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"Mal d'Afrique" in Italy: Translating African "Cultural Idioms of Distress" for more Effective Treatment

Mary Ellen Toffle[a,b]*

[a]*University of Messina, Piazza Pugliatti 1, 98122 Messina, Italy*
[b]*University of Pavia, Strada Nuova 65, 27100 Pavia, Italy*

Abstract

The DSM-V (2013) states that culture assists in diagnosis because it shapes "the experience and expression of the symptoms, signs and behaviours that are criteria for diagnosis" (DSM-V, 2013, p. 14). The idea of "cultural idioms of distress" is presented as a description of suffering among people of the same cultural group. Various "cultural idioms of distress" have been identified worldwide, ranging from the 'Susto' (Central America) to 'Maladi Moun' (Haiti) which can be correlated with various psychopathologies (DSM-V, 2013). Recent statistics reveal that there are over 105,000 Africans from the English-speaking countries of Nigeria, Ghana and Kenya currently living in Italy legally (Tuttitalia, 2014), and African immigration is increasing. The Executive Director of Frontex Fabrice Leggere stated that between 500,000-1,000,000 immigrants could arrive in the near future, departing from Libya (ANSA, 2015). It is logical to assume that more people from English-speaking Africa will arrive, especially Nigerians. The immigrants who remain in Italy will have to learn Italian but they will use their own cultural concepts by translating them from English into Italian. Speaking with medical personnel and mental health professionals presents a huge challenge for both the patient and the care provider. This poses a problem of diagnosis for the healthcare professional, who must interpret both the words used and the underlying meanings of "cultural idioms of distress" which are an expression of the patient's culture. The purpose of this study is to identify basic definitions or names for illnesses and conditions of suffering given in English by English-speaking African immigrants. But what the words actually mean must be discovered and Italian healthcare professionals and social workers must understand the underlying meanings in order to provide effective diagnosis and care. Twelve African immigrants were interviewed from a selection of African countries where English is either the official language or one of the official languages. Discussions about how they arrived in Italy, their present condition and general illnesses were conducted in English. The interviews were recorded, transcribed and analysed. The immigrants demonstrated a few cultural idioms of distress describing both physical and mental illness and other difficulties. More research should be done on other African language groups. This information should then be communicated to all health and mental health professionals and incorporated into university professional training and continuing education programs in Italy.

* Mary Ellen Toffle Tel.: 39-3281140231
E- mail: mtoffle@unime.it

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1. Introduction

The purpose of this paper is to discuss 'cultural idioms of distress' in the clinical situation and report findings of a preliminary study in Sicily of African immigrants' use of English to express distress or illness. In order to understand the motivation for this study it is important to consider the current situation of immigration in Italy, and in particular, Sicily.

1.1. Immigration Trends

Thousands of immigrants have been arriving in growing numbers from Libya since 2011. An estimated total of 170,000 immigrants (Italian Ministry of the Interior, March 3, 2015) arrived in Sicily in 2014: primarily in Lampedusa but also in various areas of the south of Italy. In February of 2015, 4,423 people arrived in Italy (Italian Ministry, 2015). Not to mention the recent prediction by Spanish Interior Minister Jorge Diaz that for 2015 the number of immigrants into Italy will soar to at least 200,000 (Diaz, 12 March, 2015, RAI).

The Italian Ministry of Internal Affairs (Ministero dell'Interno, 2015) reports that between 2011 and 2014, irregular migrants in Italy numbered around 290,000. Of these, 224,000 disembarked in Sicily, while another 40,000 – rescued in the Strait of Sicily – were then disembarked in other regions (Calabria and Apulia in particular). The peak of arrivals in Sicily was recorded in 2014 (approximately 120,000, equal to 70% of the total). Most boats carrying migrants depart from the Libyan coast (74% in 2014). Libya has become the main starting point for the voyage to Italy because of the growing political instability in the country.

