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The asylum-process, bicultural identity and depression among unaccompanied young refugees☆

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ABSTRACT

Introduction: The overall aim of the present study was to expand our knowledge about depression among unaccompanied refugee minors in the years after they were granted protection in Norway. Predictors were contextual variables in terms of the asylum-process, acculturation variables in terms of bicultural identity, and demographic information such as residence-time.
Method: Register data and cross-sectional self-report questionnaire data were collected from 895 unaccompanied young refugees (UYRs). They originated in 31 different countries, the majority was from Afghanistan, 82.4% were boys, and average residence-time was 2.5 years.
Results: The length of the asylum-process was not associated with depression while heritage identity and residence-time were. Moderating analyses showed that an over-time steady decrease in depression was present for UYRs with a strong heritage identity. The prevalence of depression symptoms dropped from an initial 40%–14% among youth with 10 years of residence. Majority identity had neither direct nor indirect effects on depression.
Conclusion: To optimize the psychosocial support offered to unaccompanied refugee minors during transition to stable resettlement, we need more substantial information about the aspects of the asylum-seeking process that increase the risk for mental health problems among them. In the years following resettlement, a strong heritage, but not majority identity was associated with lower levels of depressive symptoms. The findings are discussed in relation to structural barriers to bicultural identity formation and integration embedded in the way psychosocial support and education for these youths are structured, and implication for future research.

1. Introduction

Ongoing wars, internal political conflicts and violence, and the resulting dangers and lack of opportunities for children and youth in many countries, contribute to continuous arrivals of unaccompanied minor asylum-seekers to the borders of European countries. Their histories of separation and loss of family members and other close relationships, in addition to exposure to accumulated numbers of traumatic events before and during flight, represent risks of mental health problems several years after resettlement in a new country (Fazel, Reed, Panter-Brick, & Stein, 2012; Keles, Friborg, Idsoe, Sirin, & Oppedal, 2015). Moreover, upon arrival in their destination countries, they have to endure lengthy processing of their asylum-application, with added stressors such as unpredictable

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waiting time, uncertainty about the future, and anxiety about the outcome of the application (Berg & Tronstad, 2015). Previous studies among unaccompanied and accompanied asylum-seeking minors have concluded that the asylum context is associated with increased mental distress, particularly depression and anxiety disorders and symptoms (Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Lorek et al., 2009; Reijneveld, De Boer, Bean, & Korfker, 2005). However, the potential long term effects of lengthy, taxing asylum-processes, remain understudied, and will therefore be investigated in the present study.

Children who are granted residence, face numerous stressors of acculturation, particularly associated with adapting to and learning a new culture (Keles et al., 2015). Because of this, acculturation theory focusing on immigrants' adaptation from a stress-coping perspective (Berry, 2006; Lazarus & Folkman, 1984) predicts that refugees experience high levels of mental distress during and immediately after cross-cultural transition and resettlement in a new country. As the acculturation-related stressors diminish, and the refugees are able to negotiate differences in values, and making decisions about and reconciling ethnic group belongingness and identity (Benet-Martínez & Haritatos, 2005; Phinney, 1989; Umaña-Taylor & Updegraff, 2007), a distress reduction is expected (Gonsalves, 1992; Titzmann, Silbereisen, Mesch, & Schmitt-Rodermund, 2011; Vinokurov, Trickett, & Birman, 2002). Notably, several studies have underscored that a strong ethnic identity is a resource and a protective factor in acculturation context (Erentaitė et al., 2018; Phinney, 1990; Rivas-Drake et al., 2014; Schwartz, Unger, Zamboanga, & Szapocznik, 2010). Studies of ethnic identity typically refer to the individuals' belongingness and feelings about the *heritage* culture group e.g. (Umaña-Taylor et al., 2014). Following theoretical formulations and empirical findings that acculturation involves connections both to the heritage and the majority society culture (Berry, 1997; Celenk & Van de Vijver, 2014; Schwartz et al., 2010), other researchers have concentrated on various forms of *bicultural* identity, that incorporates feelings and attitudes towards the heritage *and* majority ethnic groups as important, conceptually distinct, adaptation processes, e.g. (Benet-Martínez, Leu, Lee, & Morris, 2002; Phinney & Devich-Navarro, 1997).

Previous research findings have confirmed a small significant association between depression and length of stay among unaccompanied refugee minors (URMs) (Keles, Idsoe, Friborg, Sirin, & Oppedal, 2017). However, there is limited knowledge about the ways that bicultural identity plays out over time in relation to depression among them. Hence, the present study expands on previous research on depressive symptoms among URMs, by including the length of the asylum-seeking process as a risk factor, and heritage and majority (bi-culture) identity as protective factors. Knowledge about risk and protective factors of mental health problems among URMs can help us better plan measures to reduce depressive symptoms, and give direction to supportive interventions to promote their integration.

