

GENDER DIFFERENCES IN RECOVERY AND QUALITY OF LIFE AMONG SCHIZOPHRENIC PATIENTS IN KARACHI

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Abstract

The present study is aim to discuss the gender differences in recovery and Quality of life among schizophrenic patients of Asghar Psychiatric hospital Karachi. A sample of 70 patients including male (n=39) and female (n=31) was selected. Only patients with schizophrenia in recovery were selected in study purpose. Purposive sampling method was used to select the sample. All patients were screened using Demographic sheets, RAS-DS (Recovery Assessment scale- Domains and stages) and WHOQOL-BRIEF (WHO Quality of life Scale) to be administered to the sample. The result of the study indicated that significant differences of recovery score among male and female respondents were found. Female patients were higher scores of recovery with regards to all domains of RAS-DS and the males showed significantly better quality of life with regards to all domains: Physical health (88%), Psychological health (82%), Environment (89%) and Social relations (69%) than females.

Keywords: Family history, female patients, recovery, Schizophrenic patient, quality of life, male patient

Introduction

Psychotic disorders, especially schizophrenia is a debilitating mental illness that results as misery of an individual and it can also change the quality of life with all its serious symptoms and its dramatic features. Pakistan is a developing but still a low-income country. Poverty, redundancy, low literacy, malnutrition, gender biases, break-up of social relationship, terrorism, corruption and increased stress level are the most common factors. Recent studies concluded the presences of mental illness in Pakistani rural areas are reported as 15% in males and 46% in females.¹ The percentage of mental disorders in Pakistan has increased. The percentage of schizophrenia is 1.5%. Depression and anxiety disorder prevalence in the Pakistani society was 34% (range is 29%- 66% in females and 10%-33% in males) and the factors connected with the illness were female, young age, low literacy, low economical resources and widespread restriction on women to stay as housewives.²

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¹S. Nishter, National Action Plan for Prevention and Control of Non-Communicable Diseases and Health Promotion in Pakistan, (Islamabad, Pakistan. Tripartite Collaboration of The Ministry of Health, Government of Pakistan, 2001).

²A. Gadit, N. Khalid, State of Mental Health in Pakistan: Services, Education and Research, (Karachi: Hamdard Foundation, 2002) 36-58.

The schizophrenic patients' families also face its negative social and economic influences because it imposes huge financial impact and burden on other family members of the affected person. Schizophrenia affects not only the individual and his whole family, but it also affects the whole community and society. There is a vital role of the patient's family during and after the illness. Joint and the strong family system can give comfortable support from stress. Raynond Cochrane, (Professor of psychology in University of Birmingham, U.K) has carried out research on Pakistanis who living in Britain, has found that Pakistanis have low percentage of disease and have good opportunities of recovery because of their strong, caring and combine family system. Like other developing countries, low rate of education and lack of awareness of mental diseases as well as false beliefs are widespread in Pakistan.

Biological scientists have researched that the schizophrenia runs in families. According to Dr. Roxanne Dryden-Edwards, former Chairman of the Committee on Developmental Disabilities for the American Psychiatric Association, several types of genes are connected with increased the risk of schizophrenia but they feel that no gene causes the schizophrenia by itself. Recent studies have suggested that schizophrenics have high percentage of rare genetic mutations. Above mention genetic differences have involved hundreds of different genes and probably disturb brain development and its activity.

Present researches concluded that socially determined differences in female and male. Genetics distinctions between genders are primarily the cause of gender differences in mental illnesses. After a calamity and an incident, male and female face various types of harmful psychological and physical health problems.³

Schizophrenia is a serious psychiatric illness which affecting 1% of both males and females during their lifetime.⁴ In Pakistani society the female's role is considered generally as just a guardian. She looks after the children and keeps her children and family secure from any dangers. It is a general concept that females are more vulnerable to different types of psychological, emotional and physical problems after the natural calamity and the incident. In some conservative societies there are many restrictions imposed on women's, because of these restrictions they cannot take part in the welfare and social activities as well as in politics. It is a general concept that females cannot play a leadership role to bring changes in the society. These stereotypes and social practices harmful for women strictly. In any disaster or incident, they considered that females cannot recover quickly. It seems that female suffer in psychological and physical illnesses more than males after any critical situation. Different researches describe that female faces high level of emotional and psychological problems as compared to male.⁵

³ C.Katz, Research on psychiatric outcomes and interventions subsequent to disasters: a review of the literature. (Psychiat Res; 110, 2004).

