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Social Work in Mental Health

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/wsmh20

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To cite this article: Hadi Farahani, Jari Martikainen, Laleh Golamrej Eliasi, Mohamed Tavakol & Timo Toikko (24 May 2024): Lay perceptions of mental health among Afghan forced migrants residing in Finland, Social Work in Mental Health, DOI: 10.1080/15332985.2024.2357357

To link to this article: https://doi.org/10.1080/15332985.2024.2357357

Published online: 24 May 2024.

SOCIAL WORK IN MENTAL HEALTH
https://doi.org/10.1080/15332985.2024.2357357

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Lay perceptions of mental health among Afghan forced migrants residing in Finland

Hadi Farahani MA[a], Jari Martikainen PhD[a], Laleh Golamrej Eliasi MA[b], Mohamed Tavakol PhD[c], and Timo Toikko PhD[a]

[a]Department of Social Sciences, University of Eastern Finland, Kuopio, Finland; [b]Department of Social Research, University of Turku, Turku, Finland; [c]Department of Sociology, University of Tehran, Tehran, Iran

ABSTRACT

This study explores lay perceptions of mental health among Afghan forced migrants in Finland. Semi-structured interviews were conducted with 25 participants. Reflexive thematic analysis was used as the method of analysis. The analysis produced two main themes: external symptoms (changes in physical appearance and behavior) and internal symptoms (burdensome feelings and sensations). Participants rarely used explicit mental health terminology, preferring nuanced culture-specific, individual expressions, and indirect communication about stress and trauma. This study contributes to the understanding of Afghan forced migrants' lay perceptions of mental health and calls for culturally-safe approaches in social work and mental health services for forced migrants.

KEYWORDS

Afghan; asylum-seeker; cultural safety; Finland; forced migration; lay perception; mental health; refugee

Introduction

Migration brings about significant life changes for individuals, whether they are moving by choice or by force. Voluntary migrants, along with their host countries, typically evaluate the economic costs and benefits associated with migration (Dustmann et al., 2017). In contrast, forced migratory movements are inherently distressing (Ford-Paz et al., 2020), and forced migrants, driven by force, compulsion, and coercion (IOM, 2019), prompt host countries to supposedly accept them based on humanitarian grounds. In the context of forced migration, it's essential to distinguish between two commonly confused categories: asylum seekers and refugees. Refugees are those who have proven the constant threat to their lives in their home countries through a court process, leading to protection in the host countries. Asylum seekers, however, still in the court processes, awaiting host countries' protection (Farahani et al., 2023).

CONTACT Hadi Farahani hadi.farahani@uef.fi Department of Social Sciences, University of Eastern Finland, Yliopistonranta 1, Kuopio 70210, Finland

While personal characteristics undeniably exert an influence on individuals' capacity to navigate the multifaceted challenges of migration (Farahani et al., 2021), the consequences of migration extend beyond individual traits. Migration might enhance material well-being (Agyekum et al., 2021) but also involves separation from family, disruption of established social networks, and departure from familiar communities (Alemi et al., 2017; Farahani et al., 2021, 2023). Even after resettlement in host countries, forced migrants commonly encounter persistent precarious living conditions, which reportedly lead to adverse mental health outcomes.

Extensive research endeavors have been dedicated to exploring the risk factors associated with the mental health of forced migrants after resettlement (Mesa-Vieira et al., 2022; Patanè et al., 2022; Salam et al., 2022). These encompass a range of factors, including post-traumatic stress, social isolation, exclusion from mainstream society, uncertainty about future prospects, cultural and language barriers, discrimination, unemployment, and intergenerational conflicts within families (Farahani et al., 2021).

The literature suggests that forced migrants often exhibit a higher prevalence of mental health problems in comparison to their host populations (Henkelmann et al., 2020; Hollander et al., 2013; Selten et al., 2012; World Health Organization, n.d.). Despite this, research indicates that immigrants tend to utilize mental health services less frequently than the majority populations residing in the host countries (Derr, 2016; Gubi et al., 2022; Zheng et al., 2022). Similarly, a report from Finland (the context of our study) revealed a higher prevalence of psychological distress among forced migrants in comparison to both the native Finnish population and other categories of immigrants (Robertsson et al., 2023). Additionally, multiple studies suggest that immigrants in Finland exhibit lower utilization of mental health services, particularly outpatient care (Kieseppä et al., 2020, 2021; Koponen et al., 2016), compared to the native population (Castaneda et al., 2020; Lehti et al., 2020; Markkula et al., 2017). This trend might be attributed to the probable underrepresentation of immigrants in mental health services within the Finnish context (Castaneda et al., 2020; Kieseppä et al., 2020; Kumar et al., 2022; Robertsson et al., 2023), or the lack of perceived need for treatment due to low mental health literacy (Alonso et al., 2018).

There are known cultural and structural barriers explaining the underutilization of mental health services by immigrants (Derr, 2016). Language barriers (including issues related to interpretation and establishing trust (Daluwatta et al., 2023), low mental health literacy (Khatib et al., 2023), limited awareness of available mental health services in the host country (Anastasia et al., 2022), skepticism toward Western mental health services (Colucci et al., 2015; Galvan et al., 2022), and inadequate insurance coverage for mental health services (Agrawal & Venkatesh, 2016; Giacco et al., 2014) are some of the known structural barriers.

Among the various cultural barriers encountered by immigrants seeking mental health services in their host countries, two intertwined factors play a complementary role. First is the cultural conceptualizations of mental health/illness and related treatments (Colucci et al., 2015). Second is the stigma surrounding the utilization of mental health services (Derr, 2016; El Khatib et al., 2023; Satinsky et al., 2019). The presence of stigma significantly affects immigrants' underutilization of mental health services. Social stigma, provoked by negative societal perceptions, poses a substantial obstacle for individuals in need of mental health support (Kour et al., 2021). Furthermore, cultural, and individual conceptualizations pertaining to mental health and illness shape immigrants' perspectives and choices regarding seeking professional assistance. These intertwined factors collectively contribute to inhibiting immigrants from seeking necessary mental health support (Galvan et al., 2022).

Culture significantly influences how mental health and its challenges are experienced and expressed, both among migrants and health and social care professionals (Kirmayer & Jarvis, 2019). This can create obstacles in understanding the perspectives of each group (M. Mölsä et al., 2017). In addition to stigma, migrants' experiences of not being understood by healthcare professionals may heighten feelings of insecurity regarding mental health services (M. E. Mölsä et al., 2010). To foster [mental] healthcare services where migrants and other recipients feel secure, a cultural safety approach has been developed (see, e.g., Curtis et al., 2019; Mortensen, 2010; Richardson & Williams, 2007).