1.1. The asylum-seeking process

Broadly speaking, a refugee is somebody whose needs for protection have been acknowledged by the United Nations, whereupon they travel to resettle in the country that has granted them refuge. Asylum-seekers, in contrast, apply for protection upon reaching their destination country, often after long and strenuous flights (UNHCR, 2015). When their applications have been approved they are referred to as refugees.

The asylum-seeking context for URMs varies among European countries. In Norway, following the asylum claim, they stay in special reception centers, separated from asylum-seeking families and adults, until there is a final conclusion in their case. Although the intention is to complete the asylum processing within three months, in reality it takes longer, and may even last for years, especially in periods when there are high numbers of new arrivals.

URMs report more symptoms of PTSD and depression than accompanied asylum-seeking and refugee children do (Bean, Derluyn, Eurelings-Bontekoe, Broekaert, & Spinhoven, 2007; Seglem, Oppedal, & Roysamb, 2014). However, the highest level of distress has been found among URMs without a decision in their asylum case, due to the lack of control and uncertainty about the future they perceive, and the distress accumulate with the length of the process (Berg & Tronstad, 2015; Jensen, Fjermestad, Granly, & Wilhelmsen, 2013). We used the time the URMs spent in asylum-centers as a proxy for the accumulated stress involved in the asylum process. We examined if this stressful period represents a risk factor for depressive symptoms in the years after they obtained residence and were permanently resettled in local communities around the country.

Our study sample consists of youth who came to Norway as unaccompanied minor asylum-seekers, and have received residence. About 67% had passed the age of majority at the time of data collection. We therefore use the term "unaccompanied young refugees" (UYRs) about our sample, but URMs when referring to unaccompanied asylum-seeking and refugee minors in general.

1.2. Time heals

The majority of URMs who have been granted asylum in Norway, are offered permanent residence and resettle in municipalities nationwide.[1] It is expected that they orient themselves towards the future, and integrate into the majority society assisted by local social workers, health and educational agencies responsible for scaffolding a secure developmental context for them.

Studies involving mental distress among URMs have confirmed a small, but significant negative association between length of stay and mental health problems (Bean, Derluyn, et al., 2007; Bronstein, Montgomery, & Ott, 2013; Seglem, Oppedal, & Raeder, 2011). However, several such study-samples included URMs with temporary or permanent residence, and did not distinguish between the asylum-seeking process and residence-time after asylum was granted (Bean, Eurelings-Bontekoe, & Spinhoven, 2007; Bronstein et al.,

[1] Since 2016 the Governement has legalized an extensive authorization of temporary leave to remain until URMs reach the age of majority. (Norsk organisasjon for asylsøkere, NOAS, 2017).

2013; Derluyn, Mels, & Broekaert, 2009). Obviously, if the asylum-seeking process increases the risk for depressive symptoms, while the level diminishes over time among children who have been granted permanent residence, the effect size of length of stay would be flawed. Our study-sample of UYRs, gives us a unique opportunity to examine the distinctive effects on depressive symptoms of one negative and one positive phase in their lives in exile.

1.3. Bicultural identity

Acculturation is a complex process among immigrants and ethnic minorities, that involves developing and navigating between practices, values, and identities of the heritage and receiving (majority) cultures (Nguyen & Benet-Martínez, 2013; Oppedal & Idsoe, 2015; Schwartz, Zamboanga, Luyckx, Meca, & Ritchie, 2013; Syed & Juang, 2018). Ethnic identity, the beliefs and attitudes we hold about our ethnic group memberships (heritage and majority culture groups), is considered a salient identity domain for immigrant youth, and forming bicultural identities a developmental task in acculturation contexts (Phinney, 1989; Umaña-Taylor et al., 2014; Verkuyten, 2008).

Social and cognitive maturation and experiences such as migration or perceived discrimination are factors that contribute to an intensification and growth in bicultural identity formation processes during adolescence and young adulthood (Douglass & Umaña-Taylor, 2015; Pahl & Way, 2006; Umaña-Taylor et al., 2014). Heritage and bicultural identities represents some of the most frequently studied aspects of acculturation in relation to mental health and psychosocial adaptation. Generally, the findings imply an association between stronger heritage identity and adaptive psychological outcomes (Erentaitė et al., 2018; Phinney, 1990; Rivas-Drake et al., 2014; Smith & Silva, 2011), even if there are exceptions (Khaylis, Waelde, & Bruce, 2007). Heritage identity can mediate between experiences such as discrimination and mental health outcomes (Erentaitė et al., 2018; Jasinskaja-Lahti, Liebkind, & Solheim, 2009). Moreover, studies have confirmed that a strong heritage identity can buffer the deleterious effect of discrimination on mental health and academic outcomes (Ikram et al., 2016; Umaña-Taylor & Updegraff, 2007; Umaña-Taylor, Wong, Gonzales, & Dumka, 2012).

Studies of bicultural identity show contextual based individual and immigrant group variation in the associations between the two ethnic identity domains, and in how they relate to various adaptation outcomes (Nguyen & Benet-Martínez, 2013; Phinney, Horenczyk, Liebkind, & Vedder, 2001). Research that included both heritage and majority culture identity domains, have demonstrated associations with positive developmental outcomes either for both individual dimensions or for combinations of them (Jasinskaja-Lahti et al., 2009; Liebkind, 2006; Nguyen & Benet-Martínez, 2013; Phinney et al., 2001; Schwartz et al., 2010; Syed & Juang, 2018).

Clinical and epidemiological research has shown that refugees suffer high levels of mental distress in the first years after resettlement (Gonsalves, 1992; Hurh & Kim, 1990; Sluzki, 1979). According to Gonsalves' experiences from clinical work (1992), it is not until around five years after relocation, when the refugees have been through a stage of identity development and change, that a reduction in mental health problems takes place. The present study is based on these studies and examines two ways that residence-time and heritage and/or majority identity might be associated with reduced distress levels: A mediating mechanism implies that as time passes by, a strengthening in heritage and majority identity takes place that results in less mental distress. Alternatively, a moderating effect implies that refugees with a strong bicultural identity may experience decreases in mental distress as the years pass by, while individuals with a weak bicultural identity continue suffering from high distress levels.

We lack knowledge about bicultural identity among URMs, and the association with depression. This is unfortunate, considering its developmental significance, the associations with well-being and reduced mental distress found with other immigrant/minority groups, and the potential for targeting this identity domain in health promoting intervention (Jasinskaja-Lahti et al., 2009; Phinney & Kohatsu, 1997; Rivas-Drake et al., 2014; Umaña-Taylor, Douglass, Updegraff, & Marsiglia, 2018). Previous findings from analyses based on data from our study sample of UYRs, have demonstrated relative high levels of heritage identity, compared to majority identity (Oppedal, Jensen, Seglem, & Haukeland, 2011). This is noteworthy, as they are not regularly exposed to family ethnic socialization which is important to the formation of heritage identities (Douglass & Umaña-Taylor, 2015; Umaña-Taylor, Zeiders, & Updegraff, 2013). Furthermore, the majority of them have experienced an accumulation of war-related traumatic events, which potentially could have contributed to a disruption of their social identities, including their ethnic identity (Muldoon, 2013; Muldoon & Lowe, 2012). Hence, studying ethnic identity among URMs may provide new insights about factors relating to their mental health.

There is an intensification in ethnic identity exploration and commitment during adolescence, exactly the stage when most URMs migrate and arrive in their countries of refuge (Douglass & Umaña-Taylor, 2015; Erentaitė et al., 2018; Pahl & Way, 2006; Syed & Azmitia, 2009). First generation immigrants report stronger ethnic identity than 2nd generation (Nassar-McMillan, Lambert, & Hakim-Larson, 2011), and a stronger identification with the receiving culture over time has also been identified (Liebkind, 1996). To our knowledge, however, no studies have investigated the dynamics of residence-time and ethnic identity in relation to depression among URMs.

1.4. The present study

The overall aim of the present study was to provide new knowledge about depression among unaccompanied refugees in Norway. Predictors were contextual variables in terms of the asylum-process, acculturation variables in terms of bicultural identity, and demographic information such as residence-time. In accordance with the acculturation framework suggested by Celenk and Van de Vijver (2014), we examined bicultural identification by two orthogonal constructs, heritage and majority culture identity (HID and MID respectively). We explored the following study questions in a population-based sample of unaccompanied young refugees in Norway: Are depressive symptoms in the years following resettlement associated with:

1. The length of the asylum-seeking process?
2. Residence-time?
3. Bicultural identity (HID and/or MID)?

Regarding the third study question, we initially assessed the unique associations of HID and MID with depression. Next we examined a potential interaction effect between HID and MID, indicating that higher levels of HID are particularly advantageous for individuals who also report high MID and vice versa. Finally, we examined if the residence-time contributed to a reduction in depression indirectly, through an increase in HID/MID identity (Gonsalves, 1992). Alternatively, we explored if decreases in depression varied as a function of the strength in HID or MID (Gonsalves, 1992), i.e. if HID/MID moderated the association between residence-time and depression.

We included age, gender, symptoms of PTS, and country of origin as control variables in the multiple regression analyses, based on findings from previous research (Keles et al., 2017; Seglem et al., 2011).

2. Method

2.1. Participants

The population base for the project was all unaccompanied asylum-seeking minors who were granted asylum and resettled between 2000 and 2011, and who were 13 years or older when their applications were approved, N = 4 051. The Norwegian Directorate of Immigration (NDI) provided register information about gender, national origin, birth date, arrival date, and date and place of resettlement. The study was approved by the Regional Committee for Medical and Health Research Ethics and the Data Inspectorate, and participation was conditioned on written consent. For youths who were younger than 16 years, additional consent to participate in the study was collected from their legal guardians. The approved ethics application included a security protocol with procedures if the data-collection should reveal unmet needs for psychosocial support among the participants.

Based on available economic resources, all known unaccompanied refugees in 41 municipalities nationwide, that differed in demographic and geographic characteristics, were targeted, $n = 1685$. Letters inviting them to participate were sent to their homes and if they were less than 16 years, also to their legal guardians. Of the total invited sample 476 refugees (28.25%) were not possible to locate; 47 (3.9%) actively declined participation, but 218 (18.0%) youth who confirmed their participation did not show up on the day of data collection. The study sample of 948 participants represented 78.4% of the final sampling frame. The few differences between participants and all non-participants of the population-based sample reflected the variation over time in the flow of unaccompanied minors. We excluded 53 participants with missing values on most items, yielding a final sample of $n = 895$.

The majority of the participants originated in Afghanistan (51%), Somalia (12%), Iraq (7%), and Sri Lanka (6%), while the remaining 24% included youth from more than 30 other countries; 82.4% were boys. Two-thirds of them ($n = 597$) had passed the age of majority (18 years), and the mean age of the study-participants at the time of the data collection was 18.62 years (*SD* 2.63). They had a mean length of stay since residence was granted of 2.51 (*SD* 2.33) years. Previous studies have shown that this sample is representative of all the UYRs in our target group (N = 4 051) in terms of origin, age, and gender. (Keles et al., 2015).

2.2. Procedure

The data collection was conducted in the local communities where the youths lived. In each of the 41 municipalities, they gathered in small groups at a location familiar to them, e.g. a group home or library, to fill in self-report questionnaires. Trained research assistants were present to support the participants. A protocol with standardized explanations of difficult concepts and English translation of the questions were available to them. The questionnaire took about 2 hours to complete. Approximately 15% of the participants accepted the offer to have translators present, who read the questions in their mother tongue. A gift voucher worth 15 euros was offered as compensation for their time.

2.3. Measures

Depressive symptoms (depression) were measured by the 20-item Centre for Epidemiologic Studies Depression Scale for adolescents CES-D; (Radloff, 1977). CES-D assesses the frequency of depressive symptoms during the past week from 0 (*rarely or never*) to 3 (*most or all of the time*). The sum scores range from 0 through 60, with higher scores indicating more depression. CES-D has demonstrated adequate psychometric properties in different adolescent and ethnic groups (Roberts, Andrews, Lewinsohn, & Hops, 1990). Cronbach's Alpha for the scale was 0.87.

Length of the asylum process (asylum-process) was calculated by subtracting the date of arrival from the date asylum was granted, based on information from the NDI.

Length of residence (residence-time) was calculated by subtracting the date asylum was granted, based on information from NDI, from the date of data collection.

Bicultural identity was measured by eight items assessing ethnic affirmation (positive affect about one's ethnicity), see (Rivas-Drake et al., 2014), from a modified version of the Multigroup Ethnic Identity Measure (MEIM) (Berry et al., 1993; Phinney, 1992). Four items concerned HID and four items MID. Participants checked how much they agreed to statements such as: “I'm proud of being Norwegian”, “I am proud of being Afghan/Somali/Iraqi/Tamil/etc., from 1 (*strongly disagree*) to 4 (*strongly agree*). Cronbach's Alpha

for HID was 0.80, and 0.75 for MID.

Intrusive PTS-symptoms were assessed by three items about exposure to war first-hand and resulting mental reactions in terms of intrusive memories and nightmares. Based on the responses of the participants, they were given a score of 0 (no war or no symptoms), 1 (experienced war, 1 symptom), or 2 (experienced war, 2 symptoms).

Information about gender, age, and country of origin was self-reported. Gender was coded 1 (boys) and 2 (girls), while age is indicated in years.

2.4. Analyses

We used IBM SPSS statistics and R for all analyses. To control for differences in depression associated with country of origin we computed four dummy variables, where 0 represented all other countries, and 1 represented Afghanistan/Somalia/Iraq/or Sri Lanka respectively. The examination of the potential mediating function of bicultural identity in the link between residence-time and depression, was based on the presence of three conditions for mediation suggested by Baron and Kenny (1986): both mediator (MID/HID) and predictor (residence-time) should correlate significantly with the outcome variable (depression), in addition to a significant correlation between predictor and mediator.

To examine potential moderating effects of bicultural identity in the association between residence-time and depression, we computed two interaction terms, residence-time x HID and residence-time x MID.

We conducted a hierarchical multiple regression analysis in four steps: First, we entered the main predictors. Second, we entered the interaction term HID x MID. The third model included all the co-variates (gender, age, the dummy variables of origin, and intrusive PTS-symptoms). Subsequently we ran two analyses in which we first entered the interaction term of HID and residence-time, and next of MID and residence-time, in a fourth model.

3. Results

3.1. Descriptives

Table 1 shows the means and standard deviations of the study variables and their inter-correlations. The mean depression score was 20.85, slightly below the suggested conservative clinical cut-off score of 23 (Roberts, Lewinsohn, & Seeley, 1991). Based on this cut-off, the prevalence of depression for the total sample was 40%. It took on average 0.94 years to process the asylum-application. However, the correlation between the asylum-process and depression was close to zero, implying that the asylum-process did not predict depression after resettlement. The mean levels of both HID and MID were above the midpoint of the scales (2.5).

3.2. Bicultural identity and depression

The results from the hierarchical regression analyses showed that longer residence and stronger HID, but not MID, had a significant association with lower levels of depression, over and above the effect of gender, age, PTS-symptoms and national origin (Table 2). However, bicultural identity was non-significant. This interaction term was therefore excluded in the subsequent analyses (Table 2).

3.3. Heritage and majority identity as mediators or moderators in the association between residence-time and depression

Table 1 shows that the correlation between residence-time and both HID and MID was close to zero and non-significant. Thus, one of the three conditions for a mediation effect was missing, namely the presence of a significant correlation between the mediator (HID, MID) and the predictor (residence-time). Regarding MID, the condition of a significant correlation between the mediator and the outcome was also missing (Baron & Kenny, 1986). Consequently, we concluded that bicultural identity indices was not a mediator between residence-time and depression among the unaccompanied young refugees.

Table 1
Means and SDs of the major study variables, and correlations between them.

	M	SD							
1. Depressive symptoms	20.85	9.50							
2. Years in asylum center	0.94	0.55	.02						
3. Residence years	2.51	2.33	-.14***	-.20***					
4. Majority identity	2.86	0.80	-.01	.05	-.00				
5. Heritage identity	3.18	.86	-.15***	.06	-.01	-.06			
6. Gender	1.18	0.33	.07*	-.05	.06	-.10**	-.01		
7. Age	18.62	2.63	-.05	-.10**	.79***	$.07^{p=.051}$	-.04	-.05	
8. PTS-symptoms	0.84	0.88	.25***	.02	-.01	.06	.05	-.14***	.08*

Note. *p < .05; **p < .01; ***p < .001. PTS-symptoms: Symptoms of post-traumatic stress.

Table 2
Hierarchical regression analysis. Dependent variable: Depressive symptoms.

	Model 1		Model 2		Model 3	
	β	t	β	t	β	t
Length of asylum processing	.00	.075	.00	.028	.01	.259
Years of residence	-.13***	−3.604	-.13***	−3.621	-.15*	−2.555
HID	-.14***	−3.981	.01	.109	-.15***	−4.349
MID	.02	-.441	.15	1.200	.06	−1.724
Interaction HID x MID			-.23	−1.382		
Gender					.24***	6.143
Age					.09	1.639
PTS-symptoms					.26***	7.431
Afghans vs others					18***	3.518
Somalis vs others					-.13**	−3.231
Iraqis vs others					.07	1.798
Sri Lankans vs others					.03	.874
R^2 change	.04***		.002		.15***	

In the fourth step of the hierarchical regression analyses, we explored whether bicultural identity moderated this association (Table 2). There was a significant interaction effect for HID, but not for MID ($\beta = -0.36$, p = .011; and $\beta = -0.13$, $p = .34$, respectively). Fig. 1 illustrates that the UYRs had high levels of depression at resettlement, regardless of the strength of their HID. However, among youths with a strong HID, the level of depression decreased steadily with increasing residence-time in Norway. Among youths with a weak HID, the depression level remained high irrespective of how long they had resided in Norway.

The interaction between residence time and HID was also examined with regard to prevalence of depression (i.e. score above cut-off). Fig. 2 shows the estimated prevalence for short and long residence-time, split by high and low HID. Noteworthy is the high initial prevalence for both identity groups (41.2–45.7%) and the subsequent reduction by roughly two thirds, to 14.3%, among the group with high HID.

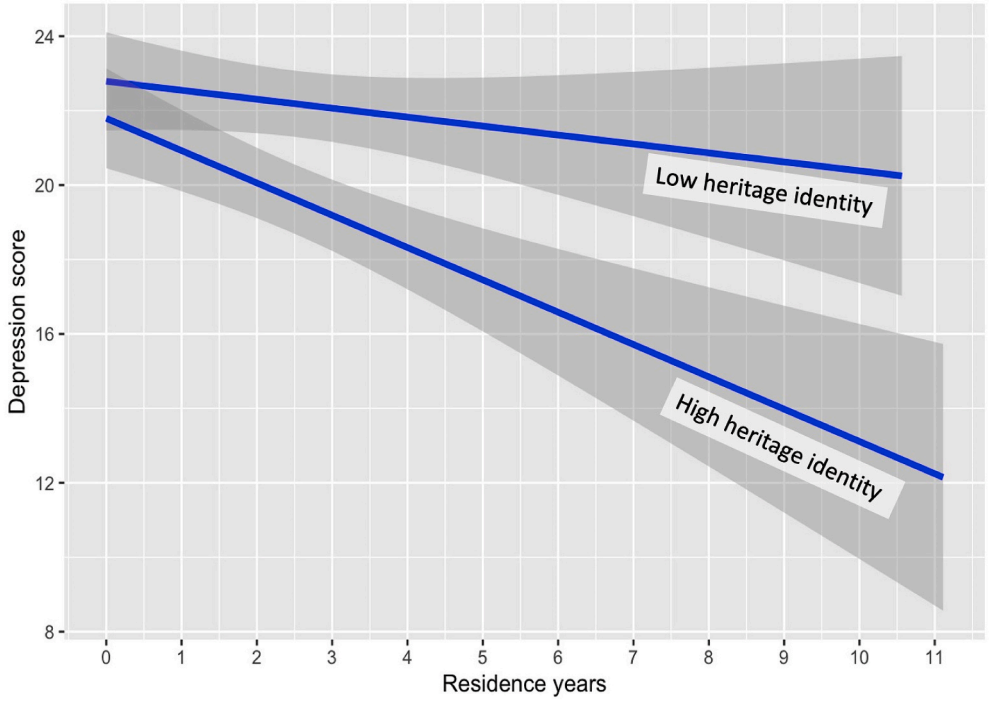

Fig. 1. Estimated mean level of depression (blue lines) and confidence interval (shaded), across residence years, split by low vs high heritage identity. (For interpretation of the references to colour in this figure legend, the reader is referred to the Web version of this article.)

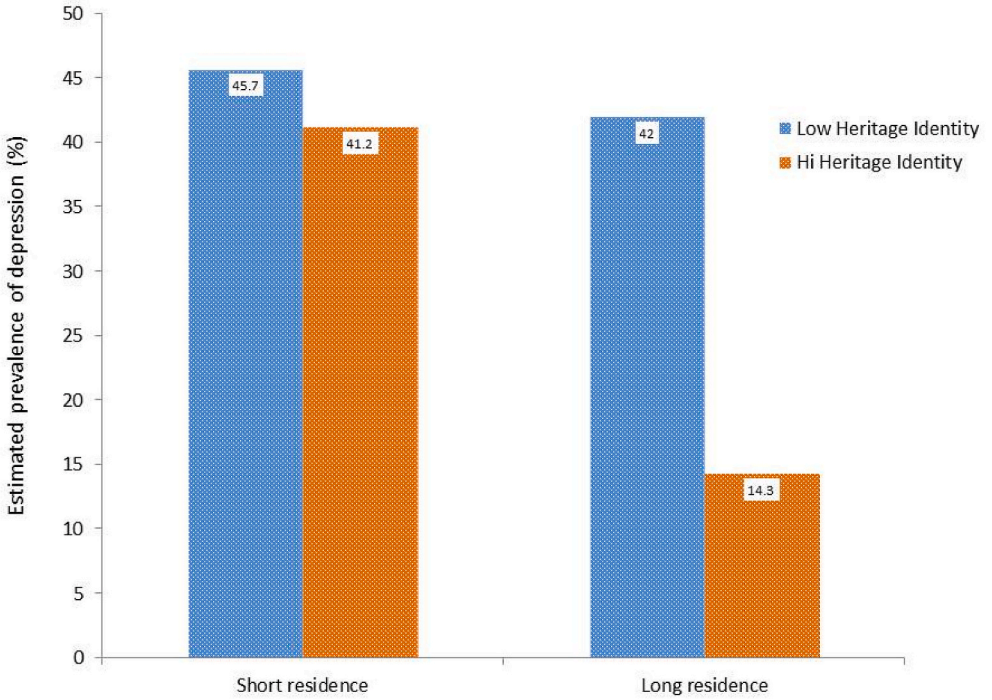

Fig. 2. Estimated prevalence of depression for short residence (beginning of residence period) and long residence (i.e. ten years after granted residence) according to low vs high heritage identity.

4. Discussion

The overall aim of the study was to examine variation in depression among UYRs in relation to the asylum-process, residence-time and bicultural identity, in terms of the positive feelings they have towards their heritage and majority culture group membership. We explored the potential positive effects of a bicultural identity, and if HID or MID mediated or moderated the association between residence-time and depression. The results showed that the length of the asylum-process did not predict depression after protection had been granted, whereas both residence-time and HID were associated with lower levels of depression. Noteworthy, there was a significant interaction effect between residence-time and HID, showing that only unaccompanied refugees with a strong HID reported lower depressive symptom levels over the years. In contrast, youths who had been granted residence even as much as 8–10 years earlier, maintained high levels of depression over time if their HID was weak.

4.1. Duration of the asylum process

The length of the asylum-process was not associated with depression among the UYRs who had obtained protection and residence. Even if research-based knowledge shows that the asylum process is associated with elevated levels of depression (Laban et al., 2004; Lorek et al., 2009; Reijneveld et al., 2005), our results indicate that the length of the asylum-seeking process is not a risk factor for URMs after they have reached the critical goal of obtaining residence. Nevertheless, other aspects of the asylum-seeking process, such as level of distress during this period, accumulation of asylum-related stressors, or degree of uncertainty about the outcome of the asylum application may be more strongly associated with depression after resettlement than the duration of the asylum-process. It should be noted that previous studies that investigated length of the asylum-seeking process in relation to mental health outcomes, involved participants who were still awaiting a conclusion in their asylum applications (Bronstein & Montgomery, 2011). Studies that incorporate aspects of the asylum-seeking process representing mental health risks among URMs (Solhaug, Oppedal, Calam, & Røysamb, 2020) may shed more light on their well-being after asylum has been obtained. This is important to optimize the psychosocial support they are offered during transition to stable resettlement.

For the children who receive residence, a long period of uncertainty is over, and the youth can look forward to and start planning their diaspora lives. In contrast, the children who are not granted protection, and instead face deportation, do not experience this kind of relief. Unfortunately, there is a research gap regarding the long term mental health consequences of the rejection of their applications.

4.2. Length of residence

Our findings support previous studies that have shown decreasing levels of mental health problems among refugee children with

increasing length of stay (Fazel et al., 2012). It is noteworthy that the healing effect of the passing of time, even if weak, is unique over and above the effect of bicultural identity, PTS-symptoms, and demographic variables.

From a stress-coping perspective (Lazarus & Folkman, 1984), acculturation researchers claim that the level of mental distress remains high among immigrants the first few years following resettlement, due to the accumulation of stressors associated with adapting to a new culture (Berry, 2006; Jugert & Titzmann, 2017). Clinical researchers have supported these assumptions (Gonsalves, 1992; Hurh & Kim, 1990; Sluzki, 1979). It was, however, not the purpose of the present study to investigate acculturation-specific stressors as predictors of a potential curvilinear association between residence-time and depression. Instead, we aimed at exploring if acculturation-related resources might protect unaccompanied refugees against variations in mental distress in different stages in the resettlement process. Future research should expand on our model, and examine if the associations between acculturation hassles and depression among unaccompanied refugees (Keles et al., 2017) varies over time and with the strength of bicultural identity indices.

4.3. Heritage and majority identity

Our finding that stronger HID was associated with lower levels of depression is in line with previous research (Erentaitė et al., 2018; Rivas-Drake et al., 2014; Smith & Silva, 2011). Having positive feelings towards and a strong sense of belonging to one's original ethnic group, is linked with a constructive sense of self and thereby with other positive psychosocial outcomes (Rivas-Drake et al., 2014; Umaña-Taylor et al., 2014). A strong HID may also provide UYRs with a sense of continuity and cohesion in their otherwise disrupted life stories.

Neither MID nor the interaction between HID and MID are significantly associated with depression. This implies that the association between HID and depressive symptoms is independent of the level of MID and vice versa. Bicultural identity formation is a complex process, in which individual forms and dimensions of heritage and majority identity, and various combinations of them, may correlate with and promote unique adaptive outcomes (Benet-Martínez et al., 2002; Phinney et al., 2001; Syed & Juang, 2018). Only HID had significant association with depressive symptoms in the present study-sample of UYRs. To expand on current knowledge about bicultural identity among unaccompanied asylum-seeking and refugee minors, future studies should include other psychological outcomes, both well-being, function, and psychopathological indices. Even if many studies demonstrate beneficial mental health outcomes of identifying strongly with both culture groups (Nguyen & Benet-Martínez, 2013; Phinney et al., 2001; Schwartz et al., 2010), other research findings indicate that the adaptive correlates of HID and MID differ. Schwartz, Vignoles, Brown, and Zaagefka (2014) showed that HID was associated with mental health and MID with behavioral outcomes. Aydinli-Karakulak and Dimitrova (2016) argued that the associations of HID and MID with mental health outcomes is influenced by the individuals' social context, implying variations between individuals, national groups and receiving countries. Several scholars have pointed to the importance of family, peer, and larger society contexts for the development of ethnic identity and for the role that HID and MID play in relation to psychological outcomes (Phinney et al., 2001; Schwartz et al., 2014, 2015; Umaña-Taylor, 2004). Only 12% of this study sample lived with family members, mostly siblings. About one half of the participants, 458 (51.2%) had contact with their families abroad, first and foremost mothers, fathers, and/or siblings (Oppedal & Idsoe, 2015). However, little is known about the impact of these family relationships on bicultural identity development or the development and maintenance of HID or bicultural identity among these youths. This would be an important focus in future research.

