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Ethnic identification, discrimination, and mental and physical health among Syrian refugees: The moderating role of identity needs

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Abstract

Using a risk and resilience framework and motivated identity construction theory, we investigated the moderating role of identity needs in the association between social identification and perceived discrimination with mental and physical health among a sample of Syrian refugees ($N = 361$) in Turkey. Results showed that there were two clusters of interrelated identity needs, namely, belonging (belonging, continuity, and esteem) and efficacy (efficacy, meaningfulness, and distinctiveness). Higher perceived ethnic discrimination was found to be associated with poorer mental and physical health but not for respondents who derived a sense of efficacy from their Syrian identity. Higher Syrian identification was associated with lower depression and anxiety but more strongly for refugees who derived a sense of belonging and continuity from their Syrian identity. The findings indicate that investigating the motivational aspects of identity formation is important for understanding when discrimination and group identification undermine or rather contribute to the well-being and health of refugees. These findings are discussed in relation to the growing research on social identities and health.

Refugees face severe negative life experiences during pre-migration and post-migration, leading them to be a "high-risk population" in the countries they settle (e.g., Akinyemi, Atilola, & Soyannwo, 2015). Many refugees are likely to experience post-traumatic stress disorder symptoms, depression, and anxiety and to suffer from poor physical health (e.g., Durà-Vilà, Klasen, Makatini, Rahimi, & Hodes, 2013; Heeren et al., 2012). A risk and resilience framework (Masten, 2014) suggests that many refugees do not only face risks but also have assets in their lives that can protect them against these risks (Siriwardhana, Ali, Roberts, & Stewart, 2014). Research has identified various risk and protective factors for refugees' mental and physical health, including discrimination and ethnic group belonging (e.g., Beiser & Hou, 2001; Noh, Beiser, Kaspar, Hou, & Rummens, 1999; Porter & Haslam, 2005). Although experiencing discrimination in the country of refuge is an important risk factor that can affect refugees' physical and mental health negatively (e.g., Montgomery & Foldspang, 2008; see also Pascoe & Richman, 2009), shared ethnic group membership with its associated social identity may function as a protective factor for refugees, constituting an important source of mental and physical well-being in the face of difficulties (e.g., Jetten, Haslam, & Haslam, 2012). It is unclear, however, under which social psychological conditions discrimination is a risk factor and social identification a protective factor for refugees' physical and mental health.

Discrimination involves unequal treatment on the basis of one's group membership, and social identification implies a sense of group belonging. Both implicate a person's sense of social identity, and such a sense provides psychological resources for addressing adversities (Jetten et al., 2012). More specifically, social identities can satisfy general psychological needs by providing, for example, a feeling of relatedness, esteem, efficacy, and continuity (e.g., Vignoles, 2011; Williams, 2001). One implication is that the negative role of discrimination for mental and physical health, and the protective role of social identification, might depend on the extent to which one's group membership satisfies these basic psychological needs (Greenaway, Cruwys, Haslam, & Jetten, 2015). For example, the perception of discrimination is expected to have a less detrimental effect on health when the particular social identity that is at stake helps people feel capable in controlling their outcomes or provides purpose and direction in life. Furthermore, a sense of social identity afforded by group membership might be especially protective when it provides a sense of belonging and continuity. Thus, in line with a risk and resilience framework (Masten, 2014), we propose that the associations between perceived discrimination and social

identification with mental and physical health depend on the degree to which the sense of social identity satisfies various psychological needs. We examine these moderation propositions among Syrian refugees in Turkey by focusing on their Syrian identity. Thus, the current study is one of the very few social psychological investigations among a highly vulnerable and difficult to reach population and thereby tries to make a social psychological contribution to an important and urgent social problem.

Social Identity Needs

Social identity theory emphasizes the importance of the identity needs of self-esteem and distinctiveness (Tajfel & Turner, 1979). Subsequent theorizing and research in the social identity tradition has extended the range of needs that can underlie social identity processes, such as belonging (Brewer, 1991) and subjective meaning (Hogg, 2000). However, the literature is fragmented, and different identity needs have been proposed by different theorists (Vignoles, 2011). An attempt to integrate these views into a unified model is the motivated identity construction theory (MICT; Vignoles, 2011). In addition to self-esteem and distinctiveness, it proposes that people strive to establish and maintain feelings of belonging, efficacy, meaningfulness, and continuity within their social identities. Thus, individuals would not only be motivated to adopt and construct social identities that allow them to think positively about themselves in relation to others (self-esteem need) and make them distinguishable from other people (distinctiveness need) but would also embrace social identities that give them the feeling that they belong to others (belonging need), make them feel competent and capable of influencing their environment (efficacy need), give them a sense that their life has purpose and direction (meaning need), and provide them with a sense of continuity over time (continuity need).

