policy addresses by the Chief Executive or in budget plans. The 2005-2009 policy addresses by the Chief Executive and the 2007-2008 yearly budget of the HKSAR government also included different policies to increase support to residents of Tin Shui Wai.

In the 2005-06 policy address by the Chief Executive launched the Head Start Programme (HSP) for children under five in poor families in the four local communities of Tin Shui Wai, Tuen Mun, Sham Shui Po and Tseung Kwan O in order to try to reduce intergenerational poverty. Five maternal and child health centres in the four communities were opened

[26] In this part, only policies from policy addresses and yearly budgets will be counted since their content to a large extent reflects the main working directions and emphasis of the government in the coming years. Also, in Tin Shui Wai, many different kinds of works and projects have been proposed and started since 2004. It is difficult to count them all.

with the co-operation of nearby nurseries, kindergartens and other related institutions. The aim of the programme was to provide needy parents with health and educational activities and counselling services.

After reviewing the existing services and programmes in Hong Kong as well as international experiences, the Commission on Poverty under the HKSAR government recommended that a child development fund be set up in Hong Kong to make effective use of resources in families, the private sector, the community and government in supporting the longer-term development of children from disadvantaged backgrounds. The Legislative Council Finance Committee approved the allocation of $300 million for the establishment of the fund in 2008. This child development fund sought to encourage participating children to plan for the future and develop a saving habit, as well as encouraging savings and the development of intangible assets (such as positive attitudes, personal resilience and capacities, social networks). The child development fund allocates funds to operating organisations to run projects throughout the territory. Each project lasts for three years. By 1 September 2014, the CDF had processed four batches of applications and funded 68 projects operated by local NGOs throughout the territory.

In the 2006–07 policy address by the Chief Executive announced that more public facilities were provided in Tin Shui Wai, in order to provide a

suitably favourable environment for the development of healthy families,. The new public facilities included a library, an indoor recreation centre with an indoor heated swimming pool, a football pitch, basketball courts, more open space and a general outpatient clinic. To meet the service needs of Tin Shui Wai, the Social Welfare Department strengthened its existing integrated services by allocating resources according to the different conditions in the district, and strengthening district planning and co-ordination.

In January 2012, the Ping Shan Tin Shui Wai leisure and cultural building that had been planned opened. The new facilities provide a venue for residents in Tin Shui Wai to relax and engage in sports. However, the building is only located near, rather than in, Tin Shui Wai, and many residents (especially those in the northern part of Tin Shui Wai) complain that they still cannot afford the transport costs to use the service since the new facilities are located far away from where they live.

To strengthen its existing integrated services, the Social Welfare Department earlier co-operated with other government departments (such as the Hong Kong Housing Authority and the Education Bureau), schools, NGOs, local stakeholders and business sectors to provide services in the community. For example, with the support of schools, NGOs, local stakeholders and business sectors in the community (in providing the

venue, volunteers, and resources, for example), an after-school service is now provided for the children and families in need.

The 2007–08 policy address by the Chief Executive of stated that in order to speed developments in recent years in Tin Shui Wai, a hospital would be built to strengthen the medical services for residents. However, as the proposed hospital site is situated in an area that may contain a marble cavity which may increase the difficulty of the construction, a longer construction period has been required for completion of the foundation works than originally planned, and the hospital has started providing services in phases from early 2017 and full service will be provided stage by stage since the government has to recruit enough professional staffs (such as doctors and registered nurses), which are always in shortage in Hong Kong, to provide the service. Before completion of the new hospital, healthcare services for Tin Shui Wai residents continue to be provided by hospitals and related specialist and general outpatient clinics under the New Territories West Cluster. In the past few years, the Hospital Authority provided additional funding to this Cluster to enhance healthcare services for residents of New Territories West. However, this still does not solve the existing problems for Tin Shui Wai residents, such as long travel times and expensive travel costs for each hospital visit.

In terms of the 2007–08 yearly budget of the HKSAR government, to meet the demand for medical services in Tin Shui Wai, "an integrated community centre for mental wellness", "a two-year pilot scheme whereby [a] chronically ill person can be provided with private clinic services for the same fee as that charged by clinics under the Hospital Authority", "a general out-patient clinic in Tin Shui Wai North", and "a hospital" would be provided (HKSAR 2008).

In 2013, the integrated service started providing a general outpatient clinic, a family medicine integrated clinic, visiting services by community nurses and community psychiatric nurses, and an allied health clinic offering physiotherapy service, occupational therapy services and services provided by registered dieticians.

To assist economic development, land owned by the government for long-term commercial use or a hotel would be developed by private companies through tender invitation. However, at the end of 2015, the development is still in the planning stage.

To encourage the unemployed and low-income employees with financial difficulties living in Tuen Mun, Yuen Long (including Tin Shui Wai), the North District and the outlying islands to find jobs across districts, a transport support scheme was proposed. Eligible applicants whose monthly income was no more than US$833 would be allowed to

claim a job search allowance of US$76.9 and a cross-district transport allowance of US$76.9 a month for up to 12 months. In 2012, the Work Incentive Transport Subsidy Scheme was introduced to help low-income earners reduce their cost of travelling to and from work and encourage them to secure or stay in employment. However, eligibility is restricted by certain criteria, such as a minimum of 36 hours per month. In other words, part-time workers cannot apply for this subsidy.

In the 2008–09 policy address by the Chief Executive, a new outdoor bazaar was proposed to be set up in Tin Shui Wai to attract more people into the area to shop and to create more job opportunities.

The result was that in 2013, the "Tung Wah Group of Hospitals Tin Sau Bazaar" operated by an NGO (Tung Wah Group of Hospitals) began operating on a non-profit-making basis. However, in 2014 only 60% of stall operators were willing to renew their tenancies as business was slow.[27]

During the years of 2008-2010 there were no specified budget items or policy announcements for Tin Shui Wai.

[27] Source: http://www.info.gov.hk/gia/general/201405/14/P201405140355.htm accessed on 21 November 2016.

Policy and planning, 2010-11 to 2015-16

Since 2010, concerns about Tin Shui Wai have fallen off the agenda, as reflected in policy addresses and the yearly budget of the HKSAR government. Apart from the 2010-11 policy address by the HKSAR Chief Executive, no specified budget items and policy proposals were made for Tin Shui Wai during the years of 2010-2016 and the years of 2011-2016 respectively.

In the 2010-11 policy address by the Chief Executive, because of the implementation of the statutory minimum wage at US$3.6 per hour by the HKSAR government, the Labour Department proposed strengthening employment services for young and middle-aged people and those with disabilities in Hong Kong as a whole. One result was that in 2012, the department set up a pilot one-stop employment and training centre in Tin Shui Wai to offer targeted assistance to job seekers. However, it is difficult for service users to have job and training opportunities in the community since such opportunities are not to be found within the community. For example, land for long-term commercial use or a hotel is still being planned in 2015, and a plan for building an elderly persons' village was cancelled in 2012 when the Hong Kong Housing Authority under the HKSAR government failed to identify any partners.

Summary of budget and policy outcomes

The above policy review indicates that the HKSAR government has made some efforts to help to solve social and economic problems in Tin Shui Wai by introducing a series of policies and projects in the past few years. Up to September 2015, the following facilities and services had been initiated:

- a public facilities building
- the Head Start Programme
- a more integrated service provided by the Social Welfare Department
- a two-year pilot scheme whereby chronically ill persons can be provided with private clinic services for the same fee as that charged by clinics under the Hospital Authority
- a general out-patient clinic in Tin Shui Wai North
- a Transport Support Scheme
- an outdoor bazaar
- a pilot one-stop employment and training centre
- an integrated community centre for mental wellness.

However, as noted before, concerns about Tin Shui Wai have fallen off the agenda since around 2010, as reflected in policy addresses and the yearly budget of the HKSAR in the years 2010 to 2016. The reason given by government is that many services and facilities have come into full operation since 2008 and the HKSAR government needs to review the effectiveness of these policies and projects before taking further action[28]. Nevertheless, as I have indicated, many of the policies and projects have limitations and thus many service needs (especially medical needs in relation to physical and mental illness) of residents in Tin Shui Wai are still not being met. For example, the hospital provides service by phase from early 2017[29]. In total, there will be 250-300 beds in the Tin Shui Wai Hospital for the 287,901 population in Tin Shui Wai[30]. This number of beds are relatively lower than other new towns and central Hong Kong, for example, there are 993 beds in the Tai Po Hospital for the 296,853

[28] Source: http://www.info.gov.hk/gia/general/201004/21/P201004210144.htm accessed on 21 November 2016.

[29] An accident and emergency department will only provide the service for 8 hours per day, instead of 24 hours per day until the Hospital Authority can employ enough professional staffs [source: *SINA* (e-newspaper). "Tin Sgui Wai Hospital will provide service by batches" 07 October 2016 (in Chinese), http://sina.com.hk/news/article/20161007/26/61/51/%E5%A4%A9%E6%B0%B4%E5%9C%8D%E9%86%AB%E9%99%A2%E5%B0%87%E5%88%86%E9%9A%8E%E6%AE%B5%E6%8A%95%E5%85%A5%E6%9C%8D%E5%8B%99-6388061.html accessed on 21 November 2016.

[30] Source: http://www.info.gov.hk/gia/general/201011/17/P201011170190.htm accessed on 21 November 2016.

population in Tai Po, a new town in Hong Kong, and there are 1,702 beds in the Queen Mary Hospital for the 251,519 population in Central and Western, a district in central Hong Kong[31].

Conclusion

In this chapter, the historical development of Tin Shui Wai and the population and community characteristics of the area have been described in detail. Because of economic changes in which many private housing projects ceased, Tin Shui Wai became a residential zone in which the distribution of public and private housing was poorly balanced (Chow and Tsang 2004). This affected the population profile in Tin Shui Wai. In Tin Shui Wai, most of residents, who were living in public housing, were low income families with or without new immigrant family members. This population profile caused many unforeseen social problems, such as high unemployment rates and unmet service needs, which also affect the mental health and wellbeing of residents. Since 2003, many family tensions, domestic violence, and spouse, child and elderly abuse cases involving family members with mental illness have been reported. Since 2005, many policies have been announced by the HKSAR government.

[31] Source: http://www.ha.org.hk/haho/ho/stat/HASR1415_3.pdf accessed on 15 May 2017.

However, the effectiveness of these policies has not been comprehensively evaluated. Moreover, inherent limitations in the policies and facilities provided to date also mean that many of the service needs of residents in Tin Shui Wai (especially medical needs in relation to physical and mental illness) are still not being met, given the density of the population now living in the area and the high level of needs.

Chapter 5

The influence of unemployment on the mental health of men and women

In this chapter, I examine the data I collected on differences in the mental health status of men and women and consider whether unemployment causes poor mental health for middle-aged men or alternatively whether poor mental health leads to unemployment, and if so, in what ways.

Over recent decades, many epidemiological studies have found gender differences in mental health. The most common finding, as noted in Chapter four, is that in most countries women are more likely to be identified as depressed than men (Kessler 2000; Burns et al. 2001; Simon and Nath 2004; Inabe et al. 2005; Department of Health 2005; World Health Organization and United Nations Population Fund 2008; Eaton et al. 2012). It is also well-documented that women are more likely than men to experience anxiety (National Institute of Mental Health 2001; World Health Organization and United Nations Population Fund 2008; Eaton et al. 2012). On the other hand, men are more likely than women to be identified as having substance use disorders or antisocial personality

disorder. Rates of psychosis are more or less similar for men and women (Rosenfield 1999; Grella et al. 2009). The above differences are caused by genetic, hormonal, psychological, social, and interpersonal differences between men and women, including exposure to various social stressors at different times in their lives (Somerset et al. 2007; Kendler et al. 2006; Nolen-Hoeksema & Girgus 1994; Hammen 2003; Nolen-Hoeksema & Jackson 2001; Rudolph and Conley 2005).

Unemployment is one of the stressors that can affect mental health status and the one on which I focused in this study. According to Pearlin et al., a stressor refers to "the experiential circumstance that gives rise to stress" (1999: 243). Sudden and unpredicted life event stressors (such as unemployment and illness) are especially harmful for mental health. Under the influence of chronic stressors (such as role and status strains), the impact of short-term stressors may be increased. For example, when a husband is unemployed, his stress arises not only from his unemployment, but may also result from pressure from his wife who expects and/or demands that he find a job as soon as possible to maintain the family financially (Stewart 2014). According to the National Alliance on Mental Illness and Mental Health America (2009), unemployed people are four times more likely to experience severe mental health problems, such as depression. However, some scholars challenge the common conception of

employment as improving the quality of life and mental health (Evans and Repper 2000). They argue that without sufficient social inclusion (such as being socially accepted by others in the society and having a sense of belonging to the community) the mental health status of people will not be improved even if they are employed. In other words, while employment can facilitate the positive development of mental health since employed people can gain identity and integrate into society, its actual impact depends on factors such as social inclusion (Evans and Repper 2000).

The evidence also suggests that unemployment has a different significance for, and hence impact on, men and women. Research shows (Artazcoz et al. 2004; Bhattacharya 2011; Olesen et al. 2013) that the experience of unemployment is a key factor undermining men's mental health because it can damage their masculine self-image because of the social expectation that they will be in full-time paid employment. However, the nature of the causal relationship between unemployment and poor mental health is not clear (Owen and Watson 1995; Hayes et al. 2008; Saunders 2008). Is poor mental health caused by unemployment, or is it that if a person has poor mental health, their working performance is affected and so leads to unemployment? In 2013, a longitudinal population study in Australia mainly focused on people aged 20 to 55 found that "mental health was shown to be both a consequence of and risk factor for

unemployment" (Olesen et al. 2013: 144). In this chapter, I examine the differences in the mental health status of middle-aged men and women in my sample. I argue that unemployment causes poor mental health for middle-aged men. I suggest that the findings from my data indicate unemployment does not seem to have the same mental health implications for women.

Measurement

As noted in Chapter three in this study, I used the Hospital Anxiety and Depression Scale to measure the mental health of respondents. To measure alcohol abuse, I used the Alcohol Use Disorders Identification Test.

Gender and mental health in the study

The data from my study show that, as measured by the Hospital Anxiety and Depression scale (HADS), the men were significantly more likely to be depressed than the women. This was a significant finding, since usually women score higher on scales of depression than men (Kessler 2000; Burns et al. 2001; Simon and Nath 2004; Inabe et al. 2005; Eaton et al. 2012). In my survey sample, a total of 57.5% of men had borderline abnormal (30.6%) or abnormal depression (26.9%) scores. For women, the total was 36.3%—either borderline abnormal (21.4%) or abnormal depression (14.9%). In

comparison, a study by the Department of Health (2005) in Hong Kong found that 55.3% of men and 59.4% of women suffered from "mild", "moderate" or "severe". This shows that the depression scores of my male respondents were worse than those of the general population in Hong Kong. The figures for the survey sample are given in Table 5.1.

	Men	Women	Overall
	N (%)	N (%)	N (%)
Normal	79 (42.5)	137 (63.7)	216 (53.9)
Borderline abnormal	57 (30.6)	46 (21.4)	103 (25.7)
Abnormal	50 (26.9)	32 (14.9)	82 (20.4)
Total	186 (100)	215 (100)	401 (100)

Table 5. 1: Depression by gender in the survey sample

(Chi-square=18.701, df=2, p<.001)

However, using the same scale, in terms of anxiety, as is usually the case, the anxiety scores for men were lower than for women. Men had scores of 24.7% for borderline abnormal anxiety, and 15.1% for abnormal anxiety. In contrast, anxiety scores for women were 27.0% for borderline abnormal, and 24.7% for abnormal (see Table 5.2 below). This gender difference was more marked that in the study by the Department of Health (2005) in Hong Kong, which found 20.6% of men and 25.5% of women suffered from high levels of anxiety (21–40 of a total possible score of 40).

	Men	Women	Overall
	N (%)	N (%)	N (%)
Normal	112 (60.2)	104 (48.4)	216 (53.9)
Borderline abnormal	46 (24.7)	58 (27.0)	104 (25.9)
Abnormal	28 (15.1)	53 (24.7)	81 (20.2)
Total	186 (100)	215 (100)	401 (100)

Table 5. 2: Anxiety by gender in the survey sample

(Chi-square=7.338, df=2, p=.026)

In my survey sample, using AUDIT as a measuring instrument, 14.9% of men and 6.5% of women had alcohol problems (see Table 5.3 below). This finding was similar to past findings in Hong Kong and elsewhere that men are more likely to have substance use disorders than women (Rosenfield 1999; Grella et al. 2009). However, as we might expect, the percentages of both men and women having alcohol problems in this study was higher than in Hong Kong in general. The gender difference in this survey also seemed to be smaller than in Hong Kong overall and more women had alcohol problems than generally in Hong Kong. According to the Hong Kong behavioural risk factor surveys 2004–2009 (Department of Health 2010), 13.8% men and 3.8% women in Hong Kong had been binge drinking (consumption of at least five glasses or cans of alcohol on one occasion) during the month prior to the survey.

	Men	Women	Overall
	N (%)	N (%)	N (%)
No alcohol problems present	160 (85.1)	201 (93.5)	361 (89.6)
Presence of alcohol problems	28 (14.9)	14 (6.5)	42 (10.4)
Total	188 (100)	215 (100)	403 (100)

Table 5. 3: Alcohol problems by gender in the survey sample

(Chi-square=7.548, df=1, p=.006)

Yet despite the high levels of alcohol problems reported in the survey, in my in-depth interviews and focus groups, all the respondents claimed that they did not have any alcohol problems or did not drink alcohol. Some respondents said that they did not drink a lot since they could not afford to because they were unemployed. One male respondent in the focus group said that he had alcohol problems before becoming unemployed. However, after becoming unemployed, he stopped drinking because he had no money for it and he needed to maintain his health.

> MR[32](FG[33]): Before I became unemployed, I liked to drink alcohol. I could drink 5–6 cans of alcohol per day … 2 cans at lunch time, 2–3 at night. If I had a meal with friends after work, I would drink more … during that period, I always argued with my wife and children because of the influence of alcohol … However, I do not drink now since I do not have money. The price of two cans of alcohol can be equal to the price of a meal. Also, actually, one of reasons for unemployment is my poor health condition … I want to have a good health now.

[32] MR=Male Respondent

[33] FG=Focus Group

However, the above findings from in-depth interviews and focus groups might not reflect the reality in Tin Shui Wai because of sampling limitations or because of an unwillingness to admit to drinking heavily. In my study, all of the respondents in the focus groups were recruited by social workers in a NGO. The respondents were relatively active and had a high motivation to seek help. Further, even though the in-depth interview respondents were not service users in any NGO, they were recruited in the community (such as in the park) and so I did not know them before the interview. This might have affected the level of trust between them and me, and so encouraged them to hide embarrassing information (such as the real level of drinking) during the interview.

In order to assess the association between different demographic factors and mental health status, a linear regression model on all respondents was conducted. Linear regression model was to assess the relationship between two variables by fitting a linear equation to observed data. One variable is an explanatory variable, and the other is a dependent variable which should be continuous. In this study, the linear regression model was used since the dependent variables, including depression, anxiety and alcohol abuse scores, were continuous. Also, the independent variables that were related to demographic factors (i.e. compositional

factors), including gender[34], marital status[35], birth place[36], educational attainment[37], and occupation[38] were selected for the analysis.

Before attempting to fit a linear model to observed data, the observations with missing the data on the outcomes were excluded. Besides, I had to determine whether or not there was an association between the variables of interest using the tool of "a scatterplot" to assess the strength of the relationship between two variables (Weisberg 2014). In this study, all liners regression analysis (including Table 5. 4, Table 5. 9, Table 6. 17, Table 6. 18 and Table 6. 19) also fulfilled this requirement (i.e. the scatterplot showed an association between the explanatory variable and dependent variable). In other words, fitting a linear regression model to the data probably provided a useful model in my analysis. A valuable

[34] The respondents were required to state their gender from two choices coded 1 for "Male" and 2 for "Female".

