Abstract

Identity development can be challenging for adolescents, particularly those from immigrant families who are required to make sense of their identity whilst accommodating themselves into different cultures. For second-generation ethnic minority adolescents, these identity formation processes may range from harmony/effectiveness to conflict/stress, having consequences for acculturation and for mental health. Focusing on an underexplored area of research, the present study aimed to examine the relationships between ethnic identity, acculturation orientations and mental health outcomes among second-generation Turkish adolescents (16-18 years old) in England. Data were collected using a self-report survey (N=220) and analysed using Structural Equation Modelling. Results demonstrated that ethnic identity was positively associated with positive mental health and that each ethnic identity component (exploration, resolution, affirmation) was differently associated with life satisfaction, self-esteem, psychological well-being and depression. Ethnic identity was also positively related to separation and negatively to marginalisation whilst no relationships were observed between integration, separation or marginalisation and mental health. Mediation analysis determined that ethnic identity was negatively associated with assimilation and in turn, more positive mental health. Findings demonstrate the complexity of understanding the nature and effects of ethnic identity for second-generation adolescents and have important implications for theory and practice.

Keywords: Ethnic Identity, Acculturation, Mental Health, Second-Generation Youth, Turkish Immigrants

Mental Health Outcomes of Ethnic Identity and Acculturation Among British-born Children of Immigrants from Turkey

During adolescence identity development plays an essential role in seeking an answer to the question of "who am I" (Erikson, 1968). Although identity development is normative for all adolescents, there are important individual and social differences that can influence this process (Arnett, 2002; Berry, 1997; Motti-Stefanidi, 2015). Evidence suggests that this fundamental period of self-understanding can be especially challenging for ethnic minority youth from immigrant families as they negotiate between two divergent cultural worlds: their heritage culture (primarily at home with their parents) and their society of settlement (mostly at the mainstream schools they attend) (Berry & Sabatier, 2010). In particular, second-generation young people (born in the receiving country and raised by foreign-born immigrant first-generation parent/s) can be caught between these cultures and face difficulties in making sense of their social identities (ethnic, national, religious) and how to best accommodate themselves in different cultures (Bosma & Kunnen, 2008; Schwartz, 2005; Schwartz, Meca, Cano, Lorenzo-Blanco & Unger, 2017). As a result, the outcomes of these identity and acculturation processes can range from harmony/effectiveness to conflict/stress for second-generation youth (Berry, 2005).

There has been considerable research on ethnic identity, mental health and well-being amongst adolescents (Brittian et al., 2015; Lantrip et al., 2015; Rivas-Drake et al., 2014b; Smith & Silva, 2011) with findings generally suggesting that having a strong ethnic identity, exploring an ethnic identity, having clear meanings and positive feelings towards ethnic identity are associated with positive mental health outcomes (Chae & Foley, 2010; Phinney, 1991; Smith & Silva, 2011). The extent to which these processes have been examined amongst second-generation youth, however, is somewhat more limited. The present research addresses this gap by examining ethnic identity, acculturation and mental health amongst an under-

researched group that experiences structural inequalities and prejudices in England with mental health consequences (D'Angelo, Galip & Kaye 2013; GLA, 2009). Specifically, this paper explores second-generation Turkish young people's ethnic identity in England and how this aligns with mental health outcomes and acculturation orientations.

Ethnic Identity Formation

Ethnic identity is central to the self-concept of many adolescents. Adolescents develop their ethnic identity from ethnic self-identifications formed in childhood and adolescence and explore the meaning of their ethnic identities by thinking, talking with others and engaging in activities (Umaña-Taylor et al., 2014). Ethnic identity is argued to be particularly important to the self-concept of adolescents from immigrant and ethnic minority backgrounds (Kiang & Baldelomar, 2016; Portes & Rumbaut, 2001). This is partly because when a second-generation person asks themselves where they are from, as the children of immigrant parent(s), their ethnic identity and culture of origin come to the fore (Portes & Rumbaut, 2001). As a consequence, identity development can be especially complex for second-generation adolescents due to the complicated negotiations between different cultures and identities (Gray-Little & Hafdahl, 2000).

According to Umaña-Taylor et al. (2004), ethnic identity formation comprises three components: (1) *exploration,* which indicates actively exploring ethnicity by engaging in culturally specific activities, behaviours and roles; (2) *resolution,* which involves a sense of commitment and understanding regarding the meaning of ethnic identity and the extent to which it plays an important role in people's lives (Umaña-Taylor, 2011); and, (3) *affirmation,* which indicates people's negative (such as feeling ashamed) and/or positive (for example affect, pride, attachment) feelings about their ethnic group memberships and the role that ethnic identity plays in shaping their lives. Through including these three components, Umaña-Taylor et al.'s (2004) model can explain not only the process of ethnic identity development

(exploring, forming, and maintaining an ethnic identity) but also the content of ethnic identity (feelings and meanings). This is vital in understanding how second-generation youth develop their ethnic identity and any associated consequences for acculturation and mental health.

These three ethnic identity dimensions are highly related to one another in ethnic minority young people with positive affirmation, high exploration and resolution indicative of an "achieved" positive ethnic identity. This involves a commitment to ethnic identity that is characterised by a period of active exploration and positive feelings towards ethnic group (Umaña-Taylor et al., 2004). Achieved positive ethnic/racial identity has been found to be related to the highest level of psychological well-being amongst ethnic minority youth (Kłym & Cieciuch, 2015; Seaton, Scottham & Sellers, 2006; Umaña-Taylor et al., 2004).

Previous research shows that having an actively-explored and meaningful positive ethnic identity can be associated with positive mental health. For example, Syed et al. (2013) found that ethnic identity exploration (participating in ethnicity-related activities vis-à-vis the search for ethnic identity) are significant in determining young people's identity coherence or confusion. The authors indicated that the relationship between the ethnic identity search (systematically questioning what an ethnic identity means) and well-being is negligible and can sometimes even be negative. However, participating actively in ethnicity-related events (trying to learn or having learnt something about what it means to be a member of an ethnic group) is found to be consistently associated with positive mental health indicators (such as higher self-esteem), as well as playing a role in developing a coherent identity which also has beneficial impacts on well-being (Syed et al., 2013). Similarly, Umaña-Taylor et al. (2004, 2014) addressed the important role of the active exploration in the meaning-making process (resolution) of ethnic identity which contributes to people's sense of clarity and well-being in turn. Both ethnic identity exploration and resolution were found to be significantly associated with family ethnic socialisation processes in Mexican-origin young people (Umaña-Taylor,

Zeiders & Updegraff, 2013) and positive predictors of self-esteem among Latinx youth in the US (Umaña-Taylor, Gonzales-Backen & Guimond, 2009; Umaña- Taylor & Updegraff, 2007).