Research has revealed that satisfaction of needs for self-esteem, efficacy, and meaning predicts higher positive affect (Vignoles, Regalia, Manzi, Golledge, & Scabini, 2006), whereas satisfaction of needs for distinctiveness, belongingness, and continuity predicts greater in-group bias (Smeekes & Verkuyten, 2014; Vignoles & Moncaster, 2007). Further, identity needs influence possible desired and feared future selves (Vignoles, Manzi, Regalia, Jemmolo, & Scabini, 2008). These identity needs often do not affect well-being separately but tend to be intertwined, and they work in concert. Depending on the circumstances and the specific social identity, some of these needs can be more strongly clustered than others. Although it might be possible to distinguish between these different needs in an experimental setting, this is less likely among real groups living in difficult social circumstances. For example, for Syrian refugees who had to flee their country while often leaving their friends and family behind, the needs to belong and to have a sense of continuity might be closely connected aspects of their Syrian identity, and facing discrimination and exclusion in the country of refuge might imply that the needs to feel capable and have a sense of purpose and direction in one's life are intertwined. In the current study, we assessed the six identity needs proposed by the MICT and examined whether underlying clusters of identity needs can be distinguished empirically. In addition, we investigated whether these identity needs play a protective role by examining whether they moderate the expected associations between Syrian identification and perceived discrimination with mental and physical health.

Discrimination and Health

Ethnic discrimination is an attack upon and a negative response to something about the self that is difficult to change, namely, one's ethnic background. Perceiving oneself as a target of discrimination tends to have a negative impact on victims' mental health, relating to lower self-esteem, higher depression, and anxiety (see Pascoe & Richman, 2009; Schmitt, Branscombe, Postmes, & Garcia, 2014, for reviews), and physical health, relating to cardiovascular diseases and poor health status (Luo, Xu, Granberg, & Wentworth, 2011; Pascoe & Richman, 2009; Williams & Mohammed, 2009). In the country of refuge, refugees are often confronted with stigmatization, unfavorable stereotypes, and discrimination which all can have negative implications for their mental and physical health (e.g., Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006; Noh et al., 1999; Verkuyten & Nekuee, 1999). The rejection–identification hypothesis argues that members of devalued groups increase their commitment to the in-group to buffer negative consequences of discrimination for their well-being (Branscombe, Schmitt, & Harvey, 1999). There is supporting evidence for this mediation hypothesis for a range of groups, including immigrants (e.g., Cronin, Levin, Branscombe, Van Laar, & Tropp, 2012; Jasinskaja-Lahti, Liebkind, & Solheim, 2009; Verkuyten & Yildiz, 2007).

In contrast to the mediating role of minority identity, a risk and resilience framework proposes that minority identity can be an asset that protects against the negative effects of known risks (Masten, 2014). Research on ethnic and racial minority groups has demonstrated that minority group identification can be a protective factor (moderator) for the negative impact of discrimination (e.g., Mossakowski, 2003; Noh & Kaspar, 2003; Umana-Taylor, 2016; Wong, Eccles, & Sameroff, 2003). The feeling of minority group relatedness and support can play an important role in protecting against the detrimental effects of stigma and discrimination (Neblett, Rivas-Drake, & Umana-Taylor, 2012). However, the results of cross-sectional and longitudinal research do not always provide empirical support for this protective role of ethnic identity among minority groups (Mossakowski, 2003; Noh et al., 1999; Umana-Taylor, 2016). One important reason for the divergent findings might be that minority identity plays

a different role in maintaining psychological well-being depending on the psychological resources that this identity provides. For ethnic minority identity to be a resource that protects individuals against the negative effects of discrimination, this identity should provide a sense of confidence and purpose (Umana-Taylor, 2016). Depending on the psychological needs that ethnic identity satisfies, discrimination might have a less detrimental effect on mental and physical health.

Refugees are typically in an insecure and vulnerable position, and they are often highly dependent on the host society. For them, ethnic discrimination places control in someone else's hands and therefore implies that others decide about what happens to you (Ruggiero & Taylor, 1997). This has negative implications for well-being and health but probably less so for individuals who derive a sense of efficacy and control from their ethnic identity. For refugees, discrimination further implies a lack of opportunities to give new directions and purpose to one's life. However, this might be less detrimental to the mental and physical health of refugees who derive a sense of meaningful existence from their Syrian identity. Therefore, we expected that ethnic identity has a protective role in the association between discrimination and mental and physical health for those Syrian refugees who derive a sense of efficacy and meaningfulness from their Syrian identity. For them, their Syrian identity can provide a psychological resource that helps them to cope with the discrimination they face. Thus, we expected a statistical interaction between perceived discrimination and a cluster of identity needs containing efficacy and meaningfulness, on mental and physical health. Additionally, we also explored the possibility that discrimination is less detrimental for mental and physical well-being for refugees who derive a sense of belonging and continuity from their Syrian identity.

Social Identification and Health

Social psychological research has demonstrated that social identification has positive effects for well-being and health (e.g., Haslam, Jetten, Postmes, & Haslam, 2009; Jetten et al., 2012), health behaviors (Haslam et al., 2009, for a review), and reducing anxiety and depression (Cruwys, Dingle, Haslam, Jetten, & Morton, 2013; Cruwys, South, Greenaway, & Haslam, 2015). This protective role of identification with social groups has been found in studies with stroke patients (Haslam et al., 2008), aging populations (Haslam, Cruwys, & Haslam, 2014), and with populations going through major life transitions (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009).