[35] The respondents had to state their marital status from four choices, namely single, married, divorced, and widowed. All choices were coded individually as 0 for "Not selected" and 1 for "Selected".

[36] The respondents had two choices, namely Hong Kong and outside Hong Kong. All choices were coded individually as 0 for "Not selected" and 1 for "Selected".

[37] The respondents had four choices for educational attainment, namely no education, primary school, secondary school and post-secondary or above. All choices were coded individually as 0 for "Not selected" and 1 for "Selected".

[38] The respondents had two choices for occupation, namely employed person (including self-employed, full time and part time person) and unemployed person. All choices were coded individually as 0 for "Not selected" and 1 for "Selected".

numerical measure of association between two variables is the correlation coefficient, which is a value between -1 and 1 indicating the strength of the association for the two variables. Also, due to the relatively small sample size, the linear regression models were used in order to bring more explanatory and statistical power to the analysis. I reported Cohen's f^2 to assess the effect size for each significant predictor in the regression equations, with 0.02 considered to be a small effect, 0.15 a medium effect, and 0.35 a large effect (Cohen 1988).

Table 5.4 provides the results of the regression analyses for assessing the compositional effect on mental health. Overall, the analysis shows that men had higher depression scores (-1.288***) than women and also, as expected, higher alcohol (-1.682***) scores. Also, unemployed respondents had higher depression (3.028***), anxiety (2.924***) and alcohol (3.482***) scores than employed respondents.

The analysis also shows that divorced respondents (2.191***) had higher depression scores than non-divorced respondents. In addition, respondents whose education level was low, particularly only primary school (1.041*) had higher scores than those who had higher education level, particularly post-secondary or above (-2.010***). For anxiety, the analysis shows that respondents, who were not married (-1.807***) had higher anxiety scores than those who were married. For alcohol abuse, the

analysis indicates that respondents whose education level was only at primary school (3.954***) had higher scores than those whose education level was higher, particularly, secondary school (-1.413***) and post-secondary or above (-1.806***).

	Depression (N=401, R^2=.254)	Anxiety (N=403, R^2=.107)	Alcohol abuse (N=403, R^2=.238)
Constant	9.072***	6.752***	4.403***
Compositional factors			
Female	-1.228***	1.284	-1.682***
Marital status			
Single	-.555	.067	.512
Married	-.318	-1.807***	.232
Divorced	2.191***	.779	-.711
Widowed	-1.323	.987	-.023
Birth place			
Hong Kong	-.039	.218	.024
Outside Hong Kong	.046	-.241	-.031
Educational attainment			
No education (including without formal or with informal education)	1.276	1.541	3.954***
Primary school	1.041*	-.440	-.764
Secondary school	-.297	-1.002	-1.413***
Post-secondary or above	-2.010***	-.122	-1.806***
Occupation			
Employed person (including self-employed, full time and part time person)	.667	.201	1.320
Unemployed person	3.028***	2.924***	3.482***

Table 5. 4: Linear regression models for assessing the compositional effect on mental health

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

In Tin Shui Wai, unemployment and underemployment are common problems that most middle-aged men and women often have to face. In my study, I explored the different significance of unemployment for men and women and found, as noted in Chapter three, that men were more likely to identify themselves as unemployed and retired than women when they were without a job. 28.7% and 18.6% of male respondents and 7% and 0.9% of female respondents stated that they were unemployed or retired, respectively, yet a higher percentage of women (46.5%) than men (0%) did not have paid work (see Table 5.5).

	Men	Women	Overall
	N (%)	N (%)	N (%)
Self-employed	4 (2.1)	4 (1.9)	8 (2.0)
Employed full-time	87 (46.3)	73 (34.0)	160 (39.7)
Employed part-time	8 (4.3)	21 (9.8)	29 (7.2)
Retired	35 (18.6)	2 (0.9)	37 (9.2)
Housewife/househusband	--	100 (46.5)	100 (24.8)
Unemployed	54 (28.7)	15 (7.0)	69 (17.1)
Total	188 (100)	215 (100)	403 (100)

Table 5. 5: Male and female unemployment in the survey sample

The average length of unemployment was 3.5 years for men and 4.9 years for women (see Table 5.6).

	Men	Women	Overall
Average	3.5	4.9	3.8
Max.	10	13	13
Min.	0.4	0.5	0.4
N	46	15	61

Table 5. 6: Length of unemployment (year) in the survey sample

The length of unemployment was apparently greater for women than men since women were mostly looking for part-time jobs with reasonable pay

in the neighbourhood. However, in the neighbourhood, the pay for such jobs was generally low. Therefore, women typically spent more time looking for a job and if they wanted to take one outside the locality the pay needed to be higher because of travel costs. During the period of trying to find a part-time job, most women did not identify themselves as unemployed since they thought that working was optional whereas the men invariably regarded themselves as unemployed. If women had a part-time job, they had more money for additional household expenditure. If they did not have a part-time job, they still had a clear role looking after their family. Members of the focus group commented:

> FR4[39](FG)： The salary is low relatively. Therefore, if you want to find a higher income job, you have to go outside the community … However, transport costs are very high in this community. You actually cannot get a lot of real income. Also, I want to take care of my son and thus don't want to work outside the community … Because of this reason, I am not looking for a job now, even though I want to work.
>
> FR5(FG)： The salary is not enough for your basic expenditure. Like me, I had a job before. However, the salary was very low and thus I quit the job after working for two weeks.

The above findings of differences in levels of unemployment for men and women (see Table 5.5) did not show for certain that men were more likely to be unemployed than women. This is because in the study, it was interesting to find that women named their current occupational status

[39] FR=Female Respondent

flexibly. In general, when they were employed, they described themselves as an employee. In contrast, when they were unemployed, they described themselves as a housewife. However, this flexibility was not voluntary. If they had a choice, most of them wanted to have a job to improve the family situation as the women in this focus group discussion indicated.

> I(FG)：What is your current occupation, housewife, unemployed person, part-time worker or full-time worker?
>
> FR1-6 (FG)：Housewife.
>
> FR4(FG)：But I had the experience of working part-time and full-time before.
>
> I(FG)：But you are a housewife now, right?
>
> FR4(FG)：Not, because of some family problem [having to take care of the children] and personal [she thinks that the salary is very low] problems, I don't work now.
>
> FR2(FG)：Because no one employs me.
>
> FR1&3(FG)：Yes, yes.

The above comments indicate that even though women would have liked to have paid work and some of them were actively seeking a paid job, they still identified themselves as housewives instead of unemployed persons. In part women did so because they received some rewards as mothers. Not having a job was less of a problem for them since they still could make a contribution to the family and fulfil their role expectations as mothers. In other words, their unemployment problem seemed tolerable and acceptable to the society, family and to their husbands.

The different meanings of not having paid work for men and women are shown very clearly in the following comment from a female respondent in one of the focus groups:

> FR3(FG)：Both men and women need to work. But women do housework better than men.

However, some women if they did not work outside the home were under pressure from their husbands if they then took time off from housework, as this discussion indicated:

> FR2(FG)：My husband does not allow me to work outside since if I work, no-one helps him preparing a meal. He said I always went out not for work. So I responded to him that I could not do housework all the time. I also needed a rest … I think I have taken my responsibility to be a housewife, so that, this is reasonable for me to go out to play for a whole day.
>
> FR5 (FG)：Yes, we need to take a rest, even though we are housewives and do not have paid work.

Some women thought that the uneven distribution of housework was created by women themselves to a certain extent, but they still followed this normal practice voluntarily.

> FR4(FG): I think we lead our husbands to not do housework. Is it? Haha…
>
> FR5(FG): Yes, this is not the problem of their ability; it is our usual practice that we do not encourage our husband to do housework. You see, many young men are also doing housework.
>
> FR6(FG)：Yes, we always tell our husbands 'please sit down and take a rest and don't disturb us when we are doing our housework'.
>
> FR4 (FG): Yes.

FR1(FG)：No. Some husbands do nothing; even if you seek their help.

FR2(FG)：This is because they have been trained to do nothing at home by their mothers since their childhood…… [laughs].

Not surprisingly, in this study, no male unemployed respondents described themselves as a househusband. All of them described themselves as unemployed. However, notwithstanding the women's claims above, many men did actually do quite a lot of housework (such as cooking, buying food, taking care of their children and so on) during a period of unemployment:

MR4(II)[40]：I take my daughter to school and go back home every day. She is 10 years old. My wife has to work so that she does not have time to take care of our daughter. I prepare meals for my daughter.

MR1(FG)：I am unemployed now and have no money. I always stay at home to prepare meals for the family members since I don't want to go out because of the cost … In the past, when I had a job, I always had a lunch out without considering the price. However, now I have to compare the price of food before buying in the market.

Men viewed doing housework as compensation for the family and their wife because they could not find a job and could not make a financial contribution to the family. For this reason (i.e. because it does not fit the standard gender division of labour), unemployment had a more negative impact on men than women.

[40] II=In-depth Interview

I asked a set of questions to those who were not working, including "retired, housewife and unemployed", in my sample about the impact of unemployment on their lives. The responses are given in Table 5.7 below. For men, the common impact of unemployment on the respondents and their family included, "Have more free time but nothing to do" (65.1%), "Face financial difficulties in the family" (53.5%) and "Feel stressed" (48.8%). For women, the common consequences of joblessness on themselves and their family included, "More time to take care of the children and family members" (64.8%), "Face financial difficulties in the family" (44.8%) and "Have more free time to do something that interests me" (41.0%). In general, men's views on the impact of unemployment were more negative than the women's. For example, apart from the choice of "affects physical health (such as always feel tired)", the proportion choosing negative effects of unemployment (see Table 5.7) among men was higher than among women. In contrast, more female respondents reported that unemployment could have a positive impact (see Table 5.8). For example:

> FR5(FG)：I have to take care of my son, so cannot work. When my son goes to school, I can go to the community centre to take part in some activities that interest me.
>
> FR4(II)：In the past, I worked as a cleaning worker. I am not working now since I have to take a rest to improve my health.
>
> FR5(II)：I was a full-time housewife once I got married since I had to take care of my husband and two daughters …now my two daughters

have grown up … When my daughters go to work, I exercise in the park or go swimming.

	Men	Women	Overall
	N (%)	N (%)	N (%)
Affects physical health (such as always feel tired)	14 (16.3)	20 (19.0)	34 (17.8)
Cannot sleep	25 (29.1)	20 (19.0)	45 (23.6)
Have bad appetite	16 (18.6)	11 (10.5)	27 (14.1)
Less communication with family members*	17 (19.8)	11 (10.5)	28 (14.7)
Go out less with family members***	37 (43.0)	24 (22.9)	61 (31.9)
Feel stressful***	42 (48.8)	21 (20.0)	63 (33.0)
Don't want to make contact with relatives and friends	10 (11.6)	11 (10.5)	21 (11.0)
Face financial difficulty in the family	46 (53.5)	47 (44.8)	93 (48.7)
Increase in conflict with family members	24 (27.9)	19 (18.1)	43 (22.5)
Go gambling	2 (2.3)	--	2 (1.0)
Drink alcohol***	11 (12.8)	--	11 (5.8)
Have more free time but nothing to do***	56 (65.1)	34 (32.4)	90 (47.1)
Total*	79 (100)	76 (100)	155 (100)

Table 5. 7: The negative effects of unemployment in the survey sample

Multiple answers were permitted. Chi-square: * $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$.

	Men	Women	Overall
	N (%)	N (%)	N (%)
Have more free time to do something that interests me*	30 (34.1)	43 (41.0)	73 (37.8)
More communication with family members	30 (34.1)	33 (31.4)	63 (32.6)
More time to take care of children and family members***	40 (45.5)	68 (64.8)	108 (56)
Feel relaxed	19 (21.6)	29 (27.6)	48 (24.9)
Better physical health	10 (11.6)	8 (7.6)	18 (9.4)
Total***	52 (100)	82 (100)	134 (100)

Table 5. 8: The positive impact of unemployment in the survey sample

Multiple answers were permitted. Chi-square: * $P < 0.05$; ** $P < 0.01$; *** $P < 0.001$.

The significance of unemployment for men and women

The above findings suggest that unemployment had more negative effects on men than on women. Further, I would argue that it was precisely

because of the very different significance of unemployment that men in this study were more likely than women to be depressed and had heightened levels of alcohol abuse when they were facing unemployment.

In order to examine the status of mental health among unemployed men and women in more detail, an analysis based solely on the unemployed respondents was conducted. Again, the linear model was used since the dependent variables, including depression, anxiety and alcohol abuse scores, were continuous. In addition, except for the factor of occupation, independent variables (i.e. compositional factors) that were related to demographic factors, including gender, marital status, birth place, and educational attainment were again selected for the analysis.

Table 5.9 provides the results of the regression analyses assessing the compositional effect on mental health just among unemployed respondents. For depression, the analysis shows that the unemployed men had higher depression (-2.818***) scores than the unemployed women. Further, divorced unemployed respondents (3.132***) and those whose education level was lower than post-secondary or above (-2.199*) also had higher depression scores. For anxiety, the analysis shows that no significant association between gender and anxiety was found. However, unemployed respondents who were not married had higher anxiety scores than respondents who were married (-4.525***). For alcohol abuse, the

analysis showed that the unemployed men, as we would expect, had higher alcohol abuse scores than the unemployed women (-4.438***). Moreover, unemployed respondents who had a lower education level (No education: 5.919***) had higher scores than those who had higher education levels (Secondary school: -2.4000***; Post-secondary or above: -2.480*). The respondents who were born in Hong Kong (Hong Kong: .728*; Outsides Hong Kong: -.732*) had higher alcohol abuse scores.

	Depression (N=67, R^2=.234)	Anxiety (N=69, R^2=.155)	Alcohol abuse (N=69, R^2=.353)
Constant	12.583***	14.229***	11.572***
Compositional factors			
Female	-2.818***	1.151	-4.438***
Marital status			
Single	-1.796	1.879	.495
Married	.318	-4.525***	-.182
Divorced	3.132***	-.458	-1.287
Widowed	-1.603	3.111	.976
Birth place			
Hong Kong	.151	.356	.728*
Outside Hong Kong	-.133	-.367	-.732*
Educational attainment			
No education (including without formal or with informal education)	1.833	2.674	5.919***
Primary school	.545	-.370	-1.072
Secondary school	-.225	-.952	-2.400***
Post-secondary or above	-2.199*	-1.389	-2.480*

Table 5. 9: Linear regression models for assessing the compositional effect on mental health for unemployed respondents

* p < 0.05; ** p < 0.01; *** p < 0.001

In addition, unemployed men in the survey had higher levels of depression, anxiety and alcohol abuse than employed men. The mean

scores of depression, anxiety and alcohol abuse for unemployed men were 10.6, 8.9 and 5.5 respectively. The mean scores of depression, anxiety and alcohol abuse for employed men were 7.8, 7.0 and 3.0 respectively. These differences were statistically significant (Chi-square=85.254, df=38, p<.001 for depression; Chi-square=88.099, df=39, p<.001 for anxiety; Chi-square=85.880, df=32, p<.001 for alcohol abuse). The above findings suggest that men had higher levels of mental illness, including depression, anxiety and alcohol abuse, than their peers when they were facing unemployment. As previously noted, many studies (Rosenfield 1999; Grella et al. 2009) have found, men's levels of alcohol abuse are usually higher than women's (Rosenfield 1999; Grella et al. 2009). However, the unemployed men in my survey had even higher levels of alcohol abuse than employed men. This implies that men's level of alcohol abuse had been heightened by their unemployment.

It was clear that unemployment was a particular stressor for these men. According to the findings from the focus group and in-depth interviews, having "paid work" was a key factor affecting the men's mental health. Unemployed men in this study were more likely to have poorer mental health in relation to both depression as they usually do not [and alcohol abuse as they usually do] than women without work. The problems of unemployment not only caused stress for the men and

affected their mental health, as the data in Table 5.7 and 5.9 have shown respectively, but also damaged their identity and self-esteem as Artazcoz and colleagues (2004) and Mossakowski (2009) have argued. Men worried especially that their unemployment would affect their relationships with their wife and children, since they could not fulfil the basic expected requirements of being a husband and father. These pressures affected their mental health, giving rise to experiences such as insomnia, feeling useless and hopeless, and refusing to go out. In addition, the data showed that even though the men faced many pressures, they seldom sought help from others—an issue considered in the next chapter.

Work was very important for men, as the following extracts indicate. The question asked was: Among different kinds of problems (such as employment/job, relationship with your spouse, family members and neighbourhood, household finance, child(ren) caring and life adaption etc.), which one affects you most?

> MR2(FG)：Economic problems. If all people have a job, all problems can be solved.
>
> MR1(FG)：For me, I have power and energy. However, there is no place for me to use them. If you live in Tin Shui Wai, you cannot work even if you want to … Now, I am unemployed. My life has no protection.
>
> MR5(FG)：Actually, the most important thing is living. If you don't have a job, your living standards will be poor. The emotional pressures will be high. This will affect your mental health and cause stress. Once you feel stressed, you will treat your children and family badly when they are not good enough. … in this community, much family violence happens for this reason.

The women had similar views on the importance of work for men, as these extracts show:

> FR6(FG)：If the men don't have a job, this is worse than for women.
>
> FR1(FG)：Especially for those who are working, but suddenly are unemployed. They want to have a job.
>
> FR3(FG)：Yes, the influence of unemployment on men generally is bigger than on women.
>
> FR1(FG)：Yes. If they are unemployed, they can only sit at home since they don't know how to take care of children and do housework.
>
> FR4(FG)：They will feel that they are useless.
>
> FR1(FG)：Yes, my husband experienced the same situation before.
>
> FR4(FG)：Therefore, their temper will be bad.
>
> FR2(FG)：Yes. The frequency of having a bad temper becomes more.
>
> FR1(FG)：More. They argue with you more. If they don't have job, they will have more time. The conflict among couples will be more.

These comments indicate that when men were unemployed, they worried that they could fulfil their roles as husband and father appropriately (such as being the breadwinner for the family). This created considerable pressure on them and thus affected their mental health:

> MR1(II)：I face financial problems. I have been unemployed for five years … I was fired because I was too old. It is difficult for a middle-aged man to find a job again. I am receiving the CSSA [Comprehensive Social Security Assistance Scheme] now. I feel I am useless.
>
> I：As a man, what is the most important factor affecting your mental health? Such as 'employment/working', 'couple relationship', 'family relationship
>
> MR1(II)：Erm … job and family. However, the job is more important than family.

> MR4(II): Of course working. Working is important for me. I can get self-esteem and respect from others. If a man cannot earn money to support the family, this means he is a loser and useless. This is the basic requirement to be a good man. Simply, I am not a good husband, daddy or man.

In contrast, almost all the women respondents in this study said that their children and family were very important to them since this was their unique role in their life and either they did not have paid employment, or if they had a job, did not usually regard it as the most important thing for them. Thus, they tried to do their best for their family as they could and this created pressures on them that could affect their mental health, as evidenced by experiences such as insomnia or refusing to go out. One source of pressure came from taking care of their children:

> FR6(FG)：Women are mostly concerned about how to teach their children.
>
> FR4(FG)：We don't have job, so we must put all attention on our family.
>
> FR5(FG)：I am especially concerned about my children's education, such as the problem of studying outside the community.
>
> FR1(FG)：Apart from teaching the children, maintaining the family with limited money is always our second concern because prices are very high in this community.
>
> FR4(II): The family is the most important thing for a woman, especially her children. I am a traditional woman, a career is not important for me. I was working in the past because I wanted to earn more money to support my children's additional expenditure on education. A career should be secured by my husband, not me … The Chinese always say "parents worry about their children forever" [養兒一百歲, 長憂九十九] … my children have been unemployed for a few years. I am very worried.
>
> FR1(FG)：If the academic performance of my children is not good, I will find it hard to find a solution. Of course, I want to appoint a private tutor

> for them to improve their study. But I don't have the money. All of this makes me feel sad and I cannot sleep.
>
> FR3(II)：My husband is unemployed now … No money of course affects my mental health. I have to always worry about living. I am worried that if I do not have enough money, I cannot support my children to finish their study.

