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ILLNESS NARRATIVES

A Point in the Heart: Concepts of Emotional Distress Among Albanian-Speaking Immigrants in Switzerland

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Abstract Cultural variability regarding concepts of distress for common mental disorders (CMD) has been reported extensively in cultural clinical psychology across the globe. However, little is known about illness narratives in social communities from Southeast Europe. The purpose of this paper is to identify cultural concepts of distress (CCDs) among Albanian-speaking immigrants in Switzerland and to integrate the findings into literature from other parts of the world. Twenty semi-structured qualitative interviews were conducted using the Barts Explanatory Model Inventory (BEMI). A set of concepts was described through content analysis and semantic network analysis. The results show complex expressions of distress, which are mainly associated with post-migration living difficulties. Social problems and life-changing events mark the onset of the most common symptoms. Self-management and social support were described as the most important coping behaviors. Participants expressed trust in physical health care but little belief in psychotherapy. There is indication that mental illnesses are stigmatized in this population. It is therefore important to use non-stigmatizing terms in health communication. Moreover, individuals from this community consider suffering to be

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part of life, and they assume that this suffering must be endured with patience. It is vital to address these beliefs in psychological interventions.

Keywords Cultural concepts of distress · Global mental health · Cultural clinical psychology · Albanian immigrants · Switzerland

Introduction

In recent decades, cultural concepts of distress (CCDs) have been increasingly discussed in transcultural psychiatry and cultural clinical psychology (Kirmayer et al. 2014; Kohrt et al. 2014; Ryder et al. 2011). The increasing consensus that mental health is shaped by culture (Kirmayer and Ryder 2016; Ryder et al. 2011) has led to a growing body of evidence that explores CCDs and their role in research and interventions in the field of global mental health.

As a response to global migration and the cultural diversity of societies, it has become increasingly essential to consider perceptions of distress outside European and North American psychiatric nosology. The ways in which culture affects mental health are multifaceted. Mental health has proven to be strongly related to social categories such as social class, gender, or ethnicity (Fernando 2010; Harris et al. 2006; Smedley 2012; Wilkinson and Marmot 2003). These social determinants are cultural constructs (Bhabha 2004; Hall 1997), and evidence shows that the relationship between these social categories and mental health varies across cultures (Ferrari et al. 2013). Kirmayer and Ramstead (2017) suggested that culture is embodied and enacted. In line with empirical findings from different parts of the world (e.g., Guarnaccia et al. 2003; Hinton and Kirmayer 2013; Hinton et al. 2010), they described how the social and cultural context shapes embodied experiences of psychological distress.

Culture shapes the phenomenology of mental disorders as well as people's assumptions about their causes. Attempts to describe mental health phenomena in a culturally sensitive manner have brought forward a variety of terms such as "explanatory models" (Kleinman 2003), "idioms of distress" (Nichter 2010), and "culture-bound syndromes" (Simons and Hughes 1985). In a systematic review of the literature, Kohrt et al. (2014) used the term CCD as "an attempt to aggregate these different concepts without implying cultural exclusivity" (p. 336). The term CCD is also used in the DSM-5: "Cultural Concepts of Distress refers to ways that cultural groups experience, understand, and communicate suffering, behavioral problems, or troubling thoughts and emotions" (American Psychiatric Association 2013:758).

For future research concerning CCDs, Kohrt et al. (2014) recommended that researchers indicate whether a particular CCD described in a given context includes etiological assumptions or not. Western diagnostic categories for mental disorders are merely descriptive, and most of them do not consider causes of disorders as diagnostic criteria with the exception of diagnoses specifically related to traumatic or adverse events (Maercker et al. 2013). Some CCDs include etiological assumptions such as *susto* ("fright," Weller et al. 2002) or *malady moun* ("humanly

caused illness," American Psychiatric Association 2013), whereas others seem to be merely descriptive such as *kufungisisa* ("thinking too much," Abas and Broadhead 1997).

Hinton et al. (2016) and Kaiser et al. (2015) compiled evidence showing that "thinking too much" or "thinking a lot" is a very common CCD in many cultures. In different cultural contexts, "thinking a lot" describes a person's thinking about distress-inducing topics in an intense way, with the consequence of negative moods and mental and somatic symptoms (Hinton et al. 2016). Kaiser et al. (2015) showed that, depending on the cultural context, "thinking too much" appears to have aspects of etiology, symptom, and syndrome, but it is not reducible to one of those categories. The authors concluded that "thinking too much" should not be considered as a gloss for a specific mental disorder in a specific culture. As a non-stigmatizing idiom of distress in many contexts, it can be used to facilitate communication in health settings.

Culture also has a major influence on the social consequences, functional impairment, and stigmatization of mental health problems (Goffman 1963; Montesinos et al. 2012; Karamustafalıoğlu 2010; Koschorke et al. 2017; Rao et al. 2007; Thornicroft et al. 2007; Van Hook 1996). In many cultures, symptoms of distress are mainly expressed through somatic symptoms (Kirmayer 1996; Ryder et al. 2011). A systematic review showed that individuals in non-Western cultures tend to report bodily symptoms rather than affective ones (Ma-Kellams 2014). In contrast, Ryder et al. (2008) suggested that a Western "psychologization" is more culturally specific than a (Han) Chinese somatization. These researchers found that individuals in a Euro-Canadian sample reported more psychological symptoms than did Chinese individuals, and this difference between the two samples was larger than the difference in reports of somatic symptoms. Somatic conceptualization of distress has been argued to protect individuals from stigma or lowered self-esteem because somatic symptoms are often more socially accepted than physical ones (Kirmayer 1996). Accordingly, Ryder et al. (2008) hypothesized that stigma mediates the relationship between culture and presentation of symptoms (i.e., psychological vs. somatic symptoms of depression). However, this hypothesis was not supported because stigma was related to general symptom level in both (Euro-Canadian and Chinese) samples.

Hinton and Lewis-Fernández (2010) argued that idioms of distress influence the way social groups respond to a sufferer, i.e., notions of stigma and (consequently) self-stigma. Responses to symptoms of distress partly depend on culturally shared assumptions about the severity and possible consequences of such symptoms. For example, according to Karasz (2005), South Asian immigrants in the United States assume "that depressive symptoms lead to becoming pagal—'crazy'—or becoming physically ill" (p. 1631). In this context, persons with depressive symptoms might be reluctant to express such symptoms due to fear of social exclusion. Therefore, symptom expression is often closely interlinked with culturally specific assumptions concerning symptoms of distress and anticipated (potentially discriminatory) behaviors of family members or the community. The example of *pagal* clearly shows the importance of distinguishing between reports from (nonclinical) key

informants in a particular sociocultural setting and participants' self-labeling, i.e., reports about their own illness experience (Kohrt et al. 2014).

In this sense, CCDs are polysemic and idiosyncratic phenomena (Good 1977; Pedersen et al. 2010) that can implicate key conflicts at the interpersonal and societal level in a metaphorical way, and they reflect ideas about the functioning of the body and mind in a given cultural context (Hinton and Lewis-Fernández 2010). A closer look at language and metaphors—i.e., paying attention to the details and nuances in how suffering is expressed—is one way in which bodily, personal, and cultural mediation of illness experience can be grasped (Kirmayer 1992). For example, Rechsteiner and Meili (2018) and Meili et al. (2018) explored metaphors related to traumatic stress and post-traumatic growth in culturally diverse samples. They showed that metaphors reflect implicit worldviews and beliefs embedded in cultural contexts.

Finally, having outlined how culture shapes different aspects of mental health (i.e., symptom presentation, language and metaphors, etiological assumptions, as well as social consequences and stigma), it is also worthwhile to consider the many similarities we find across the globe. Ryder et al. (2008) showed that differences between Euro-Canadian and Chinese participants with regard to somatic versus psychological symptom presentations disappeared when questionnaires were used instead of clinical interviews. Moreover, notions of mental health-related stigma can be found in most parts of the world (Koschorke et al. 2017), and there is documentation that evidence-based psychological interventions such as problem solving and behavioral activation reduce symptoms and increase functioning in very diverse cultural contexts (Cuijpers et al. 2018; Heim et al. 2018). Although cultural adaptation of such interventions seems to increase their effectiveness (Benish et al. 2011; Hall et al. 2016), the evidence suggests that "common elements" of psychological interventions have a positive effect in many parts of the world (Singla et al. 2017).

To the large corpus of already existing literature on CCDs in the Southeast/Far East, Latin America, and Africa (e.g., de Jong and Reis 2010; Desjarlais 1991; Gross 2016; Kohrt and Hruschka 2010; Nichter 1981; Pedersen et al. 2010; Weaver 2017), we aim to contribute evidence for CCDs in Southeast Europe using the example of Albanian-speaking immigrants in Switzerland. Illness narratives from this particular community have rarely been studied within cultural clinical psychology so far. This study draws on previous *ethnopsychological* studies in the field of mental health. In general, ethnopsychology examines how individuals in different cultures conceptualize psychological concepts such as the self, emotions, and human nature (White 1993). Keys et al. (2012) used the term ethnopsychology to describe "culturally-guided concepts of mind–body phenomena" in Haiti (p. 556). In ethnopsychological studies related to mental health, people's narratives are analyzed with a clear view on their assumptions about causes of distress and possible ways to overcome it, physiological and spiritual meanings attributed to suffering, and the distinction between universal human suffering and mental illness (e.g., Keys et al. 2012; Kohrt and Hruschka 2010). This also implies analyzing how language and metaphors are used to express psychological distress in a culturally congruent manner, considering social structures, social consequences of suffering and mental illness, and characteristics of the mental health system (e.g., the doctor-patient relationship).

In this study, we aim to explore how Albanian-speaking immigrants in Switzerland perceive emotional distress and which concepts of distress emerge in their narratives. Aside from symptom expression, we focus on the question of whether their reports include specific etiological assumptions. Furthermore, we differentiate between participants' self-labeling and explanations given by key informants (Kohrt et al. 2014) from the community to get more information about key concepts of psychological distress. Finally, we also focus on metaphors related to distress and recovery as an additional source of information.

Cultural Background

By "Albanian-speaking immigrants" we mean persons with immigration experiences either in the first or second generation from Southeastern European countries of origin, i.e., Albania, Kosovo, Macedonia, Montenegro, or Serbia. According to Dahinden (2005), the migration of Albanian individuals to Switzerland can be divided into three main phases. First, at the end of the 1960s, the first major wave of Albanian-speaking immigrants came especially from the former Yugoslavia as seasonal workers. Second, at the end of the 1980s, the intensity and form of Albanian immigration changed as a result of political unrest in the former Yugoslavia. Family fathers brought their wives and children to Switzerland as part of family reunification. Third, due to the political conflict in Kosovo between the two ethnic groups of Serbs and Albanians in 1998–1999, hundreds of thousands of people from the Albanian-speaking ethnic group became refugees, and many of them sought temporary protection and safety in Switzerland. Over time, Albanian-speaking individuals from Kosovo became one of the largest populations of non-Central-European immigrants in Switzerland (Federal Statistical Office 2017).

A survey among the Swiss population showed that 3% (258,415 persons) listed the Albanian language as one of their main languages (Federal Statistical Office 2018). These people are from different countries of origin (i.e., Albania, Serbia, Kosovo, Macedonia, or Montenegro). The biggest group of Albanian-speaking immigrants in Switzerland is from Kosovo. Sharani et al. (2010) estimated that 150,000–170,000 persons with a Kosovar background live in Switzerland, and they are mostly concentrated in the German-speaking regions. The Federal Council of Switzerland classified Kosovo as a safe country in 2009. Since then, Kosovo-Albanians have no longer been classified as asylum seekers or refugees with the exception of people who are politically persecuted. Most Kosovo-Albanians have a permanent residence permit or Swiss citizenship. Today, Albanian-speaking immigrants are integrated into public life and the education system regardless of their country of origin. Health insurance is mandatory in Switzerland, providing all immigrants with health care. There is an increasing number of Albanian-speaking health practitioners in Switzerland. While the first generation of immigrants in Switzerland was not always able to pursue the professions that they had learned in their country of origin, the situation is different for the second generation. They have reached higher levels of education and work in various sectors including politics, finance, education, and health care (Sharani et al. 2010; Dahinden 2005).

In preparation for our study, a comprehensive literature review was conducted to compile evidence on CCDs among Albanian-speaking individuals across the globe. The search provided relatively little evidence. One reason for this might be that persons from Kosovo appear in many study samples as refugees or asylum seekers from the former Yugoslavia, mostly without an indication of ethnicity. Below we review studies that are particularly relevant to our research.

In recent years, studies reporting high prevalence rates for post-traumatic stress disorder or depression among the ethnic Albanian population in Kosovo have been published, especially due to war trauma (e.g., Eytan et al. 2015; Fanaj and Melonashi 2017; Kashdan et al. 2009; Shahini and Shala 2016). Several studies have also highlighted how factors of pre-migration (e.g. war, torture, being close to death) and post-migration living difficulties (e.g., separation from family, loss of social status, unemployment) affect the mental health of asylum seekers, refugees, and immigrants in "Western" (i.e., North American and European) countries in general (e.g., Bogic et al. 2015; Grant and Keltner 2011; Levitt et al. 2005; Li et al. 2016; Mähönen and Jasinskaja-Lahti 2013; Morgan et al. 2017; Morina et al. 2018; Silove et al. 1997).

Findings from these studies parallel the results of studies on Albanian-speaking immigrants in Switzerland. An epidemiological study showed that Kosovar Albanian immigrants suffer from high rates of common mental disorders (Morina et al. 2016). Several studies have emphasized that patients with Kosovan background in Switzerland and other countries showed tendencies to somatization (Maier and Straub 2011; Morina 2007; Junod Perron and Hudelson 2006). Moreover, they tend to deal with their symptoms by themselves or seek medical treatment, whereas psychological therapy does not seem to be an often-used strategy (Dow 2011; Dow and Woolley 2011; Kienzler 2012). Studies also have indicated that one's family is more important than one's own individual suffering (Dow 2011; Heigl et al. 2011), which might explain the reluctance to seek individual psychotherapy. Furthermore, Dow and Woolley (2011) and Kienzler (2012) showed that mental disorders were stigmatized among Albanian-speaking individuals, and therefore mental health-related problems were kept more within the family rather than discussed with a mental health professional. Moreover, Morina (2007) showed that Kosovo-Albanian immigrants in Switzerland considered their psychological distress to be "given by God" and therefore not remediable.

Methodology

Participants and Recruitment

Participants for the qualitative interviews were recruited through Albanian-speaking general practitioners of Kosovar descent in Zurich as well as through Albanian networks (i.e., events from different social groups and associations,[1] social media channels, and direct contact of key informants). To achieve a greater contrast of

[1] Society Switzerland—Albania, Albanian Student Association Studenti, Women's Choir Lyra, Association Parandalo, Kosovar Cultural Center Zurich, Kosovar Consulate of Zurich.

CCDs, we searched for persons who had already sought medical and/or psychological treatment as well as persons from the general population who expressed interest in study participation as key informants. The two groups received different information sheets. To fulfill the inclusion criteria, participants were required to (i) have an Albanian-speaking background, (ii) have Albanian or German language skills, (iii) be over the age of 18, and (iv) have consulted the general practitioner because of emotional distress or to express interest for participating in the study as a key informant.

Several people informed by their general practitioner were reluctant to participate in this study due to its focus on emotional distress and mental health. They stated that they had no mental illness despite the fact that the general practitioner considered them as being distressed.

Procedures and Measures

The study was approved by the ethics committee of the Canton of Zurich, Switzerland, in February 2017 (BASEC-Nr. 2016-02218). All interviews were conducted in Zurich in July and August 2017 by the first author in Albanian ($n = 14$) or German ($n = 6$). Interviews took place in different settings, i.e., in a treatment room at the general practitioner's office ($n = 10$), the University Department of Psychology ($n = 8$), and a primary school ($n = 2$). The informed consent form, which was sent to participants prior to the interview, was discussed verbally point-by-point before being signed by the participants and the interviewer. The participants were informed that they could stop the interview at any time without giving an explanation. During the interview, notes were taken on the printed interview guide to capture labels of distress, to record important keywords, and to formulate comprehension questions. After 20 interviews, information saturation (Glaser and Strauss 1998) was reached, meaning that the information provided by participants only confirmed what had already been said in previous interviews.

We used the semi-structured Barts Explanatory Model Inventory (BEMI), which was developed by Rüdell et al. (2009) for assessment of cultural variations in illness perceptions. The BEMI consists of 12 open questions that cover five dimensions: (i) identity/perceived "symptoms"/complaints/labels, (ii) cause/etiology, (iii) timeline/course, (iv) consequences, and (v) control/cure/treatment. The BEMI was selected because it is considerably shorter than other similar instruments, e.g., the Explanatory Model of Illness Catalog (EMIC, Weiss et al. 1992), the Short Explanatory Model Interview (SEMI, Lloyd et al. 1998), or the McGill Illness Narrative Interview (MINI, Groleau et al. 2006). Translation and back-translation of the BEMI questions from English to German and Albanian were done by EH, MS, and an accredited translator. The final translations with the closest semantic equivalence to the original text were examined by MS, NM, and EH. To ensure the clarity of the questions, a pilot test with four Albanian-speaking persons was conducted and found to be acceptable.

