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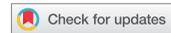
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Stress of home life and gender role socializations, family cohesion, and symptoms of anxiety and depression

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ABSTRACT

This cross-sectional study investigated the relation of sociocultural prescriptions of gender role socializations to differences in stress at home and to anxiety and depressive symptoms for adolescent girls and boys, with family cohesion as a mediator. A total of 244 boys and 285 girls aged 13–17 years recruited from Accra, Ghana completed the Short Mood Feeling Questionnaire, Spielberger State Anxiety Inventory, Stress of Home Life and Family Cohesion self-report scales in April 2015. In each sample, two mediation analyses were conducted using Structural Equation Modelling. Exposure to stress at home that was perceived to result from sociocultural prescriptions of gender role norms largely accounted for anxiety and depressive symptoms among girls, whereas this relation was non-significant among boys. Significant indirect relations through low family cohesion to anxiety symptoms were observed for girls and boys but not to depressive symptoms for boys. These findings suggest that differences in gender role socializations at home may account for individual differences in associations between exposure to stress at home and anxiety and depressive symptoms as well as explain the differential indirect relations through low family cohesion. Improving family cohesion while reducing stress at home may contribute to reducing stress and thus anxiety and depressive symptoms.

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KEYWORDS

Anxiety; depressive symptoms; family cohesion; gender role socialization; stress of home life

Gender stereotyping confers different expectations for girls' and boys' behavior, and an orientation toward traditional gender roles helps sustain these imagined expectations. While Western scholarship has extant literature on the relationship between gender roles and psychiatric symptoms, our search for previous studies that investigated relationships between gender roles and symptoms of anxiety and depression in Ghana yielded no results. In Multiple meanings of manhood among boys in Ghana (Ampofo and Boateng 2007), gender roles, including gender socialization in the context of home, were discussed. In gender role socializations, young adolescent boys remarked that the clearest differences in gender identity were found in household chores. For young adolescent boys,

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typical female chores, such as cooking, cleaning, and laundry, must be forsaken or only performed to “help” out (Ampofo and Boateng 2007).

In Ghana, more adolescent girls engage in household chores than boys, and whether the Ghanaian boys accepted or rejected some of the more common notions of masculinity, they recognized that such notions were imbued with power, and the boys knew that men had more power and authority than women (Ampofo and Boateng 2007). This may explain why in rural and urban family homes division of labor remains largely unequal as household chores are almost exclusively the responsibilities of females.

The sociocultural context of Ghana contributes to the different expectations for girls and boys in their home life. Ampofo and colleagues showed that roles, responsibilities, control, arguments, and disagreements in home life may be differentiated by gender roles (Ampofo and Boateng 2007). In a community-based gender sensitization workshop (Abane 2004) organized in the Western region of Ghana to challenge the cultural values and beliefs about femininity, the following conclusions were made. As result of low school participation, women and girls were sometimes denied equal opportunities with men and boys. The wide gender gap between men and women resulted from sociocultural variables, such as negative cultural gender beliefs, poverty, teenage pregnancy, and ignorance (Abane 2004). Governments and non-governmental agencies have provided significant interventions, such as girl-child education to bridge the disparity among boys and girls in many aspect of social life, including school enrollment, to uplift the status of girls (Ministry of Gender, Children and Social Protection of Ghana 2014, 2015)

Gender role orientations have been implicated in higher rates of internalizing symptoms in girls than boys, especially in adolescence, including anxiety (Derdikman-Eiron et al. 2011; Leikanger, Igul, and Larsson 2012; Muris, Meesters, and Knoop 2005) and depressive symptoms (Angold et al. 1999; Hankin and Abramson 2001). However, the results regarding observed gender differences are mixed. For example, Angold et al. (1999) found that accompanying hormonal changes are implicated in adolescent girls' report of more symptoms of depression. Hankin and Abramson (2001) found that girls encoded interpersonal negative experiences in greater detail and in larger associative cognitive networks connected to affective nodes. Leikanger, Igul, and Larsson (2012) also found that a heightened sensitivity rather than biological sex was implicated in adolescent girls' report of more symptoms of anxiety. Further, Muris, Meesters, and Knoop (2005) found that gender role orientation (i.e., how closely adolescents identify with masculine and feminine roles and behaviors), more than anything else, accounted for the largest variability in girls' report of more symptoms of anxiety.

As noted above, the preponderance of studies has shown that stress is associated with symptoms of depression and anxiety. In particular, stress at home was significantly positively associated with symptoms of anxiety and depression among a sample of 400 boys and 637 girls aged 13–18 years (Byrne, Davenport, and Mazanov 2007). Factors that contribute to stress at home include conflict within the home or the domestic situation, lack of control and trust within the home situation, and difficulties experienced in the home (Byrne, Davenport, and Mazanov 2007). Family systems or aspects of the family, such as family members and family structure (i.e., interrelationship among family members), may also function as risk or protective factors that contribute to development or psychological distress, such as anxiety symptoms (Cowan and Cowan 2006). Age has been positively associated with symptoms of anxiety, peaking during adolescence, especially among girls (Leikanger, Igul, and Larsson 2012). Recent studies of Ghanaian high school students aged 14 to 21 years ($N = 770$) and Ghanaian university students aged 18–49 years ($N = 431$) years found positive relationships between academic performance stress and anxiety, and depression that also negatively affected academic success of students (Cole et al. 2014; Glozah and Pevalin 2014). Higa-Mcmillan, Francis, and Chorpita (2014) reported that evidence from several studies have shown an inverse relationship between family socioeconomic status and child anxiety and depression although the size of the effect was small and some other variables correlated more strongly with child anxiety status than was socioeconomic status per se. Other studies have found that a supportive home environment, including family cohesion, emotional bonding, and supportive parenting, completely mediated the relationship between neighborhood socioeconomic disparities and antisocial behaviors in a sample of children and adolescents who participated in the Environmental Risk Longitudinal Twin Study in England and Wales (Odgers et al. 2012).

The preponderance of previous studies has been conducted in Western cultural settings. It is therefore important that research on the topic is extended to non-Western cultural settings. This will also address the paucity of evidence for the relationship between gender role socializations in home life and symptoms of anxiety and depression. In the present study, the role of family cohesion was investigated in the relationship between stress at home and symptoms of anxiety and depression in a sample of girls and boys from Ghana. The following hypotheses were tested:

- (1) Stress at home would be associated with anxiety and depressive symptoms in girls but not in boys.
- (2) Family cohesion would be negatively associated with anxiety and depressive symptoms in both boys and girls.
- (3) Stress at home would be indirectly related to anxiety and depressive symptoms through low family cohesion in both boys and girls.

Methods

Participants

Participants were randomly selected in April, 2015 from whole classes in six junior and senior high schools in the Greater Accra region of Ghana. The eligibility criterion was adolescents aged 13–17 years. A total of 628 adolescents recruited participated, with a response rate of 98 percent.

Measures

English versions of all questionnaires were used because all students in this study could speak, read, and understand English.

Stress at home

Stress at home subscale from the Adolescent Stress Questionnaire (ASQ) (Byrne, Davenport, and Mazanov 2007) was used and had been previously used in an adolescent sample in Ghana with a Cronbach's alpha of 0.72 (Glozah and Pevalin 2014). The scale is scored on a 5-point Likert-type scale with response categories ranging from 1—"Not at all stressful (or is irrelevant to me)" to 5—"Very stressful." Example items include "Disagreements between you and your father" and "Not being taken seriously." It consists of ten items with total scores ranging from 10 to 50. Total score is derived by summing the affirmed response to all items with high sum scores indicating high stressor experience (Byrne, Davenport, and Mazanov 2007).

Spielberger state-trait anxiety inventory

Symptoms of anxiety were assessed by using the state anxiety scale of *state-trait anxiety inventory* (STAI) (Barnes, Harp, and Jung 2002; Spielberger 1983). The state anxiety inventory consists of 20 items measuring respondents' level of state (current) anxiety, rated on a 4-point Likert-type scale with response categories ranging from 1—"Not at all" to 4—"Very much so." Example items include "I feel at ease" and "I feel nervous." Total score ranges from 20 to 80 (includes reverse scored items). Higher sum scores indicate more symptoms of current anxiety. The STAI has been widely used in adolescent samples (Barnes, Harp, and Jung 2002; Byrne, Davenport, and Mazanov 2007; Moksnes et al. 2010a, 2010b). Internal consistency was high with values ranging from 0.83 to 0.91.

Short mood and feeling questionnaire

The brief thirteen-item short *mood and feeling questionnaire* (MFQ) (Angold et al. 1995) was used for assessing depressive symptoms. All thirteen items are negatively phrased and rated on a 3-point Likert-type scale with response categories ranging from 0—“Not true” to 2—“True.” Example items include “I felt miserable or unhappy,” and “I did everything wrong.” Total score ranges from 0 to 26. High sum scores indicate high severity of levels of depressive symptomatology (Angold et al. 1995). The Short MFQ has high reliability score; Cronbach’s $\alpha = .90$ (Costello et al. 1991).

Family cohesion

The family cohesion subscale from the Resilience scale for adolescents (READ) was used. The scale is rated on a 5-point Likert type scale, with all items positively phrased. Example items include “In my family, we share views of what is important in life” and “I feel comfortable with my family.” Apart from establishing reliable construct validity (Friborg et al. 2005) and predictive validity in a prospective study (Hjemdal et al. 2006), READ has also shown good psychometric qualities with an internal consistency score $\alpha = .91$ (Hjemdal et al. 2011).

Socioeconomic status

Socioeconomic status was measured by adding together the current employment status of fathers and mothers, or guardians in the case of adolescents who are not living with their biological parents, and the highest education attained by fathers and mothers, or guardians. Educational level was classified as (7) University PhD or Professional Doctorate, (6) Master’s degree, (5) Vocational/ Technical college (4) Skilled courses for recognized trades, (3) High School (Junior/Lower) (2) Primary School, (1) Pre-Primary (Kindergarten). A similar approach has been used in a sample of adolescent Ghanaians by Glozah and Pevalin (2014). Employment status was classified as (1) Working or (0) Not working. A composite score was then computed for levels of socioeconomic status. The total score ranged from 2 to 16 with higher scores indicating better socioeconomic circumstances. The results were collapsed into (≤ 6) low, (7–12) average, and (≥ 13) high socioeconomic status.

Procedure

The study protocol was approved by the Regional Committee for Medical Research Ethics (REK) in Norway and the Ghana Health Service Ethical Review Committee (GHS—ERC) in Ghana. Parental or guardian consent was

sought. Prospective participants received information letters that briefly explained the purpose of the study and written consent forms to be given to their parents or guardians to be signed and returned. In all stages of the data collection, it was emphasized that participation was voluntary, anonymous, and confidential, and that the participants were free to withdraw from the study at any time with no consequences. The principal researcher was present during administration with a research assistant who helped in administering and collecting the survey instruments during all data collections.

Statistical analyses

Participants with more than 15 percent missing values in the questionnaire were deleted scale by scale from the analyses. The remaining missing data points were replaced by mean imputation. A similar approach has been used elsewhere, such as using the scale mean score (Olstad et al. 2015) and using the scale mode (Moksnes et al. 2010a). Cronbach's alpha was computed to estimate the internal consistency of all measures used. Frequencies and mean scores were analyzed for all measures. Pearson correlations were performed to examine the bivariate associations between variables in the study. Point-Biserial correlations were conducted to examine the relationship between a dichotomous variable (family structure: "nuclear" or "extended") and continuous variables (e.g., family cohesion, symptoms of anxiety and depression). Variables that were significantly correlated with the mediator variable or one or both of the outcome variables at $p < .15$ were included in the model to control for their associations. Variables included were age, socioeconomic status, drug misuse, stress from school performance, and financial stress. In each sample of boys and girls, two mediation analyses were performed using Structural Equation Modelling (SEM) with maximum likelihood estimation in Stata 14. The analyses investigated the relationship between stress at home and anxiety and depressive symptoms and the extent to which this relationship could be explained by the relationship to family cohesion. Symptoms of anxiety was the outcome variable in the first analysis, while symptoms of depression was the outcome variable in the second analysis.

The advantage of using SEM as an approach to mediation analyses is that SEM enables the fitting of a single model to estimate the indirect, direct, and total effects simultaneously. As the hypothesized model is recursive, assessing model fit was not considered because all recursive path models are identified with no degrees of freedom (Acock 2013). However, a significant mediating relationship was established when the 95% bias-corrected bootstrap confidence interval based on 1000 bootstrap samples did not contain zero. This procedure provides a bootstrap confidence interval and standard errors for the mediated relationships and was found to have advantages over the

traditional causal steps approach in testing mediation and other approaches, namely product of coefficients approach and the distribution of the product strategy (also called the *M*-test) (Hayes 2012).

Results

The final study sample comprised 244 boys and 285 girls aged 13-17 years (Mean = 15.43, *SD* = 1.51 years and Mean = 15.10, *SD* = 1.50 years, respectively). A total of 90 (about 17 percent) of the respondents were in the low socioeconomic category, 273 (about 52 percent) were in the average socioeconomic category, and 166 (about 31 percent) were in high socioeconomic category, respectively.

In the SEM mediated model, SES was significantly positively associated with family cohesion (standardized $\beta = .20$, $p = .017$), financial stress was significantly positively associated with anxiety symptoms ($\beta = .18$, $p = .039$) and depressive symptoms ($\beta = .32$, $p = .008$), while drug misuse ($\beta = .19$, $p = .013$) was significantly positively associated with anxiety symptoms but not depressive symptoms among the sample of boys (Table 1.). After adjusting for SES, financial stress, and drug misuse in the SEM mediated model for both sexes, among the girls, stress at home was significantly negatively associated with family cohesion but significantly positively associated with anxiety and depressive symptoms. Among the boys, stress at home was significantly negatively associated with family cohesion but non-significantly positively associated with anxiety and depressive symptoms.

Total, direct, and indirect effect models among sample of girls

As hypothesized, stress at home was significantly associated with anxiety and depressive symptoms in the girls, which confirmed hypothesis one (Table 2). In support of hypotheses two, family cohesion was significantly negatively associated with anxiety and depressive symptoms among the girls (Table 2).

A significant indirect relation through low family cohesion was observed for stress at home to anxiety symptoms, (unstandardized $B = .08$, 95% bias-corrected bootstrap CI: 0.022, 0.154), and to depressive symptoms ($B = .03$, 95% bias-corrected bootstrap CI: 0.008, 0.067) (Figure 1).

In support of the third hypothesis, we observed an indirect relation through low family cohesion of stress at home to anxiety and depressive symptoms in the girls as: (1) the sizes of the regression parameters in the total effect models were reduced in the indirect effect models (i.e., the direct effect of stress was smaller than the total effect of stress); and (2) no zero was included in the 95% bias-corrected bootstrap confidence interval for the indirect effects.

Table 2. Mediating relation of family cohesion in the relationship between stress of home and anxiety and depressive symptoms in girls.

Effect	Symptoms of anxiety			Symptoms of depression		
	B (SE)	<i>p</i> value	Bias-corrected bootstrap 95% CI	B(SE)	<i>p</i> Value	Bias-corrected bootstrap 95% CI
<i>a</i>	-0.02 (0.01)	.005		-0.02(0.00)	.005	
<i>b</i>	-4.24 (0.86)	<.001		-1.73(0.47)	<.001	
<i>c</i>	0.17 (0.09)	.044		0.10(.05)	.045	
<i>c'</i>	0.09 (0.09)	.299		0.07(0.05)	.163	
<i>a x b</i>	0.08 (0.03)	.013	[0.022, 0.154]	0.03(0.01)	.029	[0.008, 0.067]

Note. CI = confidence interval; B = Unstandardized path coefficient; SE = Standard Error; *a* = relations of stress at home to family cohesion; *b* = relations of family cohesion to anxiety and depressive symptoms after adjusting for stress at home; *c* = total relations of stress at home to anxiety and depressive symptoms; *c'* = direct relations of stress at home to anxiety and depressive symptoms; *a x b* = mediating relations of family cohesion in the relationship between stress at home and anxiety and depressive symptoms (i.e., the indirect relation through family cohesion of stress at home to anxiety and depressive symptoms).

Total, direct, and indirect effect models among sample of boys

In partial support of our second hypothesis, family cohesion was significantly negatively associated with symptoms of anxiety but not depressive symptoms among boys (Table 3 and Figure 2). Consistent with our first hypothesis, stress at home was not significantly associated with anxiety and depressive symptoms among boys. Thus, the total effect models were non-significant, indicating that no statistically significant relationships existed between stress at home and anxiety and depressive symptoms among boys.

Baron and Kenny (1986) argued in their seminal paper that an effect that does not exist cannot be mediated, and therefore evidence of a statistically significant total effect model was necessary prior to conducting mediation analyses. More recently, Hayes argued that this may be prematurely ending the hunt for evidence of indirect relations (Hayes 2009). Therefore, further analyses were conducted to investigate the indirect relations.

A significant indirect relation was observed of stress at home through low family cohesion to symptoms of anxiety ($B = .05$, 95% bias-corrected bootstrap CI: 0.006, 0.126) as no zero was included in the 95% bias-corrected confidence interval for the indirect relations. For depressive symptoms, no significant indirect relation through family cohesion was observed ($B = .01$, 95% bias-corrected bootstrap CI: -0.004, 0.043) as the 95% bias-corrected bootstrap confidence interval contained a zero, despite the reduction in the size of the regression parameters in the total effects models to the indirect effects models.

Discussion

The key findings in the study indicated that exposure to stress in the home as result of socioculturally prescribed norms for girls' responsibilities was

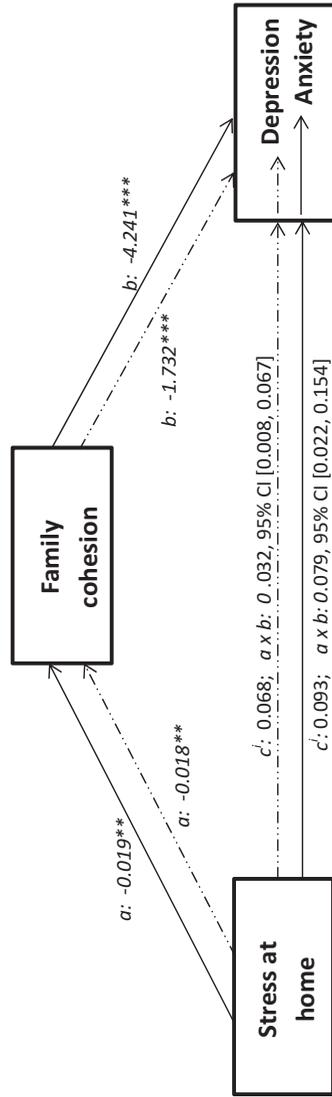


Figure 1. Mediating relations of family cohesion in the relationship between stress at home and symptoms of anxiety (solid line) and depression (dash line) among a sample of adolescent girls.

Note. Values are unstandardized path coefficients.
 $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$.

Table 3. Mediating relation of family cohesion in the relationship between stress at home and symptoms of anxiety and depression in boys.

Effect	Symptoms of anxiety			Symptoms of depression		
	B (SE)	<i>p</i> Value	Bias-corrected bootstrap 95% CI	B(SE)	<i>p</i> Value	Bias-corrected bootstrap 95% CI
<i>a</i>	-0.02 (0.01)	.013		-0.02(0.01)	.013	
<i>b</i>	-2.59 (0.92)	.011		-0.72(0.57)	.212	
<i>c</i>	0.02 (0.11)	.861		-0.05(0.00)	.395	
<i>c'</i>	-0.03 (0.11)	.821		-0.06(0.00)	.291	
<i>a</i> × <i>b</i>	0.05 (0.02)	.105	[0.006, 0.126]	0.01(.01)	.298	[-0.004, 0.043]

Note. CI = confidence interval; B = Unstandardized path coefficient; SE = Standard Error; *a* = relations of stress at home to family cohesion; *b* = relations of family cohesion to anxiety and depressive symptoms after adjusting for stress at home; *c* = total relations of stress at home to anxiety and depressive symptoms; *c'* = direct relations of stress home to anxiety and depressive symptoms; *a* × *b* = mediating relations of family cohesion in the relationship between stress at home and anxiety and depressive symptoms (i.e., the indirect relation through family cohesion of stress at home to anxiety and depressive symptoms).

associated with a positive relationship with levels of symptoms of anxiety and depression for girls but not for boys. For girls, exposure to stress at home was further associated with access to lower levels of family cohesion, which in turn was negatively associated with symptoms of anxiety, and depression. For boys, the indirect relation of stress at home through low family cohesion to symptoms of anxiety and depression was differently related. Exposure to stress at home was associated with lower levels of family cohesion, which in turn was negatively associated with symptoms of anxiety, whereas no indirect relation of exposure to stress at home through family cohesion to symptoms of depression was found. Overall, socio-culturally prescribed gender role socializations at home highlighted unique outcomes of associations regarding the associations of, for example, expectation for household chores and labor division differentially related to symptoms of anxiety versus depressive symptoms in adolescent girls and boys in Ghana.

Gender socialization begins from birth through childhood and differentiates development of the sexes into their gender roles, which are sustained by prescribed social gender role orientations. Thus, gender roles for boys and girls are mutually constituted—the psychological and the sociocultural prescriptions of gender norms are associated with each other (Markus and Hamedani 2007; Markus and Kitayama 2010). In a sample of adolescent girls and boys, exposure to stress at home, which included expectations from parents, interactions with adults, conflicts in the home, disagreement and arguments at home, abiding by rules and regulations, control over one's life, and parents hassling the adolescent, had a differential indirect relation through low family cohesion to

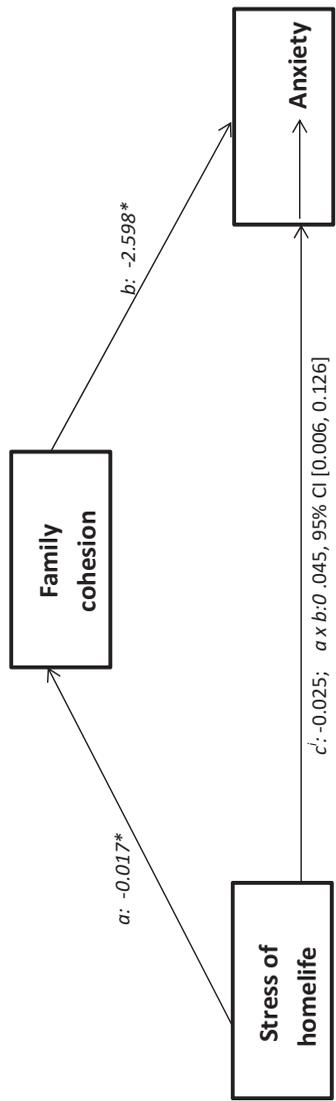


Figure 2. Mediating relations of family cohesion in the relationship between stress at home and symptoms of anxiety among a sample of adolescent boys.
Note. Values are unstandardized path coefficients.
 * $p < .05$.

depressive symptoms. While our findings in the sample of girls were consistent with previous studies of anxiety (Derdikman-Eiron et al. 2011; Leikanger, Igul, and Larsson 2012) and depressive symptoms (Angold et al. 1999; Hankin and Abramson 2001), a strong positive and cohesive family relationship was a positive factor in the relationship between stress at home and anxiety and depressive symptoms. Girls reported higher levels of anxiety and depressive symptoms, at least in part because they had less access to family cohesion, marked by not feeling comfortable in the family, the family not agreeing to and sharing views of what girls considered important, and not doing things together to support each other.