A culturally safe healthcare service underscores the significance of cultural traits while recognizing the uniqueness of individuals. The cultural safety approach ensures a "safe" healthcare environment, avoiding oversimplification of diverse human behaviors into cultural stereotypes and creates a power balance between the service users, and providers (Richardson & Williams, 2007). It emphasizes that people using healthcare services should feel safe in an impartial, non-intimidating setting (Lau & Rodgers, 2021). In a culturally safe approach, it's important for service users to recognize their own cultural assumptions, and for service providers to understand the health beliefs of the users as well as to become aware of and critically reflect on their own conceptions of mental health (Curtis et al., 2019). This enhancement becomes particularly vital when engaging with forced migrants from diverse cultural and linguistic origins (Farahani et al., 2023; Jun, 2018; King et al., 2022; Murray et al., 2010; Savic et al., 2016).

Care providers' cultural knowledge and skills are integral to the cultural safety approach (Mortensen, 2010). However, it does not focus on generalized, a contextual knowledge about different ethnic groups. Instead, it strives to understand challenges related to cultural differences in a particular context, aiming to create culturally relevant and safe healthcare

practices (Curtis et al., 2019). Given that the cultural understanding of mental health may vary among different groups of migrants and that various host countries may present distinct challenges for migrants from diverse ethnic and cultural backgrounds (Anis & Turtiainen, 2021; Close et al., 2016), it is imperative from a cultural safety perspective to engage different migrant groups within a host country in fostering mutual understanding. Internationally, the cultural safety approach has been partially adopted in social work and social work education (Fernando & Bennett, 2019; Thompson & Duthie, 2016). Yet, discussions on this approach in Finland have been limited thus far (Järvensivu et al., 2016), leaving a noticeable gap in comprehending the cultural as well as individual conceptualization and perception of mental health among various forced migrant groups.

This study is part of a larger research project, which includes other substudies focusing on examining the risk factors of mental health among Afghan forced migrants in Finland, as well as the barriers to their utilization of mental health services. However, this paper specifically focuses on studying their lay perceptions of mental health. These conceptions are crucial as they shape their communication about mental health, their seeking of assistance and care, and their experiences of safety or unsafety when using mental health care services in Finland (Kirmayer & Jarvis, 2019).

While prior research has explored Afghan refugees' cultural perceptions of mental health and illness on a global scale (Alemi et al., 2014; Lavdas et al., 2023; Miller et al., 2006; Yaser et al., 2016), there is a notable absence of prior studies on this issue within the context of Finland. Similarly, within the Finnish context, prior studies have examined mental health issues among migrant communities such as Somali (M. E. Mölsä et al., 2010), Russian, and Kurdish populations (Rask et al., 2016). However, this is the first study specifically focusing on the mental health of Afghan forced migrants in Finland. Hence, it is vital to understand their conceptions of mental health and engage them in co-creating culturally safe mental health care services. This study contributes to the cultural understanding of mental health among Afghan forced migrants, who represent the third-largest migrant group in Finland, with the aim of responding to Finnish healthcare professionals' (M. Mölsä et al., 2017) and social workers' (Anis & Turtiainen, 2021) need to enhance their cultural understanding and practice when working with diverse groups of migrants.

Nevertheless, when exploring the cultural perceptions of Afghan forced migrants, it's essential to consider Afghanistan's rich diversity, encompassing various cultures, ethnicities, and languages (Farahani et al., 2023). The country also faces significant class disparities and gender issues, influencing access to education. Refugees and asylum seekers within this research came from diverse ethnic, cultural, and class backgrounds. Thus, our objective isn't to

create universally applicable knowledge; instead, our findings remain distinctly contextual.

Studying lay perceptions of mental health among Afghan migrants

The study of how individuals and communities understand health and illness has been explored across scientific disciplines. For instance, Arthur Kleinman's (1980) work in *Medical Anthropology* has made notable contributions to this field. Kleinman's concept of lay explanatory models emphasizes the interconnectedness of culture and healthcare systems. Explanatory models shape people's understanding of illnesses and influence their approach to treatment (Kleinman, 1980, 2020). Additionally, in *Medical Sociology or Sociology of Health*, culture is known to be a determinant of health/illness behavior: "culture functions as the encompassing context within which health and illness behaviors manifest and unfold" (Cockerham, 2009). Irving Zola's (1966) work highlights how diverse cultural backgrounds influence individuals' subjective understanding of symptoms, which often differ from medical norms. Health psychologists, in turn, examine representations of illness. These representations affect patients' compliance with treatment and their symptoms and outcomes. Similar to lay explanatory models, illness representations influence patients' beliefs about the causes and consequences of their illness, treatment expectations, and adherence to prescribed procedures (Leventhal et al., 1984).

Existing literature uses various terms to describe people's perceptions of mental health. Some refer to it as mental health literacy (Jorm et al., 1997), while others use terms like lay perceptions (Werner, 2005) or lay beliefs/knowledge/theories (Furnham & Kirkcaldy, 2015). These concepts all share a common focus on "knowledge and beliefs surrounding mental disorders, which aid in their recognition, management, or prevention" (Jorm et al., 1997, p. 182). Nevertheless it is important to note that people's lay perceptions of health and illness may not align with the biomedical models endorsed by Western health professionals (Markova & Sandal, 2016; Patel, 1995), but understanding the lay perceptions of mental health can offer valuable insights into why forced migrants underutilize services and how they seek help.

Patel (1995) conducted a review of beliefs pertaining to mental illness in studies concerning Sub-Saharan African countries. The findings revealed that these people typically attribute the causes of both physical and mental illness to external factors (Patel, 1995). Building upon Patel's (1995) insightful exploration, Alemi et al. (2016) suggested that like Sub-Saharan African people, Afghans have a situational belief system, meaning that they often contextualize symptoms of depression within social issues or emotional reactions to circumstances, moving beyond a biomedical belief system. Similarly, in their focus group interviews with mental health professionals working with Southeast

Asian elderly refugees in the U.S., Lee et al. (2010) observed that these refugees predominantly attribute depression to external causes, "such as situational stress or supernatural factors" (p. 339).

