

CLASS AND MENTAL HEALTH: AN ANALYSIS OF ADOLESCENT HELP-SEEKING
BEHAVIOUR

by

Kayla Coolen

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Abstract

There is a disparity between rising levels of mental health problems and low levels of mental health service uptake among Canadian adolescents. While there are resources available for adolescents, they are not accessing the help they need. While research has focused on help-seeking behaviour, there is a limited body of knowledge examining the way that adolescents perceive a need for services. Additionally, few studies consider the complex role of class in the help-seeking process of adolescents in Canada. This study analyzes data from the 2012 Canadian Community Health Survey - Mental Health Component (CCHS-MH) to examine the impact of class on three stages of the help-seeking including the presence of poor mental health, a perception of need for mental health services, and service uptake using Bourdieu's notion of Capital. Logistic Regression modeling uncovers the complexity of class as it relates to the mental health of Canadian adolescents and provides a unique contribution to the understanding of accessibility of resources based on social position.

List of Abbreviations Used

CCHS-MH	Canadian Community Health Survey – Mental Health
MHL	Mental Health Literacy

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Chapter 1: Introduction

The state of mental health among Canadian adolescents is deteriorating, and rates of mental illness are increasing. According to the Mental Health Commission of Canada (2013), one in five need mental health care. Approximately 5% of male youths and 12% of female youths aged 12-19 have experienced a major depressive episode, with a total of 3.2 million adolescents at risk of depression (MHCM, 2013). This data is an increase from 1989 when rates of depression ranged from 2.7% to 7.8% across genders (Cheung & Dewa, 2006).

While the number of adolescents with mental illness has increased, service uptake has not followed suit. Less than 20% receive the services they need to improve their mental state (MHCM, 2013). According to the Canada Health Act, all Canadians should have free access to all medically necessary care (Health System and Services, 2018), and under these conditions adolescents who need mental health care should be able to get services, regardless of their economic circumstances. Yet, not everyone seeks the care that they might need. While the rise of mental illness among youths is alarming, the low rates of service uptake are even more alarming. Lack of proper intervention potentially leads to extended periods of suffering and poorer quality of life for young people.

Moreover, the fact that youth with mental health issues are not getting help indicates a failure on the part of service providers to access mental health resources or fully leverage the resources spent on them. In 1994, a reported \$14.4 billion was spent on mental health care, making mental illnesses some of Canada's most expensive conditions (Lim et al., 2008). In 2017, a budget increase of nearly \$200,000 was allocated by the Nova Scotia provincial government in response to a 70% increase in suicides of adolescents on Cape Breton Island between 2014 and

2015 (Weeks, 2017). If adolescents are not properly receiving mental health care, then such resources are not well spent, which could lead to potential budget cuts in the future.

This thesis explores the relationships among mental health conditions, states of need, and utilization of services, in order to shed light on the paradoxical relationship between the rise of mental health problems and low mental health service use. Literature in public health suggests that “mental health literacy” (MHL) is an agent that shapes the way people navigate their mental health conditions and cope with problems (Jorm, 2012). Mental health literacy refers to an individual’s ability to assess their mental health conditions more effectively and seek proper kinds of care when required (Ibid). This concept is developed in the realm of public health, and it has been applied to improve individual capacity to cope with mental health problems. It also provides a useful theoretical framework to understand help-seeking behaviour. However, issues such as what determines people’s level of MHL or how to measure the MHL are less established.

In the sociological literature, a Bourdieusian approach to forms of capital and habitus can offer insight into help-seeking behaviours in mental health. Unlike theories of MHL, which are more clinically oriented, theories about the determinants of various forms of capital are well-established, and so are measures for these concepts. They shed light on what might affect differences in help-seeking. As a result, I will apply Bourdieu’s theory of social stratification as based on various forms of capital in order to offer better understand help-seeking behaviours. Specifically, I will explore whether and how individual class positions are associated with perceptions of and experiences with mental health conditions, as well as help-seeking behaviours. Further, I will examine whether and how social class affects these mental health experience and how this varies across gender and racial groups. Thus, these examinations will

clarify how mental health service use is related to class structure in a society, as well as its relation to gendered and racialized social conditions.

The following chapter (Chapter 2) provides a review of the literature that portrays the condition of mental health problems and help-seeking behaviours, as well as theoretical frameworks for the analysis. Chapter 3 lays out methodological approaches, including the dataset and variables, as well as modeling techniques. In Chapter 4, the results of the analysis will be discussed in detail. In Chapter 5, I will discuss the implications of the findings and address the paradox of mental health conditions and help-seeking. Through this research, which systematically examines mental health conditions and help-seeking behaviours with various forms of social class characteristics, I aim to offer explanations to the paradox of low mental health resource use among Canadian adolescents.

Chapter 2: Literature Review

2.1 Mental Health and Adolescence

Across North America, youth are increasingly showing signs of stress and poor mental health (Fleury et al., 2012; Lynam & Cowley, 2007, p. 138; Wei, Kutcher & Szumilas, 2011). According to the Mental Health Commission of Canada, 1.2 million Canadian youth are affected by mental illness (Health Canada, 2018) and affective disorders are becoming increasingly common among adolescents (Cummings, 2014; Rickwood & Braithwaite, 1994). An American study reports that nearly 8% of adolescents experience depression in a given year, while 12% of adolescents will experience affective disorders at some point in their lives (Cummings, 2014 as cited by SAMHSA, 2009). Adolescence is a critical developmental period in the lifespan, and mental illness in adolescence can have life-altering consequences. Not only are youth who experience poor mental health more at risk of performing poorly academically and experiencing issues in socializing (Wei, Kutcher & Szumilas, 2011), they are also at higher risk of substance abuse, unemployment, and suicide (Cummings, 2014). Meanwhile, the period of adolescence is when most mental illnesses have their onset (Rose et al., 2014; Wei, Kutcher & Szumilas, 2011). Thus, it is essential to address increasing mental health problems among adolescents.

If mental illness is rising among Canadian adolescents, one would assume that rates of service uptake would be increasing as well; yet, evidence shows otherwise. In Canada, approximately one-fifth of adolescents have a diagnosed mental disorder (Wei, Kutcher & Szumilas, 2011). While some research shows evidence that rates of service uptake have risen, such studies also indicate that the majority of people suffering have unmet needs (Mackenzie, Gekowski & Knox, 2006 as cited by Kessler et al., 2005). This imbalance is also reported in European studies, which find that the vast majority of adolescents with severe symptoms of

anxiety and depression do not seek help for their problems (Zachrisson, Rödje & Mykletun, 2006, p.6). A German study of adolescents reported only 18.2% of youths with anxiety disorders and 23% of youths with depressive disorders used mental health services (Essau CA, 2005 as cited by Gulliver, Griffiths & Christensen, 2010, p.1). Why do so few youths who have mental illnesses utilize the help services?

2.2 Help-Seeking Behaviour for Mental Health Problems and its Determinants

The process of help-seeking for mental health problems generally follows three stages: recognition of problems (Coles et al., 2015; Jorm, 2012), willingness to seek help from available mental health resources (Rickwood & Braithwaite, 1994), and the actual seeking of care and/or use of mental health services (Gulliver, Griffiths & Christensen, 2010). The first barrier to mental help-seeking is, therefore, not recognizing poor mental health. Studies suggest many adolescents struggle in this regard. According to Coles et al. (2015), only half of adolescents who have symptoms of depression can recognize their actual problems and far fewer recognize anxiety (p.61). The inability of adolescents to detect mental health problems is a common explanation for their low service uptake (Coles et al., 2015; Jorm, 2012). Even when they recognize some mental health problems, *willingness* to seek help from mental health practitioners can be another hurdle (Rickwood & Braithwaite, 1994). It is only after individuals recognize some symptoms and they are willing to communicate or share those experiences with others that they can explore viable care options or start seeking care (Gulliver, Griffiths & Christensen, 2010).

For adolescents, however, a significant barrier to accepting one's condition and sharing one's feelings with others is stigmatization. For adolescents, who tend to be preoccupied with the options of their peers and desire to "fit in", the stigma associated with mental illness acts as an

even more significant barrier to accessing care than it does for adults (Dubow, Lovko, & Kausch, 1990; Gulliver, Griffiths, & Christensen, 2010). Researchers also report that adolescents have concerns over confidentiality and often feel that their problems are too personal to share with others (Dubow, Lovko, & Kausch, 1990; Gulliver, Griffiths, & Christensen, 2010). These voices reflect the fear of disclosure of mental health conditions and indicate the levels of stigma associated with mental health issues. As a result, many adolescents—approximately 75-85% — seem to avoid seeking help because they feel they can handle their problems on their own (Dubow, Lovko, & Kausch, 1990; Fleury et al., 2012). While stigma has been identified as a barrier to help-seeking, scholars have suggested an additional social determinant of mental health process, which improves help-seeking behaviour among adolescents. In particular they suggest that ‘mental health literacy’ affects whether or not youth access services (Coles et al., 2016; Jorm et al. 2006; Jorm, 2012; Kim, Lim & Park, 2015).