⁴LN. Robins, JE. Helzer, and MM. Weissman, Lifetime prevalence of specific psychiatric disorders in three sites, (Arch Gen Psychiatry, 1984) 41(10):949-958.

⁵ M. L. Bickman, and N. Robinson. "Natural disaster and Depression: A Prospective investigation of reactions to the 1991 Midwest Floods", 1991 {journal on-line}; available at <http://business.highbeam.com/435401/article-1G1-64831111/natura-disaster-and-depression-propective-investigation> (accessed in Oct 2017)

Dr Mobeen Akhter is one of the psychiatrists in the Pakistan said, general concept in the society in which schizophrenia is considered to be incurable. Though this is a complicated disease, yet in this, 50% patients can live a normal life after treatment, 40% patients can live a normal life but they have to take medicine on a regular basis. If they don't use medicine regularly than the symptoms of illness may increase. The remaining 10% patients are of course those who have less chances of a normal life. Experts say that there is a need of the early start of treatment because old cases can convert into complex cases and chances of return to normal life may decrease. To save a patient with schizophrenia means to save a family from relationship breakups, unemployment, incomplete education etc.

A large number of studies have indicated that schizophrenic females have more recovery in the symptoms of disease than male patients. They also have high score of good response, clinical and functional remission, recovery, lower rates of hospitalization, longer time to relapse and higher rates of social and environmental adjustment than male patients.^{6,7, 8, 9}

According to the finding of Worldwide-schizophrenia outpatient health outcomes (W-SOHO), which study related to the outcomes and recovery of the schizophrenic patient. This study conducted in 37 countries and this research indicated a better course and better outcome in female patients.^{10, 11, 12}

A recent study in United State, on schizophrenia and other psychotic disorders covering the sample of 97 patients also reported significant improvement or recovery in psychotic activities and functioning in women's as compared to men's over a 20 year period.¹³

Quality of life is a concept of an individual, his status in his life in the aspect of the culture and their social values in which they live and in relation to their aims and goals,

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- A. Fothergill. The neglect of gender in disaster work: an overview of the literature. In *The gendered terrain of disaster- through women's eyes*, (Westport: Praeger, 1998), eds. E. Enarson and B. H. Morrow, 11-25.
 - F.H. Norris, K.L. Friedman, B. L. Watson, M.F. Chen, and A.L. Karoung, Epidemiology of trauma: frequency and impact of different potentially Traumatic events on different demographic groups, (*J consult clinical psychology*; 2002) 60:409.
 - ⁶ M. C. Angermeyer, J. M. Goldstein, and L. Kuehn.. Gender differences in schizophrenia: rehospitalization and community survival., (*Psychol Med.* 19(2), 1989), 365–382.
 - ⁷ J. M. Goldstein. Gender differences in the course of schizophrenia. (*Am J. Psychiatry.* 145(6), 1988), 684–689.
 - ⁸ R. K. Salokangas. Prognostic implications of the sex of schizophrenic patients, (*Br J Psychiatry*, 1983), 142: 145–151.
 - ⁹ J. Usall, S. Araya, and S. Ochoa, *et al.* Gender differences in a sample of schizophrenic outpatients, (*Compr. Psychiatry*, 2001), 42(4): 301–305.
 - ¹⁰ J. M. Haro, D. Novick, J. Bertsch, J. Karagianis, M. Dossenbach, and P. B. Jones, Cross-national clinical and functional remission rates: Worldwide Schizophrenia Outpatient Health Outcomes (W-SOHO) study. (*Br J Psychiatry*, 199(3), 2011), 194–201.
 - ¹¹ R. Iniesta, S. Ochoa, and J. Usall, Gender differences in service use in a sample of people with schizophrenia and other psychoses, (*Schizophr Res Treatment*. 365452, 2012).
 - ¹² D. Novick, J. M. Haro, and J. Hong, *et al.* Regional differences in treatment response and three years course of schizophrenia across the world. (*J Psychiatry Res.* 46(7), 2012), 856–864.
 - ¹³ L. S. Grossman, M. Harrow, C. Rosen, R. Faull, and G. P. Strauss, Sex differences in schizophrenia and other psychotic disorders: a 20-year longitudinal study of psychosis and recovery, (*Compr Psychiatry*, 49(6), 2008), 523–529.