1.2. Who are the immigrants?

Historically Sicily has been a first-point destination for those immigrating from Asia, Africa and Mediterranean Europe (Liciardello & Damigella, 2011). Sicily has become the landing spot for immigrants, and specifically the island of Lampedusa. So much so that immigration to Sicily has become an ongoing phenomenon. (Sacco, 2012; Cutugno & Sacco, 2015). Most of these immigrants are from the Middle East primarily (Syria) and various countries of both Sub-Saharan Africa and North Africa. Syria (25%) and the countries of Eastern Africa (20% of Eritreans and 3% of Somalis), followed by the countries of West Africa (Mali, Nigeria and Gambia with about 16%) Many perish at sea while the lucky ones are evacuated from sinking vessels or rescued from the open sea. According to a recent newscast (Euronews, 2015) an estimated 3500 immigrants died in the Mediterranean Sea in 2014. Human traffickers, primarily Libyan, exploit desperate immigrants with the help of corrupt police, and send them to sea (Redattoresociale, 2015).

Irregular migrants who arrived in Italy by sea were mainly men (about 75% in 2014), while the number of children was around 17% in 2012 (latest available data). In 2014 the source countries of origin were mostly suffering from critical political and humanitarian crises. (ISMU 2014; / Italian Ministry of Internal Affairs, 2015).

In recent years, due to the increasing migratory pressure, the number of asylum seekers has also increased in Italy - though at levels which are lower than those of many other European countries having a long history of immigration-with Italy receiving 26,620 applications (Eurostat Statistical Database, 2013). Border rejections are the lowest in Europe as well; 2013 saw 7,370 border rejections as compared to 192,775 border refusals in Spain (Eurostat Statistical Database, 2013).

1.3. Reasons for immigration

Survival seems to be the main reason for immigration: hopeless economic and political situations, genocide, hunger, ethnic and religious persecution are the main reasons. Immigrants spend huge amounts of money and risk their lives to cross the sea in flimsy boats, rafts, and overcrowded fishing trawlers that often tip over or sink . It is difficult to be sure of the number of lives lost; the United Nations High Commission for Refugees estimates that more than twenty thousand lives have been lost since the year 2000. (UNHCR, 2015).

Once again, according to the latest estimates of the UNHCR, about sixty thousand migrants reached European coasts in 2013. In 2014, with the continued exacerbation of the Middle-Eastern geopolitical crisis, the number of arrivals was over a 130,000 thirty thousand. Recently Spanish Interior Minister Jorge Diaz predicted that for 2015 the number of immigrants into Italy will soar to at least 200,000 (Diaz, 12 March, 2015, RAI).

1.4. Integration in Italy

Although a great number of immigrants use Sicily as an arrival point and expect to go to Northern Europe, many of them settle in Sicily (Licciardello & Damigella, 2011) and other parts of Italy. Integration has become an extremely important and controversial global issue (Terranova & Toffle, 2014) that needs to be addressed.

1.5. Nigerian immigrants in Italy

One immigrant group is the target of this study: Africans who come from countries where English is either the main language or one of the main languages. If these groups settle in Italy, and many already have, it will be of great importance for the health system to know something about them, their communication styles and the way they express distress, albeit physical or mental.

The most recent statistics (2013) on the number of Nigerians in regularly in Italy are quoted at 56,476; it is estimated that between 3,000-4,000 enter every year; the population was up 17% from the previous year (tuttitalia.it, 2014). The justification for this research was based on the fact that conditions in Nigeria are worsening, and more Nigerian immigrants are arriving in Italy, with a probable increase in the near future.

2. Problem statement

The numbers of English-speaking African immigrants are increasing. The Italian health system is not ready to handle the challenges of communicating with them.

Recent statistics reveal that there are over 105,000 Africans from the English-speaking countries of Nigeria, Ghana and Kenya currently living in Italy legally (Tuttitalia, 2014), and African immigration is increasing. The Executive Director of Frontex Fabrice Leggere stated that between 500,000-1,000,000 immigrants could arrive in the near future, departing from Libya (ANSA, 2015) It is logical to assume that more people from English-speaking Africa will arrive, especially Nigerians. They communicate in English, and medical personnel will have to deal with them in English. The immigrants who remain in Italy will have to learn Italian but they will use their own cultural concepts by translating them from English into Italian. So one way or another it will be necessary for the Italian health professional to understand what Nigerian and other English speaking African immigrants say. Speaking with medical personnel and mental health professionals presents a huge challenge for both the patient and the care provider. This poses a problem of diagnosis for the healthcare professional, who must interpret both the words used and the underlying meanings of "cultural idioms of distress" which are an expression of the patient's culture.