Not only the processes of exploration and resolution, but also the content of ethnic identity has been found to be associated with mental health. For example, positive feelings towards ethnic identity have been observed to be related to positive psychosocial adjustment in Latinx and African American youth (Syed et al., 2013), and fewer depressive symptoms among African American youth (Mandara et al., 2009). Further, it was found that higher ethnic identity affirmation (positive feelings towards ethnic identity) was associated with positive mental health (lower anxiety and depressive symptoms) in Latinx, Asian and African youth (Brittian et al., 2013) and higher satisfaction with life amongst ethnic minority youth in the US (Yoon, 2011). The positive links from ethnic identity exploration, affirmation and resolution to self-esteem are also mirrored amongst Jewish Americans (Weisskirch, Kim, Schwartz & Whitbourne, 2016). Thus, previous research consistently shows the associations between young people's positive feelings towards their ethnic group and positive mental health among different minorities (Brittian et al., 2015; Lantrip et al., 2015; Rivas-Drake et al., 2014b).

To date, however, much of the research on minority youth ethnic identity formation and mental health has been conducted in the US and there have been relatively few ethnic identity studies rooted in the European context (Erentaitė et al., 2018; Syed, Juang & Svensson, 2018). Within Europe, studies focusing on Turkish young people's ethnic identity have mostly been conducted in Germany and the Netherlands. These studies have demonstrated that lower ethnic identity formation (low exploration and commitment) was associated with externalising (aggressive behaviours) and internalising problems (anxiety and depression) in Turkish young people (Belhadj Kouider, Koglin & Petermann, 2014; Erentaitė et al., 2018) and that maintaining a Turkish identity was positively associated with well-being for young people who have Turkish ancestry in Bulgaria and Germany (Dimitrova et al., 2015).

To our knowledge, no previous studies have examined second-generation Turkish young people's ethnic identity in the UK using Umaña-Taylor et al.'s model. The present study extends current understanding by examining why there might be a relationship between ethnic identity and mental health. The focus here is on acculturation which has been shown to be both predicted by ethnic identity and to be predictive of mental health outcomes (Erentaitė et al., 2018; Smith & Silva, 2011; Virta, Sam & Westin, 2004).

Acculturation

Psychological approaches to acculturation suggest that acculturation is closely related to the social and cultural aspects of identity (Ozer, 2017) but that this relationship is complex and context dependent (Phinney, 2003). Acculturation can be understood as "an adaptation process that takes place as the immigrant adopts some ideas, values, and behaviours of the host culture and (typically) retains some of the ideals, values, and beliefs of his or her culture of origin" (Schwartz, 2005, p. 302). Although psychological and socio-cultural adaptation processes sometimes take years or, indeed, generations, it is argued that acculturation is a mutual/reciprocal interaction between two individuals/groups including immigrants and/or ethnic minorities, such that individuals can engage with a range of acculturation strategies (Berry, 2005).

In his acculturation model, Berry posits four acculturation strategies. *Assimilation* refers to not wishing to maintain one's own cultural heritage and actively searching for daily interaction with the mainstream culture. *Separation* develops when people want to maintain their heritage culture and wish to avoid interactions with the other culture/s. When there is an interest in both maintaining one's heritage culture and engaging in interactions with other group/s, *integration* (also called biculturalism) occurs. And finally, *marginalisation* refers to having little interest in cultural maintenance (often for reasons of enforced cultural loss) or in

fostering and maintaining relationships with other/s (often for reasons of exclusion or discrimination).

Of these potential acculturation orientations, commentators have suggested that integration is an effective adaptive orientation for certain ethnic minority youth (Schwartz, Zamboanga, Rodriguez & Wang, 2007). In order to be integrated, second-generation adolescents need to adopt the basic values of the receiving society, adapting to the social life and national institutions within those societies (Berry, 2001; Berry & Sabatier, 2011). Acculturation research claims that ethnic identity can remain strong when people participate in the larger society (Phinney, 2003) and that when people socially relate and identify themselves to both their heritage culture and the larger society in which they live, they tend to have better well-being than if they are connected to only one or the other culture, or to neither culture (Berry, 2017; Berry & Sam, 1996). Evidence also demonstrates that ethnic identity is positively associated with integration. For example, second-generation Albanian American youth who had positive feelings towards their ethnic identity also had a more adaptive acculturation process (Balidemaj, 2016). Vadher (2010) also found that ethnic identity in Britain was negatively related to assimilation and marginalisation, and positively with separation; the stronger the ethnic identity, the more separated the attitudes towards mainstream language and cultural traditions. These demonstrate the predictive role of ethnic identity on acculturation orientations.

Although integration has been found to be associated with higher self-esteem, dual cultural competence and flexibility (Ozer, 2017) and being able to manage multiple cultures amongst ethnic minority youth, integration may not always be a favourable option to ensure positive wellbeing and identity (Schwartz, Montgomery & Briones, 2006). This is because acculturation orientations and their effects can be context dependent. For example, integration might not be an advantageous orientation in an assimilationist context (Schotte, Stana & Edele,

2017). Evidence for contextual effects comes from Sam (2000) who found that separation (rather than integration) was associated with greater life satisfaction, and integration was related to negative mental health among ethnic minority youth in Norway. This demonstrates the importance of considering the broader national context (such as multicultural policies and diversity) to better understand the outcomes of particular acculturation orientations. Despite this critique, research generally shows that the relationship between integration and adjustment (psychological and sociocultural) is stronger than that between adjustment and separation or assimilation orientations (Ozer, 2017).

