Cohesion of the Primary Social Network and Sustained Service Use before the First Psychiatric Hospitalization

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Abstract

This study analyzed the relationship between social network dynamics and initial help-seeking behaviors. The primary social network was reconstructed for the period beginning with initial observation of unusual behavior and ending with first psychiatric hospitalization. The social network's influence was analyzed based on the concept of social network cohesion, considering both structure and content of social ties. The results demonstrate that networks succeed in referring the family member to services and in maintaining a clinical follow-up to the degree that they are cohesive. When a network lacks cohesiveness, the onset and development of problem behaviors are less easily recognized. These findings confirm the importance of social and interactional contexts in decision-making processes leading to use of psychiatric services and specify the roles they play.

Introduction

Contemporary psychiatry tends to present a largely individualistic orientation, emphasizing psychological and/or physical aspects of psychiatric disorders.[1,2] Yet, it has long been established that the nature of social relationships may be directly related to health status and that sociocultural and organizational factors also may influence illness definitions and decisions to use services.[3–6] Moreover, mainstream models applied to studies of service utilization propose conceptual models based on motivation, attitudinal perception, and auto-evaluation.[7] However, this theoretical perspective is increasingly called into question on the grounds that it neglects social contexts and interactions linked to the process of help seeking.[8–10] What is now needed is a better understanding of the help-seeking process (ie, how people actually behave in their environments and why their actions lead to different health trajectories).

According to Lapierre,[11] the concept of process involves understanding the sequence of movements, behaviors, and actions that persons perform. In the opinion of the present authors, processes—and the intents of the social actors involved in them—could be better understood by developing a clear conceptual framework that draws on both qualitative and quantitative observations. Qualitative research methods are well suited to describe issues of process, as they aim to better understand the

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context in which behaviors take place.[12,13] In conjunction with statistical analysis, qualitative data can provide a more refined picture of the complexity of human behavior.[14]

An individual's entry into an "illness career" provokes a major disturbance in the family network. Many of the individual's symptoms can create conflicts that eventually lead to a break in relations with certain family members, not to speak of friends and colleagues. A decrease in the size of the family network can entail serious consequences, especially when the network is not particularly large to begin with. In such cases, the loss of one member alone can deprive the individual of critical support. The situation is then exacerbated by the fact that, owing to the very nature of mental illness, the individual's ability to reconstruct his or her social network is challenged. In this context, the study of the primary network and its cohesion appears particularly pertinent to understanding the trajectories of persons with psychological distress.

The aim of the present study was to analyze the influence of social networks, specifically with respect to cohesion, on the help-seeking process and on the sustained use of resources before the first psychiatric hospitalization. Individuals with severe psychiatric disorders require special assistance from both formal and informal resources. Creating and maintaining links between different helping resources consequently become major issues within the context of psychiatric services. According to the hypothesis put forth here, help-seeking processes cannot be adequately understood within a "rational decision-making" framework and must be considered and analyzed within the context of social relations (ie, the processes likely to influence the behaviors and attitudes of individuals). It is posited that network dynamics, rather than the "expressed needs" or "individual motivation" of the individual, is a better predictor of individual behavior. This article examines the role of the social network in maintaining continuity of care during the first stages of a patient's psychiatric career before the first psychiatric hospitalization.

Cohesion of the Family Network

The notion of family cohesion has a long tradition in psychiatry, family therapy, and psychology,[15,16] aside from being a theme implicitly studied in contemporary sociology. Durkheim[17] introduced the notion of family cohesion in order to explain variations in suicide rates. The protective nature of religion and the family depends on the ability of networks to provide support and moral guidelines that an individual can depend on in difficult times. According to Durkheim, family relationships involve elements of obligations and constraints (social regulation) and a sense of meaning and purpose (social integration) that contribute to prevent health deterioration.