2.1. Nigerian English

English is the official language of Nigeria; historically it was a British colony and consequently the English spoken there has its linguistic roots in British English. Many linguists support the existence of "Englishes". These"Englishes" have evolved or been recognized due to the globalization of English as the lingua franca of

communication. This process started with the British Empire colonization and resulting imposition of English on the conquered nations (Crystal 1997; McArthur 1998; Trudgill & Hannah, 2002; Jenkins 2003).

2.1.1. Description of Nigerian English

The question of 'Englishes' (Crystal, 1997) and what sort of English is actually spoken in Nigeria is an interesting question. The English spoken in Nigeria includes 'Standard British English' and also other forms of English that are influenced by tribal languages, Indian English and WAPE (West African Pidgin English); (McArthur, 2002). Adekunle (1974) observed that mother tongue/tribal languages interfered with Nigerian English in the areas of vocabulary and syntax. However it was brought up that in 'Educated' Nigerian English the majority of usages result from the process of narrowing or extension of meaning or the development of new idioms. These new usages are not affected by any tribal language interference; instead verbs are simply modified (Bamgbose, 1996). Odumuh categorized the main influencing tribal languages (regional/called national) languages of Nigeria: Hausa, Yoruba and Igbo Englishes. He believes that these dialect types influence and enrich the super-ordinate Nigerian English (Odumuh, 1987). Nigerian English is thought to be an aggregate of heterogeneous grammatical structures common to Nigerian usage, having varying pronunciation peculiarities as well as socially constrained usage of some lexical items (Akere, 1982).

Other elements such as ellipsis and clipping (Kirkpatrick, 2007) can be found in Nigerian English. The use of prepositions can also vary, including the omission of 'to' in some cases (Kperog, 2012). There has been some discussion about whether Nigerian English can be considered on of the 'Englishes' and Ajani (2007) affirms "that there is a preponderance of evidence for the existence of a Nigerian variety of English". The debate about what the linguistic elements are and their influence is quite fascinating; however, the purpose of this research is quite pragmatic: to examine the English spoken by the Nigerian immigrants currently present in Sicily.

2.1.2. Code switching

It is sufficient to say that the supra-segmental phonology of Nigerian English is one of the main, and probably the most obvious feature that distinguishes Nigerian English from British English, American English and other new Englishes, especially within the West African sub-region (e.g. Ghanaian or Cameroonian English). It is also one of the main distinguishing features – apart from certain very localized lexical items – between the various regional forms of Nigerian English such as Hausa Nigerian English or Igbo Nigerian English, also referred to as Enghausa and Engligbo respectively by Odumuh (1987, cf. 1993; Jowitt 1991). Some of these features are under- and over-differentiation of phonemes and phoneme substitution (e.g. substituting a BE vowel with one that is closest to it in the various L1's); the transference of the tonal features of local languages on the stress and intonation patterns of EL, or better put, the replacement of BE stress and intonation patterns with L1 tonal patterns.

2.1.3. Discourse/communicative strategies

Most of the communicative strategies of Nigerian English are different from British English. Discourse features are different from British English due to the fact that different cultures have different rules of appropriateness. For example, the Nigerian culture avoids direct confrontation and shows respect to elders during a conversation; consequently this transfers into discourse (Ajani, 2007). In the Yoruba culture and most of Africa it is not culturally and socially appropriate to communicate in a direct manner, especially with older people; in addition to this, it is necessary to employ certain discourse practices to avoid losing face: to save the speaker from losing face and to avoid threatening face to the listener. (Ajani, 2007; Brown & Levinson, 1978; Goffman, 1955; Grice, 1975; Hymes, 1974).

2.2. Cultural issues in health and justification for this research

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) published a 'new' section about cultural issues in 2013. It includes a "Cultural Formulation"section that discusses the interaction of culture with diagnosis as

well as proposing a format for cultural assessment. There is also a section called "Glossary of Cultural Concepts of Distress" which describes some idioms of distress, cultural practices and linkages to clinical practice. Although it has included various cultures, this author thought that there must be much more to discover. Thus this research was conducted to see if there were more idioms of distress and/or descriptions of illness that are not recorded in the literature.