living standards and their expectations. This is a broad perception affected in a complicated way by individual state of mind, physical health, personality, personal views, social and personal relationships.¹⁴

Most of the studies have found that schizophrenia has an earlier onset in men than in women. Considering all measures of onset into account, like earliest sign of mental disorder, first psychotic symptoms and hospitalization, it is reported that women have a significantly later age of onset. Mostly the age of onset in females is from 25-32 years, whereas in males the age of onset is from 21-25 years.¹⁵

A multi-cultural WHO reported that in different countries the age of onset was lower in male schizophrenics.¹⁶ Another study of 392 consecutive first admissions from a defined catchment area with a diagnosis of schizophrenia, schizoaffective disorders, men indicate a single peak in their early 20's as compared to schizophrenics women have an onset at the age of 25 years.¹⁷ Similar points were concluded by others.^{18,19} Life events involved the onset seems to be more commonly observed by women. The female Schizophrenic patient shows a specific seasonality in first admissions than schizophrenic males, season of onset also different among males and females.^{20,21}

Some recent researches have suggested no gender differences in the outcomes or recovery of schizophrenia.^{22,23} European Group conducted "cross-sectional" study in 12 centers on functional outcomes and Remission in schizophrenia, 276 stable patients of schizophrenia, schizoaffective or delusional disorder. They showed no gender differences in the score of functional and symptomatic recovery; conclude that women have later onset of the disease, low negative symptoms, and also less alcohol abuse as compared than men.²⁴ Most of biological, psycho-social, and different cultural factors indicated to

¹⁴World Health Organization, Qualitative research for health Programme, (Geneva: Division of Mental Health, WHO; 1994).

¹⁵S. Szymanski, J. A. Lieberman, and J. M. Alvir. et al, Gender differences in onset of illness, treatment response, course and biological incidence's in first episode schizophrenic patients, (Amer. J. Psychiat: 152, 1995), 698-703.

¹⁶M. Hambrecht, H. K. Maurer, and I. Hafner, Gender differences in schizophrenia in three cultures. Results of the WHO collaborative study on psychiatric disability. (Social Psychiatry and Psychiatric Epidemiology, 1992) 27:117-21.

¹⁷H. Hafner, S. Behrens, and J. de Vry, Implications for sex difference in Schizophrenia, (Psychiatry Research, 1991), 38:125-34.

¹⁸H. Hafner, K. Maurer, W. Loflier, The influence of age and sex on the onset and early course of Schizophrenia, (Br. J. Psychiat. 1993), 162:80-86.

¹⁹S. V. Farnone, W. J. Chen, and M. Goldstein, et al. Gender differences in age at onset of Schizophrenia. (Br. J. Psychiat, 1968), 14:625-29.

²⁰N. Takei, E. O'Callaghan, and P. Shatno, et al. Season at admission rates in the psychosis. (Br. J. Psychiatry, 1992), 161 :506-11.

²¹N. Takei, and R. M. Murray. Gender differences of Schizophrenia in Seasonal admission in Scotland. (Br. J. Psychiatry, 1993), 162 272-73.

²²Z.Z. Cernovsky, J. A. Landmark, and R. L. O'Reilly, Symptom patterns in schizophrenia for men and women, (Psychol Rep. 1997), 80(3 pt 2):1267-1271.

²³A. Labelle, M. Light, and F. Dunbar, Risperidone treatment of outpatients with schizophrenia: no evidence of sex differences in treatment response, (Can J Psychiatry. 2001), 46(6):534-541.

²⁴S. Galderisi, P. Bucci, A. Üçok, and J. Peuskens, No gender differences in social outcome in patients suffering from schizophrenia, (Eur Psychiatry, 2012) 27(6):406-408.

define these gender differences. These factors include the following tendencies in female patients:

1. Later onset of illness^{25,26},
2. Low negative symptoms^{27,28},
3. Less severe forms of disease²⁹,
4. Better premorbid functioning^{30,31},
5. Better social functioning or social adjustment^{32,33},
6. Good response to antipsychotics^{34,35},
7. Lower frequency of socially undesirable behavior during treatment^{36,37},
8. The potential and protective role during treatment process³⁸.

World Health Organization conducted a research study on the involvement factors of gender on the age of onset, symptoms and course of schizophrenia in seven researches of three different cultures in different areas. This research was reported that female schizophrenics did not have early age of onset and they have more nonspecific symptoms like irritability and tiredness than male schizophrenics. Males have more hyper-emotional behavior like alcohol abuse and social withdrawal”.