Furthermore, extensive research has shown that for ethnic and racial minorities, in-group identification has benefits for well-being (Smith & Silva, 2011, for a review). However, some studies have found that minority group identification is not associated with psychological well-being (Rivas-Drake et al., 2014, for a review). Research has also shown that stronger ethnic or racial identification can have a sensitizing effect about one's disadvantaged minority position and therefore leads to increased depression and other mental health problems (McCoy & Major, 2003; Noh et al., 1999; Sellers, Smith, Shelton, Rowley, & Chavous, 1998). These discrepant findings suggest that there are relevant individual difference moderators in the association between minority group identification and well-being. If a group identity does not provide an individual with important psychological resources, then stronger group identification will be of little or no consequence for his or her well-being. Hence, there is little reason to expect that individuals with higher minority group identification will show better well-being when this identity does not, for example, provide feelings of belonging, relatedness and continuity. On the other hand, to the extent that an individual derives these feelings from their minority identity, then stronger group identification should be beneficial for mental and physical health. This means that the association between ethnic identification and health can be expected to depend on the level of need fulfillment that Syrian identity provides.

Within the profound changes and challenges that refugees face, identification with their Syrian identity might provide for some Syrian refugees a sense of belonging and continuity, whereas for others, it might illicit a feeling of disruption and loss. We expected that for Syrian refugees who more strongly derive a sense of belonging and continuity from their Syrian identity, ethnic identification would play a more positive role for mental and physical health. Thus, we expected a statistical interaction between ethnic identification and a cluster of identity needs containing belonging and continuity, on mental and physical health (see also Vignoles & Moncaster, 2007). Additionally, we will explore whether stronger ethnic identification is also associated with more positive mental and physical well-being for refugees who derive a sense of efficacy and meaningfulness from their Syrian identity.

Syrian refugees in Turkey

The current study was conducted in a unique context of Syrian refugees in Turkey. Syria's civil war has been described as the worst humanitarian crisis of our time, with extraordinary levels of violence, human rights violations, and millions being uprooted from their homes. The conflict has produced an unprecedented refugee crisis, with around 7.6 million people being internally displaced in Syria and around four million having sought refuge in the neighboring countries such as Turkey, Jordan, and Lebanon (UNHCR, 2015). Prior to their migration, refugees typically experience traumatic events including targeted prosecution, forced family separation, and impoverishment, and these experiences contribute to mental health problems such as depression, anxiety, and trauma-related psychopathology (Siriwardhana et al., 2014).

Turkey has declared an open door policy for refugees from Syria and provided them a "temporary protection" since April 2011. Currently, there are around 3.1 million Syrian refugees in the country, making Turkey the largest host of refugees in the world (UNHCR, 2015). However, Turkey does not grant Syrians "refugee status," which would imply legal rights, but only grants a temporary asylum seeker status. It is estimated that almost 90% of the refugees live outside refugee camps in rural and urban areas, in extremely challenging conditions with limited access to basic services. The ever growing number of refugees living outside the camps makes the organization of relief and support programs difficult to implement, and refugees struggle to survive under very difficult conditions, experiencing urgent social, educational, vocational, and health-related problems. Syrian refugees face major challenges, for example, in finding housing and work, or they have to work under very poor conditions and for low wages. Additionally, in many parts of the country, there are strong intergroup tensions in communities hosting Syrian refugees. For example, in 2014, following an alleged murder of a Turkish landlord by his tenant in a southeastern city of Turkey, local people attempted a serious lynching campaign against Syrians in their homes and looted their businesses. Furthermore, public surveys indicate that anti-Syrian sentiments are common with 86% of the Turkish people wanting the government to stop the intake of refugees and 30% supporting the view that refugees should be sent back to their home country (The Center for Economic and Foreign Policy Studies, 2014).

Within this context, we examined whether underlying clusters of identity needs can be distinguished empirically. In addition, following a risk and resilience framework, we investigated whether clusters of identity needs moderated the expected associations between perceived discrimination and Syrian identification with mental and physical health. Specifically, we expected that Syrian identity has a protective role in the association between discrimination and mental and physical health for those Syrian refugees who derive a sense of efficacy and meaningfulness from this identity. Further, we expected that ethnic identification plays a more positive role for mental and physical health for Syrian refugees who more strongly derive a sense of belonging and continuity from their Syrian identity.

Method

Participants

A total of 361 Syrian refugees aged between 18 and 75 (202 men and 152 women, 7 unknown, M_{age} = 32.50, SD = 11.86) participated in the study. Although 28.5% of the participants reported that they graduated from primary school, 22.4% indicated that they completed secondary school, 30.8% completed high school, and 18.4% completed a Bachelor's degree and higher educational levels. Questionnaires were completed in two cities, one in the west (Istanbul) and one in the southeastern part of Turkey (Antep) where some of the highest numbers of refugees live outside the camps (Istanbul, 400 000, and Antep, 350 000). The completion of the questionnaire took about 25–30 minutes, and participants gave informed consent to participate in the study.

All the questions were translated and back-translated to Arabic from English by two native Arabic speakers, except for the mental health and physical health measures for which established Arabic translations are available. Five Syrian research assistants were trained in data collection and administered the survey to the participants in Arabic, in their homes. If the participants needed help with reading, the research assistants read the questions to the participants and recorded their answers.

Measures

Syrian identification. A four-item scale was used for measuring how strongly participants identified with their Syrian background. Participants were asked to report to what extent they identified with "Syrians in Turkey," "Syria as their homeland," "their Syrian family," and "Syrian Muslims." The response scale ranged from 1 (*strongly disagree*) to 5 (*strongly agree*). The reliability of the scale was satisfactory (Cronbach's alpha = .73). An initial exploratory factor analysis using principal component analysis and varimax rotation showed that the scale was unidimensional (explaining 57% of the variance), with all items loading on a single factor (>.65).

Identity needs. The identity motives scale was originally introduced by Vignoles et al. (2006) and consisted of six distinct identity needs. Following Smeekes and Verkuyten (2014), each need (self-esteem, continuity, distinctiveness, meaning, belonging, and efficacy) was assessed by two items. Sample items are "Being a Syrian gives me a feeling of continuity between the past, present and future" (continuity), "Being Syrian gives me a sense of belonging to other Syrian people" (belonging), "The fact that I am Syrian gives me a proud feeling" (self-esteem), "Being Syrian gives me the feeling that I am special" (distinctiveness), "I feel efficacious and strong when I think about being Syrian" (efficacy), and "My Syrian identity gives a purpose and meaning to my life" (meaningfulness). The response scale ranged from 1 (*strongly disagree*) to 5 (*strongly agree*).

Perceived discrimination. Perceived discrimination was assessed by the Everyday Discrimination and Unfair Treatment Questionnaire (Williams, Yu, Jackson, & Anderson, 1997), which consisted of nine items that assessed chronic and routine discrimination experiences in everyday life. We changed the wording of the items to refer to experiences with discrimination

based on participants' Syrian background. Sample items are "Are you, as a Syrian person, treated with less courtesy than other people?" and "How often have you been threatened or harassed because you are a Syrian?" The response scale ranged from 1 (*never*) to 5 (*all the time*). The reliability of the scale was satisfactory (Cronbach's alpha = .76).

Physical health. This was assessed with the physical health domain subscale of the World Health Organization Quality of Life-BREF (WHOQOL-BREF) measure, which is the abbreviated version of the original WHOQOL-100 (Orley & Kuyken, 1994; WHO, 1996). The subscale consisted of seven items that measured various aspects of physical health such as daily activities, energy, fatigue, sleep, and rest. The response scale ranged from 1 (*not at all*) to 5 (*completely*). One item was dropped because it reduced reliability substantially ("How well are you able to get around?"). The overall scale showed satisfactory reliability (Cronbach's alpha = .82).

Mental health. This was assessed by the Hopkins Symptom Checklist-25 (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974) that measures how frequently participants experienced anxiety (e.g., feeling fearful, trembling, and headaches) and depression (e.g., poor appetite, feeling blue, and thoughts of ending your life) symptoms. The response scale ranged from 1 (*never*) to 5 (*all the time*). The reliability of the anxiety subscale was α = .85, and the reliability of the depression scale α was .81.

Control variables. We used age (in years), gender (1 = male, 0 = female), location (1 = Istanbul, 0 = Antep), immigration status (1 = yes, 0 = no; this question was added to control for the possibility that respondents were visitors to Turkey), and educational level (in years) as control variables in the analyses.

Results

Identity Needs

We first examined the inter-relatedness of different identity needs in an exploratory factor analysis (maximum likelihood with direct oblimin rotation). This revealed a two-factor structure, and item loadings were taken from the pattern matrix (Table 1). The items measuring continuity, belongingness, and self-esteem loaded highly (>.62) on the first factor, and the items measuring distinctiveness, meaning, and

Table 1 Summary of exploratory factor analysis

	Factors		
Items	I	II	*r*
Belonging dimension			
1. Identity continuity 1	.66	.01	.66
"Being a Syrian gives me a feeling of continuity between the past, present, and future"			
2. Identity continuity 2	.69	.01	.70
"My Syrian identity gives me a sense of rootedness in history"			
3. Identity belonging 1	.83	−.08	.79
"My Syrian identity gives me a feeling of connection with other people"			
4. Identity belonging 2	.81	−.07	.78
"Being Syrian gives me a sense of belonging to other people"			
5. Identity esteem 1	.62	.18	.69
"Being Syrian gives me a positive feeling about myself"			
6. Identity esteem 2	.43	.39	.58
"The fact that I am Syrian gives me a proud feeling"			
Efficacy dimension			
7. Identity efficacy 1	.26	.58	.68
"My Syrian identity provides me with confidence to achieve my goals"			
8. Identity efficacy 2	.21	.66	.74
"I feel efficacious and strong when I think about being Syrian"			
9. Identity distinctiveness 1	−.16	.68	.74
"Being Syrian gives me the feeling that I am different from other people in the world"			
10. Identity distinctiveness 2	−.07	.80	.76
"Being Syrian gives me the feeling that I am special"			
11. Identity meaningfulness 1	.13	.69	.74
"My Syrian identity gives a purpose and meaning to my life"			
Identity meaningfulness 2	−.02	.49	.48
"Being Syrian helps me to have a 'reason to live for' "			
Eigenvalue	4.98	2.03	
% explained variance	37.45	12.95	
Cronbach's alpha	.84	.83	