The DSM-V points out that the definition of what is defined as normal and what is defined as a pathology differ from culture to culture, at least for some types of behaviour. The degree to which a behaviour is tolerated varies across cultures, families and social environments. Whether or not a particular behaviour is considered pathological and needs psychiatric/psychological assistance is defined by cultural norms. The authors state that being aware of the influence of culture can adjust mistaken interpretations of mental illness. However, cultural meanings, norms and traditions can magnify stigma or support on the part of the family and society in general. Culture can assist in resilience or assist in particular care, such as alternative treatments. Culture can also influence the decision to accept/reject/adhere to treatments, which in turn impact the outcome of the illness. The interaction between patient and clinician is also affected by culture: cultural differences can have an impact on the diagnosis in terms of accuracy, acceptance, treatment, etc.

The DSM-V discusses three definitions that have replaced the traditional view of a 'culture-bound syndrome'. First, it defines a cultural syndrome as a group of "co-ocurring, relatively invariant symptoms found in a specific cultural group, community or context". Perhaps the syndrome is not thought of as an illness by the culture, but an outsider can recognize certain patterns and features. The example given is the 'ataque de nervios' common in Latin America.

Secondly, it defines 'cultural idioms of distress' as a linguistic term used within a culture to define some sort of suffering; cultural idioms of distress can express a wide array of problems, from discomfort, suffering from a social conditional, or everyday experiences.

Thirdly, it points out the existence of a "perceived cause" or explanation given by culture which is basically an explanatory model that explains the illness or distress. Folk healing, traditional medicine and other cultural methods come into play.

(DSM-V, p. 14).

This research is based on the second point, "cultural idioms of distress" and attempts to combine linguistic study with cultural study. The following sections give a glimpse into how mental disorders and culture are related.

2.2.1 Schizophrenia

The DSM-V also incorporates a cultural commentary inside of each section on psychiatric illness. For example, the section on schizophrenia contains an analysis of issues related to culture. It points out that "ideas that appear to be delusional in one culture (e.g. witchcraft)" may be considered normal in another culture. It states that "the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures". Clinicians must also be aware that if the communication takes place in a language other than the subject's first language, there can be significant linguistic barriers that may be mistaken for an indication of mental impairment.

2.2.2. Depression

Another example is found in the section on depression. This culture-related diagnostic issue to be aware of is that of the fact that frequently depression is not recognized as an illness. Somatic symptoms are more commonly expressed, especially insomnia and lack of energy.

2.2.3. Post-traumatic Stress Disorder

The comments on PTSD are very pertinent to this study because many of the subjects interviewed stated that they were having sleep problems and nightmares about their immigration experience. The DSM-V section on PTSD points out that the onset and severity of PTSD can vary between cultures due to the type of trauma suffered.

For example, if a subject has lived through a trauma, the onset and severity of PTSD depends on the meaning of the event for the subject, the sociocultural context and other cultural factors. The impact of particular experiences and the resulting development of PTSD differ from culture to culture. Even the expressions of symptoms can vary culturally. For example, a victim of genocide may develop PTSD in varying degrees depending on his or her cultural response to it; and the expression of it will also vary, from nightmares, somatic symptoms, numbness and avoidance.

2.2.4. Definitions of culture

There are many definitions of culture. A very general yet integrated definition describes cuure as "integrated patterns of learned beliefs and behavior shared among groups"(Kohls, 2001,p. 25). In a similar fashion, the DSM-V defines culture as "systems of knowledge, concepts, rules and practices that are learned and transmitted across generations" (p. 749). It goes on to say that cultures are "open, dynamic systems that undergo continuous change over time" and they caution against generalizing and stereotyping groups because individuals today encounter various cultures and therefore develop their own identities based on their experience.

Race is a category culturally constructed that classifies humans by their superficial physical characteristics. The DSM-V states that race actually does not have a biological definition but is considered important socially because it promotes "racial ideologies, racism, discrimination and social exclusion". Racial biases and racism in general can cause misdiagnosis, increase psychiatric problems and promote bad outcomes of treatment.

Ethnicity is a group identity that is culturally constructed. It may be the result of a common language, religioun, history, or other shared aspects of a group.

The DSM-V points out that culture, race and ethnicity have an effect on health disparities. This is because they are connected to economic inequality, racism and discrimination.

All of this analysis leads up to one thing: individuals must be assessed not just in terms of their medical/psychiatric/psychological/ complaints but within a framework that relates them to their own cultural context so as to both diagnose and treat effectively. On the level of communication, discovering something about how patients describe their illnesses, in their own idioms of distress, unlocks some of the mystery of treatment.