The assessment of quality of life (QOL) has considered accurate, valid and common indicator in psychological researches on the activities and utility of the schizophrenic

²⁵M. C. Angermeyer, and L. Kühn , Gender differences in age at onset of schizophrenia. An overview. (Eur Arch Psychiatry Neurol Sci. 1988) 237:351–364.

²⁶S. Szymanski, J. A. Lieberman ,and J. M. Alvir, et al. Gender differences in onset of illness, treatment response, course, and biologic indexes in first-episode schizophrenic patients. (Am J Psychiatry. 1995), 152(5):698–703.

²⁷R. E. Gur, R. G. Petty, B. I. Turetsky, and R. C. Gur, Schizophrenia throughout life: sex differences in severity and profile of symptoms. (Schizophr Res. 1996) ,21(1):1–12.

²⁸I. M. Wieselgren, E. Lindström, and L. H. Lindström, Symptoms at index admission as predictor for 1–5 year outcome in schizophrenia, (ActaPsychiatr Scand. 1996), 94(5):311–319.

²⁹M. Weiser, A. Reichenberg, and J. Rabinowitz, et al. Gender differences in premorbid cognitive performance in a national cohort of schizophrenic patients, (Schizophr Res. 2000), 45(3):185–190.

³⁰S.E. Childers, and C. M. Harding, Gender premorbid social functioning, and long-term outcome in DSM-III schizophrenia, (Schizophr Bull. 1990), 16(2):309–318.

³¹R. M. Norman, A. K. Malla, R. Manchanda, and L. Townsend, Premorbid adjustment in first episode schizophrenia and schizoaffective disorders: a comparison of social and academic domains, (ActaPsychiatr Scand. 2005), 112(1):30–39.

³²M.C. Angermeyer, H. Matschinger, and A. Holzinger, Gender and attitudes towards people with schizophrenia. Results of a representative survey in the Federal Republic of Germany, (Int J Soc Psychiatry. 1998), 44(2):107–116.

³³J. Usall, J. M. Haro, S. Ochoa, M. Marquez, and S. Araya, Needs of Patients with Schizophrenia G. Influence of gender on social outcome in schizophrenia, (ActaPsychiatr Scand. 2002), 106(5):337–342.

³⁴S. Szymanski, J. A. Lieberman , and J. M. Alvir, et al. Gender differences in onset of illness, treatment response, course, and biologic indexes in first-episode schizophrenic patients, (Am J Psychiatry. 1995), 152(5):698–703.

³⁵R. R. Lewine, Reflections on Saugstad’s “social class, marriage, and fertility in schizophrenia” Schizophrenia Bull, 1990), 16(2):171–174.

³⁶T. R. Barnes, S. H. Mutsatsa, S. B. Hutton, H. C. Watt, and E. M. Joyce, Comorbid substance use and age at onset of schizophrenia, (Br J Psychiatry. 2006), 188:237–242.

³⁷D. J. Foti, R. Kotov, L. T. Guey, and E. J. Bromet , Cannabis use and the course of schizophrenia: 10-year follow-up after first hospitalization, (Am J Psychiatry. 2010), 167(8):987–993.

³⁸M. V. Seeman, The role of estrogen in schizophrenia, (J Psychiatry Neurosis, 1996), 21(2):123–127.

patient.^{39,40} It is very important from the bio-psycho-social point of view.⁴¹ Persons with schizophrenia in remission or recovery also show important in quality of life (QOL)⁴² but lower than that seen in healthy subjects.^{43,44} However, there is no difference found with regards to quality of life in the domain of environment. Many of the researches about schizophrenic patients have indicated higher levels of quality of life (QOL) in females than males.^{45,46}

This study explores the beliefs connected with gender difference and quality of life among schizophrenic patients in Pakistani society (Karachi). This research has produced extensive details about gender differences in schizophrenia. The main objective is to determine the gender differences in socio-demographic characteristics, remission or recovery score, and in the level of quality of life.

Objectives of the Study

1. To find out the general awareness in Pakistani society regarding gender differences in schizophrenia.
2. To determine the gender differences in socio-demographic characteristics, remission and recovery score.
3. To find out the difference in the level of QOL in both the gender in schizophrenia recovery.