Pressure on women from a husband's unemployment came from the costs of looking after their family as a whole:

> FR1(FG)：Apart from teaching the children, maintaining the family with limited money is always our concern because prices are very high in this community … Unstable and low income [from her husband] indeed affects my mental health … When you go to market to buy food, you have to think a lot since you don't have a lot of money, but want to buy enough food for children and husband … Maintaining basic nutrition of family members is my concern.

Pressure could also come from marital breakdown:

> FR1(II)：The family is the most important factor. I suffered from depression because of my marriage. In the past, I was a happy woman. In my world, I only had my husband and daughter … Nevertheless, when I discovered that my ex-husband had another lover and gained the right to take care of my daughter after the divorce, I knew that I had lost all things … As a woman, if someone takes all her things related to her family, she will be crazy, like me.

The above data confirms Pearlin (1989) and Nazroo et al.'s findings (1998) that the stressors experienced by an individual often become problems for others who are linked to them. For example, in my study, if a husband or a child was unemployed, it had the consequence that the wife or mother suffered as well. This sequence of stressors is called the "carryover effect" (Pearlin 1989: 247).

However, unlike men, even though they faced many pressures, the identity and self-esteem of women as housewives and mothers was less likely to be affected when they were facing the problem of unemployment. This was because the women still thought that they were a good wife and mother since they found many ways to deal with these family problems. Furthermore, as I discuss in the next chapter, the study shows that women were more likely to seek help from others (including informal and formal networks) when they faced problems. This also reduced the pressure on them:

> FR2(II)：Unemployment of course will cause some pressure on me. However, luckily, I have many friends to talk with. I can tell them what I feel and worry about. They can give us a lot of advice … In addition, my parents also support me so much. They don't give me a lot of pressure. They always talk with me … When I have a financial difficulty, they will help me to solve the problem.

The gendered division of labour

The above data indicates that a key factor (life event stressor) affecting the mental health status of men and women was whether they could fulfil their social role expectations or not. In my interviews and focus groups, it was common for the respondents, especially the male respondents, to use the words "should", "have to" and "must" in their discourse. I have emphasized these words in the extracts below using italics. When the

respondents could not fulfil their expected role and responsibilities, they experienced stress:

> MR1 (II)：My parents always tell me that I *should* take the responsibility to support the family. However, after marriage, I cannot do so. This makes me feel disappointed and feel no confidence to complete a task by myself. I worry that I don't have this ability to do so.
>
> MR1(FG)：In the past, I could choose a job. But now, when I live in Tin Shui Wai, no one employs me since I live so far away. Also, I am old now. The employers know that you are over 50 years old. They tell you to go home and wait for the result [i.e. no employment offers] … If you have children who are studying, it is impossible for the wife to go out to work too. Who takes care of the children? This will only cause conflict between a couple. So the husband *has to* go out to work to support the whole family … If women have husbands, they expect the husband to earn money and they take care of the children. If the husband stays at home without working, what will the wife think? If women attend to their family and children, their husband *must* go out to work to support the family. For middle-aged men, the family is very important and this causes many pressures on men.
>
> MR4(II)：Nowadays in Hong Kong society, more and more jobs are suitable for women, such as customer service and cleaning. Therefore, their wives take the responsibility to earn money for the family. As a result, those men [like me] *have* to take the role of taking care of the children. The world is changed. Men also *have* to change, but indeed this is a hard process. I always feel I have no "face".

For the men, the pressure of social expectations sometimes came not only from themselves, but also from others, such as their wives, as the comments from these women showed:

> FR4(II)：A career should be secured by my husband, not me. I think every parent also wants their children to have a good future and prospects. When my children were young, I was concerned about their health and education. When my children were adult, I was concerned about their marriage, job and future … My daughter has been unemployed for a year. I am really afraid that she will be the same as her brother who has been unemployed for long time … Because of my [fears

> for my] children's future, I sometimes do not want to eat and cannot sleep. My husband always tells me that I should not think too much. They have their own future. However, I still worry about them.
>
> MR1(FG)： When I suffered from depression, I asked myself why I got this illness? … I think if I don't take too much responsibility for my family, I may be better. I take responsibility for my family. I love my children and wife, so that I have to find a job to take care of them. I cannot encourage my wife to go out to work since she needs to take care of the children. If I am an irresponsible person, I can leave my family. All my problems would be solved. A single man does not need to spend a lot of money. However, I cannot do so since I am a man.

The above extracts suggest that the main reason for men suffering more from unemployment was that the men and women had a different point of view on its place in their lives. From what they said in the focus group and in-depth interviews, it was clear that the main concerns of men and women were generally different. The male respondents said that their main concern was their "occupation", whereas the female respondents said it was "their children and family". These concerns in turn often became a source of stress for them as my data indicated.

Men were concerned about certain ways to make family life better, such as finding a job to support the family expenditure. Without money, they felt that they had failed:

> MR5(FG)： The main problem that we are facing is "economic" and "living conditions". If we have money, our living conditions can be improved. The family problems would disappear.
>
> MR1(II)： You know, if you have money, you can solve all problems. For my whole life, my salary was also very low. Therefore, I couldn't find a partner in Hong Kong and had to marry a woman whom I did not know before the marriage, from Mainland China … My wife is ten years

> younger than me. She is still working. She is working as a security guard. She earns more money than me and thus sometimes she blames me that I am useless for the family. She forces me to apply for the Comprehensive Social Security Assistance Scheme since she says she doesn't want to use her money to maintain my life.

The pressure for men sometimes came from their parents and their expectations about a future wife/ girlfriend. Respondents were asked: "Among different kinds of problems (such as employment/job, relationship with your spouse, family members and neighbourhood, household finance, child(ren) caring and life adaption etc.), which one affects you the most?" Responses included:

> MR3(II)：Working relationships and my father's health. I have a bad relationship with my colleagues. Almost all my colleagues are female. They like to talk about other people's secrets and private matters. I hate this … Furthermore, my father suffers from cancer. The doctor said that his situation is not good. However, my father does not want to receive treatment since he doesn't want to increase our financial burden. As a son, I want him to receive treatment. Also, I want to have more time with him … However, I cannot do so since my income is very low and my working situation does not allow me to apply for a long leave … As a man, doing a professional job and having a high salary are very important … I am 32 years old. I have never had a girlfriend. I think it is because I am a clerk and only earn a low income. If I had a better job, I could earn more money. At least, I could have the ability to find a girlfriend and get married. Furthermore, if I had a professional job and a high salary, I could afford the expenditure of my family. My father does not receive treatment since he does not want to waste our money. If I had more money, a lot of family problems might be solved.

Even though men and women seemed to have different views on the importance and main goal of their life, both men and women were also concerned about their family. For men, the way to achieve successful

family life was by having a stable job and salary. On the other hand, women tended to view a paid job as an alternative in their life. Women were concerned about personal relationships in the family (such as their children and family relationships). This also explains why, as I have noted before, women were more likely than men to name their current occupation flexibly. With different perspectives on the family, men were more likely to suffer from a particular pressure from unemployment: a feeling of shame.

According to Scheff (1990, 1997), shame and pride, are the most basic and powerful of all social emotions, and arose from self-monitoring and guarding the social bond, which is the degree to which an individual was integrated into the society. Cooley argues that most people are continually monitoring their behaviour through three phases, "the imagination of our appearance to the other person; the imagination of his judgment of that appearance, and some sort of self-feeling, such as pride or mortification" (1922: 184). People feel pride when the social bond is intact, and shame when it is threatened or severed. If that happens, individuals sense a lack of respect, as well as a negative evaluation of self by others. In some cases, the shame is hidden because individuals want to avoid the emotional pain of shame which can create more shame after feeling shame (i.e. "My shame shames me") (Scheff 1990: 3). This creates some predictable symptoms and

consequences. One of the more important effects of unacknowledged shame is low self-esteem (Scheff 1990: 88).

In my study, the social bond in question was employment. When men were unemployed, they almost always felt shame since they could not fulfil their social role as a man, husband and father. The following extracts indicate the different sources of shame.

Shame as a husband and father

> MR2(II)：I know many men who are full-time househusbands since they earn less money than their wife. For rational thinking and economic considerations, this is reasonable. However, as a man, I still cannot accept it.
>
> MR4(II)：I have to depend on the CSSA [Comprehensive Social Security Assistance Scheme] and my wife for a living. As a man, if you cannot make a financial contribution to the family, you seem to have no say at home. For example, in the past, I could decide whether to buy a TV and what type. But now I have no say since the money is not earned by me.
>
> MR5(II)：It is difficult for me to tell my wife that I could not sell any dogs in the past three months, so that, I cannot give any money to her for family expenditure, including paying the rent. This is hard for a man to say.
>
> MR1(FG)：Most wives attend to their family and children. What is a family? A family includes a husband, wife and children … For middle-aged men, the family is very important and this causes many pressures on men. You have to earn money. If not, your family will be broken, even if you help them to do housework during unemployment, since your wife is waiting for your money to buy food and take care of the children, not waiting for you to help her to shop for food and take care of the children. This is the division of labour.

With such feelings of shame, men then often had low self-esteem (such as calling themselves a useless person) and tended to hide their shame

through not seeking help from and/or not explaining their problem to others:

> MR1(FG)：After becoming unemployed, I suffered from depression for a period of time. I was a healthy guy in the past. Why did I suffer from depression? … In the beginning, I didn't know what it was. I couldn't sleep every day … I always thought that I wanted to use my hands to work and support my family … I am not a lazy guy. I only want to find a job, but I failed. I feel useless.
>
> I: What do you feel when you are unemployed?
>
> MR3(FG)：You have to support your family, so that, you have to earn money. Now, you don't have a job and have tried many ways to find a job, but failed. This causes great pressure … If you can handle this pressure that is OK. However, if not, you will become crazy. You know, why a lot of people commit suicide in Tin Shui Wai? They cannot handle the pressure.
>
> MR1(II)：No. No one can help me. This is my family problem. I don't want to tell others, even my sister and brother. I don't seek help from them because I think this is my responsibility … But the most important reason, I don't want my sister and brother look down on me, even though I have a good relationship with them … I don't have money, but I don't want to lose my self-esteem in front of them … My sons are too young. They cannot help me. Also, sons are men; they are not good at handling family relationships. When I argue with my wife and daughter, they mostly go back to their room or leave the house. Furthermore, I do not have friends and don't have contact with my neighbours. Therefore, no one can help me. Men should solve their problems themselves and not seek help from others. I have applied for the CSSA. I think that is enough … Therefore, I can do nothing. Sometimes, I sit at home for whole day thinking nothing. I feel no hope … I have a good sister and brother. … My sister sometimes invites me to have breakfast with her. I tell her I am unhappy. My brother sometimes visits me to have meal … However, I never ask my sister and brother to help me. Listening to me and providing me a free meal is enough.
>
> I: What will you do if you do not seek help when you are facing difficulty?
>
> MR4(II)：Self-adjustment. I have looked for a job for many years through my friends and the newspaper. However, I still cannot find a good job. I have been disappointed and have accepted this … who can I talk to? I have no friends at all. Also, if I have friends, they cannot always talk to me. They need to work. Also, unemployment is not a good thing. I don't

> want to tell others, including my relatives and friends … Sometimes I cannot sleep when I am thinking about my problems. Also, I always sit in the park and do nothing. I don't feel tired at night and cannot sleep. Besides, my thinking becomes negative. I am afraid that my wife will leave me one day since I am useless. Sometimes, I suspect my wife has another lover and thus check her phone calls. I know that this is not healthy, but I cannot control myself.

The burden of masculinity and hidden men

The above findings indicate that traditional expectations about the gender division of labour (i.e. men should work outside the home and should put "paid work" as the first priority in their life) were still very strong in Hong Kong, especially amongst the middle-aged, low-income groups. Because of the influence of gender expectations and ideas about masculinity which included "men should be strong, outgoing, and the breadwinner", unemployed men suffered from significantly more depression and increased alcohol problems than their employed counterparts, although it was often not reported since they seldom sought help when they were unemployed or facing financial difficulty. As many Chinese scholars have argued, shame plays an important role in social anxiety in Chinese society because of the influence of cultural factors that shape personality (i.e. the view of shame as an important aspect of moral judgment or "saving face" both for the family and the self (Xu 1982; Li et al. 2003; Li et al. 2004; Zhong et al. 2008). Furthermore, because of the emphasis on self-denial and external appraisal, shame tends to cause "a strong sense of

worthlessness and powerlessness", and leads those suffering from shame to use "more strategies of concealing of deficiencies and escaping in difficult situations" (Zhong et al. 2008: 449; Qian et al. 2001; Tangney 1992, 1995). The above findings also confirm the data and arguments from other studies about how individuals themselves view their problems in a gender-specific way (Dohrenwend and Dohrenwend 1977; Rogers and Pilgrim 2005; Kilmartin 2005).

Moreover, as we shall see in Chapter six, women were more willing than men to share their difficulties with others and were more likely to choose someone from within their network to ask for social support (especially from their friends, neighbours, social worker, doctor, or other professionals) when seeking help. This increased the opportunities for women to be referred and had contact with health-related professionals.

Based on the above findings, I suggest that not all men benefit from the patriarchal system. I contend that they face much more pressure from unemployment than women with similar social and economic backgrounds. As Connell and Messerschmidt (2005) have pointed out, only men in the hegemonic position can benefit materially, socially and politically under patriarchy. In contrast, men in subordinate or marginalized groups (such as working class, ethnic minority and homosexual men) often do not benefit from the patriarchal system. As my

study has shown, middle-aged, unemployed/low-income men faced much more pressure than women if they were unemployed because of the influence of gender stereotypes. As a result, for this reason, unemployed men were more likely to have poor mental health than unemployed women (especially depression and even higher levels of alcohol abuse as shown earlier in this chapter) and employed men.

Discussion and conclusion

To conclude, the analysis in this chapter shows that men were more likely than women to be depressed and had heightened levels of alcohol abuse when they were facing unemployment. The data also shows that men generally appeared to suffer more from unemployment than women because of the impact of the social expectations governing the gender division of labour.

The above findings do not entirely fit with previous sociological findings on gender differences in mental health, which usually show that women are more likely to be depressed than men (Kessler 2000; Burns et al. 2001; Simon and Nath 2004; Inabe et al. 2005). Past sociological discussions seem to oversimplify the situation that men and women are facing, since these studies mainly focus on the dominant position of men in situations where women are mostly subordinate. Masculinity scholars (Schauer 2004,

Connell 1995, Connell and Messerschmidt 2005) have argued that masculinity can be divided into four types: hegemonic, subordinate, complicit and marginalized. According to Connell and Messerschmidt (2005), only men in the hegemonic position benefit materially, socially and politically under the patriarchal system. In my study, the male respondents in marginalized groups not only did not benefit from the patriarchal system, which also limited their activities, such as they did not expect themselves to join the community activities and/ or to replace their wife to take the role of taking care of their children after they were unemployed because of the influence of gender stereotypes. For example, one important finding was that as a result of unemployment depression among men was higher than among women.

The key source of pressure amongst these middle-aged, marginalized men came from the social and economic changes in Hong Kong since 1980s. These changes have required more men to face structural unemployment and under-employment – a situation exacerbated by the fact that they cannot afford to travel for employment. This in turn meant these men often needed their wives to work outside the home to maintain the family financially. However, it was obvious that the respondents, especially the men, had failed fully to adopt a new set of behaviours and ideas, such as accepting the need for their wives to work outside the home to maintain

the family financially because of their structural unemployment and under-employment. As a result, the respondents felt they had failed.

Since the 1980s, the men in my study have been facing social and economic changes. They have had to face changes in the employment situation as the economy moved from manufacturing-oriented to service-oriented. Hence, as I have just noted, many middle-aged and low-skilled men were now facing the problem of structural unemployment (Suen and Tam 2000). Under this change, and with the influence of the feminist movement over the past two decades in Hong Kong, more and more middle-aged married women were willing and able to work outside the home. For example, in Hong Kong, the labour force participation rate for women increased from 47.5% in 1982 to 55% in 2016. At the same time, the labour force participation rate for men decreased from 81.3% in 1982 to 68.6% in 2016[41]. Taken together, these factors put a great financial and social pressure on the men.

In addition, the middle-aged men have had to face pressure from others. The pressure from others related to the changes in the economic role of women was, to certain extent, contradictory to the traditional

[41] Source: website of the Census and Statistics Department, HKSAR, http://www.censtatd.gov.hk/hkstat/sub/sp200.jsp?tableID=007&ID=0&productType=8

beliefs acquired through social learning that men are expected to support the family financially and thus leave their wives to stay at home to take care of family members. This contradiction has caused great pressure on the middle-aged men, as my study has shown.

The above shows that the past movement towards somewhat greater gender equality has improved the social status of women, but the movement seemed to have caused problems for the needs of marginalized male groups. Although middle-aged marginalized women also had to face pressures from the unemployment of their husbands, they could benefit from the new opportunities for women and hence had a positive change in their social status. Also, middle-aged marginalized women had an alternative to paid employment, but middle-aged marginalized men did not. Faced by major social and economic changes, middle-aged marginalized women had more job opportunities in the neighbourhood and, even if they could not find a job, they could still go back to the family to work as housewives. Therefore, as my study has found, unemployed women could identify themselves as housewives and this had a positive influence on family life despite their unemployment, while the men mostly did not identify themselves as househusbands.

In sum, under the impact of social and economic changes, both men and women had to adapt and move into an environment that was

significantly different from the one(s) in which they have previously lived, and had to learn a new set of behaviours. However, not all people could adapt to this change easily. For middle-aged unemployed men in particular, the need to adapt to a new set of behaviours and beliefs created significant pressure that had a positive association with increased depression and alcohol abuse as my survey has found.

Chapter 6

The impact of social capital on the mental health status of men and women

In the previous chapter, I pointed out that the data showed that men in Tin Shui Wai were more likely than women to be depressed and have heightened levels alcohol abuse compared with their peers when they were facing unemployment. I linked this to the social and economic changes that the middle-aged men had to face. In this section, I focus on the differences in social capital between middle-aged men and women, and their impact on mental health.

The term social capital (see Chapter two) refers to connections among individuals (often called "social networks") and the norms of reciprocity and trustworthiness among people. In Chinese society, this is called "*guanxi*" (Coleman 1990; Lin 2007). Social capital covers the stock of active connections among people. Under the process of active connection and shared values and behaviour, trust and mutual understanding among people are formed. Social capital is "the value of those assets of social

structures to actors, as resources that can be used by the actors to realize their interests" (Coleman 1990: 305).

Social capital also has an impact on levels of illness. For example, the evidence indicates that people with more social capital have better self-rated health (Eriksson et al. 2010) and mental health (Hamano et al. 2010). In particular, people with weak social networks have higher mortality rates than those who have strong ones (WHO 2003; Holt-Lunstad et al. 2010). Social support is especially useful in protecting individuals from accidents, suicide, cardiovascular disease and depression (Lin 2007). Durkheim (1952 [1897]) argued that married men are less likely to commit suicide than single men, because they are likely to receive support from their wives. People with emotional, informational and instrumental support are also less likely to suffer from both chronic and acute stress (Kim et al. 2008; Hamano et al. 2010; Bhattacharya 2011). In other words, if someone is socially isolated and alienated and lacks support, they will be more likely to suffer from mental illness.