Table 2 Means, standard deviations, and correlations for the main variables

	Mean (SD)	2	3	4	5	6	7
1. Syrian identification	4.18 (.97)	.56***	.28***	−.05	.02	−.12*	−.05
2. Identity belonging	3.89 (1.10)	—	.39***	−.02	−.04	−.03	.07
3. Identity efficacy	3.32 (1.22)		—	−.05	.13*	−.07	.08
4. Perceived discrimination	2.52 (.94)			—	−.24***	.34***	.27***
5. Physical health	3.23 (.86)				—	−.54***	−.46***
6. Depression	2.24 (.64)					—	.61***
7. Anxiety	2.04 (.66)						—

*$p < .05$; ***$p < .001$.

efficacy loaded highly (>.49) on the second factor. One item designed to measure the self-esteem need (identity esteem 2; "The fact that I am Syrian gives me a proud feeling") loaded similarly on both factors and therefore was removed from the analyses. The final two-factor structure shows relatively high adequacy (KMO = .83) and accounted for 50.43% of the total variance. Both factors were moderately correlated (.38, $p < .001$).

The scores on the items for the first factor were averaged and because the belonging items loaded the highest on this factor (Table 1), we labelled this the "identity belonging" dimension (α = .84). Second, the items for the second factor were also averaged, and because the two efficacy items loaded among the highest on this factor, we labelled this the "identity efficacy" dimension (α = .83).

Table 2 shows that the mean scores for the identity belonging dimension and the identity efficacy dimension are above the neutral midpoints of the response scales, $t(359) = 14.04$, $p < .001$, and $t(359) = 5.01$, $p < .001$, respectively. Further, Syrian identification was strong and not normally distributed (negative skewness = −1.32, tests of normality, $p < .001$). Therefore, this variable was log-transformed to normalize the distribution (skewness was reduced to −.53), and the log-transformed score was used in further analyses.[1]

Syrian identification was more strongly and positively associated with the identity belonging dimension than the identity efficacy dimension (Table 2). Further, identity belonging and identity efficacy were not associated with mental and physical health, which indicates that the association between Syrian identification and health was not mediated by identity needs. Perceived discrimination was not associated with Syrian identification, which shows that there is no empirical evidence for the rejection-identification model.

[1]Findings were very similar without the log transformation. For example, without the transformation, Syrian identification was positively and significantly associated with both identity need clusters ($r = .56$ for belongingness, and $r = .28$ for efficacy) that is similar to what is reported in Table 2.

Physical and Mental Health

Physical health. We conducted a hierarchical multiple regression analysis with age, gender, educational level, location, and immigration status as control variables (Step 1) and perceived discrimination, Syrian identification, and the two identity need dimensions (belonging and efficacy) as main centered predictors (Step 2).[2] Next and for testing our hypotheses, the two interactions between discrimination and the two identity dimensions and between Syrian identification and the two identity dimensions, as well as the interaction between discrimination and Syrian identification were added to the model in Step 3.[3] In the first step, younger participants and participants who resided in Istanbul reported higher levels of physical health compared with older ones and those living outside Istanbul (Table 3). In Step 2, perceived discrimination had a significant negative association with physical health. Syrian identification and both identity need dimensions were not significantly associated with physical health.

In Step 3, the identity efficacy dimension played a significant moderating role in the association between discrimination and physical health. Simple slope

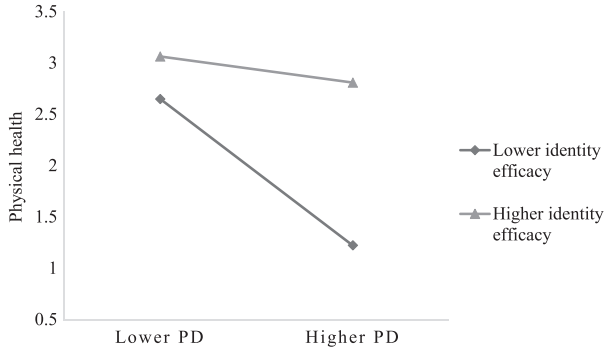
[2]As additional analyses, we added Step 4 to test for the three-way interactions between identification, discrimination, and identity needs. These analyses revealed that the addition of the three-way interactions did not contribute significantly to the explained variance of the models (all F-changes > .05), and there were no significant three-way interaction effects.

[3]The association between Syrian identification and belongingness is relatively strong, and this might be considered to be problematic for using interaction terms. However, Preacher, Rucker, and Hayes (2007) explain that a variable can function as a mediator and moderator simultaneously, indicating that a predictor variable (ethnic identification) may be associated with a moderator (identity needs). We did additional tests to check whether multicollinearity between the predictor and the moderator variables may have been an issue in the regression models. The findings showed that levels of variance inflation factor were around 1, which is well below what is considered to indicate problems of multicollinearity (5–10). Furthermore, the associations between the separate measures and the interaction terms were < .40 (Syrian identification with the interaction between Syrian identification and belongingness), with four of the six associations < .17. Additionally, we examined Mahalanobis' distance, which is a statistical measure of the extent to which there are multivariate outliers. The highest value was 11.96 which is well below the critical value of 29.89 ($df = 13$).