2.2.5. Cultural concepts of distress

This term is used to describe how different cultures "experience, understand and communicate suffering", behavioural problems or upsetting feelings or thoughts. The term is divided into three concepts: *cultural syndromes, cultural idioms of distress* and *cultural explanations or perceived causes* (DSM-V. p. 758). *Cultural syndromes* are connected to specific cultural groups and recognized by them to be a pattern. *Cultural idioms of distress* express distress not necessarily connected to specific symptoms but that are used to discuss and share experience. An example of this is "nerves" which can be connected to a wide variety of health issues. *Cultural explanations* or perceived causes are explanations of the cause and meaning of a particular illness or distress. These terms replace the use of culture bound syndrome because they acknowledge the fact that all illnesses are "locally shaped"-in other words, shaped by the person's culture.

Perhaps it is obvious that cultural syndromes are often recognized by the use of cultural idioms of distress, but not always. Cultural idioms of distress are often expressions that can express a number of problems. The above example of a common expression "nerves" is useful to understand the concept. A person having 'nerves' could be suffering from anxiety, stress, pre-menstrual syndrome, too much caffeine intake, etc. What this idiom does is express a common experience that people from the same cultural group understand; it is an opportunity to share and sympathise without knowing exactly what the problem is.

2.2.6 *Examples*

It is useful to mention the various syndromes that have been identified. It is the therapist's challenge to try to fit them into a DSM-V diagnosis. "*Ataque de nervios*"-Latin America or people of Latin origin, symptoms of emotional upset, possible screaming, crying trembling, aggressiveness; loss of control. The DSM-V diagnosis can include panic attacks, panic disorder, specified or unspecifried anxiety disorder. *Idiom of distress*: ataque de nervios

referring to a 'fit' land can be used to indicate lost of control in reponse to intense stress. " *Kyal cap"* or "wind attacks" is reported by Cambodians; dizziness, palpitations, shortness of breath, based on the belief that "kyal", a wind-like substance rises in the body and causes various problems such an dizziness, blurry vision, asphyxia; it is triggered by worrying thoughts, rising to the feet, specific odors linked to bad memories, and being in crowded spaces. The DSM-V offers possible diagnoses:various ways: PTSD, panic disorder, agoraphobia and others. "*Kufungisisa"* is from the Shona tribe of Zimbabwe. It is a cultural idiom of distress as well as a cultural explanation of disease. It is associated with thinking too much. As an explanation, it is said to cause anxiety, depression, physical problems (somatic) . It is an idiom of psychosocial distress referring to personal problems. "Thinking too much" is a common idiom of distress found in various cultures and in some cultures it is thought to cause damage to the brain and cause headaches and dizziness. The DSM-V links it to major depressive disorder, generalized anxiety disorder, obsessive-compulsive disorder, and others.

Other cultural syndromes include "*Maladi moun'"*"("humanly caused illness") is used in Haitian culture to explan various medical and psychiatric disorders. They attribute disorders to be caused by envy, malice, something deliberately caused by someone else (explanatory model). If symptoms are acute or there is a sudden change in behaviour, it can be attributed to a spiritual attack. Related cultural syndromes include the "*evil eye*" in the English speaking world (archaic) and the "*mal de ojo*" in Spanish and "*mal d'occhio*" in Italian. The DSM-5 related conditions include: schizophrenia with paranoid features, delusional disorder, persecutory type. "*Brain fag*" from Nigeria is associated with thinking too much. There are many more listed in the DSM-V but it is out of the scope of this work to discuss them.

2.2.7. *Cultural idioms of distress*

The DSM-V (2013) states that culture assists in diagnosis because it shapes "the experience and expression of the symptoms, signs and behaviors that are criteria for diagnosis" (DSM-V, 2013, p. 14). The idea of "cultural idioms of distress" is presented as a description of suffering among people of the same cultural group. Various "cultural idioms of distress" have been identified worldwide, ranging from the 'Susto' (Central America) to 'Maladi Moun' (Haiti) which can be correlated with various psychopathologies (DSM-V, 2013).

2.2.8. *Nigerian expressions of illness*

A cultural syndrome was identified by A. Lambo. He called it "Frenzied Anxiety" and it included "undue suspicion, hearing and seeing things that others cannot see; extreme anxiety (Lambo, 1962). Another popular one is the "brain fag," first reported in 1959 by an expatriate psychiatrist, Raymond Prince, among Nigerian students. This disorder has been described in students of other African countries who are exposed to the acculturative stress of a western-type education system emphasising theoretical book knowledge quite different from the practical know-how and traditional apprenticeship acquired through oral traditions from older generations in Africa.