Hypothesis

1. The family history of mental illness is prevalent among female patients.
2. The recovery score is higher among female schizophrenic patients.
3. The score of Quality of life in male schizophrenic patients is high, as compared to female patients.

In view of the gender differences in recovery and quality of life of schizophrenic patients, Karachi is the largest business center and heavily populated city of Pakistan, as shown in previous pages, the researcher intended and tried to give further insight into

³⁹Meltzer HY. Outcome in schizophrenia: Beyond symptom reduction. *J Clin Psychiatry*. 1999;60:3–7.

⁴⁰Woon PS, Chia MY, Chan WY, Sim K. Neurocognitive, clinical and functional correlates of subjective quality of life in Asian outpatients with schizophrenia. *ProgNeuropsychopharmacolBiol Psychiatry*. 2010;34:463–8.

⁴¹Awad AG, Hogan TP, Voruganti LN, Heslegrave RJ. Patients' subjective experiences on antipsychotic medications: Implications for outcome and quality of life. *IntClinPsychopharmacol*. 1995;10:123–32.

⁴²Brissos S, Dias VV, Carita AI, Martinez-Arán A. Quality of life in bipolar type I disorder and schizophrenia in remission: Clinical and neurocognitive correlates. *Psychiatry Res*. 2007;160:55–62.

⁴³Bengtsson-Tops A, Hansson L. Subjective quality of life in schizophrenic patients living in the community: Relationship to clinical and social characteristics. *Eur Psychiatry*. 1999;14:256–3.

⁴⁴Alptekin K, Akvardar Y, Akdede BB, Dumlu K, Isik D, Pirincci F, Yahssin S, Kitis A. Is quality of life associated with cognitive impairment in schizophrenia? *ProgNeuropsychopharmacolBiol Psychiatry*. 2005;29:239–44.

⁴⁵Atkinson M, Zibin S, Chuang H. Characterizing quality of life among patients with chronic mental illness: A critical examination of the self-report methodology. *Am J Psychiatry*. 1997;154:99–105.

⁴⁶Koivumaa-Honkanen HT, Viinamäki H, Honkanen R, Tanskanen A, Antikainen R, Niskanen L, et al. Correlates of life satisfaction among psychiatric patients. *ActaPsychiatr Scand*. 1996;94:372–8.

the problems arising out of the schizophrenic patients. The foregoing discussion on the gender differences in recovery and quality of life among schizophrenic patients may open a window that would lead towards gaining an insight into the schizophrenic patients' needs in their daily normal life.

Justification

The Researcher decides to investigate the gender differences in recovery score and quality of life among schizophrenic patients. The primary duty of any health care system is to provide suitable care to the patient. This, however, remained a dream for many underprivileged people, especially the population of rural areas of Pakistan. This situation continued despite the fact that all successive Governments tried to improve the situation, but there was no success worth mentioning.

In Pakistan, as well as in the rest of South Asia, family ties are very strong and deep. Because of these strong ties, most of chronic and severe psychiatric patients continue to live at home in the care of family members. The result of this situation is that mental illness could neither be fully discovered, nor could be systematically treated in Pakistan and hence it remains a potentially rich source to be tapped.

Due to fast industrialization, rapid development and vigorous socioeconomic changes it assumed morbidity and mobility. Psychiatric illnesses are much more common and have spread in Pakistan in the volumes more than realized.

These are the indications which this research will be provide the guidelines which are related to the problems of psychiatric patients, gender differences in recovery score and quality of life. Social indications of treatment for medical and psychiatric conditions will be developed and will need to be coordinated with these psychiatric and social guidelines.

Limitations

Viewing the wider importance of the topic, the researcher realizes the severity of the limitations of the study, which are described as below:

The gender differences in recovery score and quality of life among schizophrenic patients, demand a sample from all over Pakistan to accommodate the views and opinions of all regions. But the limited resources of the researcher and the time constraint do not allow such a study all over Pakistan; hence the cosmopolitan city of Karachi is taken as a universe of the study. Many favorable characteristics of this city make it more representative and facilitated than any other city or area of Pakistan.

There are different national and international organizations, biggest Government and private hospitals, many private clinics and rehabilitation centers in Karachi but due to limited time and resources; it may not be possible to study all their efforts in solving the problems. Therefore, the study confines itself to the programs planned by the famous Asghar psychiatric hospital in Karachi only.