In their research on the beliefs and knowledge about post-traumatic stress disorder (PTSD) amongst resettled Afghan refugees in Australia, Yaser et al. (2016) found that Afghan refugees' view of PTSD differ from those of Western medical models, often leading to inadequate pursuit of appropriate treatments. The study highlighted the necessity for tailored and focused mental health services and treatment strategies for Afghans based on their culture and values (Yaser et al., 2016). Likewise, Lavdas et al. (2023) underscored that Afghans' explanatory models of mental health are deeply intertwined with social and cultural contexts. Afghans tend to normalize mental health challenges, viewing them not as medical issues demanding medical attention but rather as concerns that can be ameliorated through social and emotional support (Lavdas et al., 2023). Eggerman and Panter-Brick (2010) discovered that Afghans express psychological distress through a range of idiomatic expressions, associating their mental health with prevailing societal and economic challenges in Afghanistan rather than past war-related traumas. In essence, their psychological distresses hinge on the effective functioning of various elements such as society, government, and family (Eggerman & Panter-Brick, 2010).

Brea Larios et al. (2022) identified that Afghan refugees' explanatory models of PTSD and depression in Norway are shaped by their social contexts, with a strong possibility of these perceptions evolving over time. Likewise, the research by Groen et al. (2018) concerning traumatized Afghan and Iraqi refugees in the Netherlands indicated that the cultural identity of Afghans in relation to mental health issues is influenced by the circumstances and changes within their host society. This alteration was attributed to the stress of their situation and the process of acculturation. According to Groen et al. (2018), mental health professionals can enhance their cultural competence in diagnosing and treating such cases by considering the patients' personal, ethnic, and social identities in connection with their mental health challenges.

Context of the study: Finland

At the end of 2021, the global count of forcibly displaced individuals due to conflicts, violence, persecution, and violations of human rights stood at 89.3 million (UNHCR, n.d.). Preceding the 1990s, Finland had a very restrictive immigration policy, and consequently, Finnish society was considerably homogeneous, consisting of less than 1% immigrants (Ansala et al., 2022; Statistics Finland, n.d.-a). The influx of immigrants to Finland has demonstrated a consistent and gradual rise since the 1990s. In 2021, the number of immigrants reached its highest point as the country experienced an unprecedented surge with the arrival of 36,364 individuals (Statistics Finland, n.d.-b).

In 2021, Afghan forced migrants held a prominent position among the top three nationalities seeking international protection in Finland (European Migration Network, 2022). Based on statistical data, a total of 11,144 Afghan immigrants have made their way to Finland since 1990 (Statistics Finland, n.d.-a).

Finland's ratification of the 1948 Universal Declaration of Human Rights, affirming the right to medical care for all (United Nations, n.d.), is reinforced by the Finnish Constitution, which also articulates the right to adequate social, health, and medical services for everyone in the country (Ministry of Justice, n.d.-a). However, the extent to which immigrants can access health and social care services in Finland varies based on their residence status.

After the 2023 administrative reform, Finland's social and health care services transitioned from 309 municipalities to 21 welfare areas plus the Helsinki area (Ministry of Justice, n.d.-b). As part of its goals, the reform strategically focuses on improving the integration of social and health services, underscoring its vital role in achieving a more seamless and holistic approach to care. Under the Municipality of Residence Act, Finnish citizens, immigrants with a valid residence permit, and refugees must register in a Finnish municipality (Ministry of Justice, n.d.-c). This registration grants them entitlement, by law, to receive social and health care services from both their municipality of residence and the respective welfare areas (Ministry of Justice, n.d.-d). However, adult asylum seekers (+18 years old) face challenges as they lack a domicile in any Finnish municipality. They can only access free urgent health and social care services through reception centers, provided by the nurse or social worker, and operated by the Finnish Immigration Service. If they require specialized care outside reception centers, (unless under very rare, urgent circumstances) they have to bear the costs themselves, which is often unaffordable given the monthly reception allowance of 55–290 Euros (Ministry of Justice, n.d.-e, n.d.-f). The accessibility of specialized social and health care for asylum-seekers has been a longstanding concern in Finland (Keskimäki et al., 2014; Wahlbeck et al., 2008). Additionally, the quality of these services, both in primary and specialized care for migrants (voluntary or forced migrants), has been under constant scrutiny in the country.

In terms of migrants' mental health guidance and services, those residing in reception centers consult matters related to mental health with a nurse and/or social worker, whereas those granted a residence permit use services provided by the public health and social care sector. Hence, both health care professionals and social workers need to develop cultural understanding on mental health issues when working with different groups of migrants. Social workers in Finland and elsewhere frequently encounter a complex, demanding, and sometimes contradictory position in which they serve as the primary intermediary between unquestioned, top-down government policies and services provided by society,

on the one hand, and individuals in challenging circumstances, on the other hand. In this role, social workers assume the crucial responsibility of bridging the gap, facilitating communication, and advocating for the needs and rights of various service users within the framework of governmental policies (Farahani et al., 2021). Because of this, a body of research underscores the continuing necessity for social work professionals to augment their provision of culturally safe and appropriate services (Anis & Turtiainen, 2021).

Nordic social work research has revealed that welfare systems in Nordic countries, including Finland, face challenges in effectively embracing ethnic diversity, particularly in recognizing and acknowledging ethnic and cultural differences (Anis & Turtiainen, 2021). In the Finnish context, M. E. Mölsä et al. (2010) observed that despite the increasing number of migrants, Finland predominantly operates within a monocultural framework. This aspect of Nordic and Finnish societies is also evident in the provision of (mental) health care services for migrants (Anis & Turtiainen, 2021).

The biomedical understanding of mental health and its treatments has dominated in Finland, both among laypeople and health care professionals (Kuittinen et al., 2017; Tikkinen et al., 2012). As a result, the understanding of mental health among health care professionals and migrants, as well as their perceived need for services and appropriate treatment, may significantly differ from each other (Koponen et al., 2016; M. Mölsä et al., 2017).

Studies conducted in Finland, show that migrant's mental disorders are not always recognized by the healthcare professionals, often due to cultural insensitivity or a lack of cultural literacy (Castaneda et al., 2020; Tiilikainen & Koehn, 2011). Recent studies conducted among various migrant groups in Finland highlight the challenges stemming from differing cultural understandings of (mental) health between healthcare providers and migrants. For instance, Somali people living in Finland have reported feeling that healthcare professionals do not adequately understand their needs and situations (M. E. Mölsä et al., 2010). M. Mölsä et al. (2017) found that elderly Somali immigrants favor traditional care and religious healing when addressing their mental health concerns. Nekouei Marvi Langari et al. (2022) observed that migrants from Asian countries and Russia had differing conceptions of a healthy lifestyle including physical, mental, and social health. Their study identified shortcomings in healthcare services, such as inadequate provision of counseling and a lack of culturally safe approaches to health care (Nekouei Marvi Langari et al., 2022).