2.3 *Impact and justification*

The following article (translated) appeared in the Italian newspaper, Corriere della Sera, on January 11, 2003:
"Amina wasn't able to make herself understood with gestures. She tried to describe the profound, acute and recurring pain in her lower abdomen. But, in spite of good will, the emergency room doctors in the Province of Rome couldn't understand her. She didn't speak a word of Italian or English. They sent her home thinking it was a banal stomachache. Only when the woman came back to the hospital did the doctors think it could be an gynecological problem. They were right: Amina was pregnant and she was in danger of losing the baby. This time it ended well. But for the immigrants that don't know much of our language or nothing at all, often a visit to the hospital is a gamble. … The communication difficulties between patients and doctors can lead to a wrong diagnosis, therapies that are not followed because prescriptions are not understood, operations that are too late. " The risk of not interpreting the illness of a foreigner is always a risk " states Aldo Morrone, dermatologist and Chief of Preventative Medicine at the Regina Elena Institute of Rome. And he comments that there are not just language

barriers, but also cultural obstacles. “Everyone uses different expressions to describe symptoms,” Morrone explains. “For certain Africans to have a worm in the stomach means to suffer from diarreah; for a Somalian to say that he feels like he is fainting means that he can’t talk. I remember a dramatic case. A man pointed at his throat. The emergency hospital personnel rinsed and irrigated his throat. His throat wasn’t irritated. He had a tumor.”(Corriere della Sera, Jan. 11, 2001). This is just one example of a press release highlighting the difficulties of immigrants when they need medical assistance. This study was an attempt to find out information that could be useful for Nigerian immigrants and Italian medical personnel.”

3. Purpose of Study

The purpose of this study was to identify basic definitions or names for illnesses and conditions of suffering given in English by English-speaking African immigrants. The aim was to identify and discover heretofore unknown cultural idioms of distress. It was hoped that the application of this knowledge could be of use to Italian healthcare professionals and social workers must understand the underlying meanings in order to provide effective diagnosis and care for Nigerian immigrants in Italy.

4. Methods

Fifteen African immigrants were interviewed from Nigeria, Ghana and Liberia, but it was decided to focus only on the Nigerians. (See appendix.) Discussions about how they arrived in Italy, their present condition and general medical questions were asked in English. The interviews were recorded, transcribed and analysed. The interviews were based on the “Self-Assessment of Intercultural Communication Skills”, (Hudelson, Peron & Perneger, 2011) but was ‘backwards ‘ in the sense that the skill was first taken into consideration and then the question was developed. The immigrants were all young men in their early 20’s. It is difficult to access female immigrants in the area; in fact, accessing these immigrants was quite challenging due to legalities and bureaucracy.

5. Findings

The following tables report the information found regarding medical practices and attitudes, followed by Table 2 which summarizes basic information.

Table 1. Medical practices and attitudes.

Questions	Summary of Answers
1. Obtain a medical history that is relevant to the patient’s complaint: How do you feel about telling the doctor what is wrong with you at the moment?	All interviewees felt that it was normal to discuss how they felt with the doctor. They said they would tell doctors whatever they thought was important for their diagnosis and treatment.
2. Perform a clinical examination that is targeted at the patient’s chief complaint: How do you feel about being touched by a doctor of the opposite sex?	None of the interviewees expressed any problem with being touched by a female doctor.
3. Obtain a psychosocial history from the patient: How do you feel about telling the doctor about	Three of the respondents were hesitant; they had private reasons for having left Nigeria and did not want to discuss them with the doctor.

your life?