Mental health literacy (MHL) has been defined as an individual’s capacity to attain, process, and comprehend basic knowledge around mental disorders and mental health services; thus, aiding in their recognition, management, and prevention of mental health problems (Jorm, 1997; Kim, Lim & Park, 2015). Poor mental health literacy results in reduced ability to recognize the symptoms of mental health problems. But MHL is not merely knowledge about mental health problems, but rather awareness and capacity that is directly linked to the possibility of action to benefit one’s mental health or the mental health of others (Jorm, 2012, p. 231). Studies show that increasing levels of MHL have positive effects on the scope of help-seeking behaviour (Coles et al., 2016; Jorm et al., 2006; Kim, Lim, & Park, 2015); however, MHL is not necessarily readily accessible to all adolescents.

Research shows that a fair amount of young people around the world have poor MHL (Coles et al., 2016). Adolescents have difficulty recognizing mental illnesses such as depression and social anxiety disorders in countries such as Sweden, Australia, Portugal, and the UK (Coles et al., 2016, p.57). An American study showed that only 28% of youths were able to identify a social anxiety disorder as a mental health problem, and 42% identified depression as a disorder (Coles et al., 2016). Programs meant to improve MHL have been implemented in school settings in the US, with data showing a 67% increase in knowledge about mental health, and a 71% increase in positive attitudes towards mental illness, positively contributing to de-stigmatization (Coles et al., 2016, p.61). An Australian study undertaken in the mid-90s showed improvements in beliefs about treatments and increases in awareness and knowledge about affective disorders; thus, shifting the general public's knowledge base closer to that of a mental health professional (Jorm et al., 2006).

Low MHL is associated with lower levels of service use among adolescents. According to a psychiatric study, adolescents were aware of their emotional distress but were unable to consistently define its meaning and seek appropriate help (Gulliver, Griffiths & Christensen, 2010). The lack of ability to articulate and accept the condition and recognize the need to seek proper help resonates with the low level of MHL among adolescents (Coles et al., 2016; Jorm, 2012). Thus, MHL is identified as a means to increase the prevention and treatment of mental health problems.

Nevertheless, there are mainly two problems with MHL as the sole explanation for why youth do not access services. First, research to date has not explored what determines an individual's level of MHL. That is, whether and how social factors influence their MHL level has not been examined. This lacunae exists because previous research on MHL focused on

literacy considers it an individual-level problem (Kim, Lim, & Park, 2015). More literature has begun to focus on the social context of individuals suffering from mental health problems, yet no research has examined the social factors that affect help-seeking behaviours using the MHL perspective. Second, despite its wide usage, a comprehensive and culturally robust measure of mental health literacy is yet to be established. Wei et al. (2015) show that researchers several different sets of measurements for MHL, and no robust measurement has been established. Without reliable measurements, it is hard to determine its impact on outcomes. Thus, this thesis seeks to explore help-seeking behaviour, shifting the focus from the individual adolescent to socially defined attributes that shape their mental health literacy. In doing so, I will draw on the sociological concepts of social class, gender, and race.

2.3 Class as Social Determinants of Mental Health and Help-Seeking Behaviours

In the context of mental health, Bourdieu's conceptualization of social class offers a useful theoretical framework to explore health inequality (Kim, Lim & Park, 2015; Lynam & Cowley, 2007). Economic, cultural, and social capital are commonly used across the social determinants of mental health literature (Kim, Lim & Park, 2015; Pinxten & Lievens, 2014). Cultural and social capital linked to class have in particular been shown to be closely linked to help-seeking behaviours (Offer & Schneider, 2007; Wei, Kutcher, & Szumilas, 2011). This study considers capital and social class as determinants of mental health status and as determinants of mental health service uptake.

Economic capital is considered by Bourdieu to be the basis for all forms of capital. It can be measured through income and wealth and indicates levels of economic resources that one can deploy in various aspect of one's life (Bourdieu, 1986). While few studies focus on the connection between economic capital and mental health status, the literature on mental health

service use indicates a relationship between economic capital and processes of help-seeking (Pinxten and Lievens, 2014). Where evidence is available, adolescents coming from families with low income have at a higher risk of suicide when a mental health problem is present, than those from higher-income families (Rogers & Pilgrim, 2014). This is likely because economic capital influences access to quality care (Wei, Kutcher, & Szumilas, 2011). Another Canadian study of secondary-school based help-seeking behaviour found that the quality of care and wait times for publicly funded mental health resources can be critical barriers to help-seeking behaviours for adolescents and their families (Ibid). Further, those with high economic capital have increased capacity to by-pass the public system and can access private mental health care services, such as from a psychologist or psychiatrist working in private practice (Ibid). Thus, research shows that household income influences an adolescents' ability to access mental health care.

Cultural capital is the knowledge, behaviours, and skills that one accumulates during the course of socialization; it demonstrates one's cultural competency and reinforces one's social position. Cultural capital exists in three forms: institutionalised, objectified, and embodied capital (Bourdieu, 1986). The embodiment of cultural capital manifests itself as 'taste' or markers of social class, such as the way one walks, talks, and socializes. While 'taste' is often a product of one's class and social environment, habitus is the system in which taste is used to judge the good and suitable (Bourdieu, 1986). Habitus is a system through which people perceive the behaviour of others and organize their own behaviours. In this system, people's social position is influential in defining their repertoires of behaviours, where some behaviours are valued as *normal* or *preferred*, while others are valued as less ideal (Bourdieu, 1986).

Cultural capital is relevant to mental health because differences in attitudes, beliefs, and taste, or habitus, are associated with differences not only in mental health symptoms, but in help-seeking practices (Cummings, 2014; Offer & Schneider, 2007). A family with high cultural capital may have the opportunity/knowledge to educate their children about mental health and illness and adolescents from these families maybe better-able to recognize their problems as mental health struggles. If the emotional problem in question is unrecognizable in one's habitus, the problem becomes difficult for an adolescent to comprehend and thus seek help to address.

Social capital, as defined by Bourdieu, refers to the resources available in one's social network (Bourdieu, 1986, p. 3). It is not simply the volume of social relationships, but also their quality and reliability (Portes, 1998, p. 9). Scholars suggest that adolescents, in particular, require secure social networks to access support for mental health problems (Offer & Schneider, 2007). Studies have found that individuals in a social environment with trusting relationships, a key factor of social capital, experience less stress and instability, preventing potential self-harming behaviour (Coleman, 1988; Langille et al., 2012, p. 1550).

Family members, peers and teachers are the primary sources of information about mental health for adolescents (Wei, Kutcher, & Szumilas, 2011), playing a crucial role in symptom recognition and the process of help-seeking behaviour. Family members are often considered the vital social network for adolescents and can communicate with teachers, while school counselors may help adolescents find better care than those without decent connections. However, adolescents from affluent and highly educated families, with powerful connections in their community, may defer indications of mental health needs to protect their social standing and privacy (Offer & Schneider, 2007), potentially stunting the process of problem recognition.

While the literature supports the idea that social class has a relationship with mental health status, and the help-seeking process, this relationship is not entirely clear, nor is it the only social determinant which influences the way adolescents understand and access good mental health care. Help-seeking behaviour is also a gendered and racialized process for adolescents.

2.4 Gender and Race as Determinants of Mental Health and Help-seeking Behaviour and Intersectionality

In a culturally, ethnically and racially diverse society, class is not the sole determinant of social position and mental health. In addition to social class, gender and race are considered as *prima facie* sources of stratification. Research suggests that definitions of masculinity and femininity have psychological impacts for both males and females, producing unique risk factors for mental health problems and help-seeking behaviours including differences in coping strategies, social relationships, personal resources, and vulnerability (Rosenfield & Mouzon, 2013, p. 278). For example, socially constructed femininity increases the capacity for females to express emotion freely (Briscoe, 1982 as cited in Rickwood & Braithwaite, 1994), while hegemonic masculinity requires males to restrict emotion (Good et al., 1989 as cited in Rickwood & Braithwaite, 1994). Gender thus shapes both the frequency and type of mental health problems as well as willingness to seek and receive professional help (Coles et al., 2016).

Empirically, girls perceive their mental health problems more easily or admit to mental health problems more frequently than boys (Dubow, Lovko, & Kausch, 1990; Mackenzie, Gekowski, & Knox, 2006; Rickwood & Braithwaite, 1994). A study from the National Comorbidity Survey Replication shows 29% of females suffer from depression in their lifetime as compared to only 18% of men; additionally, 34% of females as compared to 23% of males experience anxiety in their lifetime (Rosenfield & Mouzon, 2013, p. 277). Moreover, females are reported to struggle with a greater sense of loss, hopelessness, and feelings of helplessness to

improve their conditions and experience a greater number of phobias, panic attacks, and anxious states than males (Rosenfield & Mouzon, 2013, p.277).

In contrast males are more likely to have aggressive or antisocial personality traits which translate into issues with forming trusting and lasting relationships (Rosenfield & Mouzon, 2013). When boys confront such mental health problems, this can often lead to violent consequences, including suicide and substance abuse (Rickwood & Braithwaite, 1994; Rosenfield & Mouzon, 2013). Socially constructed gender expectation for females also contributes to the differences in how different genders perceive mental health and seek help for distress. That is, females are more likely seen as sufferers of affective disorders (Rickwood & Braithwaite, 1994) and are over-diagnosed based on gender expectations. Thus, a gender gap leads to the under-diagnosis of mental health problems for males and over-diagnosis for females.