Given different gender stereotypes and expectations, there is a difference between men and women in their use of social capital. Women are more likely than men to be socialised into expressive roles and to provide emotional support for both sexes (Lin et al. 1986; Rogers and Pilgrim 2005). On the other hand, men are more likely to be socialised into

instrumental roles (Emmerik 2006) which emphasize personal achievement and accomplishments (Wood and Lindorff 2001; Bhattacharya 2011). As a result, men are more effective in creating 'hard' social capital (Ibarra 1993; Emmerik 2006: 25). In other words, men are expected to be more restricted emotionally (O'Neil et al. 1986; Chan 2009b). Men are supposed to have more instrumental attitudes (i.e. to be more focused on their careers) and be less emotionally responsive. With hard social capital, men benefit from creating a sense of identity and usually have better mental health[42] even though they may have less 'soft' social capital (Ibarra 1993; Emmerik 2006). In contrast, women are trained to develop and control soft social capital effectively since they typically perform expressive roles.

Men and women's different patterns of using social capital may have a different impact on their mental health. Hard social capital (achieved through employment) actually becomes the main source of promoting and sustaining men's mental health (Wood and Lindorff 2001; Bhattacharya 2011). By contrast, women have relatively rich social capital from family, friends and community as a result of gender expectations. However, there has been limited study of the importance of having different levels of social capital in promoting mental health. As McKenzie (2006) has noted,

[42] This mental health status excludes substance use disorders.

the study of the possible mechanisms through which social capital is considered to have an impact on the rates of mental illness has not been researched empirically to any great extent. In particular, middle-aged men are seldom the focus for examining the impact of the use of social capital on mental health or the development of mental illness. In this chapter, I examine the differences in social capital of men and women and consider how these differences affect their mental health.

As I indicated in Chapter three, in order to explore the status of social capital in Tin Shui Wai in Hong Kong, I constructed a general measure of social capital from the scores on the variables I listed there. The maximum score was 132.

The amount of social capital controlled by men and women

As expected, the data from my study shows that the social capital controlled by men was less than that controlled by women. The average score for men was 51.4 whereas that for women was 56.5 (p=.065). The figures are given in Table 6.1 (below). Even though the difference was not very large and was not statistically significant, and there was greater variation in women's scores than men's, as many studies have shown, women are trained to manage social capital (especially soft social capital) effectively (Lin et al. 1986; Rogers and Pilgrim 2005), since they are

expected to perform more expressive roles. An expressive person "is said to show solidarity, to raise the status of others, to give help, reward, agree, concur, comply, understand, and passively accept" (Lin et al. 1986: 288).

Score	Men	Women	All
Average	51.4*	56.5*	54.1 #
Maximum	91	97	97
Minimum.	26	23	23
N	188	315	403

Table 6. 1: Social capital by gender in the survey sample
* t(62)=1.879, p=.065
# The maximum score is 132

More specifically, I also found that the differences in the specific areas of social support, group membership, community networks, and social cohesion between men and women were much more marked.[43]

In the study, the specific measure of social support allowed a maximum score of 72. The data shows that 5.6% of men and 16% of women obtained scores of 36–53, indicating that the women had more social support than the men. At the same time, 31.8% of men and 17.6 % of women obtained scores of only 0–17. The data for men and women are given in Table 6.2 (below) and were consistent with previous findings that women had strong needs for affiliation and nurturance (Ruderman 2006).

[43] In this study, there were no differences between men and women in the scores for the three areas "trust", "engagement in public affairs" and "sense of community". This is consistent with other studies (Taylor et al. 2007; Read 2007; Statistics Canada 2005). Also, there were no notably low scores on any of these dimensions.

In consequence, those individuals might be especially sensitive to their social environment (such as harmonious relationships with others) and therefore might be more likely to seek emotional support and help when facing problems than men.

Score	Men (%)	Women (%)	All (%)
0-17	34 (31.8)	22 (17.6)	56 (24.1)
18-35	67 (62.6)	83 (66.4)	150 (64.7)
36-53	6 (5.6)	20 (16.0)	26 (11.2)
54-72	--	--	--
N	107 (100)	125 (100)	232 (100)

Table 6. 2: Social support by gender in the survey sample
Note: The maximum score is 72. (Chi-square=10.483, df=2, p=.005)

In terms of group membership, I found that men were less likely to participate in community life. With 6 as a maximum score for group membership, 12.8% of men and 23.3 % of women obtained scores of 5–6. At the same time, 70.7% of men and 58.1 % of women obtained scores of 0–2 (see Table 6.3).

Score	Men (%)	Women (%)	All (%)
0-2	133 (70.7)	125 (58.1)	258 (64.0)
3-4	31 (16.5)	40 (18.6)	71 (17.6)
5-6	24 (12.8)	50 (23.3)	74 (18.4)
N	188 (100)	215 (100)	403 (100)

Table 6. 3: Group membership by gender in the survey sample
Note: The maximum score is 6. (Chi-square=8.754, df=2, p=.013)

In term of community networks in the survey, the maximum community networks score was 12. A total of 8.5% of men and 12.1% of women obtained a score between 10 and 12. At the same time, 17.0% of men and 12.6% of women obtained a score of 0–3. Also, if the two higher score

categories, 7-9 and 10-12 were combined; the difference between men and women was more marked (see Table 6.4). These figures indicate that women tended to have stronger community networks than men.

	Men (%)	Women (%)	All (%)
0-3	32 (17.0)	27 (12.6)	59 (14.6)
4-6	75 (39.9)	53 (24.7)	128 (31.8)
7-9	65 (34.6)	109 (50.7)	174 (43.2)
10-12	16 (8.5)	26 (12.1)	42 (10.4)
N	188 (100)	215 (100)	403 (100)

Table 6. 4: Community networks by gender in the survey sample
Note: The maximum score is 12. (Chi-square=15.975, df=3, p=.001)

In terms of social cohesion, 12 was the maximum score possible; only 3.2% of men and 7.9% of women obtained scores of 10–12 (see Table 6.5). 60.1% of men and 47.9% of women obtained scores of only 0–3.

Score	Men (%)	Women (%)	All (%)
0-3	113 (60.1)	103 (47.9)	216 (53.6)
4-6	35 (18.6)	40 (18.6)	75 (18.6)
7-9	34 (18.1)	55 (25.6)	89 (22.1)
10-12	6 (3.2)	17 (7.9)	23 (5.7)
N	188 (100)	215 (100)	403 (100)

Table 6. 5: Social cohesion by gender in the survey sample
Note: The maximum score is 12. (Chi-square=9.245, df=3, p=.026)

Men's and women's different patterns of accessing social capital

Examining the detailed content of social capital, the study showed that men were less likely to control the different dimensions of social capital, including bonding and bridging social capital, and structural and cognitive social capital, than women.

Bonding social capital

As previously indicated, bonding social capital is an intra-group phenomenon and relies on strong social ties. This can be reflected in homogeneity, strong norms, loyalty and exclusivity. A typical example is the family unit found in small close-knit migrant groups which need mutual support (Putnam 2000; Onyx and Bullen 2001; Bhattacharya 2011). In the study, only 26% of men compared with 35.4% of women reported that they "always" sought help from "family members". The figures for seeking help from "friends" were 13.3% and 17.4%, for men and women respectively (see Table 6.6).

		Family member(s) (%)	Neighbour(s) (%)	Friend(s) (%)	School (%)	Government department(s) (%)	Other NGO(s) (%)	Others (%)
Men (%)	Never	46 (30.7)	104 (69.4)	55 (36.7)	137 (91.3)	101 (67.3)	106 (70.7)	146 (97.3)
	Seldom	23 (15.3)	28 (18.7)	26 (17.3)	10 (6.7)	24 (16)	16 (10.7)	2 (1.3)
	Sometimes	42 (28)	18 (12)	49 (32.7)	--	19 (12.7)	15 (10)	--
	Always	39 (26.0)	--	20 (13.3)	3 (2)	6 (4)	13 (8.7)	2 (1.3)
	N	150 (100)	150 (100)	150 (100)	150 (100)	150 (100)	150 (100)	150 (100)
Women (%)	Never	28 (17.4)	108 (67.1)	36 (22.4)	125 (77.6)	101 (62.7)	95 (59)	141 (87.6)
	Seldom	38 (23.6)	28 (17.4)	24 (14.9)	23 (14.3)	25 (15.5)	38 (23.6)	10 (6.2)
	Sometimes	38 (23.6)	16 (9.9)	73 (45.3)	8 (5)	25 (15.5)	16 (9.9)	4 (2.5)
	Always	57 (35.4)	9 (5.6)	28 (17.4)	5 (3.1)	10 (6.2)	12 (7.5)	6 (3.7)
	N	161 (100)	161 (100)	161 (100)	161 (100)	161 (100)	161 (100)	161 (100)
All (%)	Never	74 (23.8)	212 (68.2)	91 (29.3)	262 (84.2)	202 (65)	201 (64.6)	287 (92.3)
	Seldom	61 (19.6)	56 (18)	50 (16.1)	33 (10.6)	49 (15.8)	54 (17.4)	12 (3.9)
	Sometimes	80 (25.7)	34 (10.9)	122 (39.2)	8 (2.6)	44 (14.1)	31 (10)	4 (1.3)
	Always	96 (30.9)	9 (2.9)	48 (15.4)	8 (2.6)	16 (5.1)	25 (8)	8 (2.6)
	N	311 (100)	311 (100)	311 (100)	311 (100)	311 (100)	311 (100)	311 (100)

Table 6. 6: Persons from whom help was sought in the survey sample

In general, men were less likely than women to seek help formally or informally from others than women (see Table 6.6, above). This was consistent with previous local and international findings from sociological research that in this particular respect men's attitudes and behaviour vis à vis their social world are usually more passive than women's, which creates problems for them (Hong Kong Council of Social Service 2004; Galdas et al. 2005; Liu and Iwamoto 2006; Chan 2009b; Harmony House Hong Kong 2014). For example, in Hong Kong when they faced problems, most men (in particular, low-income, low educated and middle-aged men) tried to solve the problems themselves and did not seek help formally or informally.

In my study, the data shows that when facing problems women were more likely to seek help from others than men, even though the difference was not very large. In the survey, 78.8% of men and 74.0% of women had faced problems in the past year (see Table 6.7).

	Men (%)	Women (%)	Overall (%)
No	40 (21.3)	56 (26.0)	96 (23.8)
Yes	148 (78.8)	159 (74.0)	307 (76.2)
N	188 (100)	215 (100)	403 (100)

Table 6. 7: Responses to the question: 'Did the respondent face any problems in the past year?' in the survey sample

In general, far fewer men (119) than women (151) sought any help for their problems. Yet of those who did seek help, the differences between men

and women were not very large. For example, 48.7% of the men and 51.0% of the women had sought help from one to three people in the past year (see Table 6.8 below). Women were, however, more likely to seek help from 10 or more people.

	Men (%)	Women (%)	All (%)
1 - 3	58 (48.7)	77 (51.0)	135 (50.0)
4 - 6	36 (30.3)	44 (29.1)	80 (29.6)
7 - 9	10 (8.4)	4 (2.6)	14 (5.2)
10 or more	15 (12.6)	26 (17.2)	41 (15.2)
N	119 (100)	151 (100)	270 (100)

Table 6. 8: Number from whom help was sought in the survey sample

In addition, for those who sought help from others, women (82.2%) were more likely to seek emotional support than men (63.2%), even though seeking emotional support was the commonest reason for men and women to seek help (see Table 6.9). Also, as we would expect from the data from focus groups and in-depth interviews, most emotional support for women was from family and friends. Men (42.4%) were much more likely than women (27.4%) to seek help and support for financial reasons.

Reason for seeking help	Men (%)	Women (%)	Overall (%)
Emotional support (such as giving advice)	91 (63.2)	129 (82.2)	220 (73.1)
Financial support	61 (42.4)	43 (27.4)	104 (34.6)
Material support	28 (19.4)	32 (20.4)	60 (19.9)
Caring support (such as childcare or shopping)	38 (26.4)	56 (35.7)	94 (31.2)
Others	16 (11.1)	15 (9.6)	31 (10.3)
N	144	157	301

Table 6. 9: Reasons for seeking help in the survey sample
Note: Respondents could give more than one answer so the percentages do not add up to 100%.

It appeared that the main reason men were less likely than women to seek emotional support from family and friends was not that they did not want to talk about their feelings. Rather, it was that they did not think they could find suitable people to talk to. Most men said that they could not talk to unemployed men in the community since they faced the same problems and they wanted to talk to someone who was in work. The men said that talking to others who had the same problem not only did not solve the problem, but also created more pressure since they thought the other person would think that they were hopeless. In addition, at night, most employed men went home quite late and wanted to stay at home to relax. Therefore, it was almost impossible to find an employed man to talk to because they went back home quite late and preferred to go home to rest after work. If they had friends living outside the community, men also said that they could not to talk to them since if they talked on the phone, it was far harder to talk about emotions; and second, they did not have

enough money to travel outside the community just to talk to a friend. Instead, they needed to use the money for household expenditure or job-seeking if they were unemployed. This was highlighted by the following extract from a focus group:

> MR1(FG)：For those who have a job, they mostly leave home early and come back home late. They don't even have time to talk to their children, so how they can talk to me? If someone can talk to you, they must be unemployed. Their difficulties and problems will be similar to yours. Also, their stress level will be the same as yours. So, I think there is no need to talk to them. This will only cause additional pressure and stress, right … If you have some relatives and friends living outside Tin Shui Wai, they also cannot help you or even talk to you. They are also busy. It is difficult and impossible for them to visit you if you live in Tin Shui Wai, which is too far away from the urban area. I have not seen my relatives and friends for many, many years. As many people have said, living in Tin Shui Wai is equal to ending the relationship with all of your relatives and friends [斷六親] … I have a good friend in Hong Kong Island [urban Hong Kong]. He doesn't have time to visit me. If I visit him, I have to spend at least HK$50 [around £4.2] on travelling. Apart from that, you need to have a meal with him. You need to spend around HK$100 [around £8.3]. Therefore, if you want to find someone to talk to, the first requirement is that you have money. If you are poor now, how can you still waste money on talking to friends? Also, talking with friends cannot help me to solve my problems, but I need to spend a lot of money. This is not reasonable.

As noted, women (82.2%) were more likely than men (63.2%) to seek help for emotional support from others (see Table 6.9). Emotional support for women mainly focused on child care and family problems:

> FR4：I talk to other mothers in front of school when we wait for our children to leave school. You have two or three ideas about solving the problem; other mothers also have two or three ideas. You thus can have many solutions and reduce the pressure … Also, we can talk with the team members and volunteers in the community centre.

> I：What problem(s) do you mostly talk about?
>
> FR6(FG)：Problems related to children's study … My children don't do their homework after school. I want to learn more skills to teach my children. Also, my children always play on-line games. I use many techniques to improve the problem, but none of them have worked. Therefore, I talk with others to seek advice.

My data showed that the percentage seeking material help from others for both men (19.4%) and women (20.4%) was low (see Table 6.9), since respondents thought that they would "lose face" if they did. Also, most people living in Tin Shui Wai were low-income families, so that the women thought that it was impossible to seek financial help from others. Only 42.4% of men and 27.4% of women had sought financial support (see Table 6.9). The data also showed that both men and women respondents sometimes talked to family members to reduce the pressure and stress when they faced financial difficulties:

> FG3(II)：We seldom talk about our problems, especially financial problems in the family, with others. This is not the best way to do so since it will lose "face". You know, this is Chinese culture. You don't tell others about bad things in a family [家醜不想外傳].
>
> FG5(II)：No. My husband did not want to talk about this [i.e. losing money in an investment] to others, including our relatives. However, I told my little brother secretly for emotional support since I really worry about my husband; otherwise I had no one I could talk to.

Women were a little more willing than men to seek financial aid and material help through a formal channel, such as a government department (32.7% of men; 37.3% of women), non-government department (29.3% of

men, 41% of women) or other institution, such as the church (2.7% men, 12.4% women) (see Table 6.6, above). One of the most important reasons for this help-seeking pattern was that most women thought this was their right, as one of respondents in an in-depth interview said:

> FG1(II)：I have suffered from depression for 13 years. This affects my life so much. I cannot work and take care of my daughter. I am now living on Comprehensive Social Security Assistance (CSSA).
>
> I：How do you feel you are now living on CSSA?
>
> FG1(II): I feel ok. Even though I know some people argue that I am lazy since I live on CSSA. However, I think I have to take care of my daughter and thus cannot work. As a citizen in Hong Kong, it is my right to apply for CSSA if I need to.

Men were less likely to seek financial and material support from formal channels, such as a government department, NGOs or the church, because they tended to consider their self-esteem, although they were more likely than women to talk about financial issues. Sometimes, men even used the reason of considering the feelings of family members to cover their own fear of the stigma of seeking welfare and to protect their self-esteem. Some of them believed that their problems, such as unemployment and poverty, would only last for a short time once they found a new job. In other words, men were more likely to believe that they could solve their financial and material problems by themselves:

> MR1(FG)：If you really apply for the CSSA, I am sure that your wife doesn't want to tell or talk to others about this. Your children don't want to bring their classmates to their home. You know if their classmates ask

> your children what job your father has, how do your children respond? Do you want your children to say that my father doesn't work and is receiving the CSSA now? I am sure that if your children say this, they would be laughed at by their classmates later. Applying for the CSSA not only damages your self-esteem, but also your children's … In addition, if your children grow up and find a job, this does not mean that your family situation will be improved. My son and daughter are working now. However, they can only earn around HK$6000 per month [around £500]. Their income actually cannot improve the family's financial situation. Because they can earn money, our family cannot meet the basic requirement of applying to the CSSA. I don't have a job, but my children also don't have the ability to take care of me. So what can I do? I don't want to demand that my children don't work and apply for the CSSA. They are very young. They cannot depend on the CSSA for their whole life. It is a father's responsibility to teach children to be a good citizen.

Apart from help-seeking, in the focus groups and in-depth interviews I found that none of the men told me that they had helped others. The main reason for men being less likely than women to help others was that they did not have strong social networks in the community. The study showed that both men and women were only willing to help someone whom they knew beforehand. However, because women mostly had more friends and contacts with others in the community, they had more opportunity to help others:

> FG2(FG)：Through a non-governmental organisation, I take part in voluntary service. Now, I am a member of voluntary team. I join in the voluntary service actively, such as visiting the elderly, teaching others how to cook. Also, within the team, we always help each other, such as sharing, emotional support and helping others to take care of their children.
>
> MR1(FG)：I don't have friends in Tin Shui Wai. It is because when I was employed; I always worked outside and did not stay in Tin Shui Wai. I don't know the residents and neighbours in Tin Shui Wai; how can I help them? I don't think I have this ability.

The survey produced a similar picture. Although the difference was not very large, women (74%) were more likely than men to have helped others (66%) in the past year (see Table 6.10, below). This supports previous findings (Bakan 1966; Erikson 1964; Parsons & Bales 1956; Rogers and Pilgrim 2005) that women have a greater concern for harmonious relationships with others and so are more willing to provide support to others, though the gender difference in this study was not very great.

	Men (%)	Women (%)	Overall (%)
No	64 (34)	56 (26)	120 (29.8%)
Yes	124 (66)	159 (74)	283 (70.2%)
N	188 (100)	215 (100)	403 (100)

Table 6. 10: Helping others in the survey sample

In short, in the study the bonding social capital controlled by men was generally less than that of women. Men were less likely to seek help from a friends and family members, or to help them, because of personal reasons (i.e. preferring to try and solve any problems themselves). Men were also less likely to seek help from social networks in the community, which were weaker than those of women.

Bridging social capital

As noted previously, in contrast to bonding social capital, bridging social capital is outward facing and links different groups in society. Ties among

people in different groups are weaker and sometimes more fragile than the ties among people from the same group (Putnam 2000).