At the beginning of the interviews, participants were given the opportunity to talk about their current life situation in general. As soon as they named a label for a

CCD, the BEMI questions were started, and the concepts that emerged were gradually probed. All interviews were tape-recorded and transcribed verbatim with the software application "f4transkript" (Dresing et al. 2015); they lasted 17–115 min (mean = 47 min).

Data Analysis

Data were analyzed using qualitative content analysis (Mayring 2015). The iterative process of data analysis encompassed eight steps: (i) preliminary coding to identify labels of distress and other themes; (ii) deductive development of the category system along the main aspects of the BEMI; (iii) first coding round with main categories; (iv) compilation of all text passages for each main category; (v) inductive identification of subcategories and development of a coding guide; (vi) second coding round with differentiated categories; (vii) code summaries for each category; and (viii) semantic maps. The software application MAXQDA (Kuckartz 2010) was used for coding. All interviews were coded by MS and SM. Statistical inter-rater agreements, generated by MAXQDA, were discussed in several data sessions for consensual validation (Mruck and Mey 2000) between the two multilingual coders until reaching Cohen's Kappa values over 0.75. According to Kuckartz (2014), results from qualitative content analysis can be presented in concept maps to visualize how concepts are related to each other. For the linguistic analysis of proximities and differences among labels of distress and related themes, the development of a semantic map seemed appropriate. The elaboration of the semantic map leaned on the approach and illustrations of Good (1977) and Pedersen et al. (2010).

Several dictionaries were used to determine semantic fields, i.e., the phraseological dictionary of the Academy of Sciences of Albania (Thomai 2010), an Albanian etymological dictionary (Orel 1998), Langenscheidt Handwörterbuch Albanisch–Deutsch (Buchholz and Langenscheidt 2014), two monolingual dictionaries (Dhrimo and Memushaj 2015; Thomai 2006), and web-based open-source universal mono- and bilingual dictionaries (ensq.dict.cc, www.fjalori.shkenca.org, and www.ectaco.com/English-Albanian-Dictionary, accessed on April 24, 2019).

Interpretation of results was discussed within the research team. The methodological approach benefited from the fact that the first two authors were native Albanian speakers with cultural familiarity and background knowledge. As part of the argumentative validation (Mruck and Mey 2000), the first author discussed the findings and the semantic map with two Albanian-speaking mental health professionals from Pristina, Kosovo, and eight laypersons (including one study participant) from the Albanian-speaking community in Zurich, Switzerland. It was remarkable that the people who had not participated in the interviews offered narratives and descriptions similar to the concepts in the model. The feedback on the model contributed to making the illustration more comprehensible.

Results

Sample

Of the participants ($N = 20$), the majority ($n = 13$) were women. The age range of the sample was 24 to 60 ($M = 42$; $SD = 11.8$). The sample could be divided into two age groups, with $n = 12$ belonging to the older (40–60 years) and $n = 8$ to the younger group (24–35 years). Eighteen participants reported to be of Kosovar descent, and two were of Macedonian origin.[2]

All participants from the older group preferred to speak their own regional Albanian dialect, whereas the majority of the younger participants preferred German or Swiss-German ($n = 6$). The older group of participants gave the following reasons for immigration: labor migration from Kosovo/Macedonia in the 1980s or family reunification ($n = 4$), political persecution or war in Kosovo ($n = 4$), marriage ($n = 1$), and other ($n = 3$). Among the younger group, one person was born in Switzerland, four came from Kosovo as a consequence of family reunification, and three named other reasons for being in Switzerland.

The participants' employment status can be divided into four groups: paid employment ($n = 8$), education and paid employment ($n = 2$), retraining/work integration measures ($n = 2$), and other (i.e., unemployed, retired, or disabled, $n = 8$). Nine participants had a higher education level (high school diploma and university degree). In the following results, all quotations are shown with quotation marks or in block quotations. To emphasize metaphors and linguistic specifics, literal translations are displayed in brackets.

Overall Descriptions of General Condition and Distress

The interview started with the general question, "How are you at the moment?" (Albanian: *Si jeni për momentin?*). Participants described their general condition as very good ($n = 3$), good ($n = 8$), neither good nor bad ($n = 1$), or not good ($n = 2$). Some participants ($n = 6$) described their general condition in relation to pain and stress using expressions such as "sick man," "bad because of the pain, but psychologically I am very fine," or "I have my health problems, yes … but it's okay." In general, all participants, regardless of their being recruited through general practitioners or ads for key informants, expressed emotional or psychological problems related to pre- or post-migration factors or their current living situation. Therefore, we decided to report results for the whole sample without distinguishing between "patients" (recruited at two general practitioners' offices) and "key informants" (recruited in the general population).

Distress was generally expressed as a lack of *gëzim* (joy) and *lumturi* (happiness). The interviews revealed five key labels for expressing psychological distress: *vuajtje* (suffering, misery), *brengë* (concern, care), *mërzi* (sorrow, grief, sadness),

[2] The sample presented here contains no persons from the Republic of Albania. There were Albanians from the Republic of Albania among the general practitioners and associations that we contacted, but they did not volunteer to participate.

nervozë (tension, anger, fury), and *frikë* (fear, anxiety). Although these labels appear to have similar linguistic meanings, participants associated them with different experiences with regard to cause and severity (see below). The different CCDs were perceived as *zinxhirore* (chainlike) or *pandashëm* (inseparable). These expressions illustrate that the key labels were perceived as being interconnected, one leading to another. They were also linked to physical complaints like *dhimbje* (pain) or *lodhje* (fatigue). The following quotes illustrate these findings:

> *Frikë* causes *brengë* and *brengë* causes *frikë* (…) I think the *frikë* that I cannot do everything, and that life is not as you think, and that *frikë* becomes a *brengë* and so they are *pandashëm* [inseparable]. (Albanian interview, woman, 49 years)
>
> I don't go out because of the pain. If I do not go out, I feel *mërzi*. These are *zinxhirore* [chainlike] connections. (…) When I become *nervoz* [adj. of *nervozë*], I also feel a kind of *lodhje* [fatigue]. And the pain (*dhimbje*) begins. (…) Because this pain is a chainlike type. When I have pain, *nervozizëm*[3] evolves. When I am *nervoz*, the pain evolves. (Albanian interview, woman, 56 years)

Responses of the older and younger groups of participants differed in the labels used to express psychological distress. Younger participants did not relate their distress to the Albanian language concepts expressed by the older group. Even if they partially seemed to be familiar with these concepts, they used Western concepts of distress more frequently such as *stres* (Albanian for stress), *Hoffnungslosigkeit* (German for hopelessness), or *Angst* (German for anxiety). In addition, they used terms of everyday language to describe their stress such as *überfordert sein* (German for feeling overwhelmed) or *verloren sein* (German for feeling lost).

The analysis of Albanian-language interviews revealed close similarity between symptoms and assumed causes, which made it difficult to clearly assign a particular code for a category of emotional distress. First, the participants described their distress not by naming a psychological symptom but by reporting social problems ($n = 10$), financial worries ($n = 6$), or physical pain ($n = 5$). It was difficult to obtain precise answers about any labels or definitions of psychological symptoms. Responses such as the following, from a 40-year-old woman, were typical:

> Q: Can you describe this? What happens when you are stressed?
> A: I have two children there (Kosovo). I worked there for them. Their father is in Italy. He doesn't care about them.
> Q: And with you, what does stress do to you? Can you describe it?
> A: My stress… I see that sleep is gone again. Sleep is gone again. (Albanian interview, woman, 40 years)

[3] Throughout the article, we use the term *nervozë* because this was the term most frequently mentioned by the participants. The terms *nervozizëm*, *nervozim*, and *nevrikosje* used in the dictionaries we examined seem to have the same meaning and are used synonymously with *nervozë*.

Specific Labels of Cultural Concepts of Distress

The most frequently used labels for psychological distress were *vuajtje*, *brengë*, *mërzi*, *nervozë,* and *frikë*. These terms were therefore examined more in detail and discussed in key informant interviews. Table 1 illustrates several characteristics and attributes related to these labels. The following section shows an extract of definitions as reported by the participants, accompanied by additional explanations from the dictionaries.