The developmental context of unaccompanied refugees has certain characteristics that may affect their ethnic identity. They are constantly inquired about their nationality in all formal settings, e.g. when lodging their asylum claims, in school settings, and at the child welfare services, underscoring their non-Norwegian-ness. They frequently experience ethnic-based discrimination (Oppedal & Idsoe, 2015). This may not only strengthen their HID (Branscombe, Schmitt, & Harvey, 1999), but also prevent them from developing positive identification with the majority culture that can strengthen their mental health (Jasinskaja-Lahti et al., 2009). After resettlement in Norway, they typically live in group homes with other unaccompanied refugees of various ethnicities, presumably reinforcing their heritage more than their majority culture identity exploration.

Furthermore, due to gaps in the formal education among URMs, their re-entry into the educational system usually involves catching up with the curriculum of lower grade levels. This education is typically organized in special programs, separated from ordinary schools and education programs. When URMs enter formal schooling, they tend to be 2–3 years older than their classmates, which represents a barrier to interpersonal relations with the majority students and other classmates (Oppedal, Guribye, & Kroger, 2017). We may speculate if contextual factors embedded in the institutionalized support of unaccompanied refugees may strengthen their HID processes, while simultaneously depressing their social integration into the majority culture networks that could promote the development of an adaptive MID. We need more research-based information about bicultural identity among URMs, factors that promote and prevent its development, and about adaptive combinations and psychosocial correlates of HID and MID.

4.4. Heritage identity moderates the association between the passing of time and depression

Youths with short residence-time reported similar high levels of depression regardless of the reported level of their HID. However, the symptom level among youths with a strong HID decreased steadily over time. The prevalence of depressive symptoms above the clinical cut-off of 23, was high for both HID groups. Importantly, among youths with a strong HID, there was a substantial drop in the prevalence, from the initial 41.2% to 14.3% after 10 years. The prevalence remained stable irrespective of the residence-time among youths with a weak HID.

The significant interaction effect of residence-time and HID underscores the salience of HID for the unaccompanied refugees, implying that experiencing positive affect about one's heritage ethnicity is a developmental resource and resilience factor among

them. This needs to be taken into consideration among school personnel, practitioners, social workers, and clinicians in charge of supporting these youths and implementing interventions to promote their integration and mental health.

4.5. Limitations

The heterogeneous sample involves participants from 33 national groups, most of them too small to study independently. National group variation was not the focus of this study, and we may have missed information about cultural differences in the link between ethnic identity, residence-time and depression, an important target for future research.

The cross-sectional design of the study does not provide information about causal directions, and references to variables that "have an effect on" and "predict" refer to associations between variables in this setting. Residence-time represents groups of unaccompanied refugees that differ with respect to length of residence, rather than individual changes that occur over time. Ideally, longitudinal designs are preferred to conclude about mediating and moderating effects. To advance our knowledge about predictors of depression among unaccompanied refugees, follow-up studies should address these limitations.

The included construct of ethnic identity comprises only the dimension identity affirmation of the complex identity construct. There is also no information about underlying developmental processes, such as exploration and commitment (Marcia, 1980; Umaña-Taylor et al., 2014). More comprehensive indices of ethnic identity may provide additional knowledge about how unaccompanied refugees negotiate their belongingness to different cultures. Importantly, studies combining qualitative methods such as semi-structured interviews with questionnaire data could provide more in depth information about bicultural identity formation, and should be considered in designing future research. Even if our study sample is demographically representative for the total group of URMs that came to Norway as asylum-seekers from 2000 to 2010, there is a need for information about the generalizability of our findings to other refugee receiving countries, to accompanied refugees, and other immigrant groups.

5. Conclusions

This study is unique in that it involves a big sample of URMs that have received protection and residence. We have provided new knowledge about variation in depression among youths at high risk of mental distress, by showing that a positive identification with one's heritage culture is associated with resilient outcomes over time. Nevertheless, a positive identification with the majority culture was not associated with reduced mental distress. We therefore speculate if factors embedded in the institutional support, such as living arrangement and remedial education programs, of unaccompanied young refugees strengthen their HID processes. This particular developmental context may simultaneously discourage social processes that could promote a MID and social integration, by reducing the opportunities to engage in, and develop relationship with ethnic Norwegian peers. More research based knowledge and a deeper understanding of the role of context for the association across time between bicultural identity and mental health indices may have implications not only for the mental health and integration of unaccompanied refugees, but for immigrant youth at large.

Our findings support previous studies showing that maintaining strong connections to the heritage culture is associated with mental well-being among ethnic minority and immigrant background youth, e.g. (Erentaitė et al., 2018; Oppedal, Keles, Cheah, & Røysamb, 2020; Rivas-Drake et al., 2014). This is important for policy makers, educators, mental health professionals and other practitioners responsible for the integration and well-being of young refugees to take into consideration. While learning the majority language and establishing supportive majority culture networks is crucial for successful adaptation to the resettlement societies, facilitating strong belongingness and positive affect towards the heritage culture groups is also essential in positive youth development.

Declaration of competing interest

None.

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