Table 3 Multiple regression models predicting life satisfaction, physical health, and depression

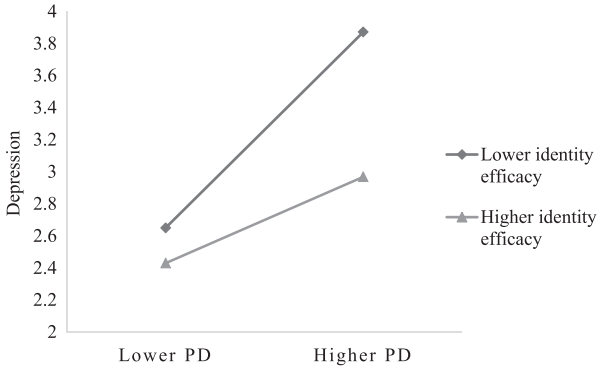
	Physical health			Depression			Anxiety		
	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3	Step 1	Step 2	Step 3
Age	−.38(.01)***	−.39(.01)***	−.39(.01)***	.08(.01)	.09(.01)	.10(.01)†	.07(.01)	.08(.01)	.09(.01)
Gender	−.04(.09)	−.01(.10)	.01(.10)	−.05(.07)	−.09(.07)	−.09(.07)	−.10(.08)†	−.10(.08)†	−.10(.08)†
Education	.08(.01)	.06(.01)	.04(.01)	−.17(.01)**	−.15(.01)**	−.14(.01)*	−.10(.01)	−.08(.01)	−.06(.01)
Migration	.08(.16)	.10(.16)†	.10 (.15)*	.01(.12)	−.02(.12)	−.02(.12)	.07(.13)	.03(.13)	.03(.13)
Location	.17(.10)**	.12(.10)*	.12(.10)*	−.11(.08)†	−.04(.07)	−.05(.07)	−.13(.08)*	−.09(.08)	−.10(.08)†
Discrimination		−.21(.05)***	−.22(.05)***		.32(.04)***	.32(.04)***		.26(.04)***	.24(.04)***
Syrian ID		.08(.11)	.08(.12)		−.19(.09)**	−.19(.09)**		−.13(.10)†	−.15(.10)*
ID belonging		−.05(.05)	−.01(.06)		.08(.04)	−.01(.04)		.06(.04)	.01(.04)
ID efficacy		.09(.04)	.06(.04)		−.07(.03)	−.04(.03)		.04(.04)	.06(.04)
Discrimination × identity belonging			−.10(.06)			.11(.04)			.03(.05)
Discrimination × identity efficacy			.16(.05)*			−.13(.03)*			−.07(.04)
Syrian ID × identity belonging			.06(.09)			−.12(.07)*			−.13(.07)*
Syrian ID × identity efficacy			.11(.08)*			−.08(.06)			−.07(.07)
Syrian ID × discrimination			−.01(.12)			−.04(.09)			−.04(.10)
R^2	.19	.25	.29	.05	.18	.22	.04	.12	.14
F change	14.14***	5.64***	3.09***	3.11**	11.92***	2.78**	2.63*	6.09***	1.97†

Note: Standardized coefficients and standard errors (in parentheses) were presented. ID = Syrian identification.
*$p < .05$; **$p < .01$; ***$p < .001$;



Note. PD = Perceived discrimination

Fig. 1: Interaction effect between perceived discrimination and identity efficacy on physical health.



Note. PD = Perceived discrimination

Fig. 3: Interaction effect between perceived discrimination and identity efficacy on depression.

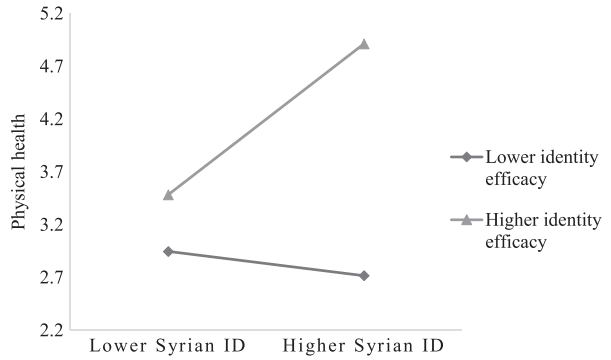
analyses (Aiken, West, & Reno, 1991) demonstrated that participants with higher identity efficacy (+1 *SD*) did not have lower physical health when they perceived more discrimination, β = −.06, t = −1.07, p = .29, whereas participants with lower identity efficacy (−1 *SD*) reported significantly lower levels of physical health when discrimination was higher, β = − .36, t = −3.88, $p < .001$ (Figure 1).

The interaction between Syrian identification and identity efficacy was also significant (Table 3). Simple slope analyses indicated that for participants with lower identity efficacy, Syrian identification was not significantly related to physical health, β = −.06, t = −.36, $p > .250$. In contrast, for participants with higher identity efficacy, Syrian identification was positively associated with physical health, β = .36, t = 2.47, p = .01 (Figure 2). The final model explained 29% of the variance in physical health.

Depression. Step 1 of the regression analysis showed that participants with higher education and those who lived in Istanbul were less depressed compared with the ones with lower education and living outside Istanbul (Table 3). In Step 2, perceived discrimination had a significant and positive association with depression, whereas stronger Syrian identification was related to lower depression. The association between discrimination and depression was significantly moderated by identity efficacy (Step 3). For participants with higher identity efficacy, discrimination was less strongly associated with depression, β = .13, t = 2.29, p = .02, compared with participants with relatively lower identity efficacy, β = .31, t = 5.17, $p < .001$ (Figure 3).