Vuajtje

Etymologically, the term *vuajtje* is "borrowed from Lat. vivere 'to live' or 'to survive' with a semantic development suggesting an intermediate state of 'surviving' or 'living through'" (Orel 1998:516). Our data reflect this assumption with expressions such as "vuajtje is a sign that you are alive." Most of the narratives about *vuajtje* refer to adverse experiences such as pre-migration stressors and post-migration living difficulties, either current or past. Additionally, *vuajtje* implied the *mungesë* (absence), a condition of homesickness and longing because of the absence of family members. *Vuajtje* appeared as an experience of soul/spiritual pain. Metaphors such as burden, emptiness, and heaviness or a turbulent path were used to describe *vuajtje*:

> It is not going out of my head. It also burdens the soul. It feels like a hole… it has become like emptiness in my chest. It is dragging me down [drags my heart down] and my work and everything. I feel it like heaviness, heaviness of soul. (Albanian interview, woman, 48 years)

Vuajtje was used as an overarching term of distress that includes the following labels.

Brengë

This label was described either as a symptom of distress (constant worry and fear on different scales) or a cause of other somatic or mental complaints. A closer description of *brengë* relates to other labels such as *nervozë* (tension, anger, fury), *nerva* (nerves), *frikë* (fear), *stres* (stress), *mërzi* (worry), *dhimbje* (pain), *shqetësim* (restlessness, agitation), *ndezje e brendshëm* (internal inflammation), and *lodhje* (fatigue). *Brengë* notes the beginning of rumination triggered by different causes. It has two connotations, either transient or of long duration. Transient *brengë* can occur due to a temporary and solvable problem (e.g., passing a final exam). The unfulfilled desire to return to one's homeland or failure in achieving one's career goals in Switzerland is expressed metaphorically as a *pikë në zemër* (point in the heart), which one must endure for a long time and occurs as intrusive thoughts and worries. Moreover, unfulfilled desires and failure leave the feeling of being neglected and not taken seriously, which causes *brengë* and *mërzi*. Those complaints were accompanied by narratives about the economic and social status in Switzerland as well as the country of origin.

Table 1 Characteristics and attributes of Albanian labels of CCD

Albanian labels of CCD	Features	English translation
Vuajtje	*mungesë*	Absence
	mall	Longing, nostalgia
	rrugë e trazuar	A tumultuous road
	*vermissen**	Miss
	*Kummer**	Sorrow
	*Leiden**	Suffer
	dhimbje shpirtore	Soul/spiritual pain
Brengë	*nervozë*	Tension
	nerva	Nerves
	frikë	Fear
	stres	Stress
	mërzi	Sadness
	dhimbje	Pain
	shqetësim	Restlessness, agitation
	ndezje i brendshëm	Internal inflammation
Mërzi	*mungesë*	Absence (of something)
	merak	Worry
	gájle	Worries, care
	mendime të këqija	Bad thoughts
	vajtim	Mourning, lamentation
	hidhërim	Soreness, unhappiness, dejection
	*traurig**	Sad
	trishtim	Sadness, melancholy, misery
	*Heimweh**	Homesickness
	*Zerrissenheit**	Fragmentation, disunity
	mërzi e familjes	Sadness of/for the family
	*gelangweilt**	Bored
	*niedergeschlagen**	Depressed, downcast
	*besorgt**	Worried, anxious
	*vermissen**	Miss
	pikëllim	Affliction, grief, sorrow
Nervozë	*inat*	Anger, ire, rage,
	shkatërrim i vetvetes	Self-destruction
	agresion	Agression
	nervozizëm	Irritability, edginess, nervousness, restlessness, nervosity
	hidherim	Disappointment, sorrow, sadness
Frikë	*nervozë*	Tension
	panikë	Panic
	trishtim	Sudden fear
	siklet	Anxiety, embarrassment, torment, discomfort, lather

*Pronounced in German

Mërzi

The complex label *mërzi* was used for different states depending on the cause: i) transient sadness, ii) negative thoughts (*mendime të këqija*), iii) worry (*merak*), iv) persistent grief after the death of loved ones, v) homesickness (*malli*), vi) suffering from family problems, or vii) boredom (*"e kam mërzi"*—"I don't like this"). *Mërzi* can also be the result of bearing *brengë* for someone or something for a long time (having concerns about someone or something). Persistent, severe *mërzi* can lead to mental illness such as depression. The Western concept of depression is understood as a disease, but this is not true of *mërzi*, as this quote underlines:

A: My mother told me that if I stayed *mërzitshme* [adj. of *mërzi*] one day I would get sick. You will go mad, she told me.
Q: Does this mean that *mërzi* is not a disease for you or your mother?
A: I grew up with *mërzi*. I don't know how to live any other way.
Q: So, it is not a disease?
A: Maybe this is a disease for somebody, I don't know. For me *mërzi* is a part of my life. I don't classify it as a disease because I grew up with it and grow old with it, it's always with me. (Albanian interview, woman, 50 years)

The following examples of paraphrasing *mërzi* show how close it comes to the concept of depression: *pikëllim* (affliction, grief, sorrow), *hidhërim* (bitterness), and *trishtim* (sadness, melancholy, misery). *Mërzi* appears as "phases or stations" and leads to an apathetic state, overall pain sensations, and crying. It can be a trigger for panic attacks, flashbacks, and severe rumination, especially in times of inactivity.

Frikë

Fear or anxiety were described as *frikë* and mostly linked to a specific situation (e.g., fear of traffic accidents, fear of flying, fear of intimate partner violence). In the narratives, it was related to age ("As you get older, you become more anxious") and assumed to be a personal trait ("I am a coward by nature, I'm very anxious"). It also appears as social anxiety ("I am afraid of people who look serious"). Descriptions of *frikë* included somatic symptoms such as bodily experience, breathing problems, tightness in the chest, shaking, motionlessness, or loss of energy and strength. Metaphors such as "like carrying a sack on the shoulders" or "black cloud" were used for *frikë*. In particular, persons who reported pre-migration stressors reported states of *frikë*. Police sirens or other loud noises can trigger flashbacks with memories of traumatic experiences that are accompanied by *frikë*, which is described as a sudden loss of control, aggressiveness, and nervousness. Therefore, *frikë* often originates in a traumatic event and persists for a long time after that ("We grew up with trauma, every day in *frikë*, but I knew no other life").

Nervozë

The label *nervozë* was used to describe a "restless soul/spirit," either as a personal trait ("My daughter was born with *nervozë*") or a state experienced in reaction to a

critical situation or daily hassles, such as ongoing disputes with family members. *Nervozë* expresses itself through arguing, screaming, getting loud, or becoming intolerant and difficult. Physical sensations (e.g., dizziness, body heat, head trembles) were often reported. A semantic proximity to the term *nerv* (nerve) became evident: "The nerve gives off too much electricity," "You need strong nerves to overcome *nervozë.*" A "loss of control" describes persons with *gjak të nxehtë* (hot blood) with which they bring the *nervozë* to the outside. Transient *nervozë* was described as distress "at the moment." Furthermore, *nervozë* can be continuous if problems remain unsolved. Continuous *nervozë* is perceived as a change in someone's personality that is noticed by others. Moreover, *nervozë* can intensify chronic pain or be the cause of physical complaints such as headaches or stomach pain.

Western Concepts of Mental Disorders

Participants in the older group did not use categories of mental disorders for describing their symptoms even when it became clear in their narratives that they had been in psychotherapy. When it came to Western categories of mental disorders, interviewees tended to change from the Albanian to the German language within the same sentence, as shown in the following example.

A: There is the effect that you become *psychisch* [German mental]… *mërzitu, mërzitu, mërzitu* [Albanian sorrow, sorrow, sorrow], become *psychisch.*
Q: And what does that mean, *psychisch*?
A: *Psychisch*, when you're *krank* [German sick], *psychisch.* (Albanian interview, woman, 55 years)

Descriptions of depression (mentioned by three participants) and burnout (mentioned by one participant) were very general and focused on physical characteristics, with symptoms like disturbance of vital feelings. Participants also used the term stress (or Albanian *stres*) for any kind of mental distress. However, the Albanian term *stres* (stress) was often used in its plural form *strese* (stresses). We therefore assume that participants referred to stressors rather than to an emotional state when using this term. Participants associated *stres* with a variety of responsibilities and current living problems in Switzerland:

Q: What is *stres* for you?
A: *Stres* is *Sorge* [German worry]
Q: *Sorge*? Like *Brengë* [Albanian worry]?
A: Yes, the work does not exhaust you, but the *brengë* exhausts you. (Albanian interview, woman, 49 years)

Stres was often used and described as the cause of *brengë*, *frikë,* or *nervozë*, but there was no evidence of a specific definition or proper translation of *stres*. Therefore, we desisted from analyzing *stres* as a separate Albanian label. As the following dialogue shows, the Albanian term *stres* was also used interchangeably with *frikë* to describe a state of severe anxiety.

A: I was in hospital for two weeks because of stress [Albanian *prej stresit*]. The police have once taken me to [place of the hospital], where they said that my medical findings were good, but it was because of the stress. They told me to go and I went there willingly. Because if you go in Kosovo, they think you are… it is slightly different. But here I went willingly.
Q: And what was the treatment for?
A: The treatment was because of the stress, because of the violence I got from my husband, he kicked me out of the apartment, beat me, called me on the phone. These were the stresses and I went to the hospital.
Q: What treatment was that in [place of the hospital]?
A: The treatment because of the *frikë* [fear/anxiety].
Q: Was this a psychologist or a psychiatrist?
A: That was a psychologist. (Albanian interview, woman, 40 years)

This example might indicate stigma related to mental disorders, e.g., in the avoidance of mentioning psychiatric inpatient treatment or in not completing a sentence ("in Kosovo, they think you are…"). The following quote also reflects the opinion that severe mental distress is a state of craziness, related to fear and social distance:

I don't think I'm *budallë* [crazy]. I don't see myself as a *budallë* [crazy person]. And I don't think so. I used to be afraid of that, too. When I had so much, much… panic in my body, I was afraid, I said: Hey, am I going crazy or what's going to happen to me? What is this all about? I did not know that, like this disease that I have today, that psoriasis, arthritis, that *frikë* [fear] too is a kind of illness that someone has experienced. (Albanian interview, woman, 50 years)

The younger participants ($n = 5$) were more open to speak about their diagnoses or the mental health problems of family members in terms of Western concepts in German language (e.g., death wish, depression, bipolar disorder, borderline). However, we did not analyze the narratives of the younger group around Western diagnoses any further, because we wanted to focus our analysis on Albanian-language concepts.

Assumed Causes, Etiology, and Context

For better understanding of possible causes and the context of psychological distress, we analyzed reports about the three stages of migration (pre-migration, immigration, and post-migration) and came to the following conclusions. Narratives about pre-migration stressors (e.g., political and social exclusion, persecution, detention, torture, or war) generally emerged later in the interviews and only among four informants. In addition, two young women reported about the imprisonment of their fathers in the 1980s. Both fathers had rebelled against the Serbian regime before fleeing to Switzerland. Circumstances and events regarding immigration were mentioned only marginally (e.g., escape to Macedonia) to explain reasons for immigration and to contextualize experiences in the early days in Switzerland. The

vast majority of participants ($n = 16$) considered their current problems as the primary causes of their distress such as financial worries due to unemployment or unsatisfying employment conditions ($n = 12$); diverging cultural values or beliefs within the family ($n = 9$); chronic pain due to hard physical work, surgeries, or accidents ($n = 7$); livelihood instability after divorce ($n = 2$); recurring thoughts about a cured tumor or cancer ($n = 2$); and worries of being sent back to Kosovo as a result of losing residency status ($n = 1$).

In general, participants assumed distress to be caused by (i) traumatic or adverse events named as *fatkeqësi* (misfortune, adversity) or *tragjedi* (tragedy), (ii) a social or financial crisis, or (iii) unfulfilled desires. Despite the narratives about potentially traumatic events, the analytic category of "trauma" appeared as a marginal phenomenon, expressed either explicitly with the term *traumë* (trauma) or metaphorically through *plagë* (wound) and *lëndim shpirti* (hurt/pain/wounding of the soul/spirit).

Timeline/Course of the Symptoms

Social problems and life-changing events (e.g., migration, loss of employment, accident, surgery) marked the onset of symptoms in the view of most participants, while the course of symptoms lasted from 1 to 20 years. Thirteen persons reported cyclical periods of their distress, especially those with *mërzi, nervozë,* and *frikë*. Seven participants assumed that their distress would last for a very long time or even their whole life, especially when referring to *vuajtje* and *brengë*. Another seven stated that they did not know what the course of their symptoms would be, and five assumed that their distress would disappear once a specific problem would be solved. One woman reported that her distress usually lasted no more than a month but that it was recurrent.

Degree of Impairment and Consequences

In response to this closed question from the BEMI, 14 participants stated that their distress had a big impact on their life, four considered the impact to be small, and two regarded the impact as being moderate. Very few positive aspects of distress were mentioned, e.g., being more empathetic, being motivated, being dedicated, or developing the will to overcome a situation. In contrast, the list of reported negative consequences of distress was much longer, as displayed in Table 2.

Control, Cure, and Treatment Expectations

The most challenging questions seemed to be the ones about coping strategies and treatment expectations. Responses to these questions varied greatly across participants depending on age, gender, principles and beliefs, prior experience of psychotherapy, and the degree of impairment.

Table 2 Notions of consequences of distress

Themes	Concepts
Emotional/psychological/ cognitive consequences, personality change	No willingness, no desire, self-hatred, despair, demotivation, helplessness, sadness, anger, fear, feeling desperate, rumination, bad dreams, withdrawal, loss of hope, loss of feelings, less happy, more aggressive, feeling insecure, difficulties in concentrating, not being able to read something, become intolerant, becoming a pessimist, blaming oneself
Behavioral consequences	Lose control, berate oneself, scream, argue, listlessness, not being active, resignation, distancing oneself, painkiller abuse, tobacco abuse, noise sensitive, crying
Somatic consequences	Weakness, loss of energy, fatigue, the whole body hurts, body trembles, sweating, weight gain, nausea, weight loss, insomnia, vitamin deficiency, tension, headache, stomach pain, back pain, heart pain, heart pressure, neck and shoulder pain, leg cramps, uterine ulcer, chronic pain, tightness in the chest
Social consequences	Not being able to communicate, isolation, avoiding social contact, loss of authority, loss of status, change of the role in the family, change of sexual relation with partner
Financial/economic consequences	Can't pay for gym classes for my kids, can't afford to go out for a drink with friends, cannot support my family financially, cannot support my community, cannot go on vacation

Self-Management—I Carry it in My Heart (Albanian E mbaj në zemër*)*

Participants reported about self-management mainly in the sense of self-regulation and coping with expressions such as "I take good care of myself" (Albanian *e marr vetën me të mire*). One participant stated, "I invest heavily in overcoming *vuajtje*. I try not to swallow it [Albanian *të përbije*], as we say, to put it into my heart [Albanian *e marr në zemër*], but to deal with the problem." Most participants kept their distress to themselves and wanted to be alone ($n = 13$). This was expressed in strategies such as withdrawal through intentional silence or distraction through work and other activities (e.g., walking, reading, writing poems, or listening to music). To have *durim* (withstand, endurance, patience) was mentioned in cases of low expectations for change ($n = 10$). One participant expressed the corresponding belief by saying, "You cannot change certain things. You have to go along with it." Four participants considered their distress to be "given by god" (*ajo është dhënë nga zoti*) or "fate" (*fati*). These participants did not consider treatment as being necessary or even appropriate. They expressed the view that nothing but *durim* was needed to overcome distress. Only three persons expressed a religious affiliation to Islam, but they also emphasized that they did not actively practice their faith.

Social Support—You are the Cure of My Heart (Albanian Ti je ilaçi i zemrës sime*)*

Many participants expressed that the family and trustworthy friends were the first instances for seeking help in case of any form of distress ($n = 14$). Social support was defined along with specific role expectations in the social system. Only

experienced persons are asked for advice, e.g., "Taking advice from an experienced person in the family is something like psychotherapy." Participants also expressed that just "spending time" with persons who experienced the same adversities will create a space for "shared suffering," e.g., "Even if it was tragic for us, even if we had a lot of *vuajtje*… But I was with my family, with my people. We also shared the *mërzi* in two." Participants further expressed that problems can be solved together if a person shares a similar perspective, and sometimes the mere presence of the family members has a healing effect.

Social support can also be overstretched and lead to symptoms. The younger generation often takes over parental functions in the care of parents and siblings ($n = 4$), especially when immigrant parents are restricted in childrearing (e.g., due to a lack of language skills to help with schoolwork, or due to their own distress or illness). Siblings often have to support each other to a greater extent. If that structure fails due to the sickness of a sibling ($n = 3$), this can lead to more distress.

The results also showed some barriers that make social support more limited and difficult: (i) the instability within the family itself can cause interpersonal problems and distress; (ii) the distance to family members who live abroad limits the possibilities for sharing the suffering; (iii) most participants did not want to be a burden on the family; and (iv) many stated that it was not always necessary to talk about worrying thoughts to someone ($n = 11$), especially when these worries are related to the past that is not changeable (e.g., war experiences; $n = 4$). The intention to talk to someone emerged more often in the context of specific current problems that could potentially be solved with someone's help.

Psychological Treatment

Ten informants reported that they had accessed psychological treatment either in the past or in the present. Only three out of these ten participants emphasized the positive effect of psychotherapy. Especially older persons with severe traumatization due to pre-migration stressors reported that they had received psychological treatment in Switzerland for several years ($n = 3$) including hospitalization ($n = 3$).

Five others described the limited success of psychotherapy because support by the psychologist "by talking" was mostly experienced as helpful only "at the moment." Other reasons for skepticism towards psychotherapy were that it cannot solve family problems ($n = 6$) and the different cultural background of the psychologist ($n = 2$). In contrast to the older participant group, four of the younger group members mentioned the positive effect of psychotherapy in coping with their own family problems. Also, efforts to convince parents about psychotherapy were expressed.

Social and Legal System

Nine respondents had significant expectations about the social and legal system in Switzerland contributing to the treatment of their physical and mental health problems (e.g., social welfare benefits, residence permit, access to paid work). In particular, paid work was seen as a good way of distracting oneself from worries and

stress (e.g., "If I had a job, I would not have to constantly worry about the family problems," "The stress is because of the ex-husband. But the work was a way to get rid of the stress.").

Medical Treatment

Participants (n = 10) who were interviewed in the rooms of the general practitioners focused on their many treatments (e.g., physiotherapy, medication, vitamins) and expressed confidence in medical care in Switzerland. However, the participants complained about the clinician's limited time. Medication (e.g., analgesics, antidepressants, sedatives) was not considered to be a satisfactory permanent solution.

Discussion

This study examined CCDs among Albanian-speaking immigrants in Switzerland. In line with previous ethnopsychological studies (Keys et al. 2012; Kohrt and Hruschka 2010), the purpose of this study was not merely to find Albanian labels for psychological distress and possible correspondence or overlap with Western diagnostic categories. We rather aimed to go beyond such labeling to explore participants' assumptions about the causes of their suffering, their implicit concepts of how body and mind interact, how language is used to express psychological distress in a culturally congruent and socially acceptable manner, and what expectations people hold about the course (and relief) of their suffering. To our knowledge, this is the first study of its kind focusing on Southeastern European individuals. Our results highlight remarkable similarities with results from ethnopsychological studies in other parts of the world (e.g., Keys et al. 2012; Kohrt and Hruschka 2010), which are described below.

Figure 1 shows a generalized semantic map displaying the process of perceived causes; the key mental health-related labels *vuajtje*, *brengë*, *mërzi*, *nervozë,* and *frikë* with examples of interlinked metaphors and symptoms; and behavioral responses in terms of coping strategies, help-seeking, and treatment options. The linguistic interpretation of the data and the semantic map were developed based on 14 Albanian-speaking interviews. Six interviews were conducted with younger participants, who preferred to speak in the German language. As their responses clearly differed from the responses given by the older group in the Albanian language, we decided not to include their responses in the semantic map. The semantic map is described more in detail in the following sections.

Interlinked Causes and Symptoms

Our results revealed that consequences of pre-migration stressors (e.g., loss of home, traumatic events) were seen as a burden that cannot be changed and can affect a person for their entire life. For current psychological distress, post-migration stressors (e.g., social and economic problems, worries about the future)

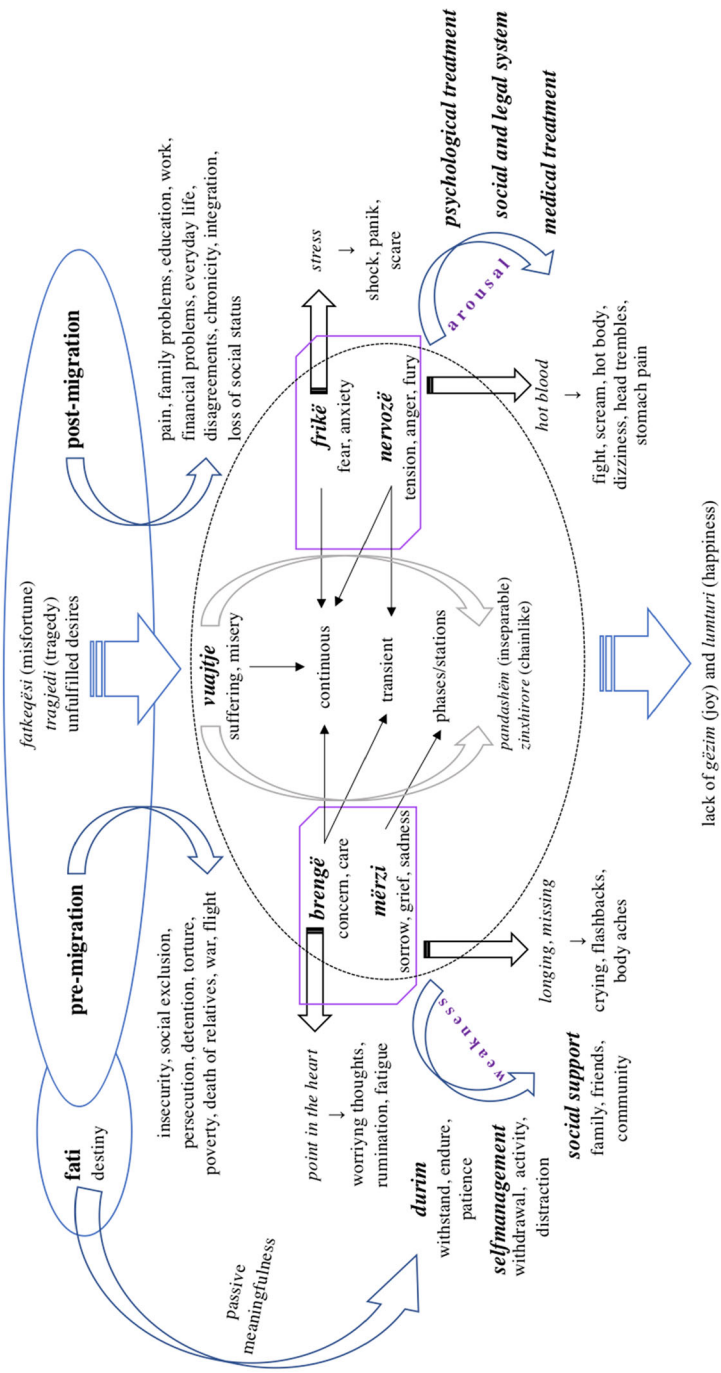

Fig. 1 Generalized semantic map showing the process of assumed causes, labels of CCD related to common symptoms and timeline, and help-seeking and treatment expectations (Albanian-speaking participants, 31–60 years, n = 14)

were reported to be more relevant than pre-migration stressors. Both pre- and post-migration stressors were closely linked to symptoms in the narratives, and it was challenging to isolate them as separate analytic categories. Similar results were described by Karasz (2005), who illustrated that South Asian immigrant women in the United States labeled the problem by the situation that had caused the symptom.

Our results also showed that respondents perceived the labels of psychological distress as *zinxhirore* (chainlike) or *pandashëm* (inseparable) and not as separate categories. For example, *brengë* serves as a cause for further symptoms and conditions, i.e., permanent worries and rumination can evoke *frikë* and *nervozë* and lead to somatic symptoms. *Vuajtje*, *brengë,* and *mërzi* describe different conditions of weakening distress, while *nervozë* and *frikë* represent both trait and state labels for aroused distress. Participants also described that symptoms of psychological distress were closely intertwined with physical symptoms such as pain or fatigue. This can be interpreted as a close connection between body and mind, which would require further exploration.

Participants in this study perceived unfulfilled desires in their current life to be as burdensome as traumatic events in the past, or even more so. This result parallels findings from Nepal (Kohrt and Hruschka 2010), where failure or lack of success in specific areas of life were considered among the worst events that can occur in life. As an example, migrant workers who had not achieved the expected wealth in the Gulf States considered this to be a traumatic experience. This is echoed in the testimonies of our study participants, who considered the lack of success, employment, or wealth in Switzerland as among the primary causes of their suffering.