Network theory, too, has a strong tradition concerning the notion of cohesion. Most observers in this field of research agree that cohesion is a function of the direct relationship between actors (structural aspect) and the positive nature of their exchanges (content aspect).[18] The presence of a clique in the network is an important aspect, as it allows for direct and singular exchanges. These exchanges are believed to be a major source of personal identity and sense of belonging to the group.[19] In terms of content, cohesion is based on the quality of relations (ie, the conciliative and cooperative attitudes among members of the network). Attitudes should be more similar in cliques with positive ties, especially when the attitudes concern important considerations for which comparisons remain limited for the most intimate members.[20]

In line with the work of House et al,[2] it is proposed here that social support and regulation are two key mechanisms operating in the help-seeking process and that this process occurs more frequently within cohesive networks. Social support is treated as a complex, ongoing, transactional process between the individual and his or her social network[21] rather as a static personal characteristic. For example, the family can influence health behavior by providing a range of support, including information, understanding, and emotional and instrumental support.[22] Social regulation is an aspect of social control used to enforce informal norms. It involves how people who know one another on a personal basis react to behaviors.[23] According to Umberson,[24] the informal social control of

behavior can operate through two different mechanisms: (1) internalization of norms resulting from overall socialization processes and (2) application of direct external pressures. A clear and consistent normative system can emerge from a multiplex or cohesive network and be strong enough to exercise pressure or constraint on a member's behavior,[25] which may then engage a person in health behaviors having the effect of reducing stress in the family. The question posed here, then, is the following: How do the dynamics of social networks affect the help-seeking actions of persons who experience major psychiatric problems for the first time and their subsequent access to helping resources? Several other interrelated questions are also posed: How is it that certain networks manage to identify a problem and seek advice or help regarding the problem, but are then unable to sustain relations with existing resources? Once a person is in contact with services, how sure can we be that he or she will remain in contact? What role can a cohesive social network play in continuity of care, especially in the early stages of the illness trajectory?

Methods

Subjects

The subjects included 80 psychiatric outpatients of the Louis-H. Lafontaine Psychiatric Hospital in Montreal, Quebec, Canada. Subjects had to have an active psychiatric file and a diagnosis of schizophrenia or major affective disorder according to the *International Classification of Diseases* (ICD-9).[26] To obtain a more homogeneous sample, a third criterion was added: Patients had to be age 18 to 30 years at the time of selection (some patients had turned 31 by the time they were interviewed). Of 160 eligible subjects initially identified, 19 could not be traced in the community and 4 were excluded for medical reasons. Of the 137 remaining individuals, 57 refused to participate, resulting in a 58.4% participation rate. Interviews were conducted with 80 patients, and 48 interviews were conducted independently with family members. Nearly all participants were interviewed individually. There were no statistical differences—at the .05 significance level—between participants and refusers in terms of the following factors: gender, age, number of hospitalizations, and number of months since first hospitalization.

Data collection procedure and basic concepts

The data were collected retrospectively through interviews and from the patients' psychiatric files. These files were read according to coding guidelines in order to identify: (1) sociodemographic and clinical data, (2) help resources used, and (3) information that could specify the social context and network action during the observation period (ie, from start of unusual behaviors to first hospitalization). The authors reviewed the complete charts of the patient, beginning with the very first contact with the hospital (emergency department or outpatient clinic) and including outpatient clinic charts. The medical files from other institutions also were available when patients had been hospitalized elsewhere. It must be underscored here that the present research would not have been possible without the high quality and large quantity of data contained in the medical files. Semi-structured, intensive interviews were conducted with the respondents. They were asked to provide narratives of salient, representative, and difficult network interventions that occurred before the first hospitalization. Interviews were conducted by the lead author and lasted from 45 to 150 minutes. Key concepts of the study were drawn from these narratives: initial unusual behaviors, primary network, content of relations between network members, social support, and network regulation functions. The qualitative nature of the research was marked by a fieldwork approach.

Initial unusual behaviors, as acknowledged by the family, were identified using the methodology developed by Perrucci and Targ.[27] Families used different criteria in estimating the individual's time of entry into illness. (For more details on this first phase of the "illness trajectory" see Carpentier et al.[28]) Mean interval between beginning of initial unusual behaviors and first hospitalization was

2.6 years; this observation period ranged from 4 days to 17 years and followed a variety of patterns. The notion of primary group, as defined by Brugha et al,[29] served to operationalize *primary network* as those individuals closely linked to the person who take part in the most important decisions or in the daily living of the person. These can include family members as well as friends and professionals. The concept of *network cohesion* is based on two dimensions. The first is structural, corresponding to the presence of at least one social clique in the network (relations between a minimum of three actors, including the patient). The second is content, indicating the nature of the ties between members of the primary network (ie, the simultaneous coexistence of quality and attunement between actors).

As Table 1 indicates, five categories of helping resources were considered. Overall, the 80 patients enacted a total of 75 contacts with services during the observation period. Although arbitrary, the "sustained user" criteria were nonetheless defined according to a certain clinical relevance. Two criteria were used. First, a minimum frequency of consultations was defined (see Table 1, column 6). Second, the services had to be consulted on a voluntary basis. For example, 17 individuals consulted outpatient clinics, but only 11 had at least three consultations within a period of 6 months. Of the 25 individuals having been in contact with social services (social workers, school psychologist, etc), 12 were excluded because consultation was nonvoluntary (correctional services, youth protection, etc), while the others consulted on a preventive basis. According to these criteria, 55 subjects (68.8%) did not maintain the services used before the first hospitalization. Of the remaining 25, 12 maintained one service, 7 maintained two, and 6 maintained three during the observation period.

Data analysis and issue measurement

The interviews and case notes were subjected to content analysis to determine the processes that allowed network members to become aware of the onset of the problem and the manner in which

Table 1

Helping services as used by a cohesive network (CN) and a less cohesive network (LCN) and the established criteria in determining maintained utilization status ($n = 80$)

Helping service	CN ($n = 44$)	LCN ($n = 37$)	Total ($n = 80$)	Days of use (SE)	Minimum consultation period	New total maintained user ($n = 80$)
Outpatient clinic	15	2	17	67.20 (22.0)	Minimum of three consultations in 6 months	11
Specialized mental resources	8	2	10	41.12 (19.6)	Minimum of two consultations in 3 months	9
Family doctor	12	0	12	64.60 (42.5)	Minimum of 3 months of consultation	10
Social services	14	11	25	134.27 (59.3)	Minimum of 3 months of consultation	13
Community support group	5	6	11	0.77 (.77)	Minimum of 2 months of attendance	1
Total			75			44

SE, standard error

Table 2

Qualitative criteria for selected variables and frequency of cohesive network (CN) and less cohesive network (LCN)

Concepts	Dimensions	Description/indicators	CN	LCN
Cohesion	Structural aspect	Network made up of a clique of at least three actors, including patient, who are linked together		
	Content aspect	*Cooperative actions:* Network actors feel close to each others, can express their opinions, and can discuss problems		
		Attunement: Actors intend to remain in network, show no intention to disengage		
		Respond to both dimensions	44	36
Social support	Daily living	Parent or spouse provides daily living support	41 (93.2%)	25 (69.4%)
	Instrumental	Providing job, financial assistance, an alternative, and temporary residential setting, etc	13 (30.0%)	2 (5.5%)
Regulation	Indirect influence	Respondent talks about presence of *conventional* behavior within network or *way to act;* presence of a model or an influent person who can constrain behavior	12 (27.3%)	2 (5.5%)
	Direct influence	Negotiation or elaboration of strategies, active guidance in treatment choice, escort patient to activities, encourage to do something, promote good habits, supervision of behavior, capacity to make patient act, form of sanction	15 (34.1%)	2 (5.5%)

they reacted to it. The data underwent four steps of processing: (1) preparing verbatim transcription of the interview, (2) doing coding and inverse coding (as a validation procedure; performed by the lead author), (3) compiling thematic profiles, and (4) elaborating flow charts. As shown in Table 2, a careful classification of the qualitatively identified variables was conducted (cohesion, social support, and regulation).

Regarding the content dimension of the cohesion concept, two criteria were defined to establish the quality of relations between the actors: (1) members of the network had to demonstrate the intention to cooperate and give mutual support during difficult times and (2) the network must not be in the process of disintegrating or splintering, and members did not try to avoid one another. The structural criterion (presence of a clique) and the content criterion (quality of relations) were both considered as necessary conditions (simultaneously) for discriminating between networks with "cohesive" and "less cohesive" features. According to the structural classification, 62 families had at least one clique within their network. However, 18 of these families were not considered cohesive, as they did not meet the content criterion. A total of 44 cohesive networks were identified in the sample.

Generally, researchers conceptualize social support as the provision of instrumental, emotional, and communicative aid to the individual. However, the two last dimensions did not prove relevant in this study. On the whole, situations before hospitalization were characterized by conflictual relationships, increasing distance between people, and progressive isolation. Virtually no patient perceived emotional support or communicative aid during this time. Network members, too, spoke nearly exclusively of the patient's daily living and some instrumental support. Regulation was conceptualized as (1) an internalization or self-justification process on the part of either the patient or the network members and (2) a member's direct action that could *constrain* a patient's behavior. Table 2 describes the indicators of the two concepts of support and regulation and the extent to which these indicators were present in cohesive networks (CNs) and less cohesive networks (LCNs).

Information came from different sources (patient, family, psychiatric file), and qualitative and quantitative methods were used to determine the findings' consistency. Regression analysis assessed the relationship between sustained service use and independent variables. Variables identified in the literature[30–33] as influencing service use include network cohesion, diagnosis, duration of observation period, place of residence, gender, and ethnicity.

Results

Subjects were 62% male and 38% female. Mean age was 28.3 ± 2.3 years for males and 28.8 ± 2.2 years for females. There was no significant inter-gender age difference. More than half the subjects (58.8%) had an educational level below high school, and 66.3% received social welfare assistance. A quarter of the subjects came from families who had immigrated to Canada. The 80 primary networks were relatively small, with three or fewer individuals who were predominantly family members (86.7%). Table 3 lists the members of the networks according to level of cohesion. It is noteworthy that mothers and fathers made up more than half of the members of the network and that cohesive networks comprised at least one more family member than did the less cohesive ones.

Multivariate analyses

About one third (31%) of psychiatric service users consulted and maintained at least one helping resource during the period from initial unusual behaviors to first hospitalization. No significant differences emerged between the two groups in terms of length of observation period (CN: mean = 2.87, standard deviation [SD] = 3.5 years; LCNs: mean = 2.28, SD = 2.8 years; $F = 1.004$, $df = 78$, not significant [NS]). Table 4 shows the six independent variables considered simultaneously in the logistic regression model. When sex, race, diagnosis, and residential factors were controlled for, a longer observation period appeared to be related to a greater likelihood of consulting helping resources. This suggests that a rapid development of symptoms allows little time for the network to organize or develop support and regulatory mechanisms. Moreover, individuals in cohesive networks were more likely to seek and maintain help than were those belonging to a less cohesive network.

Qualitative analysis: cohesion and service utilization

Following an individual's entry into the "illness trajectory," the majority of families expressed, to different degrees and at different moments, the need for advice and help in order to understand what was happening to their family member. In rare cases (cases 9 and 51), families expressed the view that the actions of public services (school and health clinic) were at the root of the problem. This opinion was entered in the patients' medical files but was not reiterated at the interviews. Through family support groups, parents became convinced of the "unpredictability" of the onset of psychiatric problems and the difficulty of identifying someone or something as "responsible." Though there was

Table 3

Members of patients' primary network during the observation period ($n = 80$)

	Cohesive network ($n = 44$)		Less cohesive network ($n = 36$)		Total ($n = 80$)	
	n	%	*n*	%	*n*	%
Mother	41	26.8	28	32.2	69	28.7
Father	40	26.1	12	13.8	52	21.7
Partner/spouse	7	4.6	6	6.9	13	5.4
Grandparents	1	0.7	2	2.3	3	1.2
Adoptive parents	0	0.0	6	6.9	6	2.5
In-laws	7	4.6	0	0.0	7	2.9
Aunt, uncle	2	1.3	2	2.3	4	1.7
Brother, sister	37	24.2	17	19.5	54	22.5
Treating psychiatrist	3	1.9	0	0.0	3	1.3
Mental health professionals	1	0.7	3	3.5	4	1.7
Colleagues	3	1.9	4	4.6	7	2.9
Social workers	2	1.3	2	2.3	4	1.7
Family doctor	2	1.3	0	0.0	2	0.8
Friends	5	3.3	4	4.6	9	3.8
School staff	2	1.3	1	1.1	3	1.2
Total	153	100.0	87	100.0	240	100.0
Number of family actors	135	88.3	73	83.9	208	86.7
Other network members	18	11.7	14	16.1	32	13.3
	Mean	**SE**	**Mean**	**SE**	**Mean**	**SE**
Family network	3.07	.15	2.03	1.21	2.60	.13
Other network members	0.41	.09	0.39	.11	0.40	.07
Total	3.48	.15	2.42	.24	3.00	.15
Density	0.84	.04	0.31	.06	0.60	.05

SE, standard error

a general desire for professional intervention, this was not necessarily accompanied by the wish to see outside agents substitute for family members. The majority of families believed that professionals should be discreet, complementary agents and that parents and friends should remain the principal actors in maintaining the well-being of their family member. This position was expressed especially in families belonging to minority cultural communities. The evolution of psychiatric difficulties led to a profound disturbance in the functioning of family life, particularly for the primary caregiver who faced an increasing burden of care. With the progressive development of unusual behaviors, help offered within the primary network came up against increasing limitations. Simultaneously, the perceived need for outside help grew. Public services, both specialized and nonspecialized, were viewed as the only recourse for the families. Community groups, when families were aware of them, were considered to lack the necessary expertise to deal with problems deemed as highly complex by families.

Two distinct phases preceded the help-seeking process. First, family members recognized and accepted that the individual was being progressively affected by a thought disorder. Second, to establish contact with services, families had to possess certain skills or abilities in order to be able

Table 4

Final logistic regression model including six simultaneous variables ($n = 80$)

Dependent variables					
Index of use of service on a voluntary and preventive basis	0—No sustained use of services, 55 (68.8%) 1—Sustained use of services, 25 (31.2%)				
		Value—Logistic regression			
Independent variables		**B**	**SE**	**Exp (B)**	***p***
Sex	1; Men: 49 (61.3%) 2; Women: 31 (38.8%)*	.2152	.38	1.24	NS
Ethnicity	1; French Canadian: 60 (75%) 2; Other: 20 (25%)*	−.5204	.79	.59	NS
Diagnosis	1; Schizophrenia: 58 (72.5%) 2; Major affective disorder: 22 (27.5%)*	.0170	.44	1.01	NS
Observation period	Mean = 2.6 (SE = .36) years	.5648	.16	1.75	<.001
Residence	1; Family/spouse: 66 (82.5%) 2; Other: 14 (17.5%)*	.4157	.62	1.51	NS
Network cohesion	1; Cohesive network: 44 (55.0%) 2; Less cohesive network: 36 (45.0%)*	1.3139	.42	3.72	<.01

SE, standard error; NS, not significant

*Category of reference

to lead the individual toward helping resources and to ensure his or her compliance. Mechanisms related to social support and regulation, which illustrate the processes that operate within family networks and lead to the use of helping resources, follow.

Networks possessing cohesive characteristics

As mentioned above, criteria were adopted to assess network cohesiveness. In terms of structure, the network had to comprise at least one clique and, in terms of relationship content, there had to be evidence of cooperation between members. One of the most important elements identified in the cohesive networks was the existence of a "discussion zone," that is, a specific moment or space (symbolic or material) where the principal members could talk. In terms of network analysis, it is here that the importance of cliques (ie, configurations of at least three actors who are in communication with one another and who have direct access to other members) becomes patent. The presence of a tie between members allows for the development of discussions that initiate the process of "awareness" of the appearance and development of the family member's behavioral problems. For example, in one instance (case 64), the two parents stated that they had constantly discussed the behaviors of the individual, which progressively led them to the conclusion that the actions of the individual deserved special attention. These parents did not agree on when the problems began. For the mother, it was a layoff and personal bankruptcy that prompted the individual's illness; for the father, it was an earlier suicide attempt. Nevertheless, the most important aspect was the large volume of information transmitted between family members. In other words, it was through the process of discussion that families became more aware of a reality that they could not initially grasp or comprehend (given their close involvement)—that of the unusual experiences of their family member.

This awareness led to a "response" by the family, and generally to some kind of social support activities. For instance, in one case an individual was allowed to use the family's car and provided with an apartment (case 20); in another, the person was given a job by an uncle (case 75). Most families had resources or means through which the individual could feel a sense of social integration. However, this support also served as a "means of negotiation" in order to ensure the patient's cooperation.

After awareness, the next process involved the family encouraging the emotionally troubled person to consult professional services. Along with their supportive role and growing understanding of the problem, families acted through suggestion or encouragement, and even by providing "direction" (or an ultimatum) to the family member. At this point, the regulation mechanism became apparent, and direct or indirect influence could be observed. Several forms of indirect or "internalized" social control were noted in the interpersonal relationships. For instance, contact with services might be facilitated by a family tradition valuing psychoanalytic consultation (case 62). In another situation (case 2), the presence of a well-respected general practitioner motivated consultation. In yet another (case 42), the individual identified a family member as a guide in his or her personal development: "I have seen my sister being repeatedly hospitalized and refusing any form of help. I promised myself not to do the same thing." The family's capacity to influence the person indirectly can be reinforced if the family is supported by the advice of a third person who is not part of the individual's daily routine (eg, family doctor, brother).

"Direct" influence or active behavior also was observed in families. Many parents accompanied the patient on visits to a professional, a behavior that facilitated access to services and also ensured follow-up. In another instance (case 18), the individual's mother asked school staff for help dealing with the "perfectionist attitudes" of her child and was referred to a social worker. One mother was convinced that it was up to the family to direct the person toward services before delegating responsibility for referral to the professionals, and so she actively sought professional involvement (case 34). Energetic steps taken by this mother seemed to influence the individual to seek help. According to the mother, "He didn't have the choice."

Networks without a dominant cohesive element

By definition, less cohesive networks do not benefit from direct or cooperative links between members. It was noted that individuals in these networks were not able to sustain service use prior to their first hospitalization. The absence of strong ties and the fact that there were fewer actors within the network militated against the processes described above occurring (ie, awareness of the problem, followed by application of social support based on an understanding of the problem, and, finally, development of an action plan to seek outside helping resources).

A variety of reasons may explain the absence of this pattern in cases where these is no cohesive network. First, difficulty in assessing the severity of symptoms may be related to the absence of other people who would be available to discuss the parents' fears and the problematic nature of the behaviors of their family member. As long as the psychiatric nature of the behaviors was not confirmed, certain families judged the behaviors of their family member to be typical of adolescence or related to his or her personality. One family illustrated this very well (case 6): a single mother who worked as a psychiatric nurse in a psychiatric ward did not have a confidant with whom she could discuss the behavior problems of her child. While she did discuss them on one occasion with her ward psychiatrist, she was unable to discuss it with anyone on a regular basis. The rare contacts with her ex-husband were superficial. For instance, following the child's first hospitalization, the ex-husband commented: "You see, it was nothing serious, just a small crisis because of drugs . . . the doctors released him immediately." During the interview the woman added: "I am alone, I divorced 19 years ago, and I have very little means." While such families may seek outside expertise, information or advice is rarely discussed and analyzed within and, when it is, it may be within a small network or a conflictual context.

Second, the size of the network appears to be an important feature for several reasons. Within a small primary network few can take over for daily living problems, responsibilities cannot be shared, and fewer members are available to ensure follow-up with professionals. Divorced or separated couples did not necessarily have fewer resources. On the contrary, in certain cases the person may have benefited from the separate networks of each parent. At the same time, however, conflicts between separated parents sometimes nullified any possibility of developing a coherent help-seeking strategy: "Love is being disputed rather than shared" (case 46).

Third, conflictual family relations that are disintegrating, ambiguous, or lacking collaboration may lead to negative consequences. A mother (case 45) spoke of the conflicts with the rest of her family: "When we have money, everyone comes over. Now that I have nothing, no one comes. I've learned my lesson. You can't count on family." Another mother (case 13) spoke of the disintegrating family network following a separation: "We went from a pretty home in the suburbs to a small apartment in the city. It was a shock for the children; there was no place to play." It was in this context of social isolation that the family member began his psychiatric career. Later on, when the person reduced his social activities and stopped working, his mother asked him to apply for social welfare. The person waited several months before applying and, when he finally received a small benefit, he rarely paid his mother any room and board. The mother also asked him to see a doctor, but "he ignored me, did nothing, and denied having any problem." Another mother described herself in a similar situation (case 7): "I realize today that I should have insisted more that he see someone; I just didn't know what to do at the time." Another parent (case 28) admitted to not having enough resources: "He begged me for money; he sold the furniture. I was alone with him and in a depression."

Finally, these families also were confronted with another difficulty: monitoring the person and ensuring continuity of helping services. These families often delayed help seeking and, with the passage of time, the troubled person's reluctance to seek help grew. Even if the social network believed that certain actions had to be taken, what was lacking was the capacity to follow through with the supportive action or "direction" to strongly encourage members to seek help. In these networks, there were signs of dissatisfaction and feelings of powerlessness toward services. In the

event that the family and the patient sought external help, solid helping ties between parents and professionals did not seem to endure. Family members spoke of the physician or psychiatrist as the person who "hands out medication," and much less as the one who provides information or advice to reach decisions. In this context, the ties between the family and the professional remained too superficial to establish a stable helping relationship.

Discussion

The present study explored the social processes that might explain in part how and why certain individuals seek and maintain a relationship with health services prior to their first psychiatric hospitalization. The results suggest that the use of help-seeking resources for a psychiatric disorder is associated with the presence of a cohesive social network. In the opinion of the authors, the predominant service utilization model developed during the 1960s and still in use today (the sociobehavioral model or the health belief model[34,35]) must be reevaluated, as these models were originally conceived in response to physical health problems, and often in the context of prevention. The problems encountered in the mental health area are quite different. The dependency of the individual requires greater family participation in the help-seeking process. It was noted that the response to apparent psychiatric illness was as much a process of social influence as it was a result of individual action. As observed by Hammer[36] 20 years ago, a network approach would allow the description of the social processes involved, distinguishing them from individual attitudes, expressed needs, or symptomatology, in order to further understanding of the help-seeking process with respect to mental health services.