In the study, I found that because of the relatively homogeneous socio-economic characteristics of the population in Tin Shui Wai, the distant location, and high transport costs, most middle-aged men and women, especially those who were unemployed, were unlikely to have the advantage of knowing people with a different socio-economic status than those who were not affected by these factors:

> MR1(II)：I seldom go outside the community since it is costly to do so.
>
> FR3(II)：I seldom go outside for playing, eating and shopping since I think it will waste a lot of money … For friends, I have no friends outside the community.
>
> MR4(II): No money, no life. I don't go outside the community since the transportation cost is high. Also, after unemployment, I have no friends. All of my friends were my colleagues in the past. Now, we don't contact.

In addition, even though some respondents sometimes travelled outside the community, they only had contact with their intra-group (such as family members, relatives and friends). In other words, they had limited opportunities to have contact with people from a different background and class except in the context of work:

> MR2(II)：I work in Hong Kong Island. Mostly, I go outside the community for work. Also, I visit my parents in Shatin every Saturday night. On Sunday, my wife and I go to Shatin to visit my wife's parents and brothers. Apart from that, I sometimes, maybe 1–2 times per month, have a gathering with my friends. Actually, I always go outside the community for work and play.

> MR3(II)：I go outside the community for 5–6 days per week because of working and part-time studying. Tin Shui Wai is only a place for me to sleep.

In short, both middle-aged men and women in Tin Shui Wai in the survey seldom knew people of high socio-economic status.

Structural social capital

As Coleman (1988) has argued, structural social capital refers to relationships, networks, associations, and institutions that link together people and groups. Structural social capital can be measured by the analysis of linkages and network density. For example, the numbers of church groups, volunteer groups and interest societies may be considered an indicator of structural social capital. At an individual level, membership of groups outside the work environment can be measured.

In my study, I again found that the structural social capital controlled by men was less than that controlled by women. Only 28.2% of men but 40.9% of women had attended voluntary activities in the past year. The figures are given in Table 6.11.

	Men (%)	Women (%)	All (%)
Yes	53 (28.2)	88 (40.9)	141 (35)
No	135 (71.8)	127 (59.1)	262 (65)
N	188 (100)	215 (100)	403 (100)

Table 6. 11: Attendance at voluntary activities in the survey sample

In addition, the number of voluntary organisations or groups of which the men had been members in the past year was less than that for women (see Table 6.12).

	Men	Women	All
Average	0.71	0.93	0.83
Max.	5	10	10
Min.	0	0	0
N	186	215	401*

Table 6. 12: Membership of voluntary organisations in the survey sample

* Two respondents out of 403 did not provided answer about the number of voluntary organisations or groups of which they had been members.

The above findings also imply a different way of using the time resulting from unemployment between men and women. As the data in Chapter five has shown, 65.1% of men and 41% of women reported "having more free time but nothing to do" and "hav[ing] more free time to do something that interests me" respectively. Men were less likely to participate in community life because they saw community participation as a leisure activity and did not think it is suitable for them to become involved as they were unemployed. If they became involved, they thought other people would label them as lazy men who did not want to work, but only amused themselves:

> MR1(II)：No. I don't want to join community activities alone. I don't have friends in Tin Shui Wai. Also, my wife does not like to see me go out for leisure, without working. For her, attending community activities is time wasting. Also, attending community activities seems to be a female activity.
>
> MR4(II)：I am not interested in community participation. My basic problem [i.e. unemployment] cannot be solved, so how can I be motivated to join community activities? Also, the whole community is full of injustices and social problems. As a poorly educated man, I do not think that I can change them. Also, I have no power to do so since no one listens to me. Therefore, I do not concern myself with community affairs or vote.

Women, however, thought that community participation was a way to spend their time meaningfully (no matter whether they were unemployed or a housewife) if their health was good enough to join in:

> FR4(FG)：If the cost of community activities is not expensive, I will join them. If the cost of community activities is over HK$20 [around £1.7], I will not join since the total cost for whole family is HK$100 [around £8.3] for 4 persons … I will use this HK$100 for buying food … However, if the cost is very cheap and the activity includes a free lunch, I will join. My children and I have chance to go out. That is good.
>
> FR6(FG)：If you don't join the activities in the community, you never have opportunities to go outside the community. My family is poor. If I don't join the activities in the community, I will not have a chance to visit Ocean Park and Disney.
>
> FR5(FG)：I have to take care of my son, so I cannot work. When my son goes to school, I will join community activities. This is better than staying at home lonely.
>
> FR1(FG)：Yes, joining community activities can make me feel the time is going faster.

The above extracts from focus groups, in-depth interviews and the survey show that men felt great shame at being unemployed. They felt that they

were useless when they were jobless and thus did not have the right to enjoy leisure time and participate in the community.

Cognitive social capital

Cognitive social capital, which is sometimes viewed as a collective moral resource, includes values, norms, reciprocity altruism and civic responsibility. This can be measured by conducting surveys of the level of trust amongst neighbours and civic identity and comparing the rates of trust in different areas. At an individual level, the perceptions of community, such as the sense of belonging and trust, can also be measured (Coleman 1988).

In general, even though women were more likely than men to "always" talk with their "colleagues", "friends", "neighbours" and "family" (see Table 6.13), an interesting finding of the study was that although men and women were likely to have contact with their friends and family members, they mostly had little contact with their neighbours.

		Colleagues	Friends	Neighbour	Family
Men (%)	Never	83 (44.1)	--	76 (40.4)	34 (18.1)
	Seldom	21 (11.2)	42 (22.3)	58 (30.9)	46 (24.5)
	Sometimes	42 (22.3)	49 (26.1)	41 (21.8)	63 (33.5)
	Always	42 (22.3)	97 (51.6)	13 (6.9)	45 (23.9)
	N	188 (100)	188 (100)	188 (100)	188 (100)
Women (%)	Never	117 (54.4)	--	69 (32.1)	13 (6)
	Seldom	14 (6.5)	28 (13)	57 (26.5)	21 (9.8)
	Sometimes	34 (15.8)	49 (22.8)	57 (26.7)	95 (44.2)
	Always	50 (23.3)	138 (64.2)	32 (14.9)	86 (40)
	N	215 (100)	215 (100)	215 (100)	215 (100)
All (%)	Never	200 (49.6)	--	145 (36)	47 (11.7)
	Seldom	35 (8.7)	70 (17.4)	115 (28.5)	67 (16.6)
	Sometimes	76 (18.9)	98 (24.3)	98 (24.3)	158 (39.5)
	Always	92 (22.8)	235 (58.3)	45 (11.2)	131 (32.5)
	N	403 (100)	403 (100)	403 (100)	403 (100)

Table 6. 13: Talking with others in the survey sample

In particular, there were still a large number of respondents, both men and women, who said they never had "Contact with the residents", "Join activities with the residents", "Join family activities with other families" and/or "Attend community activities" (see Table 6.14).

		Contact with residents %	Join activities with residents %	Join family activities with other families %	Attend community activities %
Men	Never	67 (35.6)	118 (62.8)	116 (61.7)	118 (62.8)
	Seldom	49 (26.1)	32 (17)	33 (17.6)	26 (13.8)
	Sometimes	57 (30.3)	26 (13.8)	30 (16)	29 (15.4)
	Always	15 (8)	12 (6.4)	9 (4.8)	15 (8)
	N	188 (100)	188 (100)	188 (100)	188 (100)
Women	Never	55 (25.6)	99 (46)	103 (47.9)	101 (47)
	Seldom	65 (30.2)	44 (20.5)	36 (16.7)	46 (21.4)
	Sometimes	59 (27.4)	48 (22.3)	64 (29.8)	47 (21.9)
	Always	36 (16.7)	24 (11.2)	12 (5.6)	21 (9.8)
	N	215 (100)	215 (100)	215 (100)	215 (100)
All	Never	122 (30.3)	217 (53.8)	219 (54.3)	219 (54.3)
	Seldom	114 (28.3)	76 (18.9)	69 (17.1)	72 (17.9)
	Sometimes	116 (28.8)	74 (18.4)	94 (23.3)	76 (18.9)
	Always	51 (12.7)	36 (8.9)	21 (5.2)	36 (8.9)
	N	403 (100)	403 (100)	403 (100)	403 (100)

Table 6. 14: Participation in community activities in the survey sample

Some respondents reported that, though they had lived in the community for over ten years, they did not even know their neighbours' surname. They said they only said hello to their neighbours. According to respondents the limited contact with neighbours was very common in the community. They argued that this was due to the design of the housing, unemployment, and a sense of insecurity towards strangers. This situation was similar to other communities in urban areas of Hong Kong during the late 1980s and early 1990s, in which neighbourhood support began to shrink because of the economic boom and urbanization (Aberdeen Kai-fong Welfare Association Social Service Centre and Asia-Pacific Institute of Ageing Studies 2009). Respondents commented:

MR1(II)：I will say hello to them [neighbours] when we meet. However, I seldom talk to them since most of them are my wife's friends. They may tell my wife if I talk to them.

MR2(II)：However, I am seldom in contact with them since I am always away to work. I only say hello to my neighbour when we meet. For other residents, I am never in contact with them.

FR4(FG)：In the community, even though you always see some neighbours, you still don't say hello to them.

I：Why?

FR4(FG)：Laziness. Also, you don't know each other. We are afraid that we will be cheated.

I：Why is the relationship between neighbours in the community poor?

FR4(FG)：You know. In the past, the design of front door was very open. You could even look into the opposite house when you sat inside your home. Therefore, your neighbours actually seemed to live close to you … However, now, the design of front door is not open. You can know that someone walks in front of your home. However, you can never see their face.

FR1(II)：No impression at all. I don't like to have contact with them. I don't want to let them to know too much. I don't say hello to them. If they know you too much, they will tell other residents. I am a depressed person and a single mother. They must have great interest in me.

The above extracts show that some of the respondents had weak connections with residents because: 1) to a certain extent they felt shame about their current living conditions, such as unemployment, poor mental health status or having poor relationship with their wife; 2) they were not adapted to Hong Kong's cultural living environment, such as low level of trust among neighbours; 3) they lacked the will and courage to make contact with others in the community.

In addition, in the focus groups and in-depth interviews, there was evidence that some respondents had a low sense of community belonging. To a large extent, they did not like to live in Tin Shui Wai. Travel problems, low employment opportunities, high prices, and location were the most common dissatisfactions. They said that before they moved into this community, they never expected such a lot of problems. They moved into the community mainly because they were attracted by the living conditions, such as larger houses, and low pollution. Now, some wanted to leave and move to the urban area. However, they did not have finances to do this:

> MR5(FG)：The transport network is not convenient. A lot of public transport cannot be accessed here.
>
> MR5(FG)：If you only live here, this is a good place. However, if you want to work, it is very difficult.
>
> MR3(II)：I am not satisfied with my life in the community … In the past, my good friends were living nearby my home. We could always meet together, even, we could meet at midnight to have a meal. However, I have to use a lot of travelling time to find my friends and thus feel lonely.
>
> I：What do you like in the community?
>
> FR4(FG)：My house is bigger than before.
>
> FR2(FG)：The environment and house size.
>
> FR3(FG)：The environment is very good indeed. The living environment is very attractive for a lot of people. However, if you have to work and live for long time, this is not a good place … Life is very expensive and prices are also very high … even higher than in the urban area.
>
> FR2(FG)：We have to use a lot of time for travelling outside for work.
>
> FR5(FG)：Apart from time, the cost of travelling is very high.

FR1(II)：Crowded. No other special impressions of this community since I don't communicate with the residents and don't care about the community.

FR2(II)：If I have a choice, I want to leave this community and live in the city. However, rent is very high in urban areas. I cannot afford it myself.

The influence of weak social capital on mental health status

The above findings suggest that men controlled less social capital than women. The data also shows low overall levels of social capital in Tin Shui Wai with an average score of only 54, which was below the overall average of Southern Hong Kong. Compared with results from a similar study in Southern Hong Kong (Aberdeen Kai-fong Welfare Association Social Service Centre and Asia-Pacific Institute of Ageing Studies 2009), the level of social capital in Tin Shui Wai was low since the mean score of the social capital index[44] in Southern Hong Kong was 312 (maximum mark: 580). Besides, according to a comparison between the Tin Shui Wai community and Sham Shui Po by the Central Policy Unit, Hong Kong Special Administration Region (Central Policy Unity 2009), social capital

[44] In the study conducted by Aberdeen Kai-fong Welfare Association Social Service Centre and Asia-Pacific Institute of Ageing Studies (2009), the social capital index, which was called the "Caring Index", included six domains: social solidarity, social inclusion, social participation, self-help & mutual-help, individual network, and organization and business network. This index was used to measure the status of social capital among residents in Southern Hong Kong where living standards and income levels are better and higher than in Tin Shui Wai.

in Tin Shui Wai was weaker than in Sham Shui Po, which itself was one of the poorest regions in Hong Kong. In the following sections, I discuss the influence of weak social capital on mental health status.

According to Table 6.15, in this study the amount of social capital was associated with mental health status, including depression, anxiety and alcohol abuse. In particular, when people suffered from the negative effects of unemployment, which was measured by the questions (such as they could not sleep, went gambling, had a poor appetite, and so on) shown in Table 5.7, and the social capital they controlled was lower, their mental health status, including depression, anxiety and alcohol abuse, was poorer.

	Overall social capital score	Depression	Anxiety	Alcohol abuse
Overall score of social capital	--	*-.371***	*-.234***	*-.160**
Negative effects of unemployment	.508**	*.684***	*.396***	*.474***

Table 6. 15: Correlation among different variables in the survey sample
Pearson correlation: * Significant at the 0.01 level (2-tailed); ** Significant at the 0.05 level (2-tailed).

Hence, put a different way, the above findings show that mental health status among these middle-aged and unemployed people was, to certain extent, positively associated with social capital in a way that was consistent with previous findings (Hamano et al. 2010).

To compare the difference in the mental health status, overall social capital, and the negative effects of unemployment between unemployed men and unemployed women, multivariate analysis of variance (MANOVA), which was followed by pairwise comparisons to localise significant difference between groups, was used. MANOVA analysis was used as it provided a method of testing the two populations among separate and multifaceted survey questions. It was used when there was more than one dependent variable. In my MANOVA analysis, the unemployed men versus unemployed women served as the independent variable, and mental health status, including depression, anxiety and alcohol abuse, overall social capital and the negative effects of unemployment served as the dependent variables. Among the dependent variables, the negative effects of unemployment on the respondents were measured by the questions such as they could not sleep, went gambling, had a poor appetite, and so on as shown in Table 5.7. As I pointed out in Chapter three, the negative effects of unemployment were the general negative effects of unemployment for the respondents, not the symptoms and/ or diagnosis of mental illness resulting from unemployment. These were included in the analysis since I wanted to understand the more general effects of unemployment on men and women.

To apply the MANOVA, there should be an adequate sample size; data should be normally distributed; free from outliers; had no multi-collinearity; and should have homogeneous variances and covariance (Hair et al., 2009). After checking for non-violation of the afore-mentioned assumptions, the multivariate tests were conducted. These tests indicated whether groups were statistically different from each other on a linear combination of dependent variables. There are a number of multivariate test statistics, however, the most commonly reported is the Wilks' lambad. If the value of the Wilk's lambad is significant ($p<0.05$), then it indicates that differences among groups existed. In my study, MANOVA revealed a statistically significant difference between unemployed men and unemployed women in mental health status, overall social capital and the negative effects of unemployment (Wilks's lambad = .749, $F(5, 61)=4.079$, $p=.003$).

Further to check for each of the dependent variables, the test for between-subjects effect was conducted. Since here a number of dependent variables were analyzed separately, it was important to set alpha (α)-level values to avoid Type 1 errors (Hair et al., 2009). My analysis used an α value of 0.05 to minimise the bias. Additionally, for an in-depth analysis,

the size effects[45] measured by Cohen's d-prime, which Cohen (1988) defined effect sizes as small, d=.2, medium, d=.5, and large, d=.8, was also included.

According to Table 6.16, significant differences were found with unemployed men reporting higher scores of depression (Unemployed men: M=8.429; Unemployed women: M=7.385) (p=.028), alcohol abuse (Unemployed men: M=3.679; Unemployed women: M=1.487) (p=.32), the negative effects of unemployment (Unemployed men: M=1.615; Unemployed women: M=1.250) (p=.031) than unemployed women. While statistically significant, the difference in depression, alcohol abuse and the negative effects of unemployment had a small (d=-.269), medium (d=-.510) and small (d=-.249) effect size respectively. In addition significant differences were also found with unemployed women reporting higher scores of anxiety (Unemployed men: M=6.571; Unemployed women: M=8.744) (p=.021) and overall social capital (Unemployed men: M=52.359; Unemployed women: M=55.607) (p=.045) than unemployed women. While statistically significant, the difference in anxiety and overall social capital had a medium (d=-.581) and small (d=-.183) effect size respectively.

[45] Effect size is to measure the magnitude of an effect. Unlike significance tests, effect size is independent of sample size.

	Group	M	SD	Cohen's d-prime (d)	F	p
Depression	Unemployed men	8.429	3.595	.269	1.148	.028
	Unemployed women	7.385	4.159			
Anxiety	Unemployed men	6.571	3.995	-.581	5.627	.021
	Unemployed women	8.744	3.470			
Alcohol abuse	Unemployed men	3.679	5.591	.510	4.800	.032
	Unemployed women	1.487	2.383			
Overall social capital	Unemployed men	52.359	16.642	-.183	.556	.045
	Unemployed women	55.607	18.835			
Negative effects of unemployment	Unemployed men	1.615	1.350	.249	1.036	.031
	Unemployed women	1.250	1.578			

Table 6. 16: MANOVA for the difference in mental health status, overall social capital and negative effects of unemployment between unemployed men and unemployed women in the survey sample

Note: N=69 overall; Unemployed men=54; Unemployed women: 15. Cohen's d-prime (d)= M1 - M2 / spooled, where spooled =√[(s 12+ s 22) / 2].

Based on the above statistically significant difference between unemployed men and unemployed women in mental health status, overall social capital and the negative effects of unemployment, further analysis on the association between mental health status, overall social capital and the negative effects of unemployment for unemployed men and unemployed women was conducted. A linear regression model on unemployed respondents was used. Again, this was used since the dependent variables, including depression, anxiety and alcohol abuse scores were continuous.

The independent variables that were related to the demographic factors (i.e. compositional factors), including marital status, birth place, and educational attainment, overall social capital and negative effects of unemployment (i.e. contextual factors), were selected for measurement. A linear regression analysis on male and female respondents who did not have paid employment was conducted. In the context of the analysis performed here, the regression analysis allowed for estimation of 1) the overall association between compositional factors and mental health ('fixed parameters'); 2) the effect of contextual factors, measured by overall social capital; and 3) the effect of contextual factors, measured by negative effects of unemployment. The following are detailed descriptions of the three models:

Model 1: This model was used to assess the compositional effect on mental health, and included the variables of marital status, birth place (i.e. Hong Kong or outside Hong Kong), and educational attainment.

Model 2: This was the same as Model 1 with the added variables of overall social capital. Here, the model was used to assess the contextual effect of social capital on mental health after adjusting for compositional factors.

Model 3: This was the same as Model 2 with the added variable of the negative effects of unemployment on the respondents. We considered

whether the unemployment (especially its negative effects) exerted an effect on mental health after adjusting for overall social capital and other compositional factors. In other words, I want to understand whether the general negative effects of unemployment have an association with the mental illness.

Table 6.17 provides the results of the regression analyses for depression. In Model 1 the analysis shows that for men marital status and birth place were not associated with depression. However, unemployed male respondents whose education level was at primary school (4.779***), but lower than post-secondary or above (-3.699*) had higher alcohol abuse scores. For women, birth place and educational attainment were not associated with depression. However, non-single unemployed women had higher depression scores than single unemployed women (-3.970*).