Labels and Metaphors of Distress

Compared to other key labels of distress, it is remarkable that *vuajtje* does not only contain negative descriptions with explicit symptoms. It is also described as a "sign of life." However, *vuajtje* is often connected with certain narratives that point to causes of general suffering, such as pre-migration stressors and post-migration living difficulties. The metaphor *rrugë e trazuar* (tumultuous road) indicates this continuous suffering as a difficult lifelong process. Thus, *vuajtje* is an appropriate term to describe the immigrants' history and situation. Pedersen et al. (2010) found among Highland Quechua in the Peruvian Andes that *ñakary* (suffering) is defined as a collective affliction, whereas *llaki* (sorrow, sadness) is described as an individual affliction, which cannot be experienced by the collective. There is too little evidence in our study to clearly state that *vuajtje* is a collective suffering and *mërzi* describes an individual suffering, as *mërzi* also included descriptions of the history of migration and the longing for the homeland. However, more in-depth interviews could possibly reveal a similar distinction between collective and individual suffering.

Brengë and *mërzi* express a form of family care and constant worries about the family or the economic situation, but at the same time, they are expressions for thinking about adverse experiences in the past. Therefore, we view these labels as the Albanian equivalents of "thinking a lot" in different cultures (Hinton et al. 2016; Kaiser et al. 2015). The embodied metaphor *pikë në zemër* (point in the heart)

for *brengë* is a result of a traumatic or distressing situation that cannot be forgotten and activates a permanent rumination, as it could be understood in the context of yearning. We contextualize this metaphor as one of the rarely used trauma-related terms. In view of the traumatic and adverse events that some interviewees have experienced, it is remarkable that such trauma-related terms were only marginally mentioned. As in previous studies among Albanian-speaking people (e.g., Littlewood 2002), we found expressions such as *plagë* (wound) and *lëndim shpirti* (hurt/pain/wounding of the soul/spirit), which are close to the origin of the term trauma (i.e., Greek term for "wound"). The metaphor *point in the heart* furthermore indicates the notion of embodied distress and a "scarred" soul after negative life experiences, which remain in the heart and the mind in the form of thoughts and worries. The notion of a permanent presence of a "point" in the heart-mind refers not only to etiological assumptions about the causes of distress but also to the expectation that this suffering will last a lifetime and that one must live with that. This parallels findings from Nepal (Kohrt and Hruschka 2010), where people described traumatic events as leaving "scars" on the heart-mind.

Similarly, Keys et al. (2012) described illness narratives in Haiti related to the heart. In this study, heart complaints were interpreted by lay respondents within a broad psychosocial framework. One particular complaint, *doulè nan kè* (pain in the heart), was related to negative emotions such as sadness, grief, and stress, along with gastrointestinal symptoms. A *kè bat fo* (heart that beats strong) was more related to fear, worry, surprise, and weakness, whereas a *kè serè* (tight heart) was associated with shock, sadness, and pity. Further, Lasater et al. (2018) reported *duskun chauffé* (hot heart), *dusu tôôrô* (pain in the heart), and *dusukasi* (crying heart) as idoms of distress among perinatal women in rural Mali within a context of poverty, interpersonal conflict, and gender inequality. These results show that heart narratives occur in different parts of the world, and they share notions of strong emotional experiences related to adverse events.

Nervozë and *frikë* describe more agitated and externalizing states than *brengë* and *mërzi*. The anthropological literature reports different "nerves" concepts that vary across cultures. For example, *ataque de nervios* (attack of nerves) in Puerto Rico is characterized by acute emotionality (e.g., fear, rage, or grief), combined with a felt loss of control. Affected people often describe their struggling with overwhelming emotions prior to releasing the accumulated tension (Guarnaccia et al. 2003). The Mongolian concept of *yadargaa* is known as *nervous fatigue* in the Russian medical system. This fatigue-related illness embodies Mongolian health beliefs and the Russian construct *nevroz* (neurosis). Clinicians and non-clinicians assume that *yadargaa* is associated with socioeconomic changes under capitalism in Eastern Europe (Kohrt et al. 2004). Furthermore, the DSM-5 describes the term *nervios* (American Psychiatric Association 2013) as a common idiom of distress among the Latino population in North and Latin America.

In our data, *nervozë* includes the metaphor "hot blood" (*gjak të nxehtë*), which is used to describe states of anger, fury, and aggression that lead to impulsive behavior (e.g., losing control, fighting, screaming) and somatic dysfunction (e.g., dizziness, stomach pain). The meaning of the *gjak* (blood) metaphor in Albanian culture has been discussed in the literature (Elsie 2014; Littlewood 2002; Yamamoto 2015).

Blood is prominent in the customary law *Kanun of Lekë Dukagjini*, e.g., in the context of *gjakmarrje* (blood feud). The *Kanun* describes states of "boiling blood" or "blood sickness" in the context of blood feud (Elsie 2014; Littlewood 2002). Yet the concept of blood contains more than the sociocultural regulation of blood revenge. According to Littlewood (2002), the idiom of blood implies psychological notions of anger and anxiety along with other cultural aspects such as Albanian kinship and honor.

Strategies for Overcoming Distress

The concept of *fati* (fate/destiny) emerged in our data, which implies the notion that distress or suffering are "given by god" or "fate." *Fati* is not primarily a religious term but rather a culturally shared attitude for life. *Fati* derives also from the Albanian mythology as the *fatia*, a female spirit or fairy, which is a personification of a person's fate (Elsie 2001). Beliefs of *fati* are therefore embedded and influenced by historical, religious, and traditional elements. *Fati* also implies that suffering must be endured with *durim* (withstand, endurance, patience). A significant relationship between suffering and the concept of fate has been reported in the literature. The Albanian term *durim* is related to the Arabic term *sabr* (patience), one of the most essential virtues of Islamic culture (Pugh 1991), which is needed to overcome suffering. A similar but slightly different understanding of suffering was described in Islamic culture by the notion of *qadar* (fate). As Hassan et al. (2015) explained, the "acceptance of fate should not be equated with fatalism but can be better understood within a framework of self-abandonment, which is reflected in the value of patience in the face of helplessness and adversity, such as illness and loss" (p. 27). A parallel concept of suffering has also been described among Turkish immigrants in Germany (Franz et al. 2007; Reich et al. 2015). When compared to German patients, Turkish immigrants show more fatalistic or external control attributions for mental distress, which results in lower treatment motivation. This can be used for culturally adapting psychological interventions (Reich et al. 2019).

Our data also show that the process of overcoming distress is embedded in social practices (e.g., withdrawal, activity). Kienzler (2012) argued that mental health professionals in Kosovo treat "social minds," which is reflected in our data. Depending on the label, different patterns of seeking therapy and coping behavior become evident. *Brengë* and *mërzi* are more psychological expressions with a tendency to describe symptoms of weakness caused by inner conflicts. These conditions must be endured or treated mostly by self-management or social support. The labels *nervozë* and *frikë* show arousal and fight, which are expressed through various conflicts within the family and the society. These expressions are more related to intense somatic complaints and are more likely to be associated with medical and psychological treatment.

Against this background, narratives about social problems and social support within the family are closely intertwined and difficult to disentangle. It seems paradoxical that participants would emphasize social support as the most important aspect in coping with mental health problems but, at the same time, clearly state that they did not want to talk about mental health with the family. Dow and Woolley

(2011) discussed the paradox in connection with individuals' assumptions that the family and community hinder access to psychological treatment due to people's fear of social exclusion and stigma. What appears contradictory from an etic perspective seems to make sense within the worldview of the interviewees. In this context, social support is not understood as being related to the disclosure of one's feelings or psychological symptoms. Participants rather conceptualized social support in terms of either receiving help for solving concrete problems that caused the suffering, or just spending time with people who have similar experiences, without necessarily talking about these experiences. Due to the fact that immigrant families are often separated in different countries, it is understandable that the mere presence of the family members can have a healing effect, as our data suggest.

As mentioned above, participants considered their current living conditions to be as stressful as (or even more stressful than) their pre-migration stressors. A loss of social status due to immigration is often closely linked to economic problems and unfulfilled desires. Not being able to work in Switzerland had a negative effect on mental health for some participants. Accordingly, participants expressed expectations to receive support from social and legal systems to solve their financial problems and employment situation, which they expected to have a positive effect on their mental health.

Being Unhappy and Mental Illness

The general notion of distress as a lack of *gëzim* (joy) and *lumturi* (happiness) expresses the overlap between mental disorders and everyday suffering. The boundaries between "illness" and "normal suffering" are blurry and hinder the contextualization of symptoms within a clear "illness concept." In particular, the heterogeneity of meanings ascribed to the labels *brengë* and *mërzi* make it difficult to understand when a state of unhappiness and dissatisfaction becomes a "mental disorder." Although many symptoms of *mërzi* are similar to the symptom categories of depression, the terms are not simply used interchangeably. Attributes like *mungesë* (absence) and *malli* (nostalgia) in the narratives of *vuajtje* and *mërzi* underline the cultural significance of homesickness and longing in Albanian immigrants' identity. There is a similarity with the Portuguese concept *saudade*. According to Bułat Silva (2012), *saudade* expresses a variety of ambivalent feelings ranging from happiness to sadness that are related to memories. Our results also show similarities to native expressions used among the Highland Quechua in the Peruvian Andes (Pedersen et al. 2010): the Albanian *mërzi* shows a proximity to the term *llaki* (sorrow, sadness), while *pinsamientuwan* (worrying thoughts) is more similar to *brengë*.

Saudade, llaki, and *pinsamientuwan* are not considered to be mental disorders but are rather expressions for normal suffering in life. According to several anthropological studies in different populations (e.g., Kaiser et al. 2015; Kohrt et al. 2004; Kohrt and Hruschka 2010; Lasater et al. 2018; Pedersen et al. 2010), idioms of distress are not only used within the scope of psychiatric terms and are not considered to be mental disorders per se; they rather express unhappiness, dissatisfaction, and recurring thoughts in a broader framework of everyday suffering

due to sociocultural structures, e.g., migration and integration difficulties, social inequalities, social exclusion, or political violence. Kaiser et al. (2015) claimed that these terms should nevertheless be included in research as well as in clinical and nonclinical treatment with the aim of stigma reduction, health communication, and the development of culturally appropriate interventions.

Stigmatization of Mental Illnesses and Treatment

Stigma, i.e., negative beliefs and attitudes about mental disorders, seem to have played an important role during the recruitment process, and this was also reflected in the results. There is very little evidence in our data connected to labeling a state of severe mental disorder, and when it was there, it was only in the negative sense of "being crazy." We assume that participants who have gone through psychotherapy in Switzerland know the meaning of Western concepts such as depression, but they spoke vaguely about them, using terms such as "stress" or "burnout." Unlike Albanian CCDs, depression and burnout are seen as mental disorders. Based on our findings, we hypothesize that participants used "code-switching" (Muysken 2000), i.e., using German terms for mental disorders in an Albanian interview, as a strategy for avoiding negatively connoted and stigmatizing labels. Further research would be needed to support this assumption.

Stress (or the Albanian word *stres*) was often used, but more for naming concrete stressors rather than as a label for symptoms of psychological distress. The term stress did not seem to reflect as much stigmatization as depression. Dictionaries translate or define *stres* as "overload" (Buchholz and Langenscheidt 2014:632) or "bodily or mental pressure, *brengë* coming from this pressure" (Thomai 2006:987). However, not every dictionary listed *stres* as an Albanian term; therefore, we hypothesize that this concept, based on the loan word *stres,* is quite new and influenced by the Western concepts of stress or distress. However, because participants did not talk much about severe mental disorders, it would be necessary to conduct further research. It would be interesting to further explore whether the term "stress" is used to replace stigmatizing labels such as depression and enables individuals to talk more openly about mental health-related issues and psychological treatments.

Limitations

Several limitations must be mentioned. First, distinctive age-specific differences in the data were identified. Older participants preferred the Albanian language while younger participants wished to conduct the interview in German. The bilingualism of the first author allowed the inclusion of both languages. Although the statements of the younger German-speaking generation appeared to be highly interesting and relevant, they were of limited use for the study of Albanian CCDs. The German-language data regarding the Albanian CCDs were analyzed only secondarily. In our view, these data deserve further in-depth analysis in the future to contribute to a better understanding of divergent intergenerational beliefs regarding mental health

problems, as shown in previous studies with migrant families (e.g., Devakumar et al. 2014; Michael 2009; Weine et al. 2004).

A further important limitation stems from the fact that we did not obtain the medical diagnoses for participants included in our study. It might have been relevant to contextualize their narrative within a given (Western) psychiatric diagnosis. However, we did not examine overlap with Western psychiatric diagnoses in our study but rather focused on the illness narratives that emerged from participants themselves.

We also most probably have a selection bias in our data, as we can only show the perspective of the persons who were interested in voluntary participation.

As a further limitation, we did not explore spiritual healing methods for emotional distress among Albanian-speaking individuals. We assume that in their spontaneous responses, interviewees rather focused on mentioning biomedical healing methods because they did not want to link the scientific study to spiritual healing methods. Since the questions of the BEMI are not directly addressed to topics of spirituality and religion, we did not further probe regarding this topic.

And finally, since individuals from Albania did not volunteer for the interviews, we can only generalize the findings for the Kosovan and Macedonian population. However, the fact that most of the dictionaries included in the analysis were published in Albania increases our certainty that the linguistic expressions are also used in Albania.

Conclusion

Results of our study contribute to the expanding body of evidence that challenges current Western concepts of psychiatric nosology that is based merely on a descriptive, categorical, diagnostic approach. The Lancet commission on global mental health and sustainable development (Patel et al. 2018) advocated for novel conceptualizations of mental health and well-being, and the results of this study are in line with the commission's suggestions. First, they highlight the fact that mental health and well-being include satisfaction with life rather than the mere absence of mental disorders. Results from the present study add to the body of evidence showing that dissatisfaction with life and lack of opportunities largely contribute to suffering among migrant populations and might weigh more heavily than the traumatic experiences in the past.

Second, the Lancet commission stressed the fact that psychiatric diagnoses can lead to unhelpful labeling that often oversimplifies and undervalues the complexities of personal circumstances. Moreover, labels can be stigmatizing, and the impact of stigma is often even more burdensome than the symptoms that have led to the diagnosis themselves. As an alternative to the categorical diagnostic model, the Lancet commission proposed a staging model, which recognizes opportunities for intervention at all stages of the pathway from well-being to different stages of disorder. Such a model parallels the findings from this and other studies in which the border between "being unhappy" and "mental illness" is blurred. Moreover, the model highlights the need to understand people within their context and to use local illness narratives for communication purposes in health settings.

Further research on ethnopsychological models of psychological distress is needed among Southeastern European communities. Such research could further explore mind–body concepts in this group. Extensive research in Nepal (Kohrt and Hruschka 2010), Haiti (Keys et al. 2012), and among Cambodian refugees (Hinton et al. 2010) has delivered insights on such mind–body concepts. Our results lay the groundwork for future studies that could, for example, use card sorting tests (Keys et al. 2012; Kohrt and Hruschka 2010) to further investigate similarities and differences among the five labels of *vuajtje, brengë, mërzi, nervozë,* and *frikë*. Furthermore, the mind–body concept requires further exploration, e.g., by asking participants more generally about their concepts of how the mind and the body interact instead of directly asking about symptoms of psychological distress.

Taken together, our results can be used as a basis for future research as well as for communication purposes in health settings. In this context, it is essential to understand that Albanian-speaking immigrants suffer from both pre- and post-migration stressors and that the latter might be more traumatizing than the former. Second, it is important to keep in mind that individuals from this community consider suffering to be a normal part of life, and they assume that this suffering must be endured with patience. It is vital to address these beliefs in psychological interventions. Similar results have also been shown for Turkish immigrants in Germany (Reich et al. 2015). Finally, the fear of stigma related to mental disorders is noteworthy and warrants further exploration. Participants in our study tended to "switch codes" when talking about psychiatric disorders. Using non-stigmatizing terms (e.g., "thinking too much" or "feeling nervous") is recommendable in clinical settings to foster trust in the doctor-patient relationship. Results of this study can also be used to culturally adapt existing psychological interventions (Heim et al. 2018), which potentially can be scaled up to increase coverage of mental health services and alleviate the burden of disease among people suffering from common mental disorders worldwide.

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Compliance with Ethical Standards

Conflict of interest All authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in this study were in accordance with the ethical standards of the Swiss Federal Act on Research involving Human Beings and with the 1964 Helsinki declaration and its later amendments. The study was approved by the ethics committee of the canton of Zurich, Switzerland (BASEC-Nr. 2016-02218).

Informed Consent Informed consent was obtained from all individual participants included in the study.

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