Material and Methods

Study Design and Sampling

This is a hospital based cross-sectional study in nature. In this present study, the researcher has taken the sample of 70 patients diagnosed with schizophrenia in Asghar Psychiatric hospital, Karachi. The purposive sampling method was used. Among these 70 Patients, there were 39 males and 31 females. Only patients with schizophrenia in remission and recovery were selected. Those patients who had not shown any active symptom in the last 6 months were selected for the study.

Tools

All patients were screened the socio-demographic sheets, RAS-DS (Recovery Assessment scale- Domains and stages).⁴⁷ And the WHOQOL is based on self-valuated questionnaire developed by WHO (U.S version 1997).⁴⁸ It is assets quality of life and it becomes an important indicator in psychiatric research on the functioning and recovery with schizophrenia.^{49,50} Currently this is more important from the bio-psychosocial point of view.⁵¹ In this present study WHOQOL-BRIEF 26-item short version was used. It consists of four sub domains, the first domain is physical health, second is psychological health, third domain is a social relation and forth one is the environment.

Data Analysis

The chi-square test was used to analyze the data and socio-demographic profile clinical characteristic, recovery scores and comparison of quality of life of both study groups.

Results

Table 1 describes the socio-demographic profile of both the groups. The majorities (38%) of the male were married; while in the female group, the majority (39%) of a woman was separated from their husbands; majority in both the groups belonged to the lower socioeconomic class from urban areas. A majority in both the groups belonged to joint families and they were illiterates. IBM SPSS Statistics 20 version with a 5% significance level was used to determine possible significant differences in socio-demographic characteristics. Analysis of variance (ANOVA $P < 0.05$) was performed in socio-demographic characteristics between male and female numbers. No significant difference was observed in between socio-demographic characteristics with male ($p = 0.631 < 0.05$) and female ($p = 0.637 < 0.05$).

⁴⁷N. Hancock, J. N. Scanlan, A. C. Bundy, and A. Honey, Recovery Assessment Scale – Domains & Stages (RAS-DS) Manual- Version 2. (Sydney; University of Sydney, 2016).

⁴⁸U.S version. University of Washington Seattle, (Washington United States of America, 1997).

⁴⁹H. Y. Meltzer, Outcome in schizophrenia: Beyond symptom reduction. (J. Clin Psychiatry. 1999), 60: 3–7.

⁵⁰P.S. Woon, M. Y. Chia, W. Y. Chan, and K. Sim, Neurocognitive, clinical and functional correlates of subjective quality of life in Asian outpatients with schizophrenia, (Prog Neuropsychopharmacol Bio-Psychiatry, 2010), 34: 463–8.

⁵¹A. G. Awad, T. P. Hogan, L. N. Voruganti, and R. J. Heslegrave, Patients' subjective experiences on antipsychotic medications: Implications for outcome and quality of life, (Int Clin Psychopharmacol. 1995), 10: 123–32.

1- Socio-Demographic Characteristics:

Variable	Sub-Domain	Frequency		Percentage %	
		Male (39)	Female (31)	Male	Female
Marital Status	Single	12	9	31%	29%
	Married	15	7	38%	22%
	Separated	8	12	21%	39%
	Widow/Widower	4	3	10%	10%
Socio Demographic Status	Lower	25	17	64%	55%
	Middle	12	10	31%	32%
	Higher	2	4	5%	13%
Domicile	Urban	31	20	79%	65%
	Rural	8	11	21%	35%
Family Type	Joint	27	26	69%	84%
	Nuclear	9	4	23%	13%
	Extended	3	1	8%	3%
Education	Illiterate	18	13	46%	42%
	Primary	4	6	10%	19%
	Middle/Matric	11	8	28%	26%
	Inter & above	6	4	16%	13%

Table 2 reveals that family history of mental illness was more prevalent among female group (68%) than among male group (32%); this statistically difference is highly significant in both groups. Previous admission were largely reported by male respondent (77%) in comparison with females. The majority ages of onset were 26 to 35 years in both the groups. The majority duration of illness was more than two years in both male and female groups. IBM SPSS Statistics 20 version with a 5% significance level was used to determine possible significant differences in clinical characteristics. Analysis of variance (ANOVA $P < 0.05$) was performed in clinical characteristics with male and female numbers. No significant difference were observed in between clinical characteristics with male ($p = 0.679 < 0.05$) and female ($p = 0.704 < 0.05$). No significant variations were observed in between both characteristics such as (SDC, male, $F=0.663$; female, $F=0.653$) and (CC= male, 0.526; female, 0.484).

2- Clinical Characteristics:

Variable	Sub-Domain	Frequency		Percentage %	
		Male (39)	Female (31)	Male	Female
Family history of mental illness	Present	13	21	33%	68%
	Absent	26	10	67%	32%
Previous admission	Yes	30	19	77%	61%
	No	9	12	23%	39%
Age at onset	15-25	6	5	15%	16%
	26-35	25	23	64%	74%
	36-45	7	3	18%	10%
	46-55	1	-	3%	-
	56-65	-	-	-	-
	66 & above	-	-	-	-
Duration of illness	Less than 1 year	4	2	10%	6%
	More than 1 year	10	8	26%	26%
	More than 2 yrs	25	21	64%	68%

Table 3 describes in the domains RAS-DS, there were significant differences seen between male respondents and female respondents. The majority of the females showed higher levels of recovery than their male counterparts in all the domains of RAS-DS. No significant difference was observed in between RAS-DS Score with male ($p= 0.930 < 0.05$) and female ($p= 0.308 < 0.05$).

3- RAS-DS Score:

Variable	Sub-Domain	RAS-DS Score		Percentage %	
		Male (39)	Female (31)	Male	Female
RAS-DS	Do I things value	605	695	65%	93%
	Looking forward	1795	1809	64%	81%
	Mastering my illness	703	687	64%	79%
	Connecting & belonging	729	639	67%	74%

Table 4 showed significant differences in the components of Quality of life in terms of Physical health, Psychological health, Environment and Social relations. The male respondents showed higher levels of QOL than female respondents. No significant difference was observed in between quality of life with male ($p= 0.856 < 0.05$) and female ($p= 0.427 < 0.05$). No significant variations were observed in between both

characteristics such as F values (RAS-DS, male, $F=0.008$, female, 1.239) and (QL=male, 0.73; female, 0.541).

4- Comparison of Quality of Life:

Variable	Sub-Domain	QOL Level		Percentage %	
		Male (39)	Female (31)	Male	Female
WHO-QOL-BREF	Physical health	1205	816	88%	75%
	Psychological health	965	635	82%	68%
	Environment	1385	719	89%	58%
	Social relations	406	300	69%	64%

Result of Statistical Analysis of Hypotheses:

Contingency Table 1:

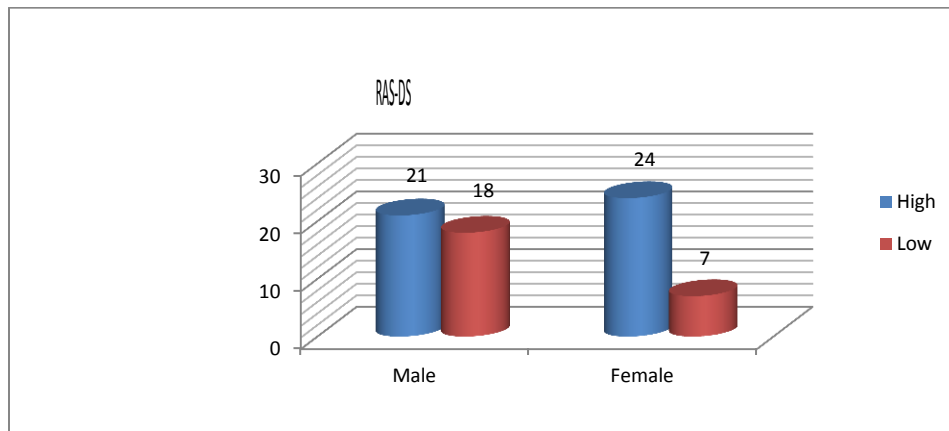
Family history of mental illness	Gender		Total
	Male	Female	
Yes	13 (19)	21 (15)	34
No	26 (20)	10 (16)	36
Total	39	31	70

The result in contingency table 1 indicates significant difference of family history of mental illness between male and female patients. As the relationship indicated by the value of the coefficient of correlation is 0.3262, which is moderately significant.