Whilst acculturation can have positive consequences for ethnic minority youth, it is important to recognise that the acculturation processes can be challenging and be associated with negative mental health outcomes (such as higher stress and depression) for those who have assimilation, marginalisation or separation orientations (Berry & Kim, 1988). Adapting to a new context can also result in individuals feeling pressure towards or against assimilation or separation, leading to acculturative stress (Ozer, 2017; Schwartz, Zamboanga, Rodriguez & Wang, 2007).

The Present Research

Previous research demonstrates the complexities of the relationship between ethnic identity, acculturation and mental health with evidence showing that both ethnic identity and acculturation can have positive and negative consequences for young people's mental health (Ozer, 2017). Less is known, however, about how these processes work for second-generation young people. The present research, therefore, aims to contribute to existing knowledge by examining ethnic identity, acculturation and mental health of second-generation Turkish young people in England, focusing specifically on Turkish young people whose families come from Turkey.

The Turkish diaspora is one of the largest immigrant groups in Europe (Crul & Vermeulen, 2003). The broader diaspora comprises mainland Turks (Turkish-speaking Turkish nationals) and Kurds from Turkey (Turkish passport-holders but ethnically Kurdish and Kurdish-Turkish- speaking) which are the focus of the present research as well as Turkish Cypriots (Turkish-speaking from Northern Cyprus). The Turkish diaspora is a disadvantaged group who can be seen and treated differently in European countries due to distinct cultures and religions (Schwartz, Byron, Zamboanga, Meca & Ritchie, 2012). In the UK, Turkish and Kurdish immigrants have mostly migrated for political reasons, which makes them different from other minorities in the UK (Erdemir & Vasta, 2007) and other Turkish diasporas in European countries (Euwals, Dagevos, Gijsberts & Roodenburg, 2010). The number of people originally from Turkey in the UK is unclear, mostly due to the ambiguous categorisation of "white others". Their population has been estimated to be between 180,000 and 250,000 (Sirkeci & Esipova, 2013). London hosts almost two-thirds of Turkish immigrants in the UK, making Turkish the seventh-largest minority language spoken in London (NOMIS, 2011).

Turkish and British cultures have several differences which may render identity formation and acculturation difficult for children of Turkish immigrants; the UK is a multicultural Western country and Turkey is neither Western nor Eastern with a unique regional position both in Europe and Asia (Yorukoglu, 2017). In particular, there are sharp contrasts between immigrant Turkish people and the native populations of Western European countries, in terms of social/cultural background (such as traditional structure of the Turkish family, different parental roles, gender roles and family/marriage practices) and religion (Crul & Vermeulen, 2003; Guveli et al., 2016; Kucukcan, 2009). Turkish people living in the UK face significant social and welfare issues such as language barriers, acculturation difficulties and discrimination, and they commonly experience mental health problems such as depression (D'Angelo, Galip & Kaye 2013; Enneli, Modood & Bradley, 2005; GLA, 2009), suicide

(Cetin, 2013; Eylem et al., 2016), negative identity (Jenkins & Cetin, 2017), invisibility (King, Thomson, Mai & Keles, 2008), and underachievement at schools (Baykusoglu, 2009). The majority of Turkish parents are deeply concerned about the transmission of traditional values to the younger generation to protect their identity from "cultural contamination" in the UK (Kucukcan, 2009). Thus, second-generation Turkish young people might feel under considerable pressure to preserve their parental/cultural values at home while simultaneously adopting some elements of the mainstream culture. Therefore, it is important to know how ethnic identity and acculturation relate to mental health outcomes for second-generation Turkish young people in England.

Evidence from second-generation Turkish young people across Europe suggests a positive relationship between ethnic identity and mental health (Aydinli-Karakulak & Dimitrova, 2016; Crul & Vermeulen, 2003; Dimitrova et al., 2015; Martinovic & Verkuyten, 2012). Research on Turkish minorities in the UK, however, is relatively limited (Atay, 2006; Cilingir, 2010; Enneli, Modood & Bradley, 2005) with only a few studies investigating Turkish youth identity, acculturation and well-being in the UK (Cetin, 2013; Enneli, 2001; Eylem et al., 2016; Faas, 2009) and no specific study examining second-generation Turkish young people's ethnic identity and mental health. The present study addresses this gap.

In this study, positive mental health is indicated by high levels of *life satisfaction, self-esteem, psychological well-being* and the absence of *depression* symptoms. Thus, young people's mental health conditions can be captured and understood comprehensively with different positive and negative indicators. In line with previous empirical literature, Umaña-Taylor et al.'s (2004, 2014) ethnic identity development and Berry's (1997, 2001, 2005) acculturation model, it was hypothesised that:

(H1.1): Greater ethnic identity would be associated with positive mental health.

(H1.2): Greater ethnic identity exploration, resolution and affirmation would be associated with higher levels of life satisfaction, self-esteem and psychological well-being, and lower levels of depression.

(H2): Acculturation orientations (integration, separation, marginalisation and assimilation) would mediate the relation between greater ethnic identity and positive mental health outcomes. No direction was specified for H2 due to the exploratory nature of this research and in light of previous research demonstrating contextual variation in the relationships between acculturation and mental health (Ozer, 2017; Schotte, Stana & Edele, 2017; Virta, Sam & Westin, 2004).

Method

Participants

The sample comprised 220 young people (131 females, 86 males, and 3 other, M age=16.73 years) who have Turkey-born Turkish/Kurdish mothers and/or fathers. All of the participants were born in the UK and identified themselves as Turkish (30%), Kurdish (49.1%) or both Turkish and Kurdish (20.9%) respectively (See Table 1).

Materials

Data were collected using a self-report survey (in English) consisting of a series of demographic questions in addition to the following scales:

The Ethnic Identity Scale was used to measure participants' ethnic identity, as developed by Umaña-Taylor et al. (2004). It consists of 17 items which are designed to assess three dimensions of ethnic identity formation: (a) exploration (the degree to which individuals have explored their ethnicity); (b) resolution (the degree to which they have resolved what their ethnic identity means to them); and (c) affirmation (affect- positive or negative- that they associate with that ethnic identity resolution). The ethnic identity scale has a 4-point Likert-type scale ranging from 1 (does not describe me at all) to 4 (describes me very well) and higher

scores reflect higher exploration and resolution, and positive affirmation. Seven items were reverse scored. This scale allows both dimensional (using the subscale scores as continuous variables) and categorical (creating ethnic identity statuses) approaches to understand ethnic identity structure (Yoon, 2011). In this study, scale total and subscale total scores were used to examine overall ethnic identity (H1.1 and H2) and its dimensions' (H1.2) relations with acculturation and mental health. Total scores of these components indicate greater ethnic identity ("achieved" positive ethnic identity with higher exploration, higher resolution and positive affirmation). With the current sample, the overall scale obtained a coefficient alpha (α=.85) showing high reliability. Similarly, high reliability is shown in its subscales of exploration (α=.82), resolution (α=.79), and affirmation (α=.88) respectively.