4. Make sure that an illiterate patient understands the treatment of his chronic disease (e.g., hypertension, depression, etc.): Do you know about diabetes? Hypertension?	This question was difficult because they were all very agreeable and said they knew something about medicine but not much; they all did know what diabetes and hypertension were, at least on a very superficial level.
5. Announce bad news (unfavorable prognosis): How do doctors tell bad news? Does he tell the patient? Who does he tell?	Here 9 people agreed that the families should be told first. The other 3 said that the doctors would not tell anyone anything because it might affect the ill person's chance to live. 4 respondents said that life and death is in God's hands and nothing can be done.
6. Discuss advantages and risks of unconventional therapies with a patient who uses them: What kind of traditional medical practices are there in your country? What do you do for headaches, stomach aches, etc.?	All of the respondents said that they use herbal remedies for minor problems but went to the hospital if they were really sick. Four people mentioned something called 'ABS' which seemed to be the name used for folk medicine.
7. Discuss a patient's religious preferences and constraints regarding his treatment: Would you be offended if the doctor asked you about your religion and how you would like to be treated?	All of them were Christian; 2 said they were Catholic; the others didn't specify
8. Communicate the importance of medical treatment to a patient who believes that his illness is due to supernatural causes: What do you think causes illness? Negativity? Envy? Witchcraft? Germs? Bad health practices?	Across the board all of the respondents said that they didn't believe in witchcraft because they are Christian. 4 said that people get sick when they work too much; 3 said that people get sick if they drink bad water. 5 said that it was in God's hands whether or not they got sick but it was important to take care of one's physical health.
9. Explore the migratory trajectory and possible traumatic experiences of an asylum seeker: Do you mind if I ask you about how you came to Italy? Do you speak Italian? How long have you been here? Can you talk about your journey from Africa? How do you feel about Italy and Italians?	It was very obvious that their journey from Libya to Italy had been very traumatic. 5 were very open about it and commented that they had seen people die; 5 said that they had risked their lives; one didn't want to talk about it. Everyone had been in Italy for at least 1 year; still waiting for documents. They all were living in immigrant centers, and went out during the day to ask for money on the streets. They all apologised for that fact and said that as soon as they got their papers they would go look for jobs, either in Sicily or elsewhere. They all said that they were very happy to be in Italy and that the Italians had treated them very well.

10. Have you had any bad dreams about your past life or your trip to come here?	Eleven admitted to having recurring nightmares.
11. Do these expressions make sense to you? -brain fag -to be sick upstairs -to join one's ancestors	No one had ever heard of brain fag; they defined 'to be sick upstairs' as being crazy; and 'to join one's ancestors' means to die.

Table 2. General information.

Questions	Answers
1. What's your name?	Mostly Western names were given, many adapted from traditional, difficult-to-pronounce tribal names.
2. Where were you born?	Mostly from Edostate/Edustiz
3. How many years of study?	Most said they had finished secondary school.
4. How many brothers and sisters do you have?	All had brothers and sisters, some killed
5. How many languages do you speak? Which ones?	Izon, Igbo, Akaya, Benin, Edo, Ibibo; everyone spoke at least two languages
6. Have you lived in other countries besides your home country and Italy?	Just Libya as a temporary spot to come to Italy
7. Did your family live in any other countries when you were a child?	No
8. How long have you been in Italy?	Answers ranged from 1-1.5 years.
9. What do you think of Italy? Italians?	Everyone likes Italy and appreciates Italians.
10. Are there any of your family members with you?	No. 3 people do not know where their families are.
11. What kind of work do you do? What did you do in your country? What would you like to do in the future?	Answers included: driver, painter, fashion designer, laborer
12. What's your religion?	Christian

As often happens with qualitative research, the questions change and the desired answers do not always take on the pre-conceived shape. It was a challenge to illicit cultural idioms of distress, partly because of the communication barrier and partly because of the affect that came out in everyone's interview. Probably being interviewed by an unlikely researcher (female, American and in the middle of a busy street) was not the best way to illicit a desired response. Also from the cultural aspect, it was probably the first time they had been interviewed for scientific purposes. Sometimes what was not said is more powerful than what is said. One of the cultural idioms of distress that was found in this preliminary research was religious in nature. Several ideas came out about how the Nigerian culture faces and deals with loss. Three of the respondents started to recount specific details about their journey to Italy in the boat. All three of them interrupted themselves and said several times "God is great, God saved me. God helped me. I wouldn't be here if it wasn't for God. God will help us." The respondents were grateful and repeated it over and over.

A recurring theme also was 'thinking' and 'thinking too much in my head' which several respondents explained to me as being a type of stress.

6. Comments

Perhaps it is easier to define physical ailments across cultures because if the words are lacking, at least the patient can point to the area of concern. Due to the problems of water supply, the word 'insect' came out with one person who was talking about drinking polluted water and feