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THE IMPACT OF SOCIAL FACTORS ON INDIVIDUALS DIAGNOSED WITH SCHIZOPHRENIA

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Abstract

The society with diverse structural and ideological influences, assumes its role in relation to behavior, attitude, belief and relations. The impact can be seen in every society globally, however the western nations have adjusted their social policies to suit these transformations, whereas nations in developing phase have failed to establish suitable systems. In Kosovo, the allocation of funds for mental health services remains insufficient, even though mental health disorders account for 12.3% of overall illnesses and 30.8% of work incapacities! The objective of this study is to examine the impact of society on the decline and recovery of individuals with schizophrenia. The study employs both qualitative and quantitative methods to provide a descriptive-analytical. A study was conducted in four municipalities of Kosovo, using individuals with schizophrenia from psychiatric institutions as subjects along with their caregivers/family members . The research found that social factors greatly contribute to the worsening of schizophrenia patients' condition. The presence of schizophrenia is evident through a higher likelihood of having a low level of education, high unemployment rates, and engaging in harmful behaviors like tobacco and alcohol use, as well as physical inactivity. Significant correlations have been observed in the subscales of positive and negative symptoms using the Self-Report PNS-Q questionnaires. It is crucial for individuals with schizophrenia to have a carefully designed strategy in place, developed in partnership with professionals from various relevant fields such as social protection, psychiatric medical services, education, and social integration plans.

Keywords: Schizophrenia, Social Factors, Well-Being, PNS-Q Self-Report.

INTRODUCTION

Societal influence has undergone transformations globally, impacting behavior, attitudes, beliefs, and relationships. Numerous factors, such as structural and ideological elements, contribute to these changes. Remarkably, the driving forces behind these shifts are gradually extending their influence to various regions, affecting nearly all societies and social groups. Consequently, the appropriate adaptation of social policies to the evolving family structure in underdeveloped nations has not consistently taken place. This can be attributed to various factors including health, social, educational, cultural, political, and economic influences.

The professional mental health service of Kosovo is facing numerous challenges due to the psychological impact of war traumas, rapid cultural and social changes, and a struggling economy with high rates of unemployment and poverty. According to

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epidemiological data from the WHO, mental health issues account for 12.3% of general illnesses and 30.8% of work incapacity. Considering these facts, urgent action is required to advance Kosovo's mental health services through effective strategic measures. The objective of this study is to examine the impact of society on the decline and recovery of individuals with schizophrenia, with a particular focus on four municipalities in Kosovo: Pristina, Gjilan, Pejë, and Gjakovë.

Furthermore, the study seeks to offer a comprehensive analysis of societal transformations and evaluate the efficacy of social policies in helping individuals with schizophrenia, drawing upon relevant literature. Moreover, this study will analyze the influence of social protection policies on changes, advancements, and present conditions of these services, with a particular focus on how these policies may have affected legislative modifications in the field of social protection.

Additionally, the study aims to assess the initial effectiveness of such legislative changes in assisting individuals suffering from schizophrenia, who fall under the category of vulnerable groups.

The information above presents an opportunity to analyze the actual data collected from participants in our study and draw conclusions about society's true effectiveness in supporting individuals with mental disorders. The main objective of this study is to assess society's acceptance of people with mental disorders, with a particular focus on the support provided to individuals with schizophrenia, as it is a top priority for aiding and preventing risks for the affected individuals, their families, and society.

The study also aims to evaluate the impact of social factors on support, treatment, and identification of risk factors for groups in need, specifically schizophrenic patients. Additionally, the effectiveness of economic assistance in supporting families in need is examined as a critical factor. Lastly, the study also seeks to validate the self-report PNS-Q questionnaire.

The research aims to fulfill the following objectives:

- *Identify risk and protective factors associated with the onset of problems in individuals with schizophrenia in the studied groups.*
- *Evaluate the influence of social factors on schizophrenia relapses and develop a program for family interventions in schizophrenia.*
- *Analyze and assess the reliability of the PNS-Q questionnaire for assessing positive and negative symptoms, to enable a rapid evaluation of symptoms and expedite patient treatment.*

The main hypotheses are:

H.1 Social factors contribute to the deterioration of schizophrenia.

H.2 Discontinuation of schizophrenia treatment is linked to a high rate of schizophrenia exacerbations.

H.3 Stressful life events exacerbate schizophrenia.

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Research questions are:

The research endeavors to answer the following questions:

- *What are the social factors that impact individuals diagnosed with schizophrenia?*
- *How does schizophrenia affect an individual's well-being?*
- *What findings have the PNS-Q-Self-report questionnaires yielded?*

This study holds paramount importance as it investigates the changing dynamics of social factors alongside changes in family structure. It underscores the role of both families and society in providing optimal support to individuals in need.