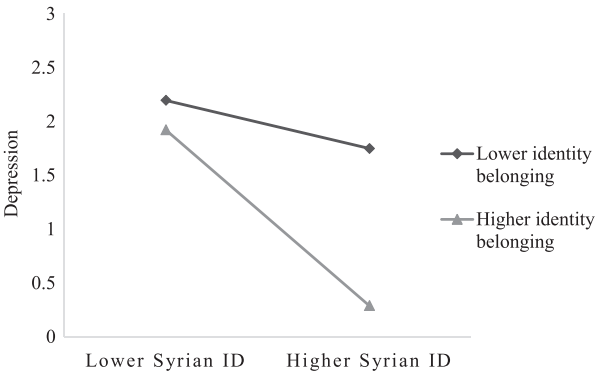
Furthermore, identity belonging significantly moderated the association between Syrian identification and depression. Simple slope analysis showed that for Syrian refugees with higher identity belonging, there was a strong negative association between Syrian identification and depression, β = −.41, t = −3.39, $p < .001$, whereas for the ones with lower identity belonging, this association was not significant, β = −.11, t = −.93, $p > .250$ (Figure 4). The final model accounted for 22% of the variance in depression.

Anxiety. Perceived discrimination was significantly and positively associated with anxiety. Syrian identification was marginally (p = .06) and negatively associated with anxiety, but this association was moderated by identity belonging (Step 3; Table 3). Simple slope analyses indicated that for participants with higher identity



Note. ID = Identification

Fig. 2: Interaction effect between Syrian identification and identity efficacy on physical health.



Note. ID = Identification

Fig. 4: Interaction effect between Syrian identification and identity belonging on depression.

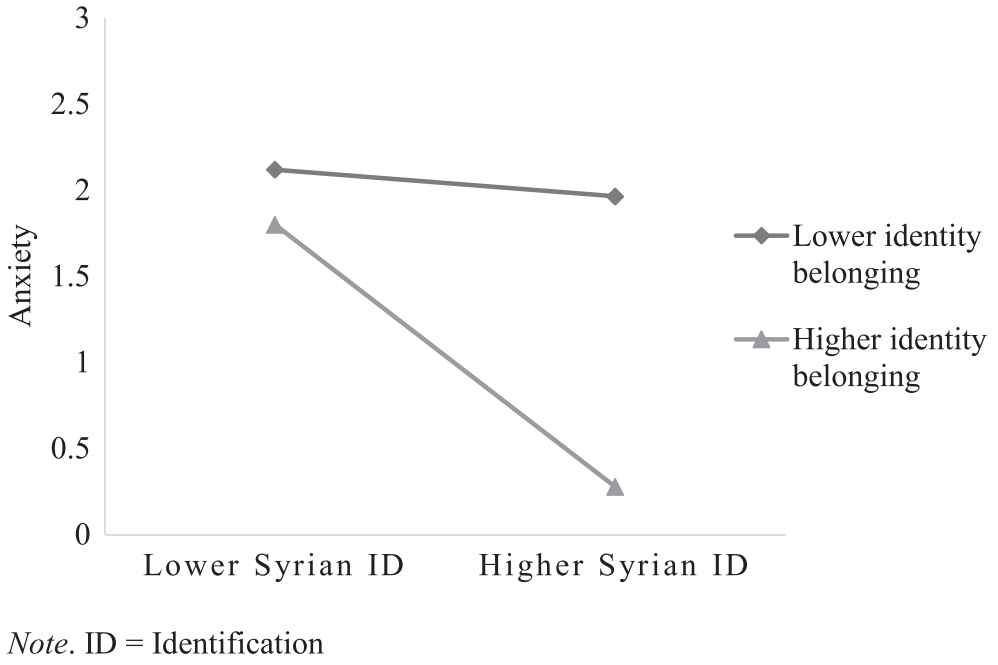


Fig. 5: Interaction effect between Syrian identification and identity belonging on anxiety.

belonging, stronger Syrian identification was associated with lower anxiety, $\beta = -.38$, $t = -2.94$, $p < .01$. For those with lower identity belonging, Syrian identification was not associated with anxiety, $\beta = -.04$, $t = -.30$, $p > .250$ (Figure 5). The final model predicting anxiety explained 14% of the total variance.

Discussion

Using a risk and resilience framework (Masten, 2014), we investigated the moderating role of social identity needs in the associations between ethnic identification and perceived discrimination with mental and physical health among Syrian refugees in Turkey. In order to consider a range of psychological needs, we followed MICT (Vignoles, 2011) and examined six identity needs that were found to be clustered in two dimensions. One cluster involved belonging, continuity, and esteem ("belonging dimension"). Syrian refugees had to leave their friends, family, and country behind; hence, maintaining a sense of belonging and continuity (rather than disruption and loss) is an important challenge that they face and that their Syrian identity can provide. The other cluster involved efficacy, distinctiveness, and meaningfulness ("efficacy dimension"), and these psychological needs might be especially relevant in relation to the country of refuge. Syrian refugees live in extremely difficult conditions usually with no legal rights, facing negative stereotypes and stigmatization, and struggling against feelings of hopelessness and a lack of purpose in the country of settlement. Their Syrian identity might be an important psychological resource for coping with these difficulties because it can provide a sense of control, distinctiveness, and meaningfulness.

We examined this latter possibility by investigating whether the efficacy dimension plays a protective role in coping with perceived discrimination in Turkey. We found that higher perceived ethnic discrimination was associated with lower mental and physical health, but not for Syrian refugees who derived a sense of control, distinctiveness, and meaningfulness from their Syrian identity. Thus, this finding, for the first time, demonstrates that the association between perceived discrimination and health depends on a cluster of psychological resources afforded by the social identity that is at stake. A sense of efficacy and meaningfulness derived from one's ethnic identity may help refugees cope with feelings of helplessness and hopelessness resulting from discrimination experiences. This moderating role of identity needs is similar to what has been found in research on the protective role of ethnic and racial minority identity (Lee, 2005; Mossakowski, 2003; Umana-Taylor, 2016). This research argues that ethnic or racial identity can be an asset that protects minority members from the negative effects of discrimination because it provides a sense of self-assuredness and support. Our findings go beyond this research by considering refugees and by looking at different identity needs. This provides a more in-depth understanding of the motivational aspects of social identities that can protect against the negative implications of known risks, including discrimination.

We did not find empirical evidence for a moderating role of the belonging dimension in the association between ethnic discrimination and health. Rather, higher Syrian identification was associated with lower depression and anxiety, but only for those Syrian refugees who derived a sense of belonging and continuity from their Syrian identity. Having to seek refuge in another country implies a process of uprooting with

the related feelings of loss and disruption. Ethnic identity can provide refugees with psychological coping resources with which to confront these adversities, but this is more likely when this identity provides them with a feeling of belonging to their Syrian community, having a cultural background that one can be proud of, and a sense of continuity with the past. Thus, these findings show for the first time that this cluster of identity needs is important for understanding when social identification has beneficial implications for mental health.

Other studies among non-vulnerable groups have demonstrated that group identification can also affect psychological need satisfaction and thereby well-being and health (Greenaway, Cruwys, et al., 2015; Greenaway, Haslam, et al., 2015). Thus, the psychological resources offered by social identities might not only determine (moderate) the impact of social identification and discrimination on people's health, but social identification also might have the capacity to satisfy (or thwart) psychological needs and thereby contribute to health outcomes. In our research, we did not find evidence for such a mediating process, and this might be due to the group that we studied. Refugees are in an extremely vulnerable position needing all their psychological resources for coping with the various risks that they face. Research in the extremely challenging context of Afghanistan has shown that Afghan cultural values provide a sense of dignity, cohesion, and meaning to life that plays a central role in the resilience of Afghan families and their children (Eggerman & Panter-Brick, 2010). From a risk and resilience perspective (Masten, 2014), it is understandable that for refugees, ethnic group identification is beneficial for mental health to the extent that their minority identity fulfills basic psychological needs (Siriwardhana et al., 2014). Our findings thus suggest that for vulnerable groups, it is important to investigate the psychological resources derived from one's ethnic identity that can play a protective role in the associations between ethnic discrimination and identification with mental and physical health.

We found no direct association between ethnic identification and physical health. This might be due to the fact that Syrian refugees in Turkey live in very difficult circumstances with few opportunities to work and receive health care, and these circumstances might be more critical for physical health compared with ethnic identification. In support of this interpretation, we found that the various demographic factors explained most of the variance in physical health. Yet the association between ethnic identification and physical health was moderated by the efficacy dimension. This suggests that the beneficial effects of Syrian identification on physical health depend on the sense of control, direction, and purpose that Syrian identity can provide.

In evaluating our findings, it is important to recognize that we used a cross-sectional design that prevents us from drawing conclusions about directions of influence. Mental and physical health might also affect perceptions of discrimination and ethnic identification, and there might be mutual directions of influence. However, an increasing number of experimental and longitudinal studies demonstrate that discrimination and social identification can have an impact on health (e.g., Haslam et al., 2009; Schmitt et al., 2014). Additionally, it would be a real, or even impossible, challenge to collect experimental or panel data among refugees. We managed to collect survey data among quite a large sample of Syrian refugees and therefore were able to conduct one of the first studies on the relation between social identity, discrimination, and health among refugees. The practical difficulties in collecting data among refugees further means that we inevitably had a selective group of respondents. For example, we were not allowed by officials to collect data among Syrian refugees living inside the refugee camps. This means that it is unclear whether the current findings can be generalized to people living in the camps in which the living conditions tend to be more severe. Furthermore, although in the statistical analyses we took various demographic factors (e.g., age, gender, city, and education) into account that might be important for Syrian identification and mental and physical health, there are other factors that we could not consider, such as employment and language impairments. Future research should examine different contextual and psychosocial mechanisms that influence refugees' social identification processes and health.

Conclusion

Using a unique sample of Syrian refugees living in Turkey, we have provided one of the very few social psychological understandings of the mental and physical health of refugees. The findings indicate that ethnic identity offers refugees important resources for trying to cope with the many risks that they face. A sense of efficacy, distinctiveness, and purpose derived from their Syrian identity seems to be particularly important for dealing with the discrimination and adverse circumstances in the country of settlement. And a sense of Syrian belonging, continuity, and esteem appears to be especially important for group identification to have beneficial effects on mental health. Overall, these findings indicate that investigating the motivational aspects of identity formation is important for understanding when discrimination and group identification undermines or rather contributes to the well-being and health of refugees.

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