Contingency Table 2:

Recovery score	Gender		Total
	Male	Female	
High	18 (23)	24 (19)	42
Low	21 (16)	7 (12)	28
Total	39	31	70

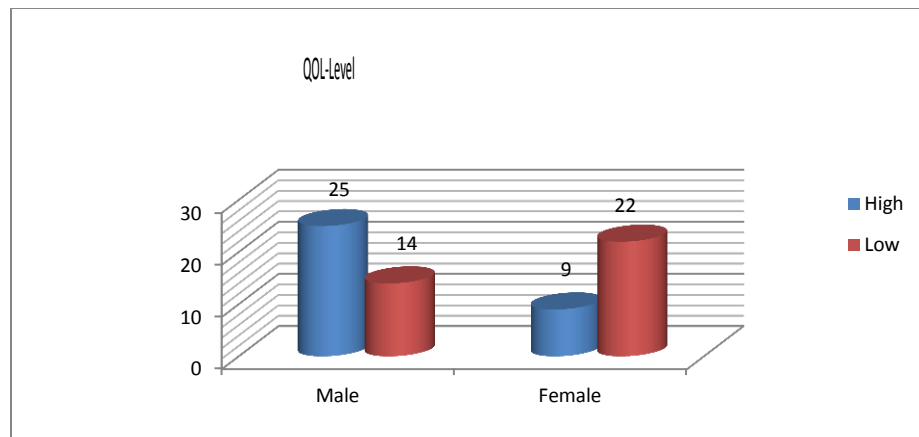
The result in table 2 shows a significant difference of recovery score between male and female respondents. As the relationship indicated by the value of the coefficient of correlation is 0.281, which is moderately significant.



Contingency Table 3:

QOL level	Gender		Total
	Male	Female	
High	25 (19)	9 (15)	34
Low	14 (20)	22 (16)	36
Total	39	31	70

The result in table 3 indicates significant difference of Quality of life between male and female patients. As the relationship as indicated by the value of the coefficient of correlation is 0.326, which is moderately significant.



Findings of the Hypotheses:

Three (3) hypotheses were formulated and the chi-square method was used to test validity.

The results are as follows:

Hypothesis No.1

The first hypothesis infers that “The family history of mental illness is prevalent among female patients.” This hypothesis is accepted.

Hypothesis No.2

The second hypothesis infers that “The recovery score is higher among female schizophrenic patients.” This hypothesis is accepted.

Hypothesis No.3

The third hypothesis infers that “The score of Quality of life in male schizophrenic patients is high, as compared to female patients.” This hypothesis is accepted.

Discussion

The present study reveals that the gender differences in recovery and quality of life among schizophrenic patients. The majorities (38%) of the male were married, a greater number of women’s (39%) were separated from their husbands in comparison to the male respondents. This difference may help to explain the differences in quality of life between males and females. The frequency of admission was significantly higher (77%) in male group as compared to female respondents (61%), which indicates that males remained more aggressive and ill than females. The difference in family history of mental illness was statistically significant (68%) in female patients than male (33%).

The difference in domicile status was significantly higher; a greater number of males (79%) belonged from urban areas than female respondents (65%). Availability of various facilities is better in urban areas.

The difference in recovery score was significantly higher in females than males with regards to all the domains of RAS-DS, a fact that a larger number of females (84%) belonged to a joint family system. So there is the possibility of getting more support in a joint family.

Considering the Quality of life, this study indicates male had a significantly better quality of life with regards to all the domains: Physical health (88%), Psychological health (82%), Environment (89%) and Social relations (69%) than female group. However; there are certain studies^{52, 53, 54, 55} that did not show significant differences in the QOL between genders. The results with regard to the difference between genders in the schizophrenic and schizo affective patients have been inconsistent and varying from place to place, social and cultural environments.⁵⁶

This study can be concluded that a significant difference in the score of recovery and quality of life was found between the genders in male and female. Females were found to be more recovered than males and males having a higher quality of life than female group.

Recommendations

Family as a basic social unit has a great responsibility to care and participate actively in the treatment and rehabilitation process of schizophrenic patients and also try to reduce misperception, stigma and discrimination against people with serious and common mental issues. Family support groups have to be established in recognition of the fact that families of mentally disturbed people need support too. In keeping with the maximum "A burden shares is a burden halved. NGO's Have to be creating a platform further people to come and share their problems with others in the same situation, who are better equipped to understand and thus support each other. The present study indicated that there is further need for clinical evaluation of schizophrenic patients to expose to score of recovery and QOL. Psychological first aid and other psychiatric therapies may be introduced and access to various facilities of treatment and rehabilitation make easy for patients.

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