As Anis and Turtiainen (2021) noted, some of the aforementioned challenges are common among migrants in general, while others are specific to certain groups of migrants, and some are individual in nature. Therefore, there is a need for studies that focus on cultural understandings of mental health among various migration groups (see also, M. Mölsä et al., 2017).

The study by Anis and Turtiainen (2021) among Finnish social work practitioners reflects the previously described problematic in the social work sector. It found that Finnish social workers experience uncertainty about their expertise in working with forced migrants. This uncertainty stemmed from a lack of cultural awareness as well as challenges posed by the structure of the Finnish welfare system, which offers varying services for migrants with different residence statuses. The study identified a need for enhancing social workers' awareness of cultural sensitivity (Anis & Turtiainen, 2021).

As the previously discussed studies demonstrate, there is a pressing need to improve cultural understandings related to mental health from the perspectives of migrants/service users (Castaneda et al., 2020; Tiilikainen & Koehn, 2011), health care professionals (M. Mölsä et al., 2017; Nekouei Marvi Langari et al., 2022) and social workers (Anis & Turtiainen, 2021). The present study aims to fill this research gap by examining the lay perceptions of mental health among Afghan forced migrants residing in Finland.

Methods

The data collection was organized and led by the first author of the study. The group of participants included 25 Afghan refugees and asylum seekers living in Finland. The demographics of the study participants are illustrated in Table 1. The first author interviewed male participants ($n = 13$), and the third author of the study interviewed female participants ($n = 12$). This decision was made based on cultural knowledge, according to which it might be more convenient for female Afghans to talk about their views with a female interviewer (Farahani et al., 2023). The interviewees had the flexibility to choose face-to-face, video call, or voice call interviews – a choice intended to enhance participants' feelings of trust and safety. The interviews were carried out as semi-structured interviews, for which

Table 1. Demographics of the study participants ($N = 25$).

Age	
18–29	6
30–40	12
41–60	7
Immigration status	
Asylum-seeker	15
Refugee	10
Years lived in Finland	
0–7	15
8–14	9
≥15	1
Marital status	
Single	7
Married	15
Widowed	3

preliminary topics regarding mental health were decided in advance. The two main questions were: What is mental health or mental illness/disorder? and how do you define mental health? However, the interviewers were open to discuss matters that emerged as meaningful based on the interviewees' answers.

Because discussions about mental health can be sensitive (Palmer & Ward, 2007), both interviewers extensively familiarized themselves with research ethics and the existing literature on interviewing individuals about sensitive topics in general, as well as mental health issues among (Afghan) forced migrants specifically. Through this preparation, the interviewers aimed to improve their capacity to address sensitive issues and refine their cultural sensitivity when discussing mental health within the context of Afghan culture. To ensure the ethical conduct of this research, ethical approval was obtained from the Ethics Committee of the University of Eastern Finland (Statement 15/2020). Participants received detailed information sheets outlining the research objectives, their rights, and potential risks involved. Voluntary participation and confidentiality were strictly maintained, and interview contents, as well as participants' names, were pseudonymized to safeguard their identities.

The interviews lasted 60–80 minutes on average each and were conducted in Dari. Afterward, the data were transcribed in the Dari language, resulting in a total of 472 typewritten pages (Calibri, font size 18, 1.5 spacing). Following the initial analysis, the relevant sections of the interviews were translated into English by the first author.

The data were analyzed using reflexive thematic analysis (Braun & Clarke, 2022a). This method was selected because it offers a way to explore both explicit and implicit meanings related to a research topic (Braun & Clarke, 2021, 2022b). The potential of thematic analysis to capture implicit meanings was crucial, particularly since the interviewees rarely mentioned mental health or mental illness explicitly. Additionally, thematic analysis was chosen because our focus was not solely on exploring individual perceptions of mental health but rather on identifying overarching themes across the data (Braun & Clarke, 2022a, 2022b).

Braun and Clarke's (2022a) model of reflexive thematic analysis comprise six stages: 1) thorough familiarization with the data, 2) coding, 3) making initial themes, 4) revising themes, 5) finalizing themes, and 6) writing the results. As the stages of analysis suggest, reflexive thematic analysis is not a linear process but rather an iterative one. Analytical decisions made at prior stages are reflected upon and justified in the subsequent stages of analysis. Even writing the results is considered a part of the analytical process, as it can prompt the researcher to reconsider and revise previous stages of analysis (Braun & Clarke, 2022a). According to Braun and Clarke (2022a, 2022b), themes presented as results of the analysis must meet two criteria: they should

be distinct from each other, and they should complement each other to form a coherent entity.

In this study, the first author extensively immersed himself in the data (in the Dari language). This immersion occurred both during the transcription process and afterward through multiple readings of the data. During this stage, his aim was to develop a comprehensive overall understanding of the data (Braun & Clarke, 2022a). In the second stage of analysis, he coded the data produced by individual participants with the aim of capturing both explicit and implicit meanings related to mental health. During the third stage of analysis, the codes derived from the individual interviews were utilized to develop initial thematic patterns. The first author translated the most illuminating/central parts of the data used for forming the initial themes from Dari into English. Following this, the first and second authors engaged in a discussion about the initial themes. They both agreed that the initial themes exhibited partial overlap and revealed a pattern that allowed them to be grouped under two overarching themes. Based on this finding, the themes were rechecked, revised, and collectively approved by all authors involved in the study.

Findings

When queried about their perspectives on what is mental health/illness and how they define mental health/illness, the participants largely refrained from offering explicit characterizations or engaging in direct discourse concerning these matters. With only a limited number of exceptions, the utilization of terms like "mental health" or "mental illness" was notably absent from their responses. Instead, their descriptions revolved around "something originating internally but manifesting outwardly," a phenomenon "emanating from within the mind," "manifestations of adversity," "stress," "something bad is happening," "worries," and "challenging encounters." These expressions, consistent with prior research, are recognized as customary manners through which Afghan refugees refer to psychological distress (Alemi et al., 2014). Table 2 shows the variety of culture-specific phrases that participants used when talking about mental health.

In our study, the participants explained their understanding of mental disorders by describing changes in people's physical appearance and visually perceivable behavior, on the one hand, and psycho-somatic feelings and sensations that deviated from the normal state of affairs, on the other hand. Hence, the participants talked about mental health issues by describing diverse symptoms that either showed externally or were felt internally. Based on this data-driven finding, we formed two main themes: external symptoms (changes in physical appearance and behavior) and internal symptoms (burdensome feelings and sensations).

Table 2. Participants' phrases expressing aspects of mental health.

Gham [غم]	Sorrow
Fekr o khial [فکر و خیال]	Overthinking
Asabi [عصبی]	Nervous/anxious
Khod zani [خودزنی]	Self-harm/self-injury
Hazian Gooei [هذیان گویی]	Delirium/talking nonsense
Divanah [دیوانه]	Crazy
Ruhi ya ravani narughi [روحی یا روانی ناروقی]	Mental illness
Delshourah [دلشوره]	Worry/anxiety
Gooshahgir [گوشه گیر]	Isolated/self-excluding
Ghamgeen [غمگین]	Sorrowful
Jegar Khon [جگرخون]	Deep sorrow
Fishar Paein [فیشارپایین]	Low blood pressure
Tashwish [تشویش]	Anxiety
Bad Kholgh [بد خلق]	Ill-tempered
Kam harf [کم حرف]	Reticent
Rang paridah [رنگ پریده]	Pale

Table 3. Themes and subthemes related to mental health.

Main Question	Theme	Sub-Theme
• What is mental health or mental illness/ disorder? • How do you define mental health?	External symptoms: changes in physical appearance and behavior	• Changes in physical appearance (e.g., pale skin, dark circles under eyes, shaking hands) • Physical symptoms (e.g., rash, wounds) • Changes in personal behavior (e.g., silence, talking to oneself, self-isolation) • Changes in social behavior (e.g., avoidance of social encounters, aggression) • Substance abuse
	Internal symptoms: burdensome feelings and sensations	• Overthinking, burdensome ideas and experiences • Stress, anxiety, and sorrow as sources of mental illness • Lack of interest, loss of position, and feelings of uselessness for men • Symptoms of insomnia • Explaining mental illness through sensations of pain

Drawing from the data, it became evident that participants primarily emphasized the external indicators of mental disorders. Their descriptions of internal symptoms often framed them in a manner that connected them to observable external manifestations. In addition, we found that men talked mainly about mental health issues based on observations of other people, whereas women also talked about their personal experiences. The themes and sub-themes are summarized in Table 3.

External symptoms: changes in physical appearance and behavior

According to the participants, mental problems, difficulties in life, and stress [Tashwish] changed people's physical appearance. They explained that pale skin, dark circles under the eyes, and a hollow gaze, among others, were visual clues referring to inner suffering:

> Mentally ill person looks very different like a pale [Rang paridah] ghost or crazy [Divanah] doing weird things. Their pale skin is like other people when their blood pressure is down [Fishar paein] and this alone is not a sufficient reason. But this combined with the nonsense doings can make me sure that the person is crazy. These doings can include anxiety [Asabi], talking to themselves, self-injury [Khod Zani] and so on. (Aman, 29-year-old married male refugee).

> The problem usually starts with lack of hope and a pale face for a long period of time. Shadows under the eyes appear like a person not slept for a long time. They talk nonsense [Hazian gooei] like seeing things that we can't. But only God knows their inside pains. (Ayub, 23-year-old single male asylum seeker).

The first data excerpt underlines the physical deviance of mentally ill people in terms of likening them to a "pale ghost" [rang paridah] or calling a mentally ill person "crazy" [Divanah]. Both expressions highlight the deviating nature of a mentally ill person; in addition, the expression "crazy" is highly pejorative in Afghan culture, which may refer to the stigma of mental illness in this cultural context (Tahir et al., 2022). The second excerpt associates a pale face and shadows under the eyes with pain and a lack of hope. Tahir et al. (2022) also found that Middle Eastern refugees used paleness to describe distress and associated it with a lack of hope. A pale face is the opposite of a healthy and vital physical appearance and, thus, describes how pain wears down a person and eats away vitality. Even though the participants named problematic inner conditions – hopelessness and stress – as the sources of physically deviant looks and behavior, they elaborated the physical appearance more than the causes and nature of the distress itself.

In addition to physical appearance, the participants explained visually perceptible symptoms and behaviors that deviate from expected "normal" behavior. These deviating forms of behavior included talking to oneself, talking about weird things [Hazian gooei], or staring at something/other people:

> There are many ways to know a person is crazy [Divanah]. One is that they are not aware of whatever they are doing, such as walking purposelessly, talking nonsense with themselves or others. (Mohsen, 34-year-old married male refugee)

> It is often obvious that a person is dealing with such problems usually from their weird behaviors. Even if not apparent, one can be seen in the yards for a long time, smoking or staring at somewhere purposelessly, I can say that its mental illness [Ruhi ya Ravani Narughi] (Abdellah, 57-year-old married male refugee)

The abnormality of these behaviors was underlined by characterizing these behaviors as something that is beyond reality, awareness or control, and can be regarded as nonsense or purposeless. Similarly, one female participant described her habit of talking to herself as something that was "out of my control." The abnormality of the habit was underlined by her son wondering

who she was talking to and her husband beating her when she unintentionally said negative things about him and his family:

> I didn't notice it then, but my son was curious to know whom I was talking with while I wash the dishes. It's totally out of my control. My husband beat me up once because he said that while I was mumbling, I swore at him and his family. (Marzieh, 60-year-old widowed female refugee)

In another case, the loss of control appeared as obsessive eating:

> There could be many signs of mental problems that some are noticed, and some are not known by the person. At some points, I could see that I couldn't stop eating. I ate everything available no matter what that was or if I was hungry. I couldn't resist eating and was thinking that it was only a salient time in my life. (Tahereh, 51-year-old married female asylum seeker)

Even though the presented data excerpts explicitly elaborate diverse deviating activities, they implicitly show that the participants associated mental disorders with something beyond rationality that makes people lose control and act irrationally. Irrational behavior was related not only to domestic life (like in the two previous examples) but also to the public sphere, where mentally ill persons were characterized in terms of violating social norms:

> I had seen many of them when I was in Kabul prior 2016 . . . It's like they don't care anymore what other people see of them or think about them. They get crazy like peeing everywhere or removing their clothes . . . Of course, people just ignore them as far as they are not posing danger to anyone. (Ragheb, 40-year-old married male asylum seeker)

Exposing oneself in the public sphere is severely disapproved of in Afghan society (Uthman, 2022), and therefore, associating mental disorder with such morally unacceptable public behavior may point to the stigma associated with mental illness in Afghan culture (Nine et al., 2022; Tahir et al., 2022). In addition to making people act irrationally, difficult experiences and stress were seen as causes engendering physical symptoms, such as rashes, wounds, and diarrhea:

> I talk about my experience when I was in Afghanistan, I knew I don't feel good, I didn't care until my body started to get itchy and suddenly it was full of spotted wounds. I never knew it relates to my heartly pain or the worries [Delshoura] that I had back then in Afghanistan (Banu, 36-year-old married female refugee)

> When stressed, I feel very bad stomachache and very severe diarrhea. Whenever I think about my relatives in Afghanistan, I feel a deep pain in my heart [Jegar Khon]. I have this issue and I know there is something wrong with me always. I just cannot control it nor I think there is something I can do about it until the situation in Afghanistan changes . . . (Hasibeh, 23 year old single female asylum seeker)

The different notions of physical and somatic changes and symptoms found in this study echo findings of prior research that have shown

how Afghan and other non-Western groups of refugees may explain mental disorders, distress, and trauma through somatic explanations, such as pain in different parts of the body (Alemi et al., 2014; Copolov & Knowles, 2023).