In Model 2, after adjusting for compositional characteristics, for both unemployed men (-.142***) and women (-.116***) those with higher scores on overall social capital, measured by social support, group membership, engagement in public affairs, trust, a sense of community, community networks, social cohesion, had lower depression scores than those with lower overall social capital scores. In particular, the impact of social capital on reducing the level of depression among the unemployed men (-.142) was greater than among the unemployed women (-.116).

Finally, in Model 3, after adjusting for compositional characteristics and overall social capital, the analysis showed that for unemployed men where unemployment had more negative effects also had higher depression scores than unemployed men where unemployment had less negative effects (.425*). However, this finding was not significant for unemployed women.

	Model 1		Model 2		Model 3	
	Male (N=28, R^2=.345)	Female (N=15, R^2=.354)	Male (N=28, R^2=.761)	Female (N=15, R^2=.499)	Male (N=28, R^2=.776)	Female (N=15, R^2=.501)
Constant	7.220***	7.297***	16.248***	13.978***	15.302***	13.571***
Compositional factors						
Marital status						
Single	3.780	-3.970*	1.871	-2.960	1.719	-2.551
Married	-.748	#	-.876	#	-.523	#
Divorced	-2.999	3.011	-1.010	.599	-1.200	.638
Widowed	#	-1.408	#	-1.408	#	-3.023
Birth place						
Hong Kong	#	1.441	#	1.441	#	.401
Outside Hong Kong	-1.095	-1.419	.142	-1.419	.346	-.368
Educational attainment						
No education (including without formal or with informal education)	#	#	#	#	#	#
Primary school	4.779**	1.556	2.020	1.556	1.883	.862
Secondary school	#	#	#	#	#	#
Post-secondary or above	-3.699*	-.939	-2.184*	-.939	-2.257*	-2.037
Contextual factors						
Overall social capital			-.142***	-.116***	-.120***	-.104 (.085)
Negative effects of unemployment					.425*	-.257

Table 6. 17: Linear regression models for depression among unemployed men and women in the survey sample

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Variables are constants or have missing correlations. They are deleted from the analysis.

Table 6.18 provides the results of the linear regression analyses for anxiety among unemployed men and women. In Model 1, single unemployed men had higher anxiety scores than non-single unemployed men (16.188**), but married unemployed men had lower anxiety scores than the non-married unemployed men (10.145***). At the same time, non-single, divorced and widowed unemployed women had higher anxiety scores than single, non-divorced and non-widowed unemployed women (Single: -3.751***; Divorced: 4.384***; Widowed: 5.146***). In addition, the analysis shows that the birth place and educational attainment were not associated with anxiety for either unemployed men or women.

In Model 2, after adjusting for compositional characteristics, for both unemployed men (-.193*) and women (-.044*) those with higher overall social capital scores, measured by social support, group membership, engagement in public affairs, trust, a sense of community, community networks, social cohesion, had lower anxiety scores than those with lower scores of overall social capital. In particular, the impact of social capital on reducing the level of anxiety among unemployed men (-.193) was greater than among unemployed women (-.044).

Finally, in Model 3, after adjusting for compositional characteristics and overall social capital, the analysis showed that for unemployed men with more negative effects of unemployment had higher anxiety scores

than unemployed men with fewer negative effects of unemployment (2.516*). However, this association was not significant for unemployed women.

	Model 1		Model 2		Model 3	
	Male (N=30, R^2=.547)	Female (N=15, R^2=.571)	Male (N=30, R^2=.629)	Female (N=15, R^2=.600)	Male (N=30, R^2=.690)	Female (N=15, R^2=.643)
Constant	16.145***	8.004***	27.597***	10.500***	31.643***	8.737***
Compositional factors						
Marital status						
Single	16.188***	-3.751***	12.063***	-3.374***	10.977**	-1.603
Married	-10.145***	#	-9.544***	#	-10.570***	#
Divorced	-6.145	4.384***	-2.678	3.483*	-.615	3.653*
Widowed	#	5.146***	#	4.623**	#	3.691*
Birth place						
Hong Kong	#	.861	#	.458	#	.623
Outside Hong Kong	.500	-.865	2.176	-.458	.900	-.613
Educational attainment						
No education (including without formal or with informal education)	#	#	#	#	#	#
Primary school	#	.385	-3.736	.043	-2.767	1.012
Secondary school	#	#	#	#	#	#
Post-secondary or above	-.500	2.430	1.552	1.893	1.900	3.366
Contextual factors						
Overall social capital			-.193*	-.044*	-.315***	.012 (.781)
Negative effects of unemployment					2.516*	-1.113

Table 6. 18: Linear regression models for anxiety among unemployed men and women in the survey sample

* p < 0.05; ** p < 0.01; *** p < 0.001

Variables are constants or have missing correlations. They are deleted from the analysis.

Table 6.19 provides the results of the linear regression analyses for alcohol abuse. In Model 1, married unemployed men had higher alcohol abuse scores than non-married unemployed men (4.270*). At the same time, single unemployed women had higher alcohol abuse scores than non-single unemployed women (2.369***). Also, unemployed women who were born in Hong Kong had alcohol abuse scores than those who were not born in Hong Kong (1.504***).

In Model 2, after adjusting for compositional characteristics, for unemployed men only those with higher overall social capital scores, measured by social support, group membership, engagement in public affairs, trust, a sense of community, community networks, and social cohesion, had lower alcohol abuse scores when compared with those with lower overall social capital scores (-.022*).

Finally, in Model 3, after adjusting for compositional characteristics and overall social capital, the analysis shows that there is no significant association between the negative effects of unemployment and levels of alcohol abuse for either men or women.

	Model 1		Model 2		Model 3	
	Male (N=30, R^2=.263)	Female (N=15, R^2=.551)	Male (N=30, R^2=.267)	Female (N=15, R^2=.576)	Male (N=30, R^2=.287)	Female (N=15, R^2=.576)
Constant	.608**	1.354***	1.283*	2.936*	2.453*	3.056*
Compositional factors						
Marital status						
Single	1.001	2.369***	.539	2.608***	.225	2.487*
Married	4.270*	#	4.337*	#	4.041*	#
Divorced	-5.258	.281	-4.870	-.290	-4.273	-.301
Widowed	#	.860	#	.528	#	.592
Birth place						
Hong Kong	#	1.504***	#	1.248***	#	1.237***
Outside Hong Kong	-5.476	-1.500***	-5.288	-1.243***	-5.657	-1.232***
Educational attainment						
No education (including without formal or with informal education)	#	#	#	#	#	#
Primary school	5.260	-.676	4.841	-.893	5.121	-.959
Secondary school	#	#	#	#	#	#
Post-secondary or above	.204	-.427	.434	-.767	.534	-.867
Contextual factors						
Overall social capital			-.022*	-.028 (.195)	-.057 (.478)	-.031 (.316)
Negative effects of unemployment					.727 (.460)	.076 (.867)

Table 6. 19: Linear regression models for alcohol abuse among unemployed men and women in the survey sample

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$

Variables are constants or have missing correlation. They are deleted from the analysis.

Discussion and conclusion

My data showed that overall middle-aged men in Tin Shui Wai controlled less social capital, including bonding, structural and cognitive social capital, than women. At the same time, there was an association between

mental health and social capital for unemployed men in particular. This finding was consistent with other studies of social capital and mental health. For example, De Silva (2006) and Hamano et al. (2010) found that social capital (especially cognitive and structural social capital) was associated with better mental health. A study of the relationship between social capital and stress among immigrants also found that bonding social capital was linked to lower acculturative stress and lower depression levels (Bhattacharya 2011). MANOVA also showed that unemployed men often controlled less social capital, and had more negative effects of unemployment and poorer mental health including depression and alcohol abuse than unemployed women. In particular, the linear regression analysis indicated that the influence of overall social capital on mental health for unemployed men was greater than for unemployed women. For example, when the unemployed men's overall social capital scores were higher, their anxiety, depression and alcohol abuse scores were lower. In contrast, unemployed women's social capital only had an influence on anxiety and depression. More importantly, the impact of social capital on reducing the level of anxiety and depression among unemployed men was greater than among the unemployed women. In addition, in Chapter five, I found that men were more likely to suffer from the negative effects of unemployment. In this chapter, I further found

from the linear regression analysis that those negative effects of unemployment had affected men's mental health, in particular anxiety and depression, after adjusting for compositional characteristics and overall social capital. Again, this finding did not apply to women. In other words, it indicated that men in subordinate or marginalised groups, such as the unemployed and the working class, were usually unable to benefit from the patriarchal system that supposedly benefited them at the expense of women. As a result, men were more likely to have poor mental health in relation to both depression and increase alcohol abuse, but had little support when they faced unemployment because they lacked social capital.

The above findings show that, as we might expect, middle-aged men and women had their own habits, norms and values as a result of traditional gender expectations - cultural capital in Bourdieu's terms (1977, 1980, 1986, 1990). The different habits, lifestyles, values, and dispositions of men and women affected their social capital development. For example, in my study, the unemployed male respondents said they were less likely to participate in social activities in the community, since they thought that it was not reasonable for unemployed men to enjoy leisure time. Also, the middle-aged male respondents preferred to work rather than stay at home to take care of the family, even though it was difficult for them to find a job. As I noted in Chapter two, according to Bourdieu's concept of cultural

capital, different social classes have their own habits, lifestyles, values, and dispositions which can be defined as ways of understanding and perceiving the world and these determine their tastes and preferences. These subjective views can become the expectations of particular social groups that in turn govern group members' behaviour. For example, under the influence of traditional gender expectations, in my study male respondents expected to focus on their jobs and not to talk about their problems (i.e. they did not expect to communicate with neighbours and they were less likely to take part in social activities). These self-expectations based on a person's own habits, lifestyles, values and dispositions - the control of cultural capital - not only affected their mental health as I argued in Chapter five, but also affected their use of social capital.

As Lin et al. (1986) and Rogers and Pilgrim (2005) have argued, men have been less likely than women to be socialised into expressive roles and have been less likely to provide emotional support for both sexes. Men have been more likely to be socialised into instrumental roles which have emphasized personal achievement and accomplishments (Wood and Lindorff 2001; Bhattacharya 2011). Because of this socialisation, men's habits, lifestyles, values and dispositions have generally tended to be focused on career achievement and have predisposed them to not

speaking about their problems or seeking help. Because of these social characteristics, these men have traditionally controlled less bonding and cognitive social capital, such as emotional support from and to others, and social relationships with others (social support/ social network). Also, because the men have been more likely to focus on work achievements, they have been less likely to be involved in, or concerned about, the community where they live in (in my study, both male and female respondents also said that the employed male residents spent most of their time at work and were seldom in the community). As a result, as my study found, the amount of social capital at community level (such as group membership, community networks and social cohesion) controlled by men was also less than that controlled by women.

The above analysis indicates that the social capital controlled by the middle-aged men and by middle-aged women, to a certain extent, was affected by their own expectations (i.e. cultural capital). As Bourdieu has argued, different socioeconomic groups possess different forms of cultural capital which affect the group's success in education and the development of social capital. In other words, social capital is not developed in social networks themselves, but in an overall system of networks which reproduce social inequality in the society (Bourdieu 1977, 1980, 1986, 1990). However, Bourdieu focuses on the context both of the debate on class

inequalities in educational attainment and of broader questions of class reproduction in capitalist societies (Sullivan 2002). In this study, cultural capital had an impact on social capital development in the context of socialisation in daily life. Table 6.20 below summarises the relationship between cultural capital and social capital among men and women in the survey sample.

According to Table 6.20 below, socialisation trained men to be more active and aggressive since they were expected to spend a significant part of their lives in economic activities. In turn, their social norms and values were affected. For example, men left home early and arrived home late in the day because of working to service the financial expenditure of the family. In contrast, their wives stayed at home to take care of the family. Cultural capital thus had a causal effect on the poor development of social capital. Table 6.20 showed a similar relationship between cultural and social capital for middle-aged women. The difference was that women controlled much more social capital than men, because of the influence of social expectations. For example, women were trained to be more passive and gentle, since they were expected to spend a significant part of their lives caring for their children. Therefore, they accepted the belief that taking care of the family was more important than having a job or developing a career. As a result, they spent more of their time with the

family, and liked to talk with friends and take part in activities in the community during their leisure time. As a result, their social capital was enriched. A detailed explanation of relationship between socialisation, cultural and social capital for middle-aged men and women is shown in Table 6.20.

Dimension		Men	Women
Socialisation ↓		Men are trained to be more active and aggressive since they are expected to spend a significant part of their lives in economic activity.	Women are socialised to be more passive and gentle since they are expected to spend a significant part of their lives caring for children.
Cultural capital ↓	**Lifestyle**	Leave home early and return home late because of work	Spend more time on family activities. Prefer to spend any spare time talking with friends and taking part in activities in the community
	Values	Believe they should have a job to cover the financial expenditure of the family. Their wives should stay at home to take care of the family.	Believe that taking care of the family is more important than having a job/ developing a career.
	Disposition	Outgoing, but do not talk about troubles to others.	Being passive and gentle, and liking to have emotional support from and to others.
Social capital	**Social support & social networks**	Rarely seek help from others for fear of loss of face and due to lack of opportunity because of work	Find it easier to seek help from others and to provide help since they have time available and like to provide and receive emotional support.
	Group membership	Limited time for group activities because of work. Despite having a lot of time at home, unemployed men are not willing to become involved in group activities because (i) they don't want others to know that they are unemployed; (ii) they believe it is unreasonable for them to enjoy leisure time.	In their spare time (e.g. when husbands are working, children at school), willingly join in community activities; believe they can use their time meaningfully and purposely.
	Community networks	Because most of time is spent working, they are seldom involved in community concerns, even those within their direct neighbourhood. Despite having a lot of time at home, unemployed men are not willing to become involved in community or neighbourhood networks because (i) they don't want others to know that they are unemployed; (ii) they believe that neighbours know one another and may thus let their wives know their secrets.	Because they are always in the community and have many friends in the community, they are more likely to be concerned about the community and their neighbourhood.
	Social cohesion	Because they don't spend a lot of time involved in community activities, they are alienated from other residents in the community.	Because they spend a lot of time involved in community activities and taking care of their neighbourhood, they are familiar with the residents in the community.

Table 6. 20: The relationship between socialisation, cultural and social capital for middle-aged men and women

Even though other studies (Wood and Lindorff 2001; Emmerik 2006) have found that the amount of social capital related to human relationships among men is less than among women, men still benefit from creating a sense of identity and having good mental health through developing hard social capital (Emmerik 2006). In other words, although men may have weak soft social capital, they can still benefit from having strong hard social capital (Wood and Lindorff 2001; Bhattacharya 2011, Olesen et al. 2013).

Nevertheless, as I argued in Chapter five, under changed economic and social conditions, many middle-aged men faced a high risk of unemployment. When they were unemployed, their hard social capital was reduced. At the same time, because of the influence of traditional expectations (i.e. men are supposed to have more instrumental attitudes and be less emotionally responsive than women), they were less likely than women to develop social support and social networks, group membership, community networks, and social cohesion. In other words, the amount of social capital controlled by men declined. Without adequate social capital, the mental health of men was affected, as many scholars have argued.

Under the influence of economic and social change, women had more opportunities to work outside and thus had more hard social capital.

However, at the same time, they could also benefit from traditional expectations. For example, women were supposed to be more emotionally responsive (Wood and Lindorff 2001; Rogers and Pilgrim 2005). Therefore, they were more likely to talk with friends and took part in activities in the community during leisure time. As a result, their social capital was enriched, as my study has found, and this could enhance the status of women's mental health, even when they were facing difficulties such as unemployment and a reduction in household income because their husbands were unemployed.

To conclude, under the influence of economic and social changes, the amount of social capital controlled by men was less than that controlled by women. Both men and women were affected by the economic and social changes, but for men this resulted in a lowering of social capital. In other words, there was a relationship between the creation of cultural capital and social capital

Chapter 7

The importance of social capital for the mental health of middle-aged men and women

As the data presented in Chapter six have shown, men had fewer components of social capital than women, and the evidence from the study indicated that this adversely associated with their mental health. The data also showed that with a low level of social support and weak group membership, community networks, and social cohesion, men's societal safety nets were less likely to protect them from the social adversities they faced. As McKenzie has pointed out, men in the community had fewer opportunities to receive the social support that is key in preventing the "progression of life's challenges into mental illness" and in "reduc[ing] pressure to the families and carers of people with mental illness" (2006: 31).

The ties among individuals in a locality can be useful for transmitting knowledge. In an area with a higher level of bonding and bridging social capital, communication is easier. Positive health messages may thus be more easily promoted than in areas where there is a lower level of social

capital. In addition, if, as we would expect, these bonded and bridged groups have a higher level of social capital, then the promotion of health norms and the regulation of deviant health behaviour, such as smoking and drug misuse is easier (McKenzie 2006).

However, as noted in Chapter four, in Tin Shui Wai the residents seldom met together because of insufficient public and social services in the community. The service provision is currently apparently similar to that in other areas of Hong Kong, since levels of service provided are based on the proportion of population, not on the nature of population. However, in Tin Shui Wai at the time of my study most of the population was deprived, and thus the demand for services was in general greater than in other areas of Hong Kong. The limited level of public and social services reduced the opportunities for residents to meet together and accumulate social capital, and the result has been adverse effects on mental health. In this chapter, I discuss the importance of the different kinds of social capital that can contribute to better mental health in middle-aged men and women in Tin Shui Wai.

The importance of social capital

In order to understand the importance of different areas of social capital, including social support, group membership, community networks and

social cohesion[46], on improving mental health for unemployed men and unemployed women, I explore the correlations between the different areas of social capital and mental health among unemployed men and unemployed women in the survey sample. Table 7.1 (below) shows that if the unemployed men had effective use and control of the four areas of social capital ("social support", "group membership", "community networks" and "social cohesion"), they were less likely to be depressed. If they had strong "community networks" and "social cohesion", they were also less likely to be anxious. And with strong "social support", and "community networks", unemployed men were less likely to have problems of alcohol abuse. For unemployed men, "community networks" was the only factor to have a protective influence in reducing the chances of all three: depression, anxiety and alcohol abuse.

Among unemployed women, in terms of depression, the data show that if unemployed women had effective use and control of the four areas of "social support", "group membership", "community networks" and "social cohesion", they too were less likely to be depressed. For anxiety,

[46] As the data presented in chapter six have shown, there were significant differences between men and women in the scores for the four social capital areas, including social support, group membership, community networks and social cohesion.

where unemployed women had strong "group membership", "community networks" and "social cohesion", they were also less likely to be anxious. However, the effective use and control of different areas of social capital did not reduce the chance of alcohol abuse in unemployed women (see Table 7.1).

		Social support	Group membership	Community networks	Social cohesion
Unemployed men	Depression	-.412**	-.206**	-.530**	-.253**
	Anxiety	-.184	-.060	-.359**	-.345**
	Alcohol abuse	-.322**	.075	-.202**	-.040
Unemployed women	Depression	-.210*	-.163*	-.552**	-.202**
	Anxiety	-.076	-.156**	-.461**	-.312**
	Alcohol abuse	-.088	.077	-.076	-.016
Overall	Depression	-.316**	-.204**	-.558**	-.253**
	Anxiety	-.123	-.092	-.376**	-.302**
	Alcohol abuse	-.276**	.020	-.206**	-.082

Table 7. 1: Correlations between different areas of social capital and mental health among unemployed men and women in the survey sample
Pearson correlation: * Significant at the 0.01 level (2-tailed); ** Significant at the 0.05 level (2-tailed).