The issue of help-seeking and poor mental health is further complicated by race. It is often reported, for example, that boys who are members of racial minority groups are further at risk for mental health problems, particularly in rates of suicide compared to white adolescents (Fernando, 2010; Rose et al., 2014; Williams et al., 1997). Yet, minority boys who suffer from affective disorders are less likely to use mental health services (Cummings, 2014). While men, as compared to women, are generally at higher risk for violent behaviour due to mental health, some research finds that behavioural manifestation of mental health problems differs between minority statuses. It is reported that black males are more prone to aggression-related to mental health problems, whereas white males are more prone to social delinquency and substance abuse problems (Rosenfield & Mouzon, 2013). Further, it is reported that black males are less likely to repress emotion and more emotionally androgynous than their white counterparts (Ibid.). It should be underscored that these behavioural differences likely reflect cultural orientations,

racialization, and stereotypes, which are shaped by historical context, rather than biological orientation. Yet, the existing literature indicates that experience of mental illness, and how they react to those problems can be influenced by racial minority status.

While girls, as compared to boys, are generally more likely to perceive mental health problems and more proactively contact both professional help and familial members, girls from racial minority background are less likely to engage in help-seeking behaviours (Rose et al., 2014; Williams et al., 1997). The National Comorbidity Survey shows 23% of white females suffer from some form of depression in their lifetime compared to only 16% of black females (Rosenfield & Mouzon, 2013, p.278). Other literature reveals there is less mental health awareness among minority girls compared to girls from the racial majority group (Coles et al., 2016). While these findings signal the intersectionality between *gender* and *race*, there is limited research focusing on whether and how *class* intersects with these positionalities. This is surprising given much research shows that race and class intersect. Among the few studies that look at the intersections across all three dimensions, one study reports that minority females with high class background have better mental health than white females of the same class status (Rosenfield & Mouzon, 2013). That is, while marginalized females may be generally more likely to experience poor mental health, their class position has a significant effect on this tendency. But for men, this is not the case, as their intersectionality reflects in their behavioural responses to poor mental health conditions. As previously suggested, white males were more likely to show anti-social behaviour, while black males are to show aggressive behaviour when they suffer from poor mental health. However, such tendency varies specifically to class origin. Black males from higher economic classes have closer levels of anti-social behaviour to white males; however, black males from lower economic classes exceed the rate of white males for anti-social

behaviours (Rosenfield & Mouzon, 2013, p.279). These findings highlight the class background shape the way gender and race influence the experience of mental health are different across different classes.

One possible explanation for how the intersection of the three dimensions work can be found in the literature on gender studies. The literature finds that economically and racially marginalized groups are blocked from dominant pathways to hegemonic masculinity that is typically symbolized with economic responsibility, and workplace success (Rosenfield & Mouzon, 2013). ‘Protest masculinity’ may form as a response, emphasizing physical masculinity (power) among those from lower socio-economic backgrounds (Rosenfield & Mouzon, 2013, p.281). This is particularly an issue for black youth who experience additional barriers to help-seeking due to racism (Rosenfield & Mouzon, 2013). Such class differences in masculinity can magnify protest masculinity in the perception of mental health conditions and help-seeking patterns. That is, the gender differences in mental health issues may be more profound among adolescents from working-class households, particularly for minority groups. This gender difference is more suppressed among elite classes where this type of protest masculinity is muted. Thus, this literature offers a ground for examining the three-way intersection among class, gender, and race, in a more *comprehensive manner*.

2.5 To Shed a Light on a Troubling Paradox

The review of the literature shows a paradoxical condition, in which the number of adolescents with mental health problems are on the rise, yet such increases are not paralleled with the rise in service uptake. While the existing literature suggests that individuals’ capacity to recognize symptoms of mental disorder and cope with the problems are shaped by MHL, the literature is silent about the social mechanisms that shapes the accumulation of MHL and there is

no clear set of measures of MHL. The Bourdieusian approach to class offers an alternative framework to explain social factors that shape help-seeking behaviours in mental health, and it is better equipped with the measurements.

For these reasons, my thesis explores the social factors that might affect the experience of mental health experiences, which may shed light on the paradox. In doing so, I will specifically examine the effect of social class, gender and race to see how they explain the varying degree of mental health conditions and service up-take. The scope of my analysis will follow the framework of the help-seeking behavior, which consists of three stages (i.e., recognition of problems, willingness to seek help, and actual service up-take) but also will account for social determinants and their intersections. Based on the review, a set of hypotheses are generated for each stage:

H1: Adolescents' social class affects their mental health condition, perceived need for seeking-help, and actual help-seeking. Each measure of social class, economic, social, and cultural aspect of class origin, will have an independent effect.

H2: Girls, compared to boys, have higher rates of mental health problems, perceptions of need to seek help, and actual help-seeking.

H3: Minority member youths, relative to their white counterparts, have higher rates of poor mental health conditions, but lower rates of perceiving a need to help-seeking, and actual help-seeking.

H4: There is an intersection of gender and race in their effect on mental health conditions, perceptions of need to help-seeking, and service uptake.

H5: The effect of class effect of mental health conditions, perception of need to seek help, and service uptake intersects with gender and race.

Chapter 3: Methods

To explore the increase of mental health problems among Canadian adolescents but their low use of the mental health services, I will examine the potential impact of social class, gender, and race. Given the nature of the research interest, which is to describe the general patterns of mental health and help-seeking behaviours and to examine whether and to what degree class, gender, and racial characteristics shape such patterns, I used quantitative approach. This approach allows me to capture the general patterns in those outcomes, using a secondary dataset provided by Statistics Canada.

3.1. Dataset

In order to analyze the mental health and help-seeking behaviours of Canadian adolescents, I use Statistics Canada's *Canadian Community Health Survey – Mental Health 2012* (CCHS-MH), Master Data file. This survey was conducted to collect “information about mental health status, access to and perceived need for formal and informal services and supports, functioning and disability, and covariates” (Statistics Canada, 2013, pg.4). Thus, this dataset contains key information for this study, including various measures of mental health conditions, the perception of a need to seek care, and actual service use, along with indicators to measure class, gender, and racialization.

Another attractive feature of the CCHS is its large representative sample. The total sample size of this dataset was 25,113, representing 28.3 million Canadians aged 15 or older, who live in ten provinces (Statistics Canada, 2013). Excluded from the CCHS-MH are peoples living on reserves, full-time employees of the Canadian Forces, and institutionalized populations (Ibid). My analysis focused solely on adolescents. Even after selecting a subset of the sample

with an age range of 15 - 19 years old, there were 2,024 respondents, which is enough to conduct multivariate analysis.

The CCHS-MH drew its sample using a multistage stratified cluster design and random sampling (Statistics Canada, 2013). To account for this sampling design, I will use the population weight for the point estimates. For standard errors, the CCHS came with a set of bootstrap weights. However, due to the small sample size, many of the regression models with the bootstrap weights did not converge. As a result, robust standard errors, using the sampling weights, are reported in the regression models. Accordingly, I have put more emphasis in substantial effect, when interpreting, than the statistical significance.

3.2. Measures

Dependent Variables

As discussed in the previous section, a process of mental health help-seeking behaviours comprises of three stages: the presence of a mental health problem, the perceiving of a need for resources to treat that problem, and lastly, service uptake (Coles et al., 2015; Gulliver, Griffiths & Christensen, 2010; Jorm, 2012; Rickwood & Braithwaite, 1994). As a result, this study includes three outcomes of interest: mental health status, perceived mental health needs, and help-seeking behaviour.

Mental Health Status

While help-seeking behaviour is also engaged in by healthy individuals, it is important to be able to distinguish among these two groups of adolescents. In the analysis this was done through the creation of the variable “MH2” to measure a general condition of mental health. MH2 has two categories, in which “0” indicates “good mental health” and “1” “poor mental health,” or, the presence of mental health problems. It draws information from three separate

indicators of mental health problems, including depression (the original variable name in the CCHS-MH is “SCRDDEP”), anxiety (“SCRDGAD”), and the emotional distress level (“DIS1”). Initially, I created three sets of dichotomous variables for each of these symptoms. However, the number of individuals who suffered from some of those conditions were too small to be used as the dependent variables in the modeling process. As a result, I have produced the final dichotomous variable “MH2” by indicating “1” if respondents reported the presence of mental health problems in at least one of the three measures. By definition, if the respondent takes the value of “1” in this indicator, they have at least one mental health problem, which warrants seeking help. This variable is also representative of affective disorders, which are the focus of the literature reviewed for this project and the most common mental health affliction for adolescents (Rickwood & Braithwaite, 1994, p. 563). One thing to note is that this variable does not represent psychosomatic disorders such as bipolar disorder and schizophrenia.

Perceived Need Status

In the second stage of my analysis, the outcome variable of interest measures whether adolescents perceived a need for mental health services. The CCHS-MH contained a derived variable “PNCDNEED,” which captures the “Overall Perceived Need in Past 12 Month (Statistics Canada, 2013) The original variable had four responses; 1= ‘no perceived need for care’, 2 = ‘all needs met’, 3= ‘needs partially met’, and 4=‘needs not met’. The original variable does not directly capture whether a respondent perceived a need, the three latter categories, which indicate the level of meeting needs indicate that individuals perceived a need for resources. In my analyses, I dichotomized this variable, where ‘0’ indicates ‘no perceived need for care.’, and ‘1’ indicates the rest of these categories. One thing to note is that this question was asked to everyone, including those who may not report any mental health problems. As a

result, those who did not have any actual problems detected in any of the objective measures may have reported a need for care. However, as I explain in the result section, those numbers were rather small.