Although this study remains, in many aspects, exploratory in nature, it does confirm the need to pursue research that combines a biographical perspective with network analysis. Some of its limitations include the recall capacity of the subjects and the possibility that the information concerning the network and the individual trajectory is incomplete. Attempts were made to diversify the sources of information in order to counter this problem. The authors interviewed family members and consulted patients' medical files. Aggregating individual reports seemed the best way to produce an accurate picture of the network and its action.[37] However, research[38] has shown that major life events and psychiatric symptoms are of such an extraordinary nature that they can be retrieved with satisfactory reliability. A second limitation of the study is related to the fact that there was no measure of subjects' level of needs prior to the first hospitalization. However, it is safe to assume that the level of distress and the need for care would have been considerable for these subjects. Hospitalization is usually preceded by a crisis period lasting several months, during which time the individual experiences a decrease in his or her social capacities while psychiatric symptoms (such as anxiety, depression, and hallucinations) grow in importance. Under these circumstances, it can be reasonably stated that hospitalized individuals, theoretically speaking, have a similar needs level and, therefore, are ready to consult resources for help. Another limitation was the subject pool, which consisted of individuals who had been hospitalized for psychiatric services and who had active files at the outpatient clinic at the time of the study. This method of subject selection does not make it possible to demonstrate whether early use of helping resources could have prevented hospitalization. Also, this study did not include those who, following hospitalization, continued consultation with alternative resources, including the family doctor or a community organization. Nevertheless, the study's sample can be considered representative of patients who receive treatment at outpatient clinics and who consult institutional services in their specific catchment area.

Notwithstanding these limitations, the study demonstrates the need to consider structural aspects of patients' network (number of actors, cliques) and the content of social ties (cooperation, stability), as well as an analysis of interactions. The concept of network cohesion, which takes into consideration these two dimensions, seems to be more appropriate, providing a more refined interpretation than does the use of family structure alone (defined as a two- or single-parent family, for instance) in

the study of the family's influence on help-seeking behavior. Furthermore, most studies view social support primarily at an individual level, or at best, as an interpersonal phenomenon.[39] Using a network approach and introducing the cohesive dimension into the picture lead to an understanding of the ways in which the support process can be seen as an emergent aspect of the network as a whole rather than as an aspect of an individual provider. The characteristics and dynamics of the network cannot be directly derived from the characteristics of its component parts or even the relationships between those parts.

The use of network cohesion as a central concept can lead to a more precise definition of social integration in its fundamental meanings corresponding to reciprocity of understanding between actors.[40] The observations made in the present study regarding social integration seem to approach those of Antonovsky, who proposed the notion of "sense of coherence" as a central factor in one's state of health.[41,42] According to Antonovsky, this sense of coherence results in an environment in which the individual experiences a sense of belonging and which allows a feeling of being supported by those who surround him or her. This feeling of cohesion within the network allows the individual to perceive the internal and external environments with optimism and facilitates the general impression that upcoming events will go as well as can be expected. Within a cohesive network, family members have a feeling of being understood and feel that those who are part of their lives are not strangers—they understand and show a desire to help. Furthermore, cohesive networks facilitate two processes—social support and regulation—that influence health-promoting behaviors such as appropriate health service use.

The large body of literature dealing with social support still leaves much to be learned about the circumstances and processes that promote and enhance the availability of this support[43] and the ways that it can influence the help-seeking process. According to Wellman and Wortley,[44] network cohesion could influence the receipt of various kinds of social support, whereas network structure seems to be crucial for access to different kinds of personal assistance.[45] Cohesive networks have the potential to mobilize more helping resources but, as mentioned above, the presence of instrumental support is insufficient to guarantee that these resources will be available to the individual. There must be an initial recognition of a problem before social support can be exercised. The presence of a "discussion network," which facilitates recognition of the onset of psychiatric problems, is an essential step in order to offer social support. The quality of ties between the actors facilitates discussion periods, which are considered implicitly or explicitly as a place to "become aware" of the importance of the problem. This awareness, which is more readily evident in cohesive networks, allows a greater attunement between the interpretation of problems and, eventually, a first sketch or idea of a helping strategy. Mitchell[46] also noted greater participation from individuals in psychotherapy sessions when they are inserted in networks allowing intimate conversations. These conversations within the network seem to enhance the will to keep contact with services. Agreement in the recognition of problems reinforces the group and facilitates implementation of strategies to assist the individual. The social network can then plan some form of behavioral social control.