Acculturation Attitudes Scale (Berry et al, 1989) was used to measure participants' acculturation orientations. It consists of 20 items designed to assess four different acculturation orientations (5 items each): assimilation, separation, marginalisation and integration. For each item participants are asked to respond to a 5-point Likert-type scale ranging from 1 (strongly disagree) to 5 (strongly agree). Items were worded and modified to assess attitudes towards "British" (national) and "ethnic background" (ethnic) and to make them less ambiguous for Turkish/Kurdish youth. A total score was calculated for each of the four acculturation orientations. The coefficient alpha values for each sub-scale were found as α=.65 for assimilation, α=.67 for separation, α=.59 for marginalisation, and α=.48 for integration within the current sample. These values are comparable with other studies (Berry et al, 2006; Vadher, 2010).

The short version of the Center for Epidemiological Studies-Depression Scale (Radloff, 1977) was used to measure the level of depressive symptoms. The scale consists of 10 items and each item is a 4-point Likert-type scale including 0 (rarely or none of the time), 1 (some or a little of the time), 2 (occasionally) and 3 (most or all the time). Two items were reverse

scored. Higher scores show higher levels of depressive symptoms. With the current sample, the scale obtained a coefficient alpha (α=.80).

The Rosenberg Self-Esteem Scale (Rosenberg, 1979) was used to measure participants' self-esteem. It is a single-factor scale and consists of 10 items with a 4-point Likert-type scale ranging from 1 (strongly disagree) to 4 (strongly agree). Higher scores show higher levels of self-esteem. Five items were reverse scored. In the current sample, the scale obtained a coefficient alpha (α=.83).

The Satisfaction with Life Scale was used to measure participants' life satisfaction. It was designed by Diener et al. (1985) to assess global cognitive judgments of one's life satisfaction. It is a single-factor scale and consists of 5 items which ask how much they agree or disagree with a 7-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree). Higher scores show higher levels of life satisfaction. With the current sample, the scale obtained a coefficient alpha (α=.84).

The short version of the Scale of Psychological Well-Being was used to measure participants' psychological well-being. It was designed by Ryff (1989) to assess positive psychological functioning with six dimensions (three items for each): self-acceptance; environmental mastery; purpose in life; positive relations with others; personal growth; and autonomy respectively. The total score of this scale was used in the statistical analysis as an indicator of overall psychological well-being. Each item is a 6-point Likert-type scale ranging from 1 (strongly disagree) to 6 (strongly agree) (Ryff & Keyes, 1995). Eight items were reverse scored. Higher scores indicate greater psychological well-being. With the current sample, the scale obtained a coefficient alpha (α=.79).

Procedure

Ethical approval was obtained from the University of Bristol's ethics committee. Survey responses were collected between June and December 2017, mostly in North London

(with participants accessed via schools, non-governmental organisations, cultural events and festivals). Some data collection was also conducted in West London, Luton, Swindon, and Bristol, and Sheffield. The majority of participants were recruited through schools. Teachers in mainstream schools in North London (where most Turkish people live, in districts such as Hackney, Harringay and Edmonton) and in Turkish weekend schools as well as Turkish directors/staff of private tutorial colleges and music/art schools were contacted to take part in the research. Teachers were informed about the study and for those who agreed to take part, parents and participants were given information sheets and consent forms, and times were agreed for data collection. Participants were also recruited through NGO-organised cultural events for Turkish youth/families in London and Sheffield that the first author was invited to attend. At these events, the organisers set up a booth or table in the parks to carry out the surveys and the data were collected from young people who were attending these events. Completing each questionnaire took approximately 20-25 minutes.

Data Analysis

Data were analysed in SPSS 25.0 and AMOS 23.0 using Structural Equation Modelling (SEM) with Maximum Likelihood estimation. To assess the goodness of models, several fit indices were used: $\chi 2$/df-ratio, RMSEA (Root Mean Square Error of Approximation), and CFI (Comparative Fit Index), GFI (Goodness of Fit Index). For these indices, the cut-off criteria for the good fit were ≤ 5, ≤ 0.06 to 0.08, and ≥ 0.90 respectively (Byrne, 2009).

Initially, 49 individuals' data were excluded from the dataset due to having over 50% of missing values (Collins, Schafer & Kam, 2001). For other missing values, the missingness rate for individual items ranged between 0.5% and 7.7%. These missing values were missing completely at random (MCAR) [EM means for each scale were not significant, $p>.01$] (Little, 1988), and they were handled with Expectation-Maximization (EM) algorithm (a form of Maximum Likelihood method) in SPSS.

Parcelling was used to reduce the number of observed variables. When the sample size is relatively small, parcelling -instead of using separate items- is statistically more reliable and has some psychometric and estimation advantages such as fewer parameters to be estimated, more stable parameter estimates and more definitive rotational results and reductions in various sources of sampling error (Hau & Marsh, 2004; Little, Cunningham, Shahar & Widaman, 2002). Two parcels were created (by using their loadings as a guide) for each latent construct of assimilation, separation, marginalisation and integration (see Table 2 for observed, latent variables and parcels).

For the main hypotheses (H1.1 and H2) both the predictor variable of ethnic identity and the outcome variable of mental health were treated as latent constructs. For H1.2, the relationship between the observed components of ethnic identity (exploration, resolution, affirmation dimensions) and mental health (life satisfaction, self-esteem, psychological wellbeing and depression) were examined. For H2, *integration*, *separation*, *marginalisation* and *assimilation* acculturation orientations were treated as mediators. Before mediation analyses, direct relationships between ethnic identity, acculturation orientations (assimilation, separation, marginalisation and integration) and mental health outcomes were tested by using separate models. Then, these simple models were transitioned to more complex model by using obtained significant variables from the simple models (Miles & Shevlin, 2004).

Results

Descriptive statistics and correlations are presented in Table 3.

Ethnic Identity and Mental Health (H1.1)

First, the direct relationship between ethnic identity and mental health was examined (see Figure 1). The data demonstrated a good fit to the model [$\chi 2$/df (52.65/13) =4.05, GFI=.94, CFI=.91, RMSEA=.10] and in support of hypothesis 1.1, ethnic identity was found to be

significantly positively associated with positive mental health (*β=.39, p<.05*, explaining 15% of the variance) amongst second-generation Turkish young people in England.

Relationships Between Ethnic Identity Dimensions and Mental Health Outcomes (H1.2)

Second, the direct links between ethnic identity dimensions and mental health outcomes, using observed variables, were analysed (see Table 4). In partial support of hypothesis 1.2, results demonstrated that ethnic identity exploration was positively related to life satisfaction (*β=.16, p<.05*) but was not related to self-esteem, psychological wellbeing or depression. Higher ethnic identity resolution and positive affirmation towards ethnic identity were positively associated with self-esteem (*β=.49, β=.31, p<.05,* respectively) and psychological well-being (*β=.29, β=.22, p<.05*, respectively) but were not associated with life satisfaction or depression. Holding positive feelings towards ethnic identity was negatively associated with depressive symptoms (*β= -.31, p<.05*).

Relationship between Ethnic Identity, Acculturation and Mental Health (H2)

To test hypothesis 2, the relationship between ethnic identity and each of the acculturation orientations were first examined. The model showed good fit to the data [χ2/df (158.80/51) =2.14, GFI=.89, CFI=.91, RMSEA=.08] with ethnic identity being positively associated with separation (*β=.35, p<.05*) and negatively associated with assimilation (*β=-.48, p<.05*) and marginalisation (*β=-.25, p<.05*). No significant association was found between ethnic identity and integration.

Next, the relationships between mental health and acculturation orientations were examined. The data showed a good fit to the model [χ2/df (168.73/52) =3.25, GFI=.91, CFI=.90, RMSEA=.08], demonstrating that assimilation acculturation orientation (*β=-.39, p<.05*) was negatively associated with positive mental health. There was no statistically significant relationship observed between either separation, marginalisation or integration on mental health and so, these orientations were not included in the full model.

The full model tested the relationship between ethnic identity, assimilation and mental health and had good fit to the data [$\chi 2$/df (226.80/42) =2.91, GFI=.90, CFI=.90, RMSEA=.08]. The standardised regression weights are shown in Figure 2 and demonstrate that ethnic identity was negatively associated with assimilation (β=-.*48*, p<.*05*), and assimilation negatively associated with mental health (β=-.*30*, p<.*05*), together explaining 25% of the variance in mental health; a substantial and medium effect size (Ferguson, 2009; Sullivan & Feinn, 2012).

The mediating role of assimilation was then examined. When assimilation was added onto the SEM model, the path from ethnic identity to mental health was still significant but reduced (from β=.*46* to β=.*28*, p<.*05*). The results of bootstrapping (see Table 5) (Shrout & Bolger, 2002) showed that the indirect effect of assimilation acculturation orientation on the relationship between ethnic identity and mental health was significant (β =.*28,* 95% CI [0.037, 0.380], p<.*05*). No further mediation effects were examined due to assimilation being the only acculturation orientation that had a significant relationship with both ethnic identity and mental health, and therefore, met the criteria for mediation (see Baron & Kenney, 1986).

The partial mediation role of assimilation acculturation orientation on the relationship between ethnic identity and mental health offers some support for hypothesis 2. Specifically, this indirect effect suggests that ethnic identity is associated with positive mental health through lower levels of assimilation among second-generation Turkish young people in England. It is important to note, however, assimilation acculturation orientation accounted for some (25%) but not all of the relationship between ethnic identity and mental health.

Alternative Model

Due to the cross-sectional nature of the present research, it is not possible to rule out bi-directional effects of the variables measured. To partially address this, an alternative model was tested to examine whether ethnic identity could in fact be a mediator of the assimilation-mental health relationship. The data did not show a good fit to this alternative model [$\chi 2$/df

(147.361/51) =2.91, GFI=.87, CFI=.85, NFI=.79, RMSEA=0.9]. Regarding parsimony fit measures, for this alternative model, the AIC was 201.361 and the BIC was 291.082. For the full model, the AIC was 152.960 and the BIC was 224.226. Lower values of these criteria indicate a better fit of the model (Symonds & Moussalli, 2011), and these results offer further support for our hypothesised model.

Discussion

Focusing on second-generation Turkish young people in England, the present research examined the relationships between ethnic identity and mental health, and the mediating role of acculturation orientations on this relationship. Based on the previous research, three hypotheses were tested.

In support of hypothesis 1.1, results showed that ethnic identity was positively associated with mental health. These findings are consistent with previous research conducted across different ethnic groups (Latinx, Asian and African Americans) demonstrating the positive relationships between ethnic identity and favourable mental health outcomes (higher psychological well-being and self-esteem, and lower depressive symptoms) (Brittian et al., 2013; Rivas-Drake et al., 2014a; Smith & Silva, 2011; Umaña-Taylor & Updegraff, 2007). This finding is also consistent with research amongst Turkish young people in the European context (Dimitrova et al., 2015; Martinovic & Verkuyten, 2012). It appears, therefore, that an achieved positive ethnic identity can be a promotive factor for second-generation Turkish young people's mental health in England. This may be because when young people feel more self-confident regarding their ethnicity, these positive identity aspects might facilitate their abilities to cope with ethnicity-related stressors, which in turn may contribute to their self-esteem and happiness (Umaña-Taylor, Gonzales-Backen & Guimond, 2009).

When exploring the relationship between the different dimensions of ethnic identity and mental health in hypothesis 1.2, results show that ethnic identity exploration was associated with life satisfaction but not with the other mental health dimensions. This finding suggests that exploring ethnic identity and engaging with ethnic/cultural activities might not only contribute to Turkish young people's ethnic identity formation, but also can make them happy through socialising with others. Indeed, previous research has highlighted that ethnic identity exploration is an important component of ethnic socialisation (Umaña-Taylor, Zeiders & Updegraff, 2013). It was also found that ethnic identity affirmation (positive feelings towards ethnic identity) was positively associated with self-esteem and psychological well-being as well as negatively associated with depression. These findings align with previous research demonstrating that individuals' positive affect towards their ethnic group is associated with fewer depressive symptoms (Rivas-Drake et al., 2014b; Brittian et al., 2015; Lantrip et al., 2015), can have positive protective-enhancing effects on self-esteem (Romero et al., 2014), and some social advantages (such as sense of belonging and social support from their community) (Smith & Silva, 2011) that are important constructs of psychological well-being.

Furthermore, findings revealed that ethnic identity resolution was positively associated with second-generation Turkish young people's self-esteem and psychological well-being. This is consistent with previous research which demonstrated that ethnic identity resolution is related to young people's positive socialisation (Umaña-Taylor, Zeiders & Updegraff, 2013) and higher levels of self-esteem (Umaña-Taylor & Updegraff, 2007). Research also showed that positive meanings about ethnic identity play vital roles in young people's well-being and mental health (Adler et al., 2015, 2016). This association can be explained by considering ethnic identity confusion (as a result of the lack of meanings and commitments) (Erikson, 1950, 1958) which may bring possible negative outcomes such as stress, conflicted social behaviours, difficulties in making choices and the lack of self-esteem (Navarrete & Jenkins, 2011).

Although these findings inform our understanding of the possible mental health implications of ethnic identity on second-generation Turkish young people's lives in England, it is important to note that these associations might differ depending on a young person's social and national context (such as country of origin, ethnicity, religion, country/city of residence and ethnic identity socialisation). It will be important for future research, therefore, to consider the interplay between contextual effects, such as diversity in society, and the social connections young people have, for example, their friendships and ethnic identity socialisation with parents and family. This would enable a deeper understanding of the complexity of ethnic identity and acculturation processes and of heterogeneity within the socio-cultural context.

In support of hypothesis 2, it was found that the assimilation acculturation orientation partially mediated the relationship between ethnic identity and mental health. Specifically, results demonstrated that ethnic identity was positively associated with mental health through lower levels of assimilation. In other words, youth who reported identifying with their ethnic group (with active exploration, clear meanings and positive feelings) were less likely to adopt an assimilation orientation, and in turn tended to report better mental health. These results are consistent with previous research which has demonstrated that assimilation can be associated with negative mental health outcomes (high stress and depression) (Berry & Kim, 1988), and that there is a negative association between assimilation and ethnic identity among ethnic minorities in Britain (Vadher, 2010). This finding might be explained by considering the possible negative effects of poor ethnic identity on engaging with the heritage culture. For example, young people who have poor ethnic identity formation (with low exploration, negative feelings, unclear meanings) might have difficulties in maintaining their own culture, resulting in feelings of exclusion from the community, lack of social support, and lack of self-knowledge. This could then act as a potential source of stress and the development of adverse mental consequences.

When examining the direct effects of ethnic identity on acculturation in the present research, it was found that ethnic identity was positively associated with separation but negatively with marginalisation. This suggests that ethnic identity is related to second-generation Turkish young people adopting separation attitudes from the mainstream British culture but at the same time, can potentially prevent young people from holding marginalisation attitudes (little or no interest in both cultures). These findings are consistent with the perspective of Berry's (1997, 2001, 2005) acculturation model and also are along similar lines to previous research. For example, Vadher (2010) found that marginalisation was negatively related to ethnic identity whereas separation was positively associated with ethnic identity among different minority youth groups in Britain. Therefore, it is plausible that ethnic identity formation is an important factor preventing the development of marginalisation orientation in ethnic minorities, however, it is important to note that ethnic identity formation can also promote separation orientation from the mainstream society.

Whilst there was evidence that ethnic identity was associated with assimilation, the acculturation orientations of separation, marginalisation and integration were not significantly associated with mental health in the present research. This finding contradicts previous research which has found positive and strong relationships between integration and psychological adaptation/well-being (Balidemaj, 2016; Berry, 2017; Berry & Sam, 1996; Umaña-Taylor & Updegraff, 2007; Virta, Sam & Westin, 2004; Schwartz, Zamboanga, Rodriguez & Wang, 2007) and links from separation and marginalisation to negative mental health (such as higher stress and depression) (Berry & Kim, 1988) across different groups such as ethnic minorities in Britain (Vadher, 2010) and Turkish people in Sweden and Norway (Virta, Sam & Westin, 2004). These non-significant results could be related to some aspects regarding the sample of the study (sample size, sample characteristics such as different

acculturation experiences of second-generation youth in British context) and statistical factors which may have underperformed due to measurement problems on Berry's acculturation scale.

For example, whilst Berry's acculturation model and scale consider individuals' behaviours and practices in different domains to explain and measure acculturation, young people's acculturation experiences and outcomes may vary widely within and between contexts. Evidence for this comes from Virta, Sam and Westin (2004) who compared Turkish young people in Sweden with those in Norway. They found that although commitment to Turkish ethnic identity and integration was found to be related to higher self-esteem and life satisfaction and fewer mental health problems amongst those in Sweden, those in Norway reported poorer well-being due to a lower degree of Turkish identity and higher perceived discrimination. It is possible, therefore, that young people can develop different forms of acculturation according to their own context (Nguyen & Benet-Martínez, 2013) and there might be multiple variants of integration (Rudmin, 2003; Schwartz, Birman, Benet-Martínez & Unger, 2017; Schwartz & Zamboanga, 2008). The domains in the acculturation model and scale, then, offer a somewhat limited understanding of the complexity of acculturation processes.