In Ghana, the sociocultural context, like many other patriarchal societies, prescribes certain behaviors that do not give girls the privilege of family decision making and equal labor division with boys at home. Boys are socialized to recognize that masculine gender roles and notions are imbued with power, and boys have no doubt that men have more power and authority than women (Ampofo and Boateng 2007). Additionally, among adolescent girls, it may be that performing these sociocultural prescriptions of gender (feminine) roles may be associated with heightened tensions, fear, risk, and danger, while failure to fulfil these socially prescribed gender roles may be associated with loss, hopelessness, and worthlessness, potentially explaining the associations of both anxiety and depressive symptoms with exposure to stress at home. This was not the same for boys because exposure to stress at home did not account for variations in anxiety and depressive symptoms. Boys undertake very little, if any, household chores or may not be monitored by parents and family and also have the privilege of more power and authority in home life than girls. Consequently, the flexibility at home enjoyed by adolescent boys over girls suggests that boys do not have the pressure associated with fulfilling sociocultural prescriptions of gender roles at home. According to Lambert et al. (1992), in a study that explored Jamaican and American parents' perspectives of child psychopathology, sociocultural attitudes and prescriptions were related to perspectives on child psychopathology through shared views and interactions. The values, beliefs, and socially prescribed norms of a social group may contribute to the development and expressions of adolescent disorders, which may in turn contribute to maintaining the disorder through cultural processes. This was also supported by Muris, Meesters, and Knoops (2005) who found that the closeness with which adolescents identify with masculine and feminine gender roles and behaviors, more than anything else, accounts for girls' reports of more psychopathology. According to Markus and Hamedani (2007), the sociocultural contexts exist with and influence the individual. In this process of mutual constitution, sociocultural prescriptions of gender

roles in home life psychologically affect the tendencies and traits of girls in an ongoing transactional and mutual process.

The family structure in Ghana may function as a protective factor whereby increasing its protective utility may reduce the strength of the positive relationship between the stress at home and symptoms of anxiety and depression when included in the model. Evidence of the family's protective utility can be found in the majority of family homes in Ghanaian social contexts in which families are built as residential groups comprising a series of close relatives—consisting of parents, children, cousins, aunts, grandparents, etc.—in which an individual has extensive access to close emotional bonding with each other. Where a nuclear family is found, in most cases, these are families who live in compound houses in which each nuclear family has its own bedroom(s) and sometimes living area but interact and share common facilities with members of the extended family (Nukunya 2003). In this kind of family structure—prominent in collectivistic cultures—people comply with family values and beliefs, which also causes a change in behavior to conform to the norms of the group. The outcome of such collective activity is a result of people's need to identify with the larger family that in return provides acceptance, concern for others, connectedness, and many other psychologically healthy outcomes.

Other strategies may be designed to enhance agreements and support in the family—such as family competency and familial shared beliefs and values, as well as involving the views and opinions of what girls consider as important in life. Especially for adolescents, interventions that aim to prevent parent-child conflict, parent hostility, and parental overprotectiveness may contribute to enhance family cohesion. It will be important to review certain socially and culturally prescribed norms that may be associated with risk, fear, anxiety, hopelessness, and worthlessness in girls, while the load and amount of household chores or domestic schedules allocated to girls can be reduced by equal labor divisions with boys at home.

Limitations and recommendations

This study had some limitations. First, the use of a cross-sectional and correlational design limited ability to discern temporal sequences of variables and thus to draw inferences of causality. Second, because a trait-specific questionnaire was not included, it is not possible to determine whether the measure of stress at home differentiated gender traits among girls and boys. Finally, the family structure in a collectivistic culture may be very different in other cultures; therefore, the results and discussion from this study may be only relevant for similar cultures. In the future, longitudinal studies that investigate socially and culturally prescribed norms in all cultures—individualistic and collectivistic—may reveal interesting causal pathways and

perhaps explain the differential indirect effect through family cohesion in the relationship between stress of home life and symptoms of anxiety and depression among girls and boys.

Conclusions

The findings suggest that differences in sociocultural gender role socializations at home and the traits encompassing feminine and masculine genders may account for the individual differences in associations between exposure to stress at home and symptoms of anxiety and depression as well as explain the differential indirect relation through low family cohesion to symptoms of anxiety and depression. Overall, this study has highlighted findings of what has been overlooked as result of socially and culturally prescribed gender role norms. The study has also outlined integrated and holistic approaches to interventions that may prove effective for ameliorating conditions of girls who were more than boys affected by the relationship between exposure to stress of home life and symptoms of anxiety and depression.

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