Distress was also explained through changes in social relationships. A tendency to avoid social contact and even total self-isolation appeared as ways to react to distress or traumatic experiences in the family. Prior research has found that psychological distress may present as social withdrawal among Afghan refugees (Miller et al., 2006; Tahir et al., 2022). In this study, social isolation was combined with a loss of interest in daily chores as well as speechlessness.

> Lack of interest in daily life occasions and tending to be alone or isolated [gooshagiri] were my main feelings. It wasn't so self-evident for myself for a long time but then my husband started nagging at me "why I got such behaviors". (Mariam, 44-year-old married female asylum seeker)

> We lost our kid, and since then my wife stopped talking for a long time and imprisoned herself in the bedroom . . . We had lots of bad conversations and quarrels of such that both still remember with regret. (Mahmoud, 35-year-old married male asylum seeker)

A starkly different change in social behavior was reported by these participants, who explained that either themselves or other people became aggressive and even acted violently toward family members or other people:

> There had been people that were so far in their illness that they became completely dangerous . . . some better be really avoided because they get easily angry and might attack other people. (Ahmad, 39-year-old single male refugee)

Eggerman and Panter-Brick (2010) found that Afghans residing in Afghanistan often react to life stressors through irritation and anger, and Alemi et al. (2016) found similar changes in temperament among Afghan refugees. Some participants observed gender-based differences in these behavioral changes. According to the participants, men tend to get more violent and women more silent, which is congruent with prior findings stating that Afghan refugee women experience domestic violence (Lavdas et al., 2023; Tahir et al., 2022).

> In children for example they tend to be pickier and behaving unnormal. In case of men, they become more violent and bad-tempered [bad kholgh]. Women can be seen working too much at home, speaking less, and crying most of the times (Somayeh, 28-year-old married female asylum seeker)

Finally, using drugs was related to mental disorders. Prior research has observed that Afghans residing in industrial countries may resort to alcohol abuse (Haasen et al., 2008) or drug abuse (Deilamizade et al., 2020). On the one hand, drug abuse was understood as a sign of mental disorder, but on the

other hand, it was understood as a way to cope with difficulties and forget them for a while.

> I got into drugs because of my issues. I think about it, and I remember so much that I went through. But people react differently. I can say that 90 percent of drug abusers in Afghanistan are those who cannot tolerate anymore the pain in reality. (Ghasem, 39-year -old married male refugee)

> You can understand for example they smoke a lot. They tend to use something that helps them forget their bad luck . . . Here can be Alcohol, because it's easier to get, in Afghanistan it was all types of drugs. (Ragheb, 40-year-old married male asylum seeker)

In our study, mental illness was explained through changes in physical appearance as well as visually perceptible behavior (Tahir et al., 2022). These symptoms and changes in behavior were something that deviated from the normal state of affairs and were largely outside of rational control. Hence, mental illness appeared as deviant, irrational, and something that cannot be understood as part of the normal course of life. This may increase the aspect of shame and stigma in Afghan refugees' perceptions of mental health (Alemi et al., 2016):

> It is very different in people, some take it in themselves and have a great capacity and feel maybe shameful to talk about it, especially men, but how far can a person take such pain? People are desperate, they don't know what to do, they tend to just sleep, overwork, or isolate themselves. (Hasibeh, 23-year-old single female asylum seeker)

Internal symptoms: burdensome feelings and sensations

While the aforementioned changes in physical appearance and behavior focused on externally perceivable features that deviate from the usual (healthy) looks and behavior, burdensome feelings and sensations deal with internal processes – thoughts and sensations – that the participants associated with mental disorders. One frequently mentioned matter was "overthinking" or "too much thinking" [Fekr o khial], which was understood as constant pondering of burdensome ideas and experiences. On the one hand, overthinking was treated as an inconclusive activity that could not provide solutions to the ideas preoccupying the mind. On the other hand, constant thinking was itself considered a burden and source of destructive behavior.

> People with mental issues think too much [Fekr o khial], and that thinking is inconclusive and idle. Does not lead to any solution or anywhere at all and just comes unintentionally and unwillingly any times. (Majideh, 45-year-old married female asylum seeker)

> Its either the reality that they run away from or too much thinking about the past or present events that leads to either drug, or suicide. Because how much a person can carry on with such a heavy heart? (Ragheb, 40-year-old married male asylum seeker)

Prior research has also noted how Afghan and Middle Eastern refugees associate too much thinking with stress and other mental disorders (Alemi et al., 2016; Feldmann et al., 2007; Miller et al., 2006). In their study conducted among Afghan refugees living in the Netherlands, Feldmann et al. (2007) found that worrying too much or thinking too much was frequently named as the cause of illness. In this study, participants regarded thinking too much as a possible cause for drug abuse and even suicide. In addition, thinking too much was perceived as excessive rumination and feelings of sorrow [*gham-geeni*] (Tahir et al., 2022).

The participants spoke about several kinds of feelings when asked to explain how they understood mental illness. One of those feelings was stress. Stress appeared to be an overwhelming feeling that can capture people and dominate their lives to the extent that people lose control of their lives:

> Stress [Tashwish] is a big part of the life of mentally ill people or it's at least one of the main reasons. They easily get stressed even severe stress for tiny matters . . . People can feel they lost control of their lives. And that shows itself in many ways (Tahereh, 51-year-old married female asylum seeker)

> Don't know how to explain but it is easy to be engaged with stress [Tashwish] and it comes easily to ruin your moment or day. Maybe because of overthinking [fekr o khial] or past memories, you always wait for a terrible thing to happen anytime (Ayub, 23-year-old single male asylum seeker)

Other feelings were anxiety, sorrow, and pain, which were often mentioned in relation to one another. In this context, pain did not refer to physical pain but rather to a deep sorrow. Participants also observed gender-based differences in feelings. Whereas men were associated with feelings of anger and anxiety, women were associated with feelings of sorrow, which made them withdraw from social contact.

> Men for example feel more [Asabi] violent and anxious, but women they hide their feelings and isolate themselves [Gooshagir]. As a woman I always feel like deep pain and sorrow [jigar khoon] going somewhere so that no one could find me. (Somayeh, 28-year-old married female asylum seeker)

In addition, female participants also thought that men may feel shame for being perceived as useless. This can be understood based on the change in life circumstances because in the patriarchal Afghan culture (Lipson & Omidian, 1992; Nguyễn-Nalpas, 2023), men are the breadwinners of the family. However, in the host country, they have lost this role as the head of the family:

> It is a fact that I felt more valuable when I was in Afghanistan with all its challenges. I directed my family then and having things more controlled according to our culture. In

> Finland it is different and for example you cannot force your children or wife to the right things. It brings uselessness. So, for men it is lack of confidence and feeling of shame or being useless if you ask. (Hashem, 54-year-old married male asylum seeker)

Another cluster of feelings reported by the participants included inactivity, indifference, and a lack of interest. On the one hand, the participants explained feeling numb and unable to do their normal daily chores (Miller et al., 2006), which they understood as a sign of something being wrong. On the other hand, they explained that they had lost interest in or the ability to do things that they had enjoyed before:

> Everybody thinks in their daily lives. But when you think too much [Fekr o khial] with no specific reason, you are trying to create an issue that does not exist. There you feel there is something wrong when you think too much and unable to do your normal things. (Mohammad, 60 year old widowed male refugee)

> It's not always obvious for the person, why something is happening. For example, why one does not want to talk with her husband or children anymore with no reason or becomes reticent [Kam harf] unlike before? Or one does not go out or do home works willingly. After a while you (. . .) you notice that things that were interesting to do before are boring and difficult to do now. (Hasibeh, 23-year-old single female asylum seeker)

For some participants, inactivity was combined with overthinking, which resulted in cognitive symptoms such as difficulty making decisions and a lack of concentration (Miller et al., 2006). Whereas some participants spoke about inactivity and a lack of initiative in general, others associated inactivity and indecisiveness with rumination of their past experiences, which seemed to pose challenges to their life management at present:

> In some people, lack of concentration and enthusiasm and ability to decide becomes problematic. They are unable to make decisions even about minor matters because they no longer care about life. (Insaf, 30-year-old married male asylum seeker)

> They usually worry a lot [tashweesh] about their current time and future or . . . overthink [Fekr o Khial] about the past events that leads them to indecisiveness. They do not see a clear vision ahead and that makes them indifferent about whatever goes on in their lives. (Majideh, 45-year-old married female asylum seeker)

Symptoms of insomnia have been reported extensively in prior studies among Afghan refugees and other groups of refugees (Miller et al., 2006; Ventevogel & Faiz, 2018). This topic was often mentioned by the participants of this study. It seemed difficulty in sleeping was considered normal until it turned into a more regular situation. One cause for sleeping difficulties was nightmares that made sleep intermittent (Alemi et al., 2014; Miller et al., 2006). This, in turn, resulted in tiredness during the day, causing concentration problems. When the participants pondered previous harrowing experiences during the daytime, it influenced their lives through nightmares:

> I know that others suffer from, for example, not being able to sleep or to sleep properly. People cannot sleep properly but, in the beginning, no one cares where it comes from . . . until it really affects your life or others in your life. (Tahereh, 51-year-old married female asylum seeker)

> I see very bad dreams often. Usually from Afghanistan. I panically wake up and cannot go to sleep. Imagine how do I feel during the day. I cannot concentrate. And tend to stay home but how often can I do that? It is with me always. (Majideh, 45-year-old married female asylum seeker)

Finally, participants talked about mental distress by describing physical sensations and sensations of pain. These included, for instance, pain in the heart, headaches, and dizziness. These ways of talking about mental illness have also been found in prior studies (Miller et al., 2006; Tahir et al., 2022).

> Sometimes I have a very bad headache. That is not because, for example, I haven't slept, or I caught a cold. It's like a part of my head is banged with a hammer and I see a blurred point in front of my eyes. In such times I only prefer to sleep in a dark room. (Banu, 36-year-old married female refugee)

> Feeling almost fainted and sleepy is when I have unreasonable worries [tashweesh]. When it's usually too late and I am for example out of home, and it takes time to get back home I faint and have to lie down on the ground somewhere to prevent it. Or sometimes it's just I am very sleepy even though have had enough rest. (Somayeh, 28-year-old married female asylum seeker)

In sum, the participants in this study talked about mental disorders by describing internal symptoms such as thinking too much, a lack of initiative, disinterest, lack of concentration, and physical sensations of pain that burdened their lives in many ways. Some of the participants explicated that these symptoms and sensations were caused by stress and difficult experiences in the past in Afghanistan. Hence, these internal symptoms may be understood as related to psychological distress, such "as mood and anxiety disorders including depressive and posttraumatic symptomatology" (Alemi et al., 2014, p. 1247).

Discussion

The aim of this study was to examine lay perceptions of mental health among Afghan forced migrants residing in Finland. We interviewed 25 Afghan forced migrants and analyzed the data using reflexive thematic analysis. Empirically, this study contributes to the understanding of the culture specific as well as individual ways that Afghan people perceive, explain, and talk about mental health, which may have practical relevance for the coordination of (mental) health services to Afghan refugees and asylum seekers in Finland. The findings of the study increase cultural understanding of Afghan forced migrants' lay perceptions of mental health and increase awareness of potentially different

explanatory models of mental health among health and social care professionals, on the one hand, and different groups of migrants, on the other hand. In addition, the results may be used in health care professionals' and social workers education and training to develop more culturally safe approaches in health and social care services in Finland. Even though this study was conducted among Afghan refugees, some aspects of our findings may be relevant for other groups of migrants as well.

The findings of this study show that when asked about mental health and mental health disorders, Afghan forced migrants talked about diverse external and internal symptoms. Notably, the participants refrained from using explicit terms such as mental health or mental illness and instead described their perceptions and experiences using various terms that emphasize the somatic and situational nature of distress. These findings align with prior research, which has consistently shown that Afghan people often conceptualize mental health within a situational framework rather than adopting a biomedical perspective (Alemi et al., 2017; Kleinman, 1980). Moreover, our research participants frequently employed expressions like "the individual from Social," "the doctor/nurse," or "the man/woman from hospital" when referring to social workers, psychologists, or psychiatrists.

In the study conducted by Yaser et al. (2016), it was noted that interviewees perceived professionals in the mental health field through a distinct cultural perspective. This finding highlights the significance of service providers clearly communicating their roles and responsibilities in service provision. Establishing effective communication and understanding between service providers and users requires fostering a culturally safe space. By establishing such an environment, service users can gain a better understanding of the services offered and manage their expectations accordingly.