Limitations and Future Directions

Although this study makes a number of contributions to understanding the associations between ethnic identity, acculturation and mental health outcomes, there are a number of limitations that are worth outlining. First, whilst the focus of the present research on the mediating role of acculturation is important and makes a contribution to the literature, future research should identify and explore other potential mediators which can account for the relationship between ethnic identity and mental health. For example, it may be that relationships with parents, same-ethnic and cross-ethnic friendships, and ethnic identity socialisation all play a role. Second, the present research adopted a cross-sectional design

meaning that causality cannot be determined. It is worth noting, however, that the full model was a better fit to the data than the alternative model. To better determine causation, future research could perhaps adopt an experimental design to determine the effects of group identification on acculturation orientations. Third, although it is an established measure, Berry's acculturation scale was found to be problematic in the present research (Ozer, 2017; Rudmin, 2003, 2009; Schwartz & Zamboanga, 2008); not only due to its low scale reliability but also in terms of the items themselves. Specifically, despite the rigorous re-wording of acculturation items to ensure relevance for participants, the potential for misunderstanding remained a possibility in certain parts. Indeed, previous research has argued that Berry's acculturation scale includes some ambiguous questions that are not always understood as intended for different groups, or in the same way by all groups (Carlson & Güler, 2018; Vadher, 2010). Future research, therefore, should aim to examine Turkish young people's acculturation orientations with more robust measures in place.

It is also important to acknowledge that although Berry's acculturation model has been applied to various acculturating ethnic groups and different cultural contexts (Ozer, 2017), it has been problematised by other theorists and researchers (see Rudmin, 2003, 2009; Schwartz & Zamboanga, 2008; Vadher, 2010). Future research could take a critical perspective towards Berry's bidimensional perspective of acculturation, especially given that it is hard to define what constitutes "successful integration". Rudmin (2003) also argued that Berry's "integration" can mean assimilation in practice in some social settings. Groenewold, Valk and Ginneken (2014) suggested that contextual factors (such as city of residence, the orientation of integration policies, experiencing discrimination, social networks) may be more important than individual factors (for example educational attainment) in explaining acculturation orientations among second-generation Turkish people in Europe. For instance, second-generation Turkish young people's experiences might differ according to multicultural policies in the UK or their

experiences/perceptions regarding Britishness. Therefore, future research should approach the phenomenon of acculturation as more context-dependent, considering youth's experiences which might change in real-life contexts according to the political and social culture of the host country. The relationship between ethnic identity, acculturation and mental health might be more complex than it currently seems.

Conclusion

This present research demonstrates that ethnic identity is associated with positive mental health through lower levels of assimilation among second-generation Turkish young people in England. These findings highlight the importance of ethnic identity (with active ethnic identity exploration, clear meanings and positive feelings towards ethnic identity) and acculturation for positive mental health. These findings contribute to the identity and the acculturation literature by confirming Umaña-Taylor et al.'s (2004, 2014) ethnic identity formation model for the sample of second-generation Turkish young people in the context of England and, for the first time, examining the mediating role of acculturation orientations on the directional relationship from ethnic identity to mental health. Further, by utilising ethnic identity as a whole in hypotheses 1.1 and 2 as well as examining the dimensions of ethnic identity exploration, affirmation and resolution separately on mental health, the present research enables a deeper understanding of the ethnic identity- mental health relationship amongst an under-researched sample. The present research also questions the use of Berry's (1997, 2001, 2005) acculturation model, contributing to calls to consider acculturation as more complex and contextually-dependant in future research.

* The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Tables and Figures

Table 1: Demographics of the Participants

Demographic	N (%)	Demographic	N (%)
Age		**Ethnicity**	
16	105 (47.7%)	Turkish	66 (30%)
17	69 (31.4%)	Kurdish	108 (49.1%)
18	46 (20.9%)	Both Turkish and Kurdish	46 (20.9%)
Gender		**Religion**	
Female	131 (59.5%)	Sunni Islam	61 (27.7%)
Male	86 (39.1%)	Alevism	133 (60.5%)
Other	3 (1.4%)	Other (Atheist and deist)	23 (10.5%
		Unstated	3 (1.3%)
Birthplace		**Birthplace**	
London	195 (88.6%)	Edinburgh	1 (0.5%)
Bristol	7 (3.2%)	Essex	1 (0.5%)
Luton	6 (2.7%)	Manchester	1 (0.5%)
Swindon	3 (1.4%)	Birmingham	1 (0.5%)
Sheffield	2 (0.9%)	Basingstoke	1 (0.5%)
Liverpool	1 (0.5%)	Ipswich	1 (0.5%)
Mother's ethnicity		**Father's ethnicity**	
Turkish	76 (34.5%)	Turkish	63 (28.6%)
Kurdish	117 (53.2%)	Kurdish	129 (58.6%)
Both Turkish and Kurdish	25 (11.4%)	Both Turkish and Kurdish	23 (10.5%)
Turkish Cypriot	1 (0.5%)	Turkish Cypriot	3 (1.4%)
English	1 (0.5%)	Unstated	2 (0.9%)
Mother's birthplace		**Father's birthplace**	
Turkey	214 (97.3%)	Turkey	216 (98.2%)
England	3 (1.4%)	Cyprus	3 (1.4%)
Cyprus	2 (0.9%)	Germany	1 (0.5%)
Germany	1 (0.5%)		