1. The Disease of Schizophrenia

1.1 How is Schizophrenia defined and what are its Symptoms?

The term schizophrenia originates from the Greek words shisis, meaning separation, and phrenos, meaning soul. Dr. Emil Kraepelin first used this word in 1887, although it is believed that the disease has existed since ancient times. In 1911, Swiss psychiatrist Eugen Bleuler described schizophrenia as a mental illness with four "A's", encompassing affect, association, ambivalence, and autism (Ashok et al., 2012). Schizophrenia is a complex mental disorder, consisting of multiple diseases rather than a single condition. Recent research suggests that schizophrenia arises from abnormalities in fetal brain development, which manifest as the disease during late adolescence. Nonetheless, the most widely accepted approach is the biopsychological perspective, which highlights the interplay of psychological, genetic, and social factors in the emergence of this disorder. In individuals with schizophrenia, there are severe disruptions in vital functioning, resulting in loss of work capabilities, dependency on others, and isolation from family and friends. This disease typically manifests between the ages of 15 and 35 and at time before age of 10 and after the age of 40, although it can occur earlier or later in life. While schizophrenia is more prevalent among socioeconomically disadvantaged groups, its incidence is consistent across different populations. The annual occurrence of new cases of schizophrenia ranges from 7.7 to 43 per 100,000 individuals (McGrath et al., 2008). The symptoms of schizophrenia can be categorized into two groups:

1) ***Positive symptoms:*** *Delusions, hallucinations, disorganized speech, disordered thoughts, catatonic behavior or severely disorganized behavior that significantly disrupt normal functioning are considered as positive symptoms in schizophrenia.*
2) ***Negative symptoms*** *in schizophrenia include emotional exhaustion, reduced spontaneous speech, lack of initiative leading to decreased functioning, isolation in enclosed spaces, and withdrawal from social interactions.*

The development of schizophrenia can be observed through three stages:

1) *Active phase.*
2) *The prodromal phase,*
3) *And the residual phase*

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1.2 What are the types of Schizophrenia?

Paranoid schizophrenia, which is the most common form of schizophrenia, is characterized by hallucinations and delusions. The most frequent type of hallucination in this form is auditory hallucinations, which are highly dangerous and compulsive, posing risks to both the individual and others. Other hallucinations such as visual, olfactory, gustatory, and coenesthetic are also reported. Ideas of persecution are the most common received ideas, although others such as jealousy, erotic thoughts, high descent, and great scientific achievements can also be present.

Disorganized schizophrenia, also known as hebephrenia, typically occurs after puberty, around the ages of 12-15. It is characterized by speech that is incomprehensible and illogical, disorganized behavior, strange facial expressions and gestures, inappropriate jokes, a preoccupation with philosophical topics, deterioration in social interactions, and isolation.

Catatonic schizophrenia is less frequently reported and is characterized by disturbances in psychomotor behavior. It can manifest as psychomotor stupor or complete catatonic stupor

Residual schizophrenia is marked by negative symptoms such as passivity, lack of initiative, neglect of self-care, limited vocabulary, regression, slowed psychomotor activity, reduced engagement in activities, and limited social contacts.

Undifferentiated schizophrenia is identified by the absence of specific symptoms associated with schizophrenia.

Simplex schizophrenia is characterized by a gradual and progressive development without prior occurrence of psychotic signs, but negative symptoms are present.

Post schizophrenic depression persists beyond the acute phase and shares symptoms with depressive episodes.

1.3 What are the Causes of Schizophrenia?

The exact cause of schizophrenia is still unknown, but it is believed to be influenced by various factors, such as genetics and the environment. Symptoms resembling schizophrenia can also be present in other conditions like Huntington's disease, Wilson's disease, epilepsy, encephalitis, meningitis, multiple sclerosis, etc. To diagnose true schizophrenia, these alternative causes must be ruled out. Despite the uncertain origin, changes in brain function relating to perception, emotion, and behavior indicate that schizophrenia is a biological condition. Some researchers speculate that neurotransmitters like dopamine and serotonin may contribute to this malfunction. Brain structures such as the limbic system, thalamus, and other regions are also involved in the development of schizophrenia. The genetic aspect of the disease provides a wealth of data, as it can be observed in relatives and even distant family members. Additionally, studies suggest that the onset of schizophrenia may occur during fetal development, potentially caused by various infections, brain disorders, circulation problems, or lack of oxygen. The theory of neurotransmitters highlights imbalances in dopamine and serotonin

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levels. Prompt recognition and accurate diagnosis are crucial for effective treatment, as delaying intervention can significantly endanger individuals affected by schizophrenia. In such cases, the distorted symptoms may affect brain structures, complicating later diagnosis. Initiating treatment as early as possible reduces the frequency and severity of episodes and may even lead to remission.

Schizophrenia has been linked to social factors including stressful life events such as the loss of loved ones, childhood abuse, and substance misuse, particularly cannabis. Furthermore, the association between cannabis use and the development of schizophrenia is notable in adolescents who have a genetic predisposition. Other causes of schizophrenia include viral infections, immune disorders, and complications during pregnancy and childbirth. It has also been observed that the disease is more prevalent in urban areas, among individuals with a low socioeconomic status and immigrant status, while being less common in rural areas, people with good financial circumstances, and residents. Additionally, family conflicts, violence, wars, and natural disasters can contribute to the onset of schizophrenia.

1.4 How can Schizophrenia be Diagnosed?

The diagnosis of schizophrenia involves a broad range of possibilities. In addition to gathering information from the patient, their family members, and their wider social circle, observation and testing of individuals are also options. These tests involve asking several questions to the person with schizophrenia.

The questions asked to patients include statements such as:

a) Do others control my thoughts?

b) Do I hear or see things that others do not hear or see?

c) Is it difficult for me to express myself in a way others can understand?

d) Do I feel disconnected from my family, society, or others?

e) Do I believe in things that others don't agree with?

f) Do others doubt what I have heard or seen?

g) Am I unsure if my thoughts are real or not?

h) Do I believe I possess magical powers that others cannot understand?

i) Do I think people are plotting against me?

j) Do I struggle to summarize my thoughts?

k) Do others treat me unfairly because they envy my abilities?

Do I have conversations with people in my head that others cannot hear?

Each of these questions should be answered by choosing one of the following options:

1) Generally

2) Very rarely

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3) Sometimes

4) Often

5) Quite frequently

6) Always

1.3 How is Schizophrenia Treated?

Schizophrenia treatment is comprehensive due to the presence of multiple triggers. Various alternatives, such as medications, psychotherapy, group, family, behavioral, cognitive, engaging, and adaptive therapy, are used for treatment. Clopazine, a specific drug mentioned in some sources, stands out from other antipsychotics as it effectively reduces suicidal tendencies, hospitalization, aggressive behavior, and tardive dyskinesia. The Cochrane Schizophrenia Group, established in Nottingham in 1994, provides valuable contributions for diagnosing, treating, and rehabilitating schizophrenia and other psychoses. This group has branches in 23 countries, including the USA, New Zealand, Brazil, China, and Germany. While not all symptoms can be completely treated and cured, it is important to highlight that schizophrenia treatment combines psychosocial interventions with drug therapies. The psychiatrist handles medication while the social worker focuses on developing social skills, including appropriate interactions with others, to help the patient learn or relearn socially acceptable behaviors. Additionally, treatment addresses personal care, life skills, money management, and other practical aspects. Specialized community centers often provide the necessary care for individuals with schizophrenia.

Treatment outside the hospital consists of minimizing symptoms and increasing the quality of life, such as:

- *Use of antipsychotic medication: The patient should continue taking antipsychotic medication even during the stabilization phase and should never stop them without the guidance of a doctor, as discontinuing them may lead to a relapse of the disease and worsen symptoms.*
- ***Group or individual psychotherapy:** can be provided by mental health services to address the patient's thinking and behavior. It is especially helpful for managing symptoms that persist despite drug treatment. Through therapy, patients can learn strategies to handle symptoms, including avoiding hallucinations. Additionally, therapy can reduce the severity of symptoms and decrease the likelihood of their recurrence. Group therapy, led by patients themselves and without a professional therapist, can also be beneficial by providing a space for individuals to discuss their illness and feel less isolated.*
- ***Psychosocial treatment:** supports patients in facing the daily challenges presented by the disease, such as difficulties in communication, self-care, and forming and maintaining interpersonal relationships. Schizophrenia often affects social functioning and motivation, leading to withdrawal from social life. Psychosocial treatment helps improve relationships, reintegrate into society, and regain a social life. Furthermore, it*

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promotes a positive mindset, motivating patients to adhere strictly to medication treatment. By combining these types of treatment, patients can achieve positive outcomes in their treatment and reduce the likelihood of the disease recurring.

- ***Programs for family education:*** *provide guidance to family members on how to support a loved one with schizophrenia. Even after discharge from a hospital, family members continue to play a crucial role in providing care. Individuals with schizophrenia may face challenges in maintaining employment and self-care, thus depending on the assistance of others. During the stabilization phase, patients may still experience psychological and medical fragility, as it can take weeks or even months for medications to alleviate symptoms.*

2. The Action of Social Factors in Harmony with Genetic Risk in Some Sensitive Individuals

2.1 Social Isolation during Childhood

Childhood social isolation has been observed by clinicians, starting with Bleuler, as a common factor among individuals who develop schizophrenia. This includes having fewer social networks and friends. Studies have found a correlation between the severity of symptoms and the size of an individual's social network. For example, He et al. (2017) discovered that excessive use of social networks was linked to impulsivity and a decrease in the gray matter volume of the amygdala. The 1946 British cohort study conducted by Jones et al. (1994) found that children who preferred to play alone between the ages of 4 and 6 were more likely to develop schizophrenia later in life. Additionally, experiencing self-reported anxiety at age 13 and teacher-rated anxiety at age 15 were found to have direct relationships with an increased risk of developing schizophrenia.

2.2 Changing Schools in Adolescence

The Swedish Census Study examined the influence of premorbid personality on the later emergence of schizophrenia in a sample of 50,087 individuals. The results showed that young men who believed they were more sensitive than their peers, had less than two close friends, preferred small social groups, and did not have boyfriends had an increased likelihood of developing schizophrenia in the future. Boydell et al. (2004) suggested a potential interaction between genes and the environment, proposing that individuals with schizoid personality traits or schizotypal characteristics may struggle to form social connections, and this social isolation could exacerbate the development of psychosis. (f.232-33).

In a study conducted by Hare (1956), it was found that social isolation, whether measured within a household, in an individual, or in a specific geographic area, exhibited a strong association with schizophrenia. This finding did not support the downward mobility hypothesis. One explanation is that disrupted social networks diminish an individual's ability to cope with psychosocial stress, thereby increasing the risk of developing schizophrenia.

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Van Os et al. (2000) demonstrated that individuals living alone face a slightly higher risk of developing psychosis if they reside in a neighborhood where fewer people live alone compared to a neighborhood with a higher prevalence of single-person households. Theoretically, this could intensify feelings of social exclusion, loneliness, and isolation in these individuals. Jablensky and Cole (1997) provided evidence suggesting that marriage has a protective effect against schizophrenia, indicating that it is not solely attributable to the idea that mentally healthier men are more likely to marry.

2.3 Migration and Ethnic Minority Status

As early as 1932, Odegard (1932) made an observation that Norwegians who had migrated to the USA had a higher likelihood of developing psychosis. The belief was that cultural and geographical differences led to feelings of paranoia and alienation. This finding, which suggests that migration is a risk factor for psychosis, has been confirmed among various migrant groups (Castle et al., 1991; Harrison et al., 1988; Selten et al., 1997, 2002; etc.). Despite addressing issues of research methodology, such as cultural variation in diagnosis, misdiagnosis, and misestimation of the denominator, studies still indicate a higher prevalence of psychosis in immigrant groups, even when they relocate to similar cultures (Bruxner et al., 1997).

Even after controlling for the urban environment, which many immigrants settle in, studies continue to show an elevated emigration effect (van Os et al., 2001). Many studies have explored the heightened rate of psychosis in Afro-Caribbean populations in the UK and the Netherlands. Genetic predisposition cannot solely explain this increased risk since it does not apply to native populations in the Caribbean (Burnett et al., 1999; Mahy et al., 1999). Additionally, the risk for second-generation siblings is significantly higher than for first-generation siblings (Hutchinson et al., 1996; Sugarman and Craufurd, 1994). Selective migration has been ruled out in the Surinamese population that migrated to the Netherlands (Selten et al., 2002). Other variables, such as neurodevelopmental impairments related to birth complications and viral infections, as well as substance abuse, have also been dismissed as causes (McGuire et al., 1995; Selten et al., 1997).

It is important to note that numerous studies have documented higher rates of schizophrenia in children of immigrants. This has been observed in various locations such as Greenland (Mortensen et al., 1999), the United States (Malzberg, 1969), and the United Kingdom among African-Caribbean populations (Harrison et al., 1988).

In the Yemenite Jewish population that migrated to Israel, Weingarten and Orren (1983) observed a significant prevalence of schizophrenia in the offspring [the adults did not integrate into Israeli society and their lifestyle was considered primitive]. Given that the entire population migrated to Israel, selective emigration cannot be considered as an explanation for these findings.

In their research, Boydell et al. (2004) concluded that "There is no satisfactory explanation for the higher rate of psychosis in children of migrants, but the variety of countries and circumstances in which this phenomenon has been observed suggests that it is driven by social factors.

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2.4 Discrimination and Unemployment

Brown and Birley (1968) conducted a study in which they observed a higher occurrence of life events occurring three weeks prior to an episode of schizophrenia. Furthermore, various studies (Malla et al., 1993; Ventura et al., 1989) have provided evidence showing a correlation between life events and relapse into psychosis. White et al. (2000) conducted a case-controlled study in London, which also found an excess of life events. These findings suggest that it is not necessarily major life events that trigger the reappearance of psychosis, but rather the occurrence of what psychoanalysts refer to as narcissistic injuries of some form in everyday life.

A portion of this sensitivity may be attributed to the influence of significant early life events, indicating the presence of "unified environment-environment interactions" (Boydell et al., 2004, p. 237). The latter proposed that "Stress may be partly derived from underlying personality traits whose genetic contribution aligns with that of schizophrenia. Alternately, individuals with susceptibility to schizophrenia may exhibit heightened sensitivity to the impacts of stress, while stress sensitivity is likewise influenced by the extent of exposure to stress during early life, which likely encompasses early life stress" (Janssen et al., 2004).

2.6 Interaction between Social Factors and Other Etiological Factors

With regards to interactions between genetic and environmental factors, Boydell et al. (2004) have acknowledged that there exists a paradox in relation to the heritability of schizophrenia. To better understand this, careful examination of epigenetics and transcriptomes is necessary. In the context of schizophrenia, epigenetics refers to the regulation of genetic expressions controlled by heritable changes, as well as modifications in DNA methylation and chromatin structure, among others. Additionally, numerous environmental and social factors seem to play a significant role. It should be noted, however, that the predictive power of each of these environmental factors is limited, as most individuals exposed to these risk factors do not develop the disease. To provide a comprehensive explanation, it appears that environmental factors exert influence on genetic susceptibility. This interaction can take various forms such as synergy, addition, multiplication, and so forth (van Os & McGuffin, 2003, p. 237-238).

The findings from adoption studies conducted in Finland and Denmark, as well as the high-risk study in Israel, have demonstrated that environmental factors impact genetic factors and heighten the risk of developing schizophrenia. These "environmental" factors possess the ability to modify the genome and override its effects. Grounded in neuroscientific research, Bolton and Hill (1996) have observed that at the molecular level, intentionality, encompassing beliefs, goal-directed plans, fears, and similar cognitive factors, prevails over biological systems. This is evident from studies that have determined the genotoxic effects of psychogenic stress on various bodily cells.

The experiment conducted by Fischman et al. (1996) illustrated that exposure of mice to stress within a 24-hour period resulted in a substantial increase in alterations in chromosomes and marrow cells. The study demonstrated that stress-induced genotoxic

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damage has the potential to occur in type II cells at both the molecular and chromosomal levels.

Regarding the impact of social factors on cognitive processing, Boydell et al. (2004) proposed that "A notable complexity of any social theory lies in the fact that the effects of social factors can influence not only brain development but also psychological processes that contribute to symptoms of schizophrenia... Individuals with persecutory delusions selectively absorb threatening information, tend to make swift conclusions, attribute negative events to external causes, and struggle to comprehend the intentions, motives, and mental states of others." It is feasible that individuals with this cognitive style are even more susceptible to developing delusions when exposed to social adversity compared to those residing in more amicable social environments. Specifically, the attributional style has been identified as the mechanism through which racial discrimination and harassment can lead to psychosis (Sharpley et al., 2001).

2.7 Socio-Economic Factors, Deprivation and Inequality, as well as Social Causation Versus Social Selection

Multiple research studies have established a connection between economic deprivation and the occurrence, prevalence, and rates of admission for psychosis, specifically schizophrenia (Croudace, 2000). Recent studies indicate that inequality also plays a significant role. Boydell et al. (2003) discovered a direct relationship between the incidence of schizophrenia and the level of inequality in deprived areas of London, even after accounting for other variables such as age, gender, absolute deprivation, and ethnicity.

There is an ongoing discourse between those who believe that social factors have an influence on the development of schizophrenia (social causation) and those who argue that individuals in vulnerable positions actively choose unfavorable social environments (social selection). However, it is important to note that certain research findings mentioned previously refute the claims made by social selection theorists. Boydell et al. (2003) revealed that nonwhite minorities face a higher risk of schizophrenia when residing in smaller minority areas, despite living in neighborhoods with a higher social status.

3. Real Examination of the Impact of Social Factors on Schizophrenia

The research describes the analysis and evaluation that results after the collection of data, and after the actual analysis and examination of the impact of social factors. Statistics (percentages, averages, etc.) are used to describe the current situation, describing concepts and identifications as a basis for this research.