Moreover, as outlined in section 31 of the Social Security Act, customers have the right to receive consultations before making decisions that affect them. This includes the right to be adequately informed about the various service options available to them. This legal mandate emphasizes the significance of providing clear and sufficient explanations to service users regarding the services offered, enabling them to make informed decisions about their care.

The way people perceive and understand mental health and its problems is anchored in broader cultural beliefs and norms, which shape their understandings of mental health (Alemi et al., 2017; Kleinman, 1980; Tahir et al., 2022). Several studies have called for understanding refugees' explanatory models and cultural perceptions of mental health because they shape the way refugees articulate their mental health issues (Alemi et al., 2014; Miller et al., 2006). The participants' descriptions of mental health as "something originating internally but manifesting outwardly" and "emanating from within the mind" and their use of related terms like "stress," "manifestations of

adversity," and "challenging encounters" underscore the cultural nuances surrounding mental health within the Afghan community.

Furthermore, the study revealed that Afghans often employ culturally specific concepts and indirect language to discuss mental health, particularly when referring to stress and trauma. This aligns with the broader literature on refugees from Afghanistan and other Middle Eastern countries, which suggests that individuals from these regions may use culturally specific terminology or speak indirectly about mental health issues, with Afghan men, in particular, finding it challenging to openly discuss their stress and traumas (Miller et al., 2008). In addition, our study shows that when asked about mental health, the participants named and explained physical symptoms – such as pale skin, rashes, wounds, and physical pain – which prior research has shown to be typical for Afghan and Middle Eastern refugees (see, e.g., Alemi et al., 2014; Tahir et al., 2022).

The aforementioned culture-based meaning systems and concepts related to mental health and illness as well as ways of explaining mental health disorders, for instance, through physical symptoms, may lead Afghan forced migrants to seek help from what might be considered the "wrong" sources, resulting in inappropriate assistance, inaccurate diagnoses, and potential delays in their access to mental health treatment (Lavdas et al., 2023; Tahir et al., 2022). As Alemi et al. (2014) noted, Afghan refugees tend to seek professional treatment for physical symptoms, even when these symptoms may originate from underlying distress. This poses a significant challenge for social and healthcare professionals, who must navigate the delicate balance of recognizing culturally typical expressions of mental health disorders while also acknowledging the individuality of each refugee.

The findings of this study shed light on the nuanced understanding of mental health and illness among Afghan refugees, highlighting the influence of cultural, and individual factors. However, it is essential to emphasize that the aim of this study is not to depict a singular typical Afghan refugee's conception of mental health. Instead, our primary objective is to stimulate dialogue and equip social and healthcare professionals with tools to identify culturally typical ways by which Afghan refugees discuss mental health disorders. This is of paramount importance because Afghan refugees may articulate mental distress as mere physical symptoms or unspecified emotional instability (Copolov & Knowles, 2023).

This study also revealed how mental illness is associated with behaviors that are perceived as irrational or socially disruptive, such as talking to oneself or public nudity. These observations underscore the stigma surrounding mental illness in Afghan culture, where deviating from social norms can result in judgment and avoidance. The pervasive shame and stigma associated with mental illness may serve as a significant barrier, preventing Afghan refugees

from openly discussing their mental health issues (Alemi et al., 2016) or hindering their access to appropriate care and support (Nine et al., 2022; Tahir et al., 2022). The stigma is so strong that mental health issues may only be noticed in their worst stages, implying that individuals may refrain from sharing their thoughts during earlier stages due to fear of social repercussions, making it difficult for them to seek help and support.

In addition, this study suggests gender-based differences in how individuals express mental health concerns. While men were more likely to exhibit external symptoms and engage in aggressive behaviors, women tended to internalize their distress, manifesting it as feelings of sorrow, withdrawal, and self-isolation. These gender-based variations may be reflective of traditional gender roles within Afghan society and can have implications for how mental health issues are addressed and supported within the community (Lavdas et al., 2023; Tahir et al., 2022).

Limitations

This study explored the lay perceptions of mental health among Afghan forced migrants residing in Finland. Reflexive thematic analysis allowed us to understand the overarching meaning patterns in the entire data. However, the findings cannot be generalized to represent the lay perceptions of Afghan forced migrants in Finland at large. In addition, even though the participants were asked how long they had been in Finland, the data did not allow us to examine whether the lay perceptions of mental health differed based on the time spent in Finland. In the future, it would be interesting to conduct a more detailed study focusing on this topic.

Conclusions and implications

While additional research is necessary, our study emphasizes the critical need for culturally safe mental health practices that address and care for the perceptions of mental health among Afghan forced migrants in Finland. The findings highlight cultural and individual factors shaping mental health conceptualization within this community, revealing stigma, cultural and gender-based expressions, and care access challenges. Culturally safe mental health interventions, prioritizing an understanding of somatic and situational expressions of distress, are essential for Afghan forced migrants. By recognizing the culturally shaped lay perceptions uncovered in this study, we illuminate the coordination challenges in social and healthcare services for vulnerable populations, particularly forced migrants, within the Finnish health care context.

To address these unique cultural and contextual factors, interventions should explicitly adopt culturally safe approaches, fostering a safe and non-judgmental environment. Recognizing the significance of somatic and

situational expressions of distress becomes crucial. It's important to note that our emphasis is not on generalizing these results to all Afghans, but on highlighting the importance of cultural safety in mental health practices. This approach creates safe spaces for each individual service user to elaborate on their mental health issues and receive appropriate care. Further research is needed to delve deeper into these themes and develop effective strategies to meet the mental health needs of Afghan forced migrants in Finland and other host countries.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The work was supported by the Olvi-Säästiö [20210610]; Oskar Öflunds Stiftelse; VERA Centre for Russian and Border Studies [931826]; Itä-Suomen Yliopisto; Kuopio University Foundation.

ORCID

Hadi Farahani MA http://orcid.org/0000-0003-4555-603X
Laleh Golamrej Eliasi MA http://orcid.org/0000-0002-6269-0751
Timo Toikko PhD http://orcid.org/0000-0001-9452-8022

Additional information

This research received support from the Olvi-Säästiö [20210610], the Oskar Öflunds Stiftelse, and the Kuopio University Foundation, which awarded working grants to [Hadi Farahani] The expenses associated with data collection were partially funded by the VERA Centre for Russian and Border Studies [931826] at the University of Eastern Finland, and the University of Eastern Finland covered the costs for open access publication.

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