Table 2: Latent and Observed Variables

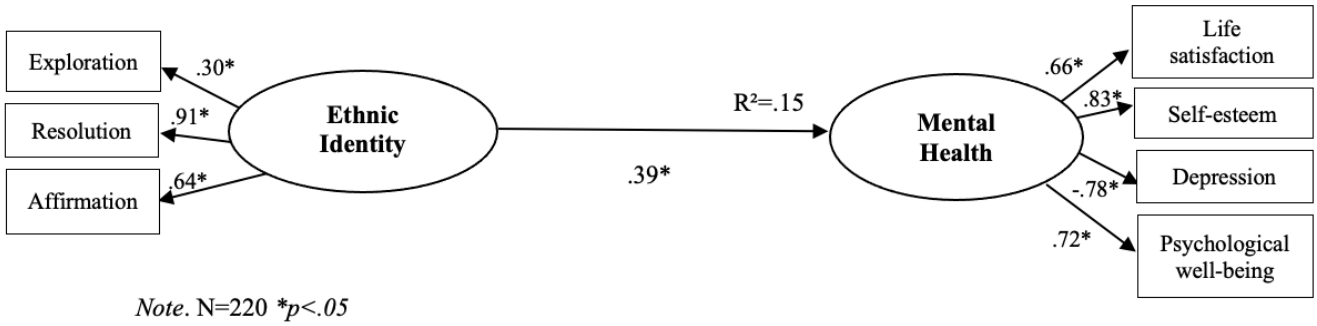
Latent Variables	Observed Variables	Definitions of Observed Variables	Items
Ethnic Identity	Exploration	Total scores of the exploration subscale of Ethnic Identity Scale	7 items
	Resolution	Total scores of the resolution subscale of Ethnic Identity Scale	4 items
	Affirmation	Total scores of the affirmation subscale of Ethnic Identity Scale	6 items
Mental Health	Life satisfaction	Total Scores of The Satisfaction with Life Scale	5 items
	Self-esteem	Total Scores of Rosenberg Self-Esteem Scale	10 items
	Depression	Total Scores of a Shortened Version of the Centre for Epidemiological Studies-Depression Scale	10 items
	Psychological well-being	Total Scores of a Short Version of Scale of Psychological Well-Being	18 items
Assimilation	ASMP1 (Parcel1)	Item 1, 10, 11 of Acculturation Scale	3 items
	ASMP2 (Parcel2)	Item 4, 15 of Acculturation Scale	2 items
Separation	SEPP1 (Parcel1)	Item 2, 8 of Acculturation Scale	2 items
	SEPP2 (Parcel2)	Item 7, 9, 12 of Acculturation Scale	3 items
Marginalisation	MARP1 (Parcel1)	Item 6, 16, 18 of Acculturation Scale	3 items
	MARP2 (Parcel2)	Item 13, 20 of Acculturation Scale	2 items
Integration	INTP1 (Parcel1)	Item 3, 14, 17 of Acculturation Scale	3 items
	INTP2 (Parcel2)	Item 5, 19 of Acculturation Scale	2 items

Table 3: Descriptive Statistics and Correlations Between the Variables

Variable	M	SD	1	2	3	4	5	6	7	8	9
1. Ethnic identity	55.98	7.56	1								
2. Assimilation	11.33	3.40	-.40**	1							
3. Separation	14.45	3.80	.19**	-.12	1						
4. Marginalisation	12.62	3.46	-.23**	.43**	-.13	1					
5. Integration	18.32	3.08	.13	-.11	-.40**	.03	1				
6. Life satisfaction	23.21	6.01	.31**	-.07	.21**	.05	.06	1			
7. Self-esteem	30.25	4.81	.29**	-.21**	.07	-.12	.10	.50**	1		
8. Depression	10.36	5.67	-.20**	.08	-.06	.08	-.08	-.49**	-.60**	1	
9. Psych. wellbeing	77.54	10.31	.32**	-.30**	.04	-.17*	.17*	.43**	.54**	-.47**	1

**p<.05, **p<.001*

Figure 1: The Path Between Ethnic Identity and Mental Health



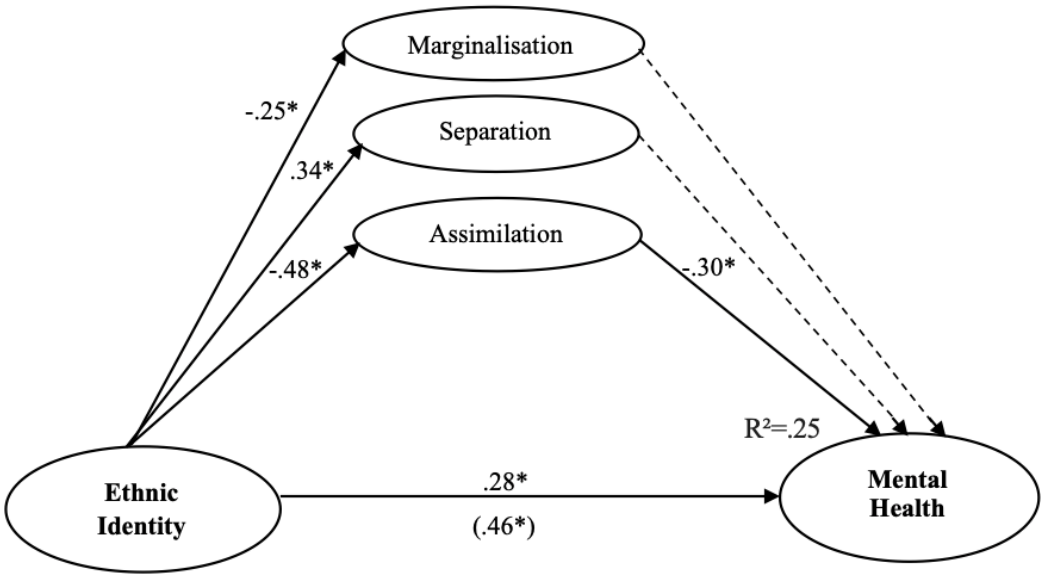
Note. N=220 **p<.05*

Table 4: The Paths Between Ethnic Identity Dimensions and Mental Health Outcomes

Predictor		Dependent	B	*β*	S.E.	*t*	*p*
Exploration	→	**Life Satisfaction**	.21	**.16**	.10	2.05	**.040***
	→	Self-Esteem	-.02	-.02	.08	-.25	.800
	→	Depression	-.02	-.01	.10	-.17	.862
	→	Psych. Wellbeing	.07	.03	.17	.40	.691
Affirmation	→	Life Satisfaction	.20	.09	.15	1.36	.173
	→	**Self-Esteem**	.31	**.17**	.11	2.63	**.009***
	→	**Depression**	-.66	**-.31**	.14	-4.75	**.001***
	→	**Psych. Wellbeing**	.84	**.22**	.25	3.44	**.001***
Resolution	→	Life Satisfaction	.36	.15	.19	1.88	.060
	→	**Self-Esteem**	.49	**.26**	.15	3.25	**.001***
	→	Depression	-.10	-.05	.18	-.57	.568
	→	**Psych. Wellbeing**	1.16	**.29**	.32	3.67	**.001***

Note. N=220 **p<.05*

Figure 2: The Paths Between Ethnic Identity, Acculturation and Mental Health



Note. N=220 ***p*<.05**

Table 5: Mediation Bootstrap Test Results for Assimilation

Path	**Mediator**	**Point Estimate (*β*)**	**95% CI**
Ethnic Identity - Mental Health	Assimilation	.28* (.46*)	[0.037, 0.380]

Note. Bootstrap is based on 1,000 resamples (Hayes, 2009). *β* =Standardized coefficients. **p*<.05.