This research was carried out by taking as a research sample patient with schizophrenia who present themselves in psychiatric institutions or mental health centers. The research was carried out in 4 municipalities of the Republic of Kosovo, including: the Clinic of Psychiatry at the University Clinical Center of Kosovo, namely in the department of Emergency and Psychiatric Intensive Care in Pristina; Psychiatry Service at the Regional Hospital in Gjakova, Psychiatry Service at the Regional Hospital in Peja; and the Mental Health Center in Gjilan. Socio-demographic measures were obtained from structured

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questionnaires. Prospective research methods were used (data collection through a previously prepared survey, as well as questionnaires - measuring instruments). The sample size, type and homogeneity were chosen according to the criteria defined based on the ICD-10 and DSM-V where respectively the patients diagnosed with schizophrenia were included. The selection of participants by random method, at the level of the region, is determined at 150 respondents.

The organization of the work was carried out during the period March-May 2016, while the data analysis was carried out during the month of June 2016. All patients selected in the research sample were offered a questionnaire to be completed.

The research utilized the PNS-Q-Self-report questionnaire as the research instrument, which consists of 68 questions in a "true" or "false" format. These questions were adapted from the SAPS/SANS scales and simplified into straightforward sentences. The patients were read the questionnaire and instructed to provide their responses. They were specifically asked to report whether the mentioned topic/symptom was present in the last month. A score of 1 was assigned for each positive response indicating the presence of a symptom, while a score of 0 was assigned for each negative response indicating the absence of a symptom.

The questionnaire was divided into 10 scales, consisting of 5 positive scales focusing on hallucinations, delusions, thought disorder, bizarre and disorganized behavior, and inappropriate affect, and 5 negative scales addressing limited affect, reduced speech, lethargy, non-socialization, and limited attention.

The data collected in the questionnaires were processed and analyzed by using the computer program SPSS for Windows (Statistical Package for Social Sciences, Version 18). The data analysis included frequencies, percentages, tables, and graphs. The data collection procedure ensured accuracy and relevance through the measurement of variables and the use of numerical expressions to represent quantity and differences. All data collected from patients and their families were analyzed completely, maintaining absolute reliability and adherence to ethical principles.

For the successful implementation, and at the same time for this research to have validity and reliability, the approval of the Professional Ethics Board in the Ministry of Health and the consent of the managers of the health institutions were obtained.

In the research, the right to privacy, anonymity and reliability was respected, since the participants had the right to express their opinions freely, but also to refuse participation in this study if they wished. Before the questionnaires were distributed, all individuals (patients) were informed about the purpose of the research, where they were also given a written letter of information.

Then they were offered the declaration of compliance, through which they declared their voluntary participation in the research, as well as ensuring the anonymity and confidentiality of the data collected from the participants. After their declaration of participation in the research, standardized and anonymous questionnaires were distributed.

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Table 1: Analysis of the PNS-Q Questionnaire - Self-reporter

No.	*PNS-Q questionnaire - Self-reporter*	yes		NO	
		Total		Total	
		No	%	No	%
1.	There are occasions when I perceive my thoughts within my mind	**311**	84.1	**59**	15.9
2.	I receive feedback from others that my vocal tones does not accuretly convey my geniune emotions	**221**	59.7	**149**	40.3
3.	Frequently my thoughts get disrupted	**263**	71.1	**107**	28.9
4.	I am convinced that other individuals have the ability to comprehend my thoughts	**196**	53.0	**174**	47.0
5.	Frequently, I am idle	**267**	72.2	**103**	27.8
6.	I percieve a decline in my sexual vitality	**234**	63.2	**136**	36.8
7.	I frequently find myself repeating the same phrases.	**234**	63.2	**136**	36.8
8.	I struggle to stay focused while performing tasks.	**271**	73.2	**99**	26.8
9.	Although I come up with good ideas, I have difficulty giving them my full attention.	**268**	72.4	**102**	27.6
10.	Internal voices are audible to me.	**268**	72.4	**102**	27.6
11.	Occasionally, others fail to comprehend the reasons behind my emotions, whether happy or sad.	**259**	70	**111**	30
12.	Often i think about extraterrestrial beings with intentions of conquering the planet.	**173**	46.8	**197**	53.2
13.	Expressing my feelings in an overt manner is not my usual tendency.	**264**	71.3	**106**	28.7
14.	Anger often arises within me without any apparent trigger.	**266**	71.9	**104**	28.1
15.	Answering questions becomes challenging as I lack the energy to respond.	**245**	66.2	**125**	33.8
16.	People frequently comment on my disorganized and unclear thoughts.	**205**	55.4	**165**	44.6
17.	On occasions, I simply observe my surroundings without active engagement.	**287**	77.6	**83**	22.4
18.	When watching a comedic film, I may appear uninterested.	**184**	49.7	**186**	50.3
19.	Establishing and maintaining eye contact with others poses a challenge for me.	**214**	57.8	**156**	42.2
20.	There are instances where I hear voices that make positive or negative remarks about myself.	**261**	70.5	**109**	29.5
21.	Being inactive tends to be my preference	**226**	61.1	**144**	38.9
22.	I am experiencing a decline in my sexual energy compared to the past.	**245**	66.2	**125**	33.8
23.	I receive covert messages through television or radio.	**167**	45.1	**203**	54.9
24.	I struggle with maintaining focus.	**229**	61.9	**141**	38.1
25.	My garments are unclean.	**139**	37.6	**231**	62.4
26.	There have been instances where we have witnessed things that are imperceptible to others.	**270**	73.0	**100**	27.0
27.	My speech lacks organization, frequently shifting from one topic to another.	**237**	64.1	**134**	35.9
28.	My mental disorder holds a unique philosophical significance.	**202**	54.6	**168**	45.4
29.	I frequently burst into laughter without a discernible cause.	**239**	64.6	**131**	35.4
30.	It is challenging for me to stay in one place.	**255**	68.9	**115**	31.1
31.	I typically do not find jokes on television amusing like others do.	**175**	47.3	**195**	52.7
32.	I have difficulty reasoning logically as I once did.	**274**	74.1	**96**	25.9
33.	I am unable to find joy or enthusiasm in various things.	**272**	73.5	**98**	26.5
34.	Others often complain that my speech is vague and unclear.	**204**	55.1	**166**	44.9
35.	I feel disconnected from all individuals.	**232**	62.7	**138**	37.3

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36.	Completing any tasks is challenging for me.	**228**	61.6	**142**	38.4
37.	At times, I scrutinize things excessively and lose track of my thoughts.	**245**	66.2	**125**	33.8
38.	I prefer solitude.	**236**	63.8	**134**	36.2
39.	Occasionally, I follow instructions from voices that are transmitted to me.	**180**	48.6	**190**	51.4
40.	Reading poses difficulties in maintaining concentration.	**262**	70.8	**108**	29.2
41.	I have committed a sin that I believe to be unforgivable.	**113**	30.5	**257**	69.5
42.	The medication I take possesses special abilities.	**253**	68.4	**117**	31.6
43.	If given the choice, I would rarely change my clothing.	**163**	44.1	**207**	55.9
44.	I am easily irritated by others at times.	**276**	74.6	**94**	25.4
45.	My sexual behavior occasionally leads me into trouble.	**113**	30.5	**257**	69.5
46.	Frequently, I am unsure of my emotions.	**274**	74.1	**96**	25.9
47.	My speech is often difficult for people to understand.	**182**	49.2	**188**	50.8
48.	I struggle to answer questions at times.	**214**	57.8	**156**	42.2
49.	The voices I hear sometimes cause me to laugh.	**221**	59.7	**149**	40.3
50.	I may not appear interested in many things, according to people.	**237**	64.1	**133**	35.9
51.	According to people, I have a frozen look.	**219**	59.2	**151**	40.8
52.	People perceive me as lonely.	**225**	60.8	**145**	39.2
53.	I tend to answer questions with a significant delay.	**241**	65.1	**129**	34.9
54.	While listening to others, I sometimes lose my train of thought.	**253**	68.4	**117**	31.6
55.	According to others, my body has an unpleasant odor.	**140**	37.8	**230**	62.2
56.	There are actual FBI employees within the unit.	**89**	24.1	**281**	75.9
57.	I lack friends.	**164**	44.3	**206**	55.7
58.	There are instances where I cannot complete a sentence I have started.	**218**	58.9	**152**	41.1
59.	Others say I am inattentive to my surroundings.	**221**	59.7	**149**	40.3
60.	Others say it emits an unpleasant odor.	**127**	34.3	**243**	65.7
61.	Occasionally, I hear peculiar voices.	**223**	60.3	**147**	39.7
62.	Initiating conversations with others is challenging for me.	**220**	59.5	**150**	40.5
63.	I believe people are transmitting their thoughts into my head.	**201**	54.3	**169**	45.7
64.	I believe my thoughts are being controlled by extraterrestrial beings.	**172**	46.5	**198**	53.5
65.	According to others, my clothes appear dirty.	**169**	45.7	**211**	54.3
66.	If invited to a party, I would accept the invitation.	**234**	63.2	**136**	36.8
67.	Explaining myself can be troublesome.	**271**	73.2	**99**	26.7
68.	There are times when others do not comprehend my laughter.	**253**	68.4	**117**	31.6

Table 2: Internal Reliability of the Subscales of the PNS-Q Questionnaire - Self-Report

Positive Scales	**N**	**%**
P1 - Hallucinations	262	70.8
P2 - Illusions	174	47.0
P3 - Mental disorder,	208	56.2
P4 - Strange / disorganized behavior	240	64.9
P5 - Inappropriate to affect	231	62.4
Positive Amount:	**223**	**60.3**
Negative Degrees	**N**	**%**
N1 – Limited to affect	234	63.2
N2 – Alogia / reduced speech	231	62.4
N3 – Avolition / apathy	209	56.5
N4 – Asocial / anhedonia	224	60.5

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N5 - Reduced attention	247	667
Negative Amount:	**229**	**61.9**

To assess the internal reliability of the positive and negative subscales of the PNS-Q self-report questionnaire, a reliability analysis was conducted (refer to table no.1 and no.2). Internal consistency is determined by calculating the average inter-score correlation. The results indicate that the questionnaire demonstrates strong internal consistency for both the positive subscale, with a score of 60.3%, and the negative subscale, with a score of 61.9%.

CONCLUSIONS

The impact of society on the worsening of schizophrenia has been investigated in the four municipalities of Kosovo: Pristina, Gjilan, Pejë and Gjakovë, providing a comprehensive understanding of these issues in our country for the first time. The research findings reveal the true condition of individuals with schizophrenia, their difficulties, and the influence of their condition on the emergence of problems.

This study presents compelling evidence of the transmission of problems among schizophrenia patients, contributing to the ongoing debate in the fields of psychiatry and psychology regarding the role of heredity and social environment across generations. Despite previous international classifications categorizing schizophrenia as separate disorders and the lack of understanding around the boundaries of these disorders, the study highlights the challenging task of disentangling the combined impact of family and society on the deterioration of schizophrenia. Additionally, the research brings forth significant findings about the interplay between emotional problems at the individual and societal levels, which have not been previously reported by the community.

Through our study, we have obtained highly detailed information about the characteristics of individuals with schizophrenia and the role that society plays in supporting them. Our approach focused on both the individual and the broader societal structure.

In examining international and coherent literature, it became apparent that society has a significant impact on either supporting or exacerbating schizophrenia. Boydell et al (2004) concluded that understanding the causes of schizophrenia must consider the social environment. They suggested that both social and biological factors, as well as their interaction, should be studied. It is important to recognize that social factors can influence brain development, reinforce psychological vulnerabilities, and contribute to lifelong developmental vulnerabilities. The study participants were selected from psychiatric health institutions and mental health centers in four municipalities of Kosovo. These patients may have a better understanding of their illness and be functioning more regularly compared to patients in other samples.

The research demonstrated that social factors play a crucial role in the progression or lack of recovery in schizophrenia. Unemployment rates among schizophrenics were found to be high based on employment statistics. Additionally, family income was insufficient to support basic living conditions for family members, indicating an extremely low income. It is challenging to establish a cause-and-effect relationship given the various

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factors at play, particularly considering the low overall employment rate in Kosovo. However, individuals with schizophrenia also had significantly low levels of education and academic advancement.

These events can also be seen as stressors that worsen the condition of sick people. The lack of awareness in Kosovë about the causes and symptoms of mental disorders, as well as the responses in the PNS-Q Self-Reporting questionnaire, reveal that sick individuals experience a high level of stigma and prejudice in society, including within their own families. This can greatly contribute to the deterioration of their condition, especially when there is also a lack of institutional support at the state level. One aspect that has not been explored in the literature is the issue of self-reporting for depression and schizophrenia. It is possible for a depressed person to answer the negative symptom questions in the same way as a schizophrenic patient, but this is not usually a concern as the diagnosis of schizophrenia may indicate the presence of depressive symptoms.

RECOMMENDATIONS

- To enhance the well-being of individuals with schizophrenia, it is essential to establish a coordinated effort involving various sectors such as the community, healthcare, education, social services, government, civil society, non-profit organizations, and all individuals who can contribute to any type of transformation. Those affected by schizophrenia and their families require a meticulously planned approach developed in partnership with professionals specialized in the respective domains.
- *Inclusion in intervention programs and activities that promote social support and do not discriminate against others, aiming to foster a sense of belonging.*
- *Utilization of a combination of psychiatric and psychological therapies to address diagnosed problems, based on objective testing and assessment tools, known for their high efficiency in practice.*
- *Implementation of education, within acceptable limits, to avoid counterproductive effects on motivation. Both regular and special schools should provide these conditions.*
- *Development of a plan for integrating individuals into social life and other domains, aiming to enhance self-esteem and foster a sense of belonging.*

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