Based on the above findings, it appears that if we want to promote better mental health among unemployed men and unemployed women, we can do this in two ways. The first, by "community networks building", is the same for unemployed men and unemployed women. Both male and female respondents talked about the importance of "community networks

building" on promoting mental health in the focus group and individual interview. A man commented:

> MR5(FG)：After the establishment of this organisation [the Hong Kong Christian Service Men's Project in Tin Shui Wai North], we can have place for talking and playing. In the past, I only walked alone in the community. Sometimes, I went to the shopping mall and sometimes I went to the public park without any purpose. Now, I can get to know more neighbours who become my friends now. I always talk with them.

The women commented:

> FR2(FG)：After having this organisation [the Hong Kong Christian Service Tin Heng Community Network Project], women in the community can get to know each other through taking part in the activities. After that, we even became volunteers and formed a volunteer team.
>
> FR4(FG)：Like me, I became a volunteer in the organization [the Hong Kong Christian Service Tin Heng Community Network Project] and had a chance to take some courses related to social skills. This improves my relationships with others. If I hadn't participated in activities in this community, I would never have met my best friends and have learned more skills.
>
> FR5(II): I have some friends in the community. They were the parents of my daughter's secondary school classmates. We knew each other for 10 years. We go to have lunch in a Chinese restaurant. Sometimes, I talk with them on the phone. In the past, we supported each other about our children's study. Now, we support each other emotionally [such as sharing family issue and difficulties with each other] … I always feel happier and less stressful after meeting with them.

My second suggested way to promote better mental health is for unemployed men to do more work individually on developing social networks with friends and neighbours, and for women to do more community work (such as encouraging people to participate socially). For

example, for unemployed men, "social support", which was mainly at an individual level, could also have a positive influence on their mental health:

> MR1(FG)：Our problems cannot be solved. However, I share my difficulty with others.
>
> I：For pressure release?
>
> MR1,2,3,4,5,(FG)：Yes.
>
> MR1(FG)：Just like you eat too much, you also need to vomit, haha.
>
> MR5(FG)：Sometimes, I talk to my friends about the pressures I face, such as family problems. After talking with them, I become less stressed and my blood pressure becomes lower now.

For women, "group membership", and "social cohesion", which could have a positive influence on women's mental health, operated mainly at the community level:

> I：As you know, in the community, those women who do not join the community activities, have fewer opportunities for contact with neighbours and are always at home, what impact will this have later?
>
> FR2(FG)：Most of them will have mental illness later.
>
> FR4(FG)：Depression and social phobia.
>
> FR1(FG)：Some will have physical illness too.
>
> I：Is this common in the community?
>
> FR1(FG)：I don't know. But I know some cases in the community.
>
> FR2,3,5(FG)：Yes, we were those persons before we became members of the community centre.

In other words, for unemployed men, strengthening social capital at both the community and individual level, such as encouraging people to

participate socially and developing social network with the neighbours, is an effective way to promote good mental health. For women, strengthening their social capital at the community level appears to be an effective way to promote their mental health.

The effective use of social capital

The above findings show that enhancing social capital had a positive impact on the mental health of the middle-aged unemployed men and women. In my study, I found that this was mainly because the effective use of social capital could actually be a way to respond to the needs of middle-aged men and women after unemployment, especially for men.

Expanding social networks

In Chapters five and six I argued that because of weak intra-group and extra-group social networks, respondents, especially men, had no effective way to solve their problems, such as unemployment, and that this created great pressure on them. However, through the positive use of social capital, some respondents managed to expand their intra-group relationships – that is, those with people of the same social background, and extra-group relationships – that is, those with people of a different social background,. For example, men and women respondents in the focus group who joined the activities in a community centre not only met

friends with similar backgrounds for social support, but also people from different social backgrounds, such as district councillors, legislative councillors, social workers or businessmen. These encounters increased the respondents' ability to solve their problems, by providing a source of emotional support, professional advice, or by providing a source of material and financial support from a businessman's donation, or the offer of a job. In my follow-up study,[47] some respondents in the focus group knew more about people from the extra-group than previously when they had not joined the community activities and thus were getting help because they had started participating in community activities.

> MR2(FG)： In the community centre, I know more about the available social resources. I gained financial support from a businessman, who supported me financially to apply for taking my driving licence examination and so I could find a job after I passed.
>
> FR4(FG)： I joined some courses about parenting. Through it, I could then know what my children think and do, and how to teach them more.
>
> FR5(FG): I joined the activities in the community centre since it provides meals and travelling opportunities. If I don't join the activities, I would never have the ability and opportunity to go outside the community.

[47] In the focus group, the respondents were invited to a service unit which is under my current working organisation. For this reason, I could learn something about what had happened to them after my study ended.

The above situation, where residents found help by joining community activities, is consistent with findings in previous studies (Chan 2009a; Chan et al. 2009).

Enhancing self-esteem and self-efficacy

As discussed in Chapter five, the data from my study showed that unemployment and financial pressures were constant problems for the male respondents. These problems not only caused them stress, but also were undermining their identity and self-esteem; for example, they felt they were useless since they could not make a financial contribution to the family. However, I also found that if those unemployed men were able to participate in the community and contribute to the community, their self-esteem and self-efficacy increased. For example, one male respondent joined the community alliance a year after my in-depth interview and became an active member in policy advocacy related to the CSSA. In the follow-up study, he told me that he had become active in community work:

> MR2(FG)：I enjoy the community participation in policy advocacy since I feel I make some contributions to the community and society. I let the outsiders understand more about the condition of residents receiving CSSA in Tin Shui Wai and our difficulties. I want people to know that our society is full of inequality. I feel I am useful, even though I am still unemployed.
>
> MR1(FG)：I have the opportunity to meet the District Councillor and the Legislative Councillor to express my view on assistance for middle-aged

> unemployed men. Even though I don't think this can result in policy change, I still do something for our middle-aged men.

Reducing feelings of insecurity towards unknown community residents

As I made clear in Chapter five, I also found that some respondents did not seek help from neighbours or have contact with them, since they had a sense of insecurity towards unknown residents. For this reason, some respondents stayed at home and/or sat in the park without any clear purpose, and this affected their mental health.

Through promoting social capital, such as structural social capital, people could be formed into a group more easily and this enhanced the linkages among different residents in the community as first a man, and then a woman, commented:

> MR5(FG)：After the establishment of this organisation [the Hong Kong Christian Service Men's Project in Tin Shui Wai North], we can have places for talking and playing. In the past, I only walked alone in the community. Sometimes, I went to the shopping mall and sometimes I went to the public park without any purpose. Now, I have more friends and talk with them in the organisation. I am happier than before. Sometimes, I talk with social workers in the organisation.
>
> FR3(II)：I sometimes go to church in the community. I participate in some group activities.

The above extracts indicate that a non-governmental service unit, church or school was an effective platform for reducing the sense of fear toward unknown residents, linking the residents in the community and reducing

insecurity. In other words, with strong structural social capital, cognitive social capital was enhanced. As a result, people could have less of a sense of insecurity in the community and their mental health could be improved, as Cullen and Whiteford (2001) and McKenzie (2006) have argued.

Discussion and conclusion

In my study, I found that women's social capital in Tin Shui Wai was greater than men's. In terms of mental health, I also found that men's mental health in relation to both depression and alcohol abuse was worse than women's when they were unemployed. Women in my sample were, however, more prone to anxiety than men. The findings suggest that in Tin Shui Wai poor mental health among the men was associated with weak social capital. In contrast, making effective use and control of social capital among men was associated with their better mental health.

The above findings show that the content of the effective use of social capital for the promotion of mental health was different between men and women, and was not similar to the traditional gender expectations. As the findings presented in Chapters five and six have shown, the men had been socialised into instrumental roles (Emmerik 2006), which emphasized personal achievement and accomplishments (Wood and Lindorff 2001; Bhattacharya 2011). In contrast, the women had been socialised to control

soft social capital effectively, since they typically performed more expressive roles (O'Neil et al. 1986; Chan 2009a). Under the influence of this socialisation, most of women expected that men would seldom express themselves with others emotionally and personally, and that men would seldom join formal organisations. Nevertheless, in this chapter, we have suggested that the effective way of using social capital to promote mental health – that is community networks and social support – differs somewhat from what would traditionally be expected. The analysis suggests that if men do more individual work, such as develop social networks with friends and neighbours, and also community work, such as encouraging people to participate socially, their mental health will be better. If women do more community work, their mental health will also be improved.

These findings give us an insight: that the mental health status among middle-aged men might be poorer than middle-aged women's because of the different development of gender socialisation for middle-aged men. This is to a certain extent the result of the middle-aged group's cultural capital. As Bourdieu (1977, 1980, 1986, 1990) has argued, different socioeconomic groups possess different forms of cultural capital, which underpin the reproduction of social inequality. In my study, the cultural capital possessed by the middle-aged group indeed affected the male

respondents' ability to face economic and social change, and thus put them at a disadvantage, so that unemployment among men led to poorer mental health than unemployment among women. This confirms Bourdieu's argument that different socioeconomic groups possess different forms of cultural capital, which underpin the reproduction of social inequality (gender inequality in my study). However, as noted in Chapter six, Bourdieu focused on the context both of the debate on class inequalities in educational attainment and on broader questions of class reproduction in capitalist societies (Sullivan 2002). In this study, the impact of cultural capital on social capital development is extended to the context of social expectations in daily life, including changes in the content of socialisation.

As pointed out in Chapter two, in his study of cultural capital, Bourdieu argued that the different distribution of cultural capital among different kinds of people is linked to class distinctions. Taste is one example of a deeply ideological category that functions as a marker of class. Taste can be an indicator for class classification. Bourdieu (1977, 1980, 1986, 1990) argued that taste actually contains the constellations of taste, consumption preferences and lifestyle practices. The whole process of presenting taste is an exercise in power. Bourdieu, as I also noted, claimed that there are three levels of taste or cultural capital: pure or legitimate taste, average (or middlebrow) taste, and popular or vulgar taste. This

classification of taste actually contain the means of power and are the instruments of domination used by the dominant class. The dominant class labels itself as a pure or legitimate group by categorizing different kinds of taste. In particular, education is an important means for the reproduction of differentiated cultural patterns (Bourdieu 1977, 1980, 1986, 1990 and Crook 1997) and is not equally available for everyone because of different cultural capital control among the parents, and thus is used for maintaining the power of the dominant class.

Nevertheless, in my study, I found that the socialisation in daily life was also powerful for the reproduction of differentiated cultural patterns, and that it reaffirmed class distinctions.

For the middle-aged group, the different pattern of culture capital between men and women was formed in daily life because of the different socialisation of men and women. Because of the different pattern of cultural capital in daily life, the amount of social capital between men and women often became very different and thus the mental health of men and women was not protected to the same way. For example, the men, because they usually had hard social capital through working, benefitted from creating a sense of identity, and thus had better mental health, even though at the same time they controlled only weak, soft social capital, such

as fewer expressive ties involving the exchange of friendship and social support,. In contrast, women, despite their lower level of hard social capital, if they were in need because of greater soft social capital could get support and help from their stronger social networks and thus their mental health was more likely to be protected.

However, I argued in Chapter five, the above relationships between cultural capital, social capital and mental health have changed under the impact of social and economic changes in Hong Kong, in which men and women have had to face changes in the employment situation as the economy moved from manufacturing-oriented to service-oriented and more and more middle-aged married women were willing and able to work outside the home with the influence of the feminist movement over the past two decades.

The above findings and analysis indicate that because of the influence of the reproduction of differentiated cultural and social patterns in the daily life, the status of the middle-aged men has not so far improved. The most important point is that the factors causing positive effects on mental health for middle-aged men have declined. The original factor causing positive effect on mental health, i.e. men's hard social capital generated by having a job, has become less significant because of economic structural

changes. The social capital factors, such as community networks and social support that have positive effects on mental health for middle-aged men are different from the factors traditionally expected in the socialisation into social life of men. As a result, the mental health of the members of the middle-aged group has become less protected and their social status, at the same time, not only cannot be improved, but also has become poorer because of the social and cultural changes.

The above analysis clearly shows that middle-aged men were more likely to be unsuccessful in adapting to the economic and social changes than middle-aged women, because of the lack of cultural capital in their daily lives. This lack of cultural capital, in other words, led to the reproduction of gender inequality and the reaffirmation of class distinctions, especially for middle-aged men.

Chapter 8

Conclusion and discussion: an approach to promoting men's mental health

The link between mental health and social capital

In this study, I have found that men's mental health in relation to both depression and alcohol abuse was worse on average than women's, with the higher levels of depression in men than women particularly notable, since women typically have higher levels of depression than men. Women in my sample were, however, as is common elsewhere, more prone to anxiety than men. The findings showed that at least in this sample unemployment had a more negative influence on men than on women. My research also indicated that the poorer mental health among the men of this study was associated with weak social capital. The data showed that for both men and women, social capital could have a positive effect on reducing level of depression and anxiety. In particular, "community networks" and "social support" had a positive influence on men's mental health, including making depression and alcohol abuse less likely. For women, "group membership", "community networks" and "social

cohesion" had a positive influence on their mental health, including reducing the occurrence of depression and anxiety, but not alcohol abuse which was already less common in women than men. Based on these findings, an approach which focuses on using social capital to promote mental health for both men and women is suggested. There is a need for a policy that seeks to promote social capital at the community and individual level for men, and social capital at the community level for women.

Discussion and implications

Based on the above conclusion, a clear picture emerged that using women as a point of comparison in the study, the gendered division of labour affected both men and women negatively. As analysts of masculinity have argued (Schauer 2004, Connell 1995, Connell and Messerschmidt 2005), masculinity whilst it may benefit men also sets limits on them at the same time as it has adverse consequences for women. These limits are enforced by a system of rewards, punishments, and social stereotypes and ideals. Both men and women are limited in their opportunities to achieve self-realization under these restrictive roles (Beattie 2004; Chan 2006; Schilt 2010).

In Hong Kong, men are to a large extent still socialized into rather traditional gender roles in different areas of their life, such as family and

work (Chan 2009b; Leung and Chan 2014; Chiu and Ho 2006; Community Business 2013; Chiu and Ho 2006). As I pointed out in Chapter two, this socialisation affects their pattern of help-seeking (Chan 2009b; Hong Kong Council of Social Service 2004; Harmony House Hong Kong 2014). A similar situation was found in my study. Because of the influence of gender expectations and ideas about masculinity, unemployed male respondents suffered from significantly more depression and increased alcohol problems than their employed counterparts and unemployed female respondents, although they were often not reported since they seldom sought help when they were unemployed or facing financial difficulty.

These findings are consistent with empirical findings from the sociological literature that some of men's problematic attitudes and behaviour, including the refusal to seek help from others (Galdas et al. 2005, Galdas et al. 2010; McCusker and Galupo 2011) are caused by gender role conflicts: that is that men find that they cannot meet the expectations resulting from gender socialization and the societal requirements associated with masculinity in their daily lives (Addis and Mahalik 2003; Good and Wood 1995; Liu and Iwamoto 2006). For example, gender-role conflict in relation to the help-seeking of men arises when characteristics of

men's gender socialisation affects their ability and/ or willingness to seek help for problems (Mansfield et al, 2005).

The above situation is even worse for men in subordinate or marginalized groups who often do not benefit from the patriarchal system (Connell and Messerschmidt 2005). According to the findings of my study, as a result of gender socialisation, the unemployed middle-aged men not only face the problem of poverty, i.e. low income or no income to support a minimum standard of living (Saunder et al. 2014), but also deprivation, i.e. lack of resources to support an acceptable minimum standard of living (Saunder et al. 2014) because their ability to deal with adversity during unemployment was limited under the influence of their learning of gender expectations (Kuczynski and Parkin 2007) that men should be the ones going out to work. As scholars (Barnes et al. 2007; Toye and Infanti 2004) in poverty studies have argued, deprivation, can be multiple, that it can cover to a range of indicators of social and economic deprivation and exclusion. In my study, the unemployed men actually were not only more likely to suffer from the negative effects of unemployment than the unemployed women, but also had a lower level of social participation in the community than the unemployed women. Men were limited their opportunities to achieve self-realization under these restricted roles (Beattie 2004; Chan 2006; Schilt 2010). And, as my study has found, this affected their mental

health. Unemployment seemed to be a factor which challenged norms of masculinity and thus limited their opportunities to achieve self-realization.

As I considered in the previous chapter, one useful way to reduce the negative influence of mental health may be to promote positive social capital for both men and women. However, as I noted, there may need to be different approaches for men and women when promoting mental health. For men, improving mental health status may involve promoting men's community and individual social capital, such as "community networks", and "social support". For women, it may involve promoting women's community social capital, such as "group membership", "community networks" and "social cohesion".

These suggestions are partly a response to existing problems caused by traditional gender stereotypes and the gendered division of labour. For example, a propos general social expectations, men In Hong Kong are usually expected to behave in a manner that is more directed towards the public and community—such as working outside, being involved in political activities and, as family head, dealing with issues extending outside the family, such as providing financial support, and dealing with conflict outside the family, etc.). In contrast, women are expected to direct their activities towards the home and interpersonal relations by taking care of their children, providing emotional support for husbands, family

members, friends, and so on. These role expectations can actually aggravate gender inequalities for both men and women, as this study has shown. If the above role expectations no longer work in promoting the mental health of men and women, we should use another approach—promoting social capital at the individual level for men, and social capital at the community level for women.

If we adopt this approach, men would no longer face their problems individually. They would be able to try to solve them with the help of social support. They would seek help from others without considering or worrying about gender expectations. For women, community networks should be further strengthened to promote their mental health. Women would no longer be stereotyped to the same extent as people primarily concerned only with human relationships through roles such as taking care of children, and providing emotional support for husbands, family members and friends. They could get support from the community to improve their mental health—getting more information to use a service when they are facing problems and getting more paid employment, for example.

To implement the above approach, I suggest three strategies—public education, the introduction of gender awareness policy, and the encouragement of individual behavioural change.

Public education

The first strategy, public education about greater gender equality for both men and women, should be promoted. In the past, any general public education on gender equality has focused on women, since feminism is relatively well developed in Hong Kong. Many women's services and organisations can be found in Hong Kong, and many women's studies courses are conducted by local universities and different local organisations. The topics they cover are broad, and include poverty (Society for Community Organisation 2011), health (Women's Committee 2011a), social life (Hong Kong Young Women's Christian Association 2012), job transformation and job opportunities (Women's Committee 2011b; Census and Statistics Department 2015), welfare policy (Women's Committee 2006a ; Society for Community Organisation 2011), health and the family (Hong Kong Young Women's Christian Association 2008), and political participation (Wong 2004; Women's Committee 2011c). These studies use a feminist framework to criticize how women are discriminated against and neglected in society.

In terms of social welfare services and other professional fields, even though more concern has recently been directed to gender issues, the focus of those services is still the influence of men's dominant position on the life of subordinate women (Leung and Chan 2014). For example, the UN

Convention on the Elimination of all Forms of Discrimination against Women was adopted in Hong Kong in 1996. In 2001, the Hong Kong Special Administrative Region Government set up a Women's Commission to promote the mainstreaming of gender issues in policies and services. Different kinds of services, laws, and policies have been introduced in Hong Kong to protect women from family violence (Women's Commission 2006a). In addition, many social services are for women only, such as residential services for abused women, a programme to encourage women to improve their all-round ability[48] and a Mother's Choice programme[49] have been set up in Hong Kong in the past few decades. In

[48] The Capacity Building Mileage Programme (CBMP) "has developed in partnership with the Open University of Hong Kong … and Commercial Radio … a Capacity Building Mileage Programme ... to encourage women to improve their all round ability as individuals; encourage/facilitate them to widen their perspectives and to develop/realise their potential; encourage them to develop their learning interest and ability, and to help remove environmental barriers and provide opportunities for women to build up their capacities. The programme is intended to help equip women with a positive mindset and enhance their inner strength so that they can cope with different life challenges. It is different from existing vocational training courses in that it seeks to facilitate women to change their perception, their attitude about themselves and their environment. Qualities which are emphasised include creativity, curiosity, personal judgement, self-reliance, self-confidence and sense of humour/optimism. The CBMP does not, however, seek to improve women's vocational skills per se, and participation in the CBMP has no direct relationship with getting employment, or more advanced academic learning" (source: http://www.ouhk.edu.hk/wcsprd/Satellite?pagename=OUHK/tcSingPage&c=C_LIPACE&cid=191135164000&FUELAP_OP=FUELOP_NewScreen&FUELAP_SITEDBID=SITE_-66&LANG=chi accessed on 18 September 2015).

[49] Mother's Choice provides and promotes loving, nurturing care for babies and children needing permanent homes, and for single girls and their families facing

early 2009, there were 10 women's services for education, 19 women's services for health, 2 women's service for employment, 12 women's service for human right, and 32 individual growth and development services for women[50]. All these services are important and play a valuable role in supporting women, which is very necessary.

In contrast, the men's movement in Hong Kong is still in its initial stages, whether in the academic field, social welfare or other professional fields. In terms of academic studies, there is a centre of gender studies in the Chinese University of Hong Kong. From Autumn 2006 to Spring 2015, over half of the courses and seminars offered by the centre were related to feminist issues. For example, there were 104 seminars on such issues in this period—of these, 48.1% were related to feminism, 10.6% were related to masculinity and 41.3% were related to both feminism and masculinity.[51] Furthermore, even though there are some studies related to men's individual growth and development (Chan 2009b) and service needs (City University of Hong Kong 2006; Hong Kong Christian Service 2007;

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crisis pregnancies (source: http://www.motherschoice.com accessed on 18 September 2015).

[50] Source: http://www.hkcss.org.hk/fs/er/services/women_service/tos.htm accessed on 20 July 2009. Since 2009, there was no single source of information and statistics about women's service in Hong Kong.

[51] Source: http://www.gender.cuhk.edu.hk accessed on 21 September 2015.

Evangelical Lutheran Church Social Service – Hong Kong 2012), men's studies in Hong Kong are still not popular and mainly focus on the role of father, not on "men" more generally (City University of Hong Kong 2006; Leung and Chan 2014). Most courses on men's studies in Hong Kong argue that men have a low involvement in family affairs, marital relationships, child care, children's education, parents' education, communication and so on. However, my study, along with other evidence suggests that men need to change their behaviour and attitudes not only to improve the situation of women but also to strengthen their ability to deal with adversity.

Services for men in Hong Kong are limited compared with services for women. In 2015, there were four counselling services for men only, some men's mutual help centres, and a few small-scale, district projects, such as a men's project in Tin Siu Wai North.[52] Apart from this, there is an official website for men provided by the Department of Health to educate men concerning their health, and to encourage changes in their attitudes and

[52] The Men's Project in Tin Shui Wai North (MPTN) run by the Hong Kong Christian Service began in 2008. The aims of the project were to enhance the sense of self-efficacy of men within the district, motivate them to build up good family relationships, and strengthen their social and community networks. This two-year-project was supported by the Community Chest in Hong Kong, and ended in July 2010 because of lack of funding (source: http://www.hkcs.org/archives/mptn/mptn.html on 21 September 2015).

behaviour.[53] In addition, a men's Commission, which some men's group have advocated since 2000, has not been established up to now (Mingpao 2006; Hong Kong Commercial Daily 2009).

In the suggested approach, public education should be also focused to a far greater extent on the needs of men as well as women. For example, men too should have the right to learn to enjoy family life in ways such as taking care of their children, seeking emotional help from others, and developing social networks outside the work environment.

Introduction of a gender awareness policy

In the second suggested stage, a policy of promoting gender awareness should be introduced. For example, nowadays in Hong Kong, few policies consider the gender needs of either women or men. Importantly policies for men still primarily concern men's unemployment problems. The mental health and family relationship needs of men are still a low priority. Hence the need in the proposed approach to introduce a gender awareness policy which not only concerns men's and women's unemployment, but also considers such aspects as men's mental health and family relationship needs. In other words, the policy for men and women's unemployment only relates to handling the problem of 'poverty',

[53] Source: http://www.hkmenshealth.com accessed on 21 September 2015.

i.e. low income or no income to support a minimum standard of living, and also the problem of 'social and economic deprivation'.

Encouragement of individual behavioural change

Finally, with support from society and social policies, individual change is also important. This change is required of both men and women because, as my study has shown, men's roles have often been confirmed by female family members—wives, daughters and mothers. Therefore, any individual changes in ways of thinking and behavior need to be done by both men and women. As Bly (1996) has said, men need to find a positive way to achieve the goal of rethinking the new gender role in modern society, and re-finding and re-establishing a new set of male roles, behaviour, thinking and relationships with women. "New Masculinity" should be promoted in a new era with support from public education and social policies that I suggested previously, as well as support from family.

Strengths and limitations of the study

This study had both strengths and limitations. Concerning the strengths, this study has contributed some empirical research on, and understanding of, the value of social capital to the mental health of unemployed and socially isolated middle-aged men in Hong Kong. In particular, the study helps in the understanding of the status, problems, and difficulties of a

group of disadvantaged men. Also, by proposing policy directions and future strategies, I offer ideas about practical support to improve their situation. With regard to the limitations of the study, the first and most important limitation is the small number of respondents in the focus groups and in-depth interviews and also completed questionnaires, and in particular the relatively small number of unemployed men who were in the survey sample. As noted in Chapter three, the sample of unemployed middle-aged men and women was small. This affects the representativeness of the study since the analysis of the relationship between unemployment and mental draws on this small sample. Related to this is the fact that my sample was not randomly selected.

Second, my study of the social roles in relation to gendered patterns of anxiety, depression, and alcohol abuse (for example, the impact of changing gender expectation toward men and women on their anxiety , depression, and alcohol abuse status) was not detailed enough to explore and explain the interesting and somewhat unexpected finding that women name their current occupational status flexibly. For example, when women are employed, they describe themselves as an employee. In contrast, when they are unemployed, they describe themselves as a housewife.

Third and finally, I paid less attention to the detailed content of social capital at community levels, such as the features of social organisation (for

example networks, norms and social trust that facilitate coordination and cooperation for mutual benefit in the community) (Putnam 1995: 67) and to its influence on the mental health of unemployed men and women. In my study, I used a compositional approach (examining the characteristics of individuals) to measure the concept of social capital, instead of a contextual approach (characteristics of place). This may limit the understanding of importance of social capital at different levels on the mental health among unemployed men and women.

Based on above limitations, I would argue that we need further larger and more detailed studies in other areas of Hong Kong on unemployment and social roles in relation to gendered patterns of anxiety, depression and alcohol abuse; further larger and more detailed studies elsewhere in Hong Kong of unemployment and differences in social capital at individual and community levels, and of its influence on the mental health of men and women. Such studies would allow the findings of this study to be examined more fully across a broader range of samples and settings.

This study clearly shows the status, problems and difficulties of a group of unemployed middle-aged men under the gendered division of labour at the time if the study. Indeed, a change in this gendered division of labour should be promoted in the coming future through the support from public education and social policies in the society which is key

support for the individuals and their family to encourage individual behavioural change.

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Appendix A

Survey questions

The mental health of unemployed and socially isolated middle-aged men in Tin Shui Wai, Hong Kong

I am a PhD student in the University of Essex, United Kingdom. I am conducting a study on the relationship between mental health and social capital among middle-aged persons. Please spend a few minutes to complete the following questions. The collected data will only be used for the purpose of study and will be kept confidentially. Thank you for your support!

Part I

1. Did you face problem(s) in the past year? □ Yes □ No (Please skip to Q5)
2. How often did you seek help from following person(s) when you were facing problems in the past year?

	Never	Seldom	Sometimes	Always
Family member(s)	☐	☐	☐	☐
Neighbour(s)	☐	☐	☐	☐
Friend(s)	☐	☐	☐	☐
Colleague(s)	☐	☐	☐	☐
School	☐	☐	☐	☐
Government department(s)	☐	☐	☐	☐
Other non-government organization(s)	☐	☐	☐	☐
Others, please specify: _____	☐	☐	☐	☐

3. How many people altogether have helped you in the past year **when you faced problem(s)**?

□ None □ 1 - 3 □ 4 - 6 □ 7 - 9 □ 10 or more

4. What kind of support did you seek in the past year?

□ Emotional support (such as giving advice)	□ Economic support
☐ Material support	□ Others, please specify: _____
☐ Caring support (such as getting help from others to take care of children or to buy food)	

5. Did you help others in the past year? □ Yes □ No (Please skip to Q8)

6. Who have sought help from you in the past year?

	Never	Seldom	Sometimes	Always
Family member(s)	☐	☐	☐	☐
Neighbor(s)	☐	☐	☐	☐
Friend(s)	☐	☐	☐	☐
Colleague(s)	☐	☐	☐	☐
Others, please specify: _____	☐	☐	☐	☐

7. What kind of support did you provide to people in need in the past year?

□ Emotional support (such as giving advice)	□ Economic support
☐ Material support	□ Others, please specify: _____
☐ Caring support (such as helping others to take care with children or to buy foods)	

8. Did you attend any voluntary activities in the past year (such as being volunteer to visit people in need)?

□ Yes □ No

9. How many voluntary organizations/ groups are you as member of in the past a year? _____

10. In the past year have you personally done any of the following things

	Yes	No
Voted in elections/ actively participated in an election campaign	☐	☐
Taken part in a protest march or demonstration	☐	☐
Concern with the local affairs (such as discuss the public issue with others)	☐	☐

11. Do you agree that most people can be trusted?

□ Strongly agree □ Agree □ Disagree □ Strongly disagree

12. How much confidence do you have in the following institutions?

	A great deal	Quite a lot	Not very much	None at all
The legal system	☐	☐	☐	☐
The police	☐	☐	☐	☐
Other government department(s)	☐	☐	☐	☐
Non-government department(s)	☐	☐	☐	☐

13. Have you been satisfied with your life in the community in the past half-year?

□ Very satisfied □ Satisfied □ Unsatisfied ☐ Very unsatisfied

14. I feel accepted as a member of this neighbourhood?

□ Strongly agree □ Agree □ Disagree □ Strongly disagree

15. How often do you talk with the following people in the past a week?

	Don't work	Never	Seldom	Sometimes	Always
Colleagues on work	☐	☐	☐	☐	☐
Friends		☐	☐	☐	☐
Neighbours		☐	☐	☐	☐
Family members		☐	☐	☐	☐

16. How often did you do the following things in the past year?

	Never	Seldom	Sometimes	Always
Have contact with community residents	☐	☐	☐	☐
Join activities (such as shopping and going to market) with community residents	☐	☐	☐	☐
Join family activities (such as having trip and meal with your family members) with community residents	☐	☐	☐	☐
Attend community activities with community residents	☐	☐	☐	☐

The following questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

17. I feel tense or "wound up":

□ Most of the time	□ A lot of the time
☐ From time to time, occasionally	□ Not at all

18. I still enjoy the things I used to enjoy:

□ Definitely as much	□ Not quite so much	□ Only a little	□ Hardly at all

19. I get a sort of frightened feeling as if something awful is about to happen:

□ Very definitely and quite badly	□ Yes, but not too badly
☐ A little, but it doesn't worry me	□ Not at all

20. I can laugh and see the funny side of things:

□ As much as I always could	□ Not quite so much now
☐ Definitely not so much now	□ Not at all

21. Worrying thoughts go through my mind:

□ A great deal of the time	□ A lot of the time
☐ From time to time, but not too often	□ Only occasionally

22. I feel cheerful:

□ Not at all	□ Not often	□ Sometimes	□ Most of the time

23. I can sit at ease and feel relaxed:

□ Definitely	□ Usually	□ Not often	□ Not at all

24. I feel as if I am slowed down:

□ Nearly all the time	□ Very often	□ Sometimes	□ Not at all

25. I get a sort of frightened feeling like "butterflies" in the stomach:

□ Not at all	□ Occasionally	□ Quite often	□ Very often

26. I have lost interest in my appearance:

□ Definitely	□ I don't take as much care as I should
☐ I may not take quite as much care	□ I take just as much care as ever

27. I feel restless as I have to be on the move:

□ Very much indeed	□ Quite a lot	□ Not very much	□ Not at all

28. I look forward with enjoyment to things:

□ As much as I ever did	□ Rather less than I used to
☐ Definitely less than I used to	□ Hardly at all

29. I get sudden feeling of panic:

□ Very often indeed	□ Quite often	□ Not very often	□ Not at all

30. I can enjoy a good book or radio or TV program:

□ Often	□ Sometimes	□ Not often	□ Very seldom

31. How often do you have a drink containing alcohol?

□ Never (Please skip to Q41)	☐ Monthly or less	☐ 2 to 4 times a month	☐ 2 to 3 times a week	☐ 4 to more times a week

32. How many drinks containing alcohol do you have in a typical day when you are drinking?

☐ 1 to 2	□ 3 to 4	□ 5 to 6	□ 7 to 9	□ 10 or more

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
33. How often do you have six or more drinks on any one occasion?	☐	☐	☐	☐	☐
34. How often during the last year have you found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐
35. How often during the last year have you failed to do what was normally expected of you because of drinking?	□	☐	☐	☐	☐
36. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	□	☐	☐	☐	☐
37. How often during the last year have you had a feeling of guilt or remorse after drinking?	□	☐	☐	☐	☐
38. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	□	☐	☐	☐	☐

	No	Yes, but not in the last year	Yes, during the last year
39. Have you or someone else been injured because of your drinking?	□	☐	☐
40. Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested that you should cut down?	□	☐	☐

Part II

41. Age:_____

42. Sex : □ Male □ Female

43. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Others, please specify: _____

44. How long have you been living in Hong Kong? □ Since birth □ _____ years

45. Hong long have you been living in this area? _____Year(s)

46. Who do you live with? (You may ✓ more than one answer)

□ Live alone	☐ Wife/ Husband	☐ Grandfather(s) and/or Grandmother(s)
☐ Father	Son(s) and/or Daughter(s) How many: _____	□ Grandson(s) and/or Granddaughter(s)
☐ Mother	☐ Brother(s) and/or sister(s)	☐ Others, please specify: _____

47. Education level

☐ No education ☐ Private tutorial ☐ Primary school ☐ Secondary school ☐ Post-secondary or above

48. Occupation:

☐ Self-employed person (Please skip to Q50)	☐ Full-time person (Please skip to Q50)	☐ Part-time person	☐ Retired person (Please skip to Q50)
☐ Housewife	☐ Unemployed person How long?_____ Did your family member(s) know that? ☐ Yes □ No Did you seek help to find a job? ☐ Yes □ No	☐ Other, please specify: _____	

49. What is the influence of no job on you and your family? *(You may ✓more than one answer)*

☐ Affects physical health (such as always feel tired)
☐ Cannot sleep
☐ Have bad appetite
☐ Less communication with family members
☐ Go out less with family members
☐ Feel stressful
☐ Don't want to make contact with relatives and friends
☐ Face financial difficulty in the family
☐ Increase in conflict with family members
☐ Go gambling
☐ Drink alcohol
☐ Have more free time but nothing to do
☐ Feel relax
☐ Better physical health
☐ More time to take care children and family members
☐ Have more free time to do something that I interest
☐ More communication with family members
☐ Others, please specify:_____

50. Your Income:	☐ Unemployed/ Retired/ Housewife	☐ Hong Kong$1-4,999	☐ Hong Kong$5,000-9,999
	☐ Hong Kong$10,000-14,999	☐ Hong Kong$15,000-19,999	☐ Hong Kong$20,000 or above

Appendix B
In-depth interview: suggested questions

1. How long have you been living in Tin Shui Wai?
2. Who do you live with?
3. What is your impression of this community? Do you like this community? Why?
4. What is your life like in this community? (guide the interviewees to answer following questions)

A. Community participation (including community activities, concern community affairs, voting). What type and frequency? If no community participation, why?

B. The impression of residents in the community

C. Contact between residents. What type and frequency? If no contact, why?

D. Life outside the community (including going outside for playing, shopping etc., contacting and visiting relatives and friends)

E. What problem(s) have you faced in the past year? Type (guide the interviewees to talk about the topics of 'employment/ working', 'couple relationship', 'family relationships', 'household financial situation', 'son and daughter's relationship', 'relationships with friends', 'life adaptation' and so on). How to coping with these problems (such as using formal and informal social support)? What has been the effect of these problems (guide the interviewees to talk about the impact on mental health)?

F. As a woman/ man, what is the most important factor affecting your mental health? (such as 'employment/ working', 'couple relationship', 'family relationship', 'household financial situation', 'son and daughter's relationship', 'relationships with friends', 'life adaptation')

Appendix C

Focus group: suggested questions

1. What is your impression of Tin Shui Wai? Why?
2. Based on your observations, what is the life of residents like in this community? (guide the interviewees to answer following questions)

A. Community participation (including community activities, concern for community affairs, voting)

B. Contact among residents

C. Relationships among residents

D. Life outside the community (including going outside for playing, shopping etc., contacting and visiting relatives and friends)

E. Common problem(s) facing you: Type (guide the interviewees to talk about the topics of 'employment/ working', 'couple relationship', 'family relationship', 'household financial situation', 'son and daughter's relationship', 'relationships with friends', 'life adaptation' and so on). How to face the problems (such as using formal and informal social support)? What is their effect (guide the interviewees to talk about the impact on mental health)?

F. As a woman/ mean, what is the most important factor affecting your mental health? (such as 'employment/ working', 'couple relationship', 'family relationship', 'household financial situation', 'son and daughter's relationship', 'friend relationship', 'life adaptation')

Appendix D

Participant information sheet

The mental health of unemployed and socially isolated middle-aged men in Tin Shui Wai, Hong Kong

Your participation is voluntary. If you do not want to participate, you have right to do so.

Purpose of the study

This aim of this study is to 1) examine and seek to understand the poor mental health of unemployed middle-aged men (women as a reference for comparison) in Hong Kong, who are unemployed and are becoming isolated socially within community (i.e. Tin Shui Wai); 2) explore the different aspects of social capital (including trust, social cohesion, sense of community, group membership, engagement in public affairs, social support, community networks and family social capital) that may contribute a better mental health for the middle-aged individuals.

What will you have to do?

For those who are attend in-depth interview or focus group:

You will have to attend 1 interview that will last approximately 1.5 hours. There you will talk about your existing help giving and help receiving condition, community participation, trust toward the community, sense of belonging of community and community networks. In addition, you will talk about the importance of above aspects in contributing to your mental health. If you find any of these questions upsetting, you do not have to give an answer.

For those who attend questionnaire survey:
There you answer a questionnaire in which cover 4 parts. The content of each part is as follows:

1st part: Your existing help giving and help receiving condition, community participation, trust toward the community, sense of belonging of community and community networks.

2nd part: Your mental health condition

3rd part: Your alcohol consumption condition

4th part: Your personal information

If you find any of these questions upsetting, you do not have to give an answer.

When you answer the questionnaire, you only have to select the answer that is closest to what you are like. There are no right or wrong answers.

Who can participate?
Any person, who is living in Tin Shui Wai, is 30-60 year-old.

What can I do if I feel disturbed by the question in the study?
If you feel disturbed by the question in the study, you can either decline to answer any questions you do not like or terminate to attend the study.

How will my privacy be protected?
All the information that you provide will be kept confidential for the research purpose only and will be saved without using any identifying information such as your name and identity card number. In the research reports, all information will be analysed for the whole group instead of each individual person. I abide with the Data Protection Act of 1998.

Who can I contact if I have inquiries?
Please contact the researcher in charge on 96843398 (Miss Chan Chi Wai) (cwchan@essex.ac.uk).