Sociological studies have primarily been concerned with formal social control, involving organized systems of reaction from specialized agencies and organizations.[47,48] Informal social control (or the regulation process) has been largely neglected in social science but is being increasingly introduced into newer models of service utilization.[2,8,49] Furthermore, social regulation theory seems to fit well with network theory in revealing the overlapping relationships and interconnections of ties, a situation recognized as having strong effects on behavior, partly because action is visible to people in all parts of the network.[50] Regulation also would appear to be another force, in addition to that of social support, underlying the operation of social ties. In this study, cohesive networks demonstrated greater ease in "directing" the individual toward helping services through the use of active social pressure (via encouragement, accompaniment, sanction, criticism) or physical and concrete action.[51] In contrast, less cohesive networks had greater difficulty confirming the onset of problems, supporting and leading the individual to help resources, and, later, maintaining contacts.

Conclusion

The purpose of this study was to document the help-seeking process and particularly the sustained use of services at the beginning of a "psychiatric illness career." While the study of professional service use has been dominated by the "factor approach" leading to the development of variable-centered theories,[52] less attention has been paid to explanatory mechanisms. Process models focus not only on who receives care, which is the main purpose of mainstream models, but also on when care is received and how the whole episode of illness proceeds.[53] Numerous studies confirm the association between the state of both physical and mental health and the support structure of the social network without, however, delineating the mechanisms that account for this association. The findings of the present study suggest two explanatory models for this association: social integration (capacity for support and awareness) of the social network and regulation (which implies the capacity of the network to impose or propose a plan of action to lead the person toward helping resources). Primary networks, which include mainly family members but other social actors as well, play an important role in determining the use of and exposure to services and, therefore, influence in a non-negligible manner the psychiatric course. The present study showed the importance of a cohesive primary network, composed of at least one clique and actors who are in relation by the cooperative nature of contacts, which is an essential element in attaining and maintaining ties with help-giving resources. If this cohesion is lacking, the mere presence of a network is insufficient to ensure a stable relationship with health services.

Implications for Behavioral Health Services

A psychiatric hospitalization is an extremely traumatizing experience, and it may be even more difficult if it is the first significant contact with public health services. For more than two thirds of the group, hospitalization took place at a time when no professional service was maintained. However, for less than a third of the sample, hospitalization occurred as the result of a progressive process toward helping resources that became increasingly specialized in formal mental health services. This trajectory appears to be beneficial, as the preliminary contacts provide information and sensitize the individual to the effects of stigma.[54] A smooth and progressive course also prevents breaks in alliances and relations among people involved and avoids provoking the anger, alienation, and rejection of the principal supporter.[55]

These observations are important within the context of professional intervention planning. According to the study, professionals are sometimes part of the primary network—although they should be mobilized further in the authors' view—and could be active in creating network cohesiveness at the first stage of illness. Their presence and active participation in the network also could be valuable assets for future stages of the care trajectory. The importance of professionals' role in the reconstruction of a disintegrated, inadequate, or altered network as a result of illness has been identified in other studies.[56,57] As proposed by Horwitz,[58] the decline of strong informal ties, related to a larger diversity of living situations and broken families, leads to a growing use of third parties to resolve problems of all sorts. As mentioned above, the implication of an outside agent, such as a family doctor or school staff, can reinforce cohesiveness. Professional services could be one of the resources solicited for helping. However, the fact remains, as the study revealed, that a less cohesive network is not conducive to the application of regulatory and integrative measures leading to help seeking. The more socially isolated the primary network, the greater the distress of families and the burden of care.[59]

Much work still needs to be done in this area of research. For instance, too much or too little support or regulation (such as oppressive monitoring by the family network or overmedication) can be deleterious to the patient's health and the help-seeking process. This study examined only a fraction of the possible family influences on these processes. More sophisticated instruments, larger samples,

and observation of more complete social networks will eventually lead to a fuller understanding of the nature and dynamics of social networks in relation to various trajectories of health and illness.

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