Help-Seeking Behaviour

The third stage of my analysis examines whether adolescents sought help for their mental health problems. The dependent variable in that stage comes from the variable “PNCFH12.” It is a derived variable which indicates whether help was received in the last 12 months for problems with emotions, mental health, and addictions (Statistics Canada, 2013). “PNCHF12” is based on five variables measuring whether respondents received information for their problems, medication, counselling or therapy, or ‘other’ types of help. When a respondent received care for at least of those types of help, s/he is considered to have sought help. In the analysis, “1” indicates “help sought” while “0” indicates “no help sought.”

Independent Variables

This study includes five explanatory variables of interest: economic capital, cultural capital, social capital, gender, and race. The first three variables correspond to three dimensions of social class, while the latter two are used as the intersectional factors.

Economic Capital

Measuring economic capital through the amount of monetary resources is the most common tool throughout the literature on capital and mental health (Pinxten and Lievens, 2014). Economic capital is measured with the total household income. The original variable in the CCHS-MH is “INC_3”. It is a continuous variable which represents the total income received by all household members before taxes in the last 12 months (Statistics Canada, 2013). To categorize this variable, I consulted the Low-Income Measure provided by Statistics Canada as

my baseline threshold for the low-income category¹. This measure of economic capital was coded into three categories: “Low Income” = 1, “Middle Income” = 2, and “High Income” = 3.

Cultural Capital

Educational attainment is an appropriate measure of cultural capital (Bourdieu, 1986). Given that adolescents are still in the phase of schooling, the best measure of cultural capital is the level of education of family rather than the individual respondent. Cultural capital, in this study, is measured with the highest level of education of family members. The CCHS-MH provides the variable “EDUDH04” as a measure for highest level of education of the household with the following categories: 1= “Less than High School”, 2= “Secondary School Graduate”, 3= “Some Post-Secondary”, and 4 = “Post-Secondary Graduate”. Based on both distributions and the representation of cultural capital in this dataset, this was further dichotomized by 1, 2, 3 = ‘0’ for ‘low education’, and 4 = ‘1’ for ‘high education.’

Social Capital

As a measure of social capital, I chose the variable “SPSDCON.” It is a derived variable that measures the overall score for the Social Provisions Scale (SPS). The SPS is a composite measure that Statistics Canada offered to capture the level of social resources that one can draw (Statistics Canada, 2013). It originates from the works by Cutrona and Russell (1989, cited by Statistics Canada, 2013), consists of five dimensions of social provisions, namely attachment, guidance, reliable alliance, social integration, and reassurance of worth (Statistics Canada, 2013). In the original forms, it is measured with 24 sets of questions; yet Statistics Canada uses the simplified version with 10 measures, which was validated by Caron (1996, cited by Statistics Canada, 2013). A higher score of SPS reflects higher levels of social support (Statistics Canada,

¹ The LIM of 2011 recommended 40,000\$ as a useful baseline for low income. A formula was then applied to determine the middle, and high-income thresholds based off the LIM.

2013). It is possible to use the 10 separate measures, yet that would make the analysis too cumbersome. As a result, I used the overall variable; and grouped into three categories, where 1 = “Low Social support,” 2=, “Medium Social support,” and 3 = “High Social support.”

Gender and Cultural/Racial Background

In this study, gender and race are included as sociodemographic indicators potentially affecting mental health and help-seeking behaviour. The respondent’s gender was measured using “DHH_SEX,” a dichotomous variable which asked the respondent if they were male or female. For cultural/racial background, I used a variable called “SDCDCGT”. It is a derived variable that identifies whether an individual is a member of visible minority groups. In the official statistics of Canada, visible minority status is defined as someone who identifies with one or more of the following: White, Black, Korean, Filipino, Japanese, Chinese, Latin American, South Asian Southeast Asian, Arab, West Asian, Latin American, Other Racial or Cultural origin, and Multiple Racial/Cultural Origins. Ideally, a finer grouping would be possible. However, due to sample size, and a lack of literature which focuses on different races and help-seeking behaviours among adolescents, this study will keep the “Visible Minority” category.² Further, I created a composite variable “gen_race,” which includes the following four categories: “White Male” = 1, “VM Male” = 2, “White Female” = 3, and “VM Female” = 4. This allows for further exploration of the intersectionality of gender and race as it relates to capital and my outcome variables.

² Categories including ‘Other racial or cultural origin’ and ‘Multiple Racial/Cultural Origins’ in “SDCDCGT” were further explored, to individually categorize each respondent of those categories into ‘White’ or ‘Visible Minority’ based on their response.

3.3 Analytical Procedure

All the dependent variables are dichotomous measures. As a result, I used cross-tabulation for describing the bi-variate relationship and logistic regression as the main modeling technique. There are three stages in the analytical process, and each stage focuses on a separate dependent variable: 1) mental health status, 2) perception of need for mental health care, and 3) service-uptake.

The first part of the analysis was used to establish the impact of class on the overall mental health status of adolescents. In this process, to analyze the effect of social class, I first ran three separate regression models to examine the economic, social, and cultural capital impacts on mental health problems. The next model included all three forms of capital. The extent to which the coefficient changes from the first set of models to the second model indicates which three dimensions of capital are inter-related in their effect on mental health status. Further, the final model includes gender and race status to examine the intersectionality between class and other attributes.

In the second stage of analysis, I examine the effect of social class on perception of mental health needs. The first model looks at the effect of mental health conditions on perceived needs. The results of this model serves as a baseline of comparison. The next three sets of models add economic, cultural, and social capital indicators. If the perception of needs does not vary across social groups, then these forms of capital do not have significant effects, after controlling for the mental health conditions. The final model in this section includes gender and race; any difference in the economic, cultural, and social capital indicators from the previous models would indicate the presence of intersectionality.

In the final stage of analysis, multivariate techniques were used to examine the effect of social class on adolescents' help-seeking behaviours, while further investigating the influence of gender and race on service uptake. In this stage, only those respondents who perceived a need for mental health services were included because the question about service use was only asked to those who responded with perceived needs. In the initial model, social class, as represented through economic, cultural, and social capital, is examined to determine its effect on help-seeking at the individual and combined levels to explore which form of capital is most relevant to the help-seeking behaviours of adolescents. Then, the next model further added gender and race as indicators for service uptake. Mental health status is then further included in the model as a control to explore symptom level and help-seeking behaviours of adolescents.

Chapter 4: Results

The main objective of this thesis is to examine why the number of youth with mental health problems is increasing, yet their use of mental health resources is not increasing at the same pace. Previous research shows that adolescent help-seeking follows a number of steps: first, the presence of mental health problems; second, perceiving a need for mental health supports; and third, the decision to seek help, or not. Each could be affected by class, gender, and race. In this section, I first examine the impact of social class, gender, and race on adolescents' mental health conditions. I then examine how these factors affect help seeking behaviour, focusing on perception of mental health needs and actual service uptake of adolescents with pre-existing perceived need for help.

4.1 Descriptive Results

First, I examine the proportions of mental problems among Canadian youth across social positions. Table 1 contains descriptive information about the variables used in this study. Among adolescents aged between 15 and 19 years old included in the CCHS-MH, over 70% report that they are experiencing poor mental health. A vast majority experience at least one type of affective disorder such as depression, anxiety, or at the very minimum, moderate emotional distress. This statistic is quite high in comparison to Canadian studies of anxiety and depression. According to academic and government research, between 15-25% of Canadians will experience a mental health problem, with adolescents, in particular, having a heightened risk for mental illness (Butler & Pang, 2014; CAMH, 2019). The difference between our findings and those reported in the literature can be explained by the fact that they used different measures of mental health outcomes.

Table 1. Distribution of the Sample by Variable		
	N	Percentage
Mental health status		
<i>Good mental health</i>	593	29.6%
<i>Poor mental health</i>	1,410	70.4%
Percieved need for mental health care		
<i>No percieved need</i>	1,632	80.9%
<i>Percieved need</i>	384	19.1%
Help-seeking behaviour		
<i>No help sought</i>	1,692	83.7%
<i>Help Sought</i>	330	16.3%
Economic Capital		
<i>Low income</i>	562	27.8%
<i>Medium income</i>	665	32.8%
<i>High income</i>	798	39.4%
Cultural Capital		
<i>No post-secondary</i>	351	21.9%
<i>Post-secondary graduate</i>	1,255	78.1%
Social Capital		
<i>Low social capital</i>	84	4.2%
<i>Medium social capital</i>	1,285	64.5%
<i>High social capital</i>	623	32.3%
Gender		
<i>Male</i>	1,028	50.8%
<i>Female</i>	995	49.2%
Race		
<i>White</i>	1,373	74.6%
<i>Visible Minority</i>	467	25.4%
N	2,024	
Source: 2012 Canadian Community Health Survey—Mental Health		

The studies available on Canadian mental health, such as those cited in previous chapters, are primarily based on data derived using measures reflecting the guidelines of affective disorders as described by the DSM-5 (Smetanin et al., 2011). Also, only those who sought intervention are counted as having a mental health problem, and those who do not seek help are

not included. In this study, poor mental health is measured based on the self-reported experience of symptoms. Respondents were considered to have poor mental health if they experienced *at least* one of the following, as laid out in the CCHS-MH: symptoms of depression, symptoms of anxiety, and a moderate level of emotional distress. The inclusion of distress, based on The Kessler Psychological Distress Scale (K10) (Australian Bureau of Statistics, 2003), also means that those who do not necessarily identify their symptoms as a mental illness are recognized, encompassing much more of the sample of adolescents. Thus, the proportion reported in this study (70%) may look quite a bit higher than estimates from other reports but is plausible.

This is further shown when we look at the perceived need for mental health care and help-seeking behaviours. The results show that 19% of the youths in the sample reported that they perceived a need to seek some form of care. This estimate is more in line with official reports on Canadian mental health problems (CAMH, 2019). Furthermore, only 16% of the respondents actually sought help for their problems. Thus, as it is reported in the literature, Canadian adolescents, despite often having mental health problems, do not perceive a need for care to the same extent of their mental health problems, let alone seek care to the same extent of their problem.

In terms of Canadian adolescents' social class, household income was used as an indicator for economic capital. Approximately 40% of the sample come from families with high income (>\$80,000), while 28% are from low income families (<\$40,000). Highest level of education of family was used as an indicator for cultural capital, and nearly 80% of respondents come from families with at least one member with a post-secondary education degree. While this simple dichotomous variable is not an ideal measure for cultural capital, it is commonly used as an indicator throughout research on mental health. Ideally, measures of 'taste' of an adolescent's

family would help to contextualize the effect of cultural capital on help-seeking behaviour. Social capital is measured using the social provisions scale, which is conceptualized as: “attachment, guidance, reliable alliance, social integration, and reassurance of worth” (Statistics Canada, 2013). About two-thirds (or 64.51%) of adolescents are classified in the “medium” social capital group, one-third (or 32.26%) in the “high” social capital group, while less than 5% are in the “low” social capital group. The inclusion of gender and race is represented using an intersecting variable at the multivariate stage to analyze the intersectionality of their effects on the help-seeking process. The gender composition is about equal between males and females, while the composition of the race variable is less so. Three-quarters of adolescents in the sample are white. Given the general population, this is expected. It is worth mentioning that this unequal composition of the race variable contributes to a low level of statistical power to detect statistical significance later in this analysis.

4.2 Stage One - Determinants of Mental Health

To probe these univariate findings further the relationship among class, gender, and race and the prevalence of mental health problems among Canadian adolescents is examined. Table 2 summarizes the distribution of incidents of poor mental health across different social groups by each of the social groups.

Table 2. Percent of Adolescents with Poor Mental Health (Weighted)		
	N	%
Economic capital		
<i>Low income</i>	630,386	64.7%
<i>Medium income</i>	747,767	71.7%
<i>High income</i>	890,224	73.8%
Cultural Capital		
<i>No post-secondary</i>	387,614	75.1%
<i>Post-secondary graduate</i>	1,438,117	68.8%
Social capital		
<i>Low social capital</i>	94,073	87.1%
<i>Medium social capital</i>	1,450,100	74.8%
<i>High social capital</i>	694,541	60.3%
Gender and Race		
<i>White Male</i>	773,083	64.9%
<i>VM Male</i>	300,747	65.7%
<i>White Female</i>	822,757	75.6%
<i>VM Female</i>	246,475	69.4%
<i>Source: 2012 Canadian Community Health Survey—Mental Health</i>		

The results presented in Table 2 indicate substantial differences in mental health conditions across class status as well as gender and racialized groups. Among the three measures of class indicators, family’s economic status seems to have a strong influence on adolescents’ mental health status. The proportions of adolescents from medium- and high-income families reporting mental health problems are 71.7% and 73.8%, respectively. They are higher than those from low-income families (64.7%). This is, however, opposite to what was expected. Since those from an economically better-off family have more resources to offer to children, one might expect that they are less likely to suffer from mental health problems. However, the findings show that adolescents with high economic capital are more likely to report poor mental health.

Family's education status, which is used as a measure of cultural capital, also influences adolescent mental health status. The result shows that the lower proportion of adolescents from families with a post-secondary degree report poor mental health (68.8%) than those who come from families without a post-secondary degree (75.1%). That is, children with highly educated parents are less likely to have mental health problems than those with parents with lower education, with a difference of about seven percentage points. In other words, adolescents from families with high cultural capital are less likely to experience poor mental health.

Adolescent's social capital also appears to influence their mental health. The results show that higher proportions of adolescents with lower levels of social capital are reporting poor mental health, relative to those with higher social capital. Adolescents with low- and medium-social capital report having poor mental health (87.1% and 74.8% respectively) at higher rates than those with high-social capital (60.3%). These findings align with the prediction that those with higher levels of social capital will have better mental health. The proportional difference between the low social capital group and the high group is more than 20 percentage points, indicating that social capital has the largest effect on adolescents' mental health status among the three measures of social class.

For gender and race, the interaction effects are evident. First, focusing on the gender difference among the white group, the proportion of white female adolescents who had mental health problems was 75.6%, which is more than 10 percentage points higher than their male counterparts (64.9%). Among visible minority group, too, females had a higher rate of mental health problems (69.5%) as compared to the visible minority male group (65.7%). Thus, for both racial groups, females have higher rates of mental health problems than their male counterparts. This aligns with the literature, but the gender gap of the white group is twice as large as the one

for the visible minority group. For the effect of race on mental health problems, the gap between white and visible minority groups is not so prominent and varies across genders. Among men, there is no substantial difference in the rates of poor mental health between visible minority males (65.7%) and white males (64.9%). For females, there is a gap where white females have a higher rate of mental health problem (75.6%) than the visible minority females (69.4%). The difference is about six percentage points. This is not, however, as large of a gap as the ones found between genders. These results do not align with my hypotheses, in that visible minorities may experience poorer mental health at a higher rate than white adolescents, but this is only slightly supported for men. For females, the finding indicates the opposite pattern. These results suggest that gender and race factors are closely intersected in their effect on mental health problem. Gender difference is evident for both racial groups but more pronounced among white, indicating that womanhood or manhood affect mental health conditions differently for different racial groups. Likewise, the race effect is only evident among females, not men, signaling that minority status does not make a difference in the rates of mental health problems among men.

Generally, the results thus far, indicate that rates of poor mental health are much higher in my analysis compared to previous estimates of rates of mental health problems. My hypotheses predicted a gradient effect between social class and good mental health, which is not the case for all dimensions of social position. Among social class indicators, higher levels of education of the household heads and social provisions are associated with lower rates of mental health problems, while higher economic status is associated with higher rates of mental health problems. Also, for gender and race, females tend to have higher rates of mental health problems than men, but the race effect is not as clear-cut. There is not much difference among males, but white females are more likely to have documented problems than visible minority females. However, these

differences do not offer insight into the intersectional relationships between class, gender, and race. In the next section, I will examine whether or not the impacts of class indicators on poor mental health change when gender and race factors are controlled. The extent to which the size of the effect changes between the models with and without those controls will suggest the presence and magnitude of each independent effect of the social class measures.

Next, results are probed further by conducting multivariate analysis of different influences of social position on poor mental health conditions. I ran three baseline models (Models 1a-1c), plus two additional models. The baseline models reflect the same results found in the bivariate analysis above, except the proportional differences are now indicated in the forms of logistic coefficients. These coefficients allow comparing how the sizes of class effects vary after controlling for other measures of social classes in Model 2. Model 3 includes gender and race variables. The changes of coefficients across the models indicate the degree to which additional factors alter the original relationships and hence suggest the interrelatedness among the factors. The results are summarized in Table 3.

	Table 3. Logistic Regression Results									
	Model 1a		Model 1b		Model 1c		Model 2		Model 3	
	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE
Economic Capital										
<i>Low income (ref)</i>										
<i>Medium income</i>	0.323 **	0.178					0.510 *	0.089	0.497 *	0.222
<i>High income</i>	0.400 *	0.171					0.577 *	0.178	0.641 *	0.215
Cultural Capital										
<i>No post-secondary (ref)</i>										
<i>Post-secondary graduate</i>			-0.314 **	0.180			-0.314	-0.702	-0.340	0.208
Social capital										
<i>Low social capital (ref)</i>										
<i>Medium social capital</i>										
<i>High social capital</i>										
Gender and Race										
<i>White Male (ref)</i>										
<i>YM Male</i>									0.012	0.287
<i>White Female</i>									0.564 *	0.188
<i>YM Female</i>									0.325	0.285
Constant	0.608	0.127	1.096	0.156	1.912	0.401	1.868	0.477	1.797	0.560
Wald chi ²	5.920		3.030		27.060		37.360		48.660	
<i>p</i>	0.052		0.082		0.000		0.000		0.000	
<i>df</i>	2		1		2		5		8	
<i>n</i>	2,003		1,589		1,976		1,575		1,443	
* Significant at $\alpha < .05$										
*** Significant at $\alpha < .10$										
Source: 2012 Canadian Community Health Survey—Mental Health										

Model 1a examines the relationship between income levels and mental health. The positive coefficients of medium and high-income dummy variables (0.32 and 0.40, respectively) suggest that these groups have greater likelihood of experiencing mental health problems relative to the low-income group. Although caution needs to be made for not using the bootstrap weights, the difference between the high-income groups and the low-income groups is statistically significant at 0.05 level. When two other indicators of social class – cultural and social capital- are included in Model 2., the effect of income level on poor mental health strengthened. The coefficients for mid- and high-income groups are 0.51 and 0.58, respectively and they are statistically significant. The level of household's economic condition partially overlaps with the other two factors of class status in such that those who are from high-income family tend to have members with higher education and social provisions. When those overlaps are removed, the gap in mental health conditions between those with a high household income and those with less becomes pronounced.

Model 1b examines the effect of education level on mental health. The negative coefficient (-0.31) means that those coming from families with at least a post-secondary degree are less likely to experience poor mental health. Again, this is in line with the findings reported previously. In Model 2, when the other two measures of class indicators are included, we see no change in the coefficient (-0.31). Thus, the positive impact of highly educated parents on adolescents remain unaffected by other aspects of social class.

Model 1c indicates the effect of social capital on mental health. The coefficients of medium and high-social capital groups were negative and showed much greater effect sizes (-0.83 and -1.50, respectively) relative to the other class measures. These large coefficients signal that effect of the social provision on mental health is the largest of the three measures of social

class. The results of Model 2, in which two other class factors are controlled, the coefficients increased slightly to -0.93 and -1.71 for medium- and high-social capital groups, respectively. That is, as it was the case with the household income, when the overlaps among three class indicators are removed, the gap in mental health conditions between those with more social provision and those with less is pronounced.

Thus, controlling for other measures of social class, the general effects of social class background did not change its direction. Those from a high household have a higher rate of mental health problems than those from a lower household income group, even when education and social factors are held constant. Likewise, those with well-educated household members and higher social provisions have lower rates of mental health problems, when other factors are leveled out. For economic and social capital indicators, the addition of controls made their effect slightly stronger, which the size of the effect for cultural capital indicator did not change at all. Taken together, the results show that different components of social class, economic, cultural, and social, have independent and unique impacts on mental health status. Higher economic capital is associated with greater rates of mental health problems, while higher cultural and social capital are associated with lower rates of problems.

In Model 3, we examined whether these patterns are altered when gender and race are included in the model as statistical controls. The general patterns did not change in this model. The coefficients for income level and educational level of the family do not change from Model 2 to Model 3, although the effect of social capital on mental health increased slightly. The coefficients for medium and high social capital categories are quite large -1.12 and -1.97, respectively, in Model 3.

The relationships between gender and race and mental health can also be drawn from Model 3. The results do not change much from the bivariate analysis. After controlling for the class factors, white females have the highest rate of mental health problems (dummy coefficient =0.56), which is a significantly higher rate than the rate of white men. Visible minority females have a smaller but positive coefficient (0.33) while visible minority males have a very small coefficient (0.01). These coefficients compare the rates of mental health problems to the reference group (white men). However, by comparing the coefficients between visible minority males and females, we can draw gender difference within the same racial group. Thus, for both racial groups, females tend to have higher rates of mental health problems. This is a similar finding to that of the bi-variate results. For race, the difference between visible minority males and white males is indicated in the former groups' dummy coefficient (0.01), while the difference between visible minority females and white females needs to compare the coefficients of these two groups. The difference is -0.23 (= 0.33 for visible minority females – 0.56 for white females) and is a greater gap than the gap for males. The effect of racial grouping on mental health problem is slightly evident among females, but not among males. Again, this is similar to the findings of the bi-variate results. Thus, the interaction effect of gender and race on mental health problems withstand after controlling for class background.

Some of these results were expected, and some were not. I expected that experiencing poor mental health is less likely among adolescents with high levels of cultural and social capital, while I did not expect higher levels of economic capital to lead to poorer mental health. It is interesting to find that three dimensions of social class had different impacts on mental health conditions. This finding offers an important point when *class* is conceptualized as a social determinant of mental health conditions. Depending on how class is measured, its impact is not

the same. This is an important point to underscore before I move onto examining the impact of class on the perception of mental care need and help-seeking behaviour in the next sections.

4.3 Stage Two- Perceived Need for Services

In the second stage of analysis, I examine the effect of social class on the perception of mental health needs of Canadian adolescents through multivariate analysis. To analyze the effects of class, gender, and race on perception of need to seek help for mental health problems, the presence of poor mental health conditions was a statistical control. Given that those who have a poor mental health condition are more likely to perceive the health, the models without controlling for this condition would produce biased estimates for predictors of class, gender, and race.

Model 1 in Table 4 shows a baseline effect of mental health conditions on the perceived need for care. Not surprisingly, adolescents with poor mental health are significantly more likely to perceive the need for mental health care than those with good mental health. The coefficient of 2.12 is quite high, and it corresponds to the probability of 0.37. That is 37% of adolescents with the presence of mental health issues report a perceived need for services. This makes a clear contrast to the group of individuals without a mental health problem, where only 4% of them reported a need. Also, the effect this factor is relatively constant across all models in this stage, maintaining its strong positive effect on perceiving mental health needs.

	Model 1		Model 2a		Model 2b		Model 2c		Model 3		Model 4	
	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE
Mental Health Status												
<i>Good Mental Health (ref)</i>												
<i>Poor Mental Health</i>	2.121 *	0.303	2.122 *	0.304	1.939 *	0.321	2.156 *	0.318	1.976 *	0.346	1.921 *	0.356
Economic Capital												
<i>Low income (ref)</i>												
<i>Medium income</i>	-0.089	0.216							-0.092	0.260	-0.187	0.271
<i>High income</i>	0.028	0.215							0.019	0.255	-0.008	0.271
Cultural Capital												
<i>No post-secondary (ref)</i>												
<i>Post-secondary graduate</i>			-0.050	0.232					0.022	0.249	0.040	0.251
Social capital												
<i>Low social capital (ref)</i>												
<i>Medium social capital</i>									-1.030 *	0.312	-1.264 *	0.351
<i>High social capital</i>									-1.220 *	0.356	-1.674 *	0.408
Gender and Race												
<i>White Male (ref)</i>												
<i>YM Male</i>											-0.284	0.394
<i>White Female</i>											0.688 *	0.231
<i>YM Female</i>											0.216	0.360
<i>Constant</i>	-3.195	0.290	-3.179	0.310	-3.038	0.357	-2.122	0.415	-1.979	0.461	-2.033	0.511
<i>Wald chi²</i>	48.920		49.070		36.450		61.770		52.670		61.920	
<i>p</i>	0.000		0.000		0.000		0.000		0.000		0.000	
<i>df</i>	1		3		2		3		6		9	
<i>n</i>	1,995		1,995		1,585		1,969		1,571		1,439	

* Significant at $\alpha < .05$

** Significant at $\alpha < .10$

Source: 2012 Canadian Community Health Survey—Mental Health

Model 2a examines the effect of household income on adolescent's perception of their mental health needs while mental health condition is controlled. The dummy coefficients for medium- and high-income groups were -0.09, and 0.03, respectively. The negative coefficient of the medium-income group signals the lower rate of perceiving a need for care relative to the lower-income counterparts, and the positive coefficient of the high-income group suggests its higher rate of perceiving a need. But the absolute values of these coefficients are very small, and close to "0", where there is no difference to the reference group. Thus, when mental health condition is controlled for, family's income level does not seem to substantially determine adolescents' perceptions of their mental health needs. Model 3 analyzes the effect of income by introducing other social class indicators as additional statistical controls. The directions and sizes of the coefficients did not change in this model (-0.09 and 0.02 for medium- and high-income, respectively). Thus, the results from Model 2a and Model 3 suggest that household income does not have much effect on perceived needs when controlling for a mental health condition. And its negligible effect is unaffected by its overlaps with other class factors.

Model 2b examines the baseline effect of adolescents' family members' education level. The dummy coefficient for the post-secondary education group was -0.05. Although this negative coefficient indicates that those coming from families with at least a post-secondary degree are less likely to perceive having mental health needs when the mental health status is controlled, this effect is marginal. Similar to the household income, a family's education level is not a substantial determinant of perceived need for care. When additional controls of other social factors are included in Model 3, the fact of the negligible effect of household education is unchanged. Although the coefficient for the highly educated households flipped to a positive value (0.02), the size of the effect is very close to 0. That is, there is not much difference in the

rates of perceiving a need for care between the households with and without post-secondary education when mental health conditions of adolescents are held constant. This tendency does not change even when economic and social aspects of class origin are controlled.

Model 2c examines the baseline effect of the social capital level of an adolescent on the perception of mental health needs while the impact mental health condition is statistically controlled. The coefficients for medium- and high social capital groups (-1.03 and -1.22) indicate a substantial negative effect of social capital on perceptions. This suggests that even after controlling for mental health status, adolescents who have higher levels of social capital are much less likely to perceive a need for care, relative to those with less social connections. When analyzing the effect of social capital while controlling for other social class indicators (Model 3 in Table 4), we see some increases in the coefficients (-1.12 and -1.45 for medium and high social capital groups respectively). As mentioned earlier, individual levels of economic, cultural, and social capital tend to overlap. Once such overlaps are removed in Model 3, or one individual from the same level of household income and education are compared, the difference in social capital makes a slightly greater difference in perception of needs for care. My analysis shows that those with a greater level of social capital are much less likely to report the need for care. The results, so far, show that the mental health condition is taken into account, only social capital has an independent negative effect on perceiving mental health needs, while economic and cultural capital does not have an impact on the perceived level of need for help.

Model 4 further examines the effect of class indicators with additional controls for gender and race. When controlling for a mental health condition, social capital, education, and gender and race, the effect of the high-income level on perceiving mental health needs did not change much from Model 3. Although the negative coefficient for medium-income decreased to -0.19 in

Model 3 (from -0.09 in Model 2), it is a small effect and not statistically significant. The coefficient for the high income further attenuated to -0.0084 in Model 4. The effect of education, too, increased slightly in this model. The coefficient changed from 0.02 in Model 3 to 0.04 in Model 4, but this is not a substantial effect. For the measure of social capital, the effect on mental health slightly increased by introducing the gender and race into the model. The coefficients are now -1.26 and -1.67 for medium and high social capital groups, respectively. Such increase signals that the levels of social capital and how they impact the perception on needs may be different across gender and race. Once the gender and racial differences are removed from the effects from the rest of the predictors in the model, social capitals play a more pronounced role in defining adolescents' perceptions of their mental health needs.

In Model 4, after controlling for mental health condition and class origin, there is a discernible gender and race difference. Per the gender difference, females are more likely to perceive need than men. The coefficient for white females (0.68) is quite high, compared to others in the model, indicating that they are much more likely than white males to perceive a need for care, holding the other factors in the model constant. Visible minority females, whose coefficient is 0.22, also have a higher likelihood of perceiving a need for care, relative to their male counterparts (coefficient = -0.28). Thus, for both racial groups, females are more likely to perceive a need for care. For race effect, visible minority members are less likely to perceive the need for care than the white group. The gaps in coefficients between visible minority and white groups are -0.28 for males (coefficient of the visible minority men), and -0.47 for females (0.22 for visible minority females – 0.69 for white females). Thus, the effect of race is more prominent among males than females, indicating that a substantial interaction effect remains even when the social class background and mental health condition are taken into account.

Generally, the results from stage two indicate that perceiving a need for help to address mental health problems is lower among adolescents with high levels of social capital, while economic and cultural capital appear to have little effect. That social capital plays a significant role in this regard was expected in the hypothesis. The results offers an insight into *how* social capital influences perceptions of need for care. One camp in the existing literature suggested that higher levels of social capital serve to increase perception of need for care, while others indicated that more social capital would curtail the propensity to feel the need for care. My findings show more support for the latter. Gender and race have impacts on the perception of need for care, as expected in the hypothesis, but do not affect the way class factors impact perception. That is, the effect of economic, cultural, social capital on perception of need are not affected by their gender and racial attributes. Most importantly, though, the presence of poor mental health is the most important determinant of perception of mental health needs. Once this factor is controlled, class indicators did not have much influence, other than the effect of social capital. In the final section, I will examine the actual uptake of care, exploring whether and how class position affects this.

4.4 Stage Three - Help-Seeking Behaviour

The last set of models examine the same variables impact on the service uptake for mental health problems. This stage of the analysis includes only respondents who have perceived a need for mental health services, excluding those who did not report a need. Due to this, my sample size is quite small, contributing to the lack of statistical power to detect statistical significance. As a result, more emphasis will be placed on the actual size of the effect.

As with both previous stages in this analysis, I ran three baseline models (Models 1a-1c) without statistical controls, plus two additional models, which include social class indicators, gender and race as control factors. Model 1a in Table 5 shows the result for the relationships,

among those who perceived a need for mental health resources, between household income and adolescents' service uptake. The coefficients of the medium and high-income groups were positive (0.35 and 0.58, respectively), indicating that, once adolescents perceived a need to seek help, the higher income of adolescents' households increases their likelihood of using a service. Translating these coefficients to the differences in probability, 87% of those from high-income households are estimated to seek help, as compared to 85% of those from medium income and 80% of those from low household income. Thus, although a majority of adolescents who perceived a need to seek help do end up using a service, those who are from high-income family have an even higher rate of pursuing services than those who are from a less well-off family. This indicates that the paradox in question may exist not in the gap between the presence of illness and service uptake, but rather, whether or not they perceive a need.

	Model 1a		Model 1b		Model 1c		Model 2		Model 3	
	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE	Coefficient	SE
Economic Capital										
Low income (ref)	0.348	0.475					0.461	0.624	0.447	0.480
Medium income	0.577	0.467					0.502	0.652	0.561	0.401
High income										
Cultural Capital										
No post-secondary (ref)			0.316	0.496			0.088	0.595	-0.161	0.795
Post-secondary graduate										
Social capital										
Low social capital (ref)					0.556	0.521	0.785	0.587	0.723	0.244
Medium social capital					0.601	0.629	0.784	0.700	0.820	0.270
High social capital										
Gender and Race										
White Male (ref)									1.128	0.208
VM Male									-0.857	0.110
White Female									-0.038	0.963
VM Female									1.326	0.753
Constant	1.395	0.360	1.559	0.427	1.228	0.464	0.699	0.602		
Wald chi ²	1.530		0.410		1.250		4.660		11.230	
p	0.466		0.524		0.534		0.459		0.189	
df	2		1		2		5		8	
n	405		323		399		320		288	

* Significant at $\alpha < .05$
 ** Significant at $\alpha < .10$

Source: 2012 Canadian Community Health Survey—Mental Health

Compared to Model 2, which includes the statistical controls for household education level and social capital, these results do not change much. The coefficients were 0.46 and 0.50 for medium and high-income groups. This tells us that the positive effect of household income on actual service uptake among adolescents with a perceived need for care is independent of other class indicators.

Model 1b in Table 5 examines the effect of education level of the adolescent's family members on service uptake. The coefficient of the post-secondary education group was 0.32, which is positive but smaller than the dummy coefficients for the household income groups. Adolescents with a family member with a post-secondary degree are more likely to seek help for their mental health, compared to those without family members with high education. The coefficient of 0.32 in this model translate to the probability of 0.86, or 86% of those with a highly educated family member is predicted to seek help, while the probability for those without such family members was 0.82. The gap in these probabilities for these two groups is no more than 4 percentage points. This is slightly smaller than the gap across household income groups.

There is, however, a significant change between Model 1b and Model 2. When other social class indicators are included (Model 2), the coefficient for the post-secondary group substantially attenuated (0.09). This result suggests that the difference in service uptake between family members education was suppressed by economic and social factors. That is, family members' education largely overlaps with income level, and to a lesser degree with adolescents' social capital. Once these overlaps are removed, or once individuals with the same economic and social capital are compared, the rates of service uptake do not vary much between those with and without a family with high educational background.

Model 1c examines the relationship between adolescents' levels of social capital level and their service uptake. The coefficients of medium and high-social capital groups are positive and quite sizable (0.56 and 0.60, respectively). That is, among the adolescents who perceived a need to seek help for mental health, greater social capital increases the likelihood of seeking help. Estimating the probabilities for each of the social capital groups, there is very little difference between the medium, and high social capital groups (85% and 86% probability of uptake, respectively) but those with low social capital has a substantially lower probability at 77%. The gap between the high and low social capital groups is almost 10 percentage points, which is a greater gap than the one observed for income group.

The large effect of social capital on service uptake slightly increases, when household income and education are included as in Model 2. In this model, the coefficients are for both medium and high social capital groups increased to 0.78. The increase of effects in Model 2 was also observed for household income factor, while household education level lost its effect. Taken together, these findings imply that most of the effect that came from a family members' high education on adolescents' service uptake were mediated by economic and social factors.

Model 3 captures changes in coefficients of class indicators based on the additional inclusion of gender and race. When comparing the coefficients between Models 2 and 3, we observe very little difference in the effect of social capital and economic capital on mental health resource use. However, the coefficient for education level changed substantially. In Model 3, the coefficient of the post-secondary education was estimated as -0.16, indicating a negative effect. That is, when controlling for gender and race and other social class indicators, adolescents who have a family member with a post-secondary degree will be less likely to seek help for mental health problems. The size of the effect is small, but it is an unexpected result.

As for the impact of gender and race on service uptake, Model 3 offers some insights. In the previous section, females were reported to have higher rates of mental health problems and perceiving a need to seek help than men. However, when a comparison is made among those who actually perceived a need, males are more likely to seek help than females. For the white group, white females have a substantive negative coefficient (-0.86), where white males are the reference group. Among the visible minority members, men's coefficient was positive (1.13), whereas the coefficient for females of this group was slightly negative (-0.04). Thus, the men's higher likelihoods to seek help over females withstand for both white and racial minority group. For the race effect, males have a larger gap in likelihood seeking help when a need perceived, compared to the gap among females. The racial difference in coefficients among males was 1.13, where racial minority men, when a need for help is perceived, are far more likely to use a mental health resource. For females, too, white females have a much lower coefficient (-0.86) than their visible minority females (-0.04), translating to that higher probability for the minority females (88%) as compared to the rate for white females (81%). These are the results where class backgrounds are controlled.

Generally, the results from stage three indicate that class status has a substantial impact on service uptake, once only adolescents who perceived a need to seek care for mental health were included. When independently assessed, a higher level of economic, cultural, and social capital is associated with a greater likelihood of pursuing help-seeking behaviour. Particularly higher levels of social capital and income lead to higher rates of service uptake. The previous analyses that focused on the prevalence of mental health problems and perceived need to help showed no sign of mediation effects among economic, cultural, and social capital. Unlike them, the results on the service uptake show that the effect of family member's education level was

suppressed by other social class indicators, suggesting a mediation process. The positive effects of economic and social capital on service uptake withstand when gender and race factors are controlled, while the effect of household education flipped the direction. This could be due to a small sample size, which leads to very unstable estimates, and further examination is warranted. The effects of gender and race on service uptake, in contrast, were rather opposite to what was expected. In our analysis, males are more likely to seek help than females, while minority members are also more likely to use services than white, once a need to do so is perceived. Again, further analysis with a larger sample size is needed to offer more robust conclusions. Yet, these offer some good points of discussion to explain the paradox of mental health condition and help-seeking behaviour.

4.5 Summary

The examination of adolescents' help-seeking behaviours for mental health resources using Canadian data reveals various important findings. The analysis systematically examined three stages of help-seeking behaviour and reveals that the rate of adolescents who have mental health problems is substantially different from the proportions of adolescents who perceived a need for care or those who actually received care, but once they perceived a need, the majority sought help.

The analysis also explored whether social class and other social attributes, such as gender and race, affect each stage of the help-seeking process. In doing so, three forms of capital, which define social class were examined, as was their intersection with gender and race. The multivariate analyses indicate that three aspects, economic, cultural, and social dimension of class attributes have unique impacts on each stage of adolescents' help-seeking process. Higher *economic status* was associated with higher rates of mental health problems; but it had no impact

on perception of needs. However, among those who perceived a need, higher household income increases the rate of service uptake. For *cultural capital*, measured by household education level, those with a family with post-secondary education tend to have fewer mental health problems than those without a highly educated family member. It did not, however, affect the levels of perceived need for care, and its effect on service uptake was suppressed by other social indicators. For *social capital*, adolescents who have extensive social network and resources tend to have lower rates of mental health problems, but that lowers the rates of a perceived need to seek help. But once adolescents perceived a need, adolescents with more social capital end up seeking care more often than those with less social capital.

Thus, each aspect of social class had a unique relationship with the three stages of mental health help-seeking. For the most part, those effects, or lack thereof, were not intervened by other class indicators. The lone exception is the effect of cultural capital on service uptake, where its positive effect was suppressed by economic and social capital. These patterns of social class and three outcomes of the help-seeking process withstand after gender and race factors are accounted for. Thus, there is little evidence that class status is intersected with gender or race, although gender and race were clearly intersected.

These analyses were conducted with the hope of shedding light on the paradoxical phenomenon of adolescents' high mental health problems and low service use. There are some caveats. Due to the small sample size, I could not estimate the standard errors with bootstrap weights. As a result, I could not offer statistical inferences with much confidence. Small sample size also prevented me from conducting a finer analysis for specific regions across Canada. Given that healthcare and education systems are under provincial jurisdiction, provincially specific analysis would have led to more meaningful analysis for social policies. Despite these

limitations, this thesis, using a nationally representative data, offers meaningful insights into the complex mechanisms shaping adolescents' mental health conditions. In the next chapter, I will discuss the implications of the findings for the paradox and potential contributions for future policy planning.

Chapter 5: Discussion and Conclusion

Deterioration of mental health conditions among Canadian adolescents gained much attention and government, educational, and other institutions have implemented a number of programs to ameliorate such conditions. However, the low-level service use among adolescents raises questions about the process of help-seeking. To better understand this paradoxical phenomenon, it is important to examine help-seeking and the potential factors that prevent and enable it. Unlike the public health literature which puts forth the notion of “mental health literacy” (MHL) and which is largely individually focused, I examined broader patterns that would influence individual help-seeking behaviours. In doing so, my analysis focused on whether and how social class shapes the help-seeking process. In this analysis, I explored the multiple dimensionality of “class,” as well as how it intersects with gender and race. This was done by assessing the help-seeking process across three stages.

My analysis offered a more comprehensive picture than what exists among current studies and offered an evidence base about the influence of “perceived need” on seeking help. A key finding from my analysis is that a perceived need for mental health support had the largest influence of the process of help-seeking behaviour. The existing literature has acknowledged that first step in seeking help is to *recognize the condition of poor mental health* (Coles et al., 2015; Jorm, 2012). However, to my knowledge, there is no literature which systematically examined the rates of individuals with a mental health problem, a perceived need for care, and actual service uptake. My analysis found that 70% of adolescents aged 15-19 in Canada were classified as having some form of mental health problems, while only 19% of adolescents reported a need. When a need for mental health support is recognized (19%) the rates of service uptake were lower (16.3%), while the rate of no perceived need (80%) is slightly lower than the rate of no

help sought among adolescents (83.7%) The proportion of those who perceived a need for care (19%) include both those with and without a mental health problem; as a result, if we try to estimate the proportion of those who felt a need only within those had a problem, the rate would likely be higher. Nevertheless, the gap between the proportion of mental health problem and the proportion in perceived need indicates that *the recognition of needs is the bigger gap than actual access after perceiving a need.*

My analysis explored three dimensions of social class and in doing so offered a more nuanced assessment of the influence of social class on mental health and access to care. My analysis shows that household income does not affect perceptions of the need for care, which is said to be a barrier to service uptake (Rickwood & Braithwaite, 1994), but this does not mean that “class” has no impact.

Among the class indicators, social capital had a largely negative impact on perceived need. The higher an adolescent’s social capital, the less likely they are to perceive a need for help. Higher social capital leads to better mental health outcomes, and positively effects service uptake once a need is perceived, but negatively effects the perceived need for help. One interpretation that can be offered from the existing literature is that people with an extensive social network may not be able to admit that they need help (Offer and Schneider, 2007).

Another explanation for this could exist in the idea that one receives all the mental health support they need from their existing social network, and do not need to seek professional, and potentially more specialized mental health support. This may have important policy implications, assuming that adolescent’s social support networks are largely made up of young peers, who likely do not have the skills to provide effective mental health support.

My thesis also showed that high household income has a negative impact on the mental health of adolescents, a positive impact on service uptake once a need is perceived, but no impact on perceiving a need. The lack of influence of household income on perceiving a need was unexpected because the existing literature indicates that higher household income is positively correlated with mental health status and health behaviours (Pinxten & Lievens, 2014). One possible interpretation of this unexpected finding is that people with low income have increased feelings of helplessness and powerlessness, contributing to their poor mental health and ability to access help (Ibid). However, the current study focuses on adolescents, who may not experience the same powerlessness due to income as an adult might, which may contribute to this unexpected finding.

Similarly, the effect of cultural capital throughout the analysis was non-existent, which was also unexpected. The existing literature indicates a positive correlation between levels of cultural capital and help-seeking behaviours (Cummings, 2014). This is potentially explained through increased MHL among those adolescents with high cultural capital. However, the process of transferring mental health literacy from family, to adolescent, is under explored in the literature and unmeasured in this analysis. The effect of cultural capital on help-seeking behaviours may not be the same for adolescents as it is for adults or as the literature suggests.

These findings offer important contributions to the way in which we understand the effect of social class on help-seeking behaviours. It was anticipated that class would positively affect the three-stage process of help-seeking behaviour among all three levels of capital. However, the findings show that the relationship between capital and help-seeking is not linear. Thus, “*class*” *has various impacts on mental health at different stages*. This has important implications for policy interventions and the analysis of social class and mental health. That is, *reducing “class”*

to merely economic factors and not accounting for the social aspect of class as is commonly done, would lead to unsuccessful policy planning.

My analysis also explored the impact of gender and race on the help-seeking process. The existing literature indicates an intersectional relationship between class, gender and race, (Rosenfield & Mouzon, 2013), however minimal research has been done to explore this relationship fully among adolescents. My findings show that gender and race are intersected. That is how gender affects mental health varies across specific race backgrounds and *vice versa*. However, class factors are not intersected with these factors; rather class maintains its effect regardless of gender and race status. This could be due to the fact that I measured “racial” category with a “visible minority”. Given that there are enormous class differences within visible minority groups, potential relationships between class and specific ethnic/racial groups might be lost. Future analysis that uses more finer racial/ethnic categories is warranted to further explore the intersectionality.

These findings offer some important points for future planning in policy and program development. They suggest that low levels of service uptake have likely more to do with lack of recognizing a need to seek help, rather than lack of care or facilities. If we were to improve mental health conditions, an effort must be made to improve the perception of mental health needs. On this front, the existing literature often points to improving individual mental health literacy. While such an effort may be pursued, further exploration should be made as to how social factors, such as class, influence an adolescent’s MHL.

In particular, a focus on improving MHL among social networks of adolescents may increase the likelihood that they might perceive a need for help. In doing so, multiple dimensions of class attributes, not confined to economic aspect of class, should be considered. An effort may

be pursued in further investigating the direct impact of MHL on perceiving of mental health needs, with services allocated to improving adolescents' understanding of mental health in general, and what can be done to improve their mental health problems both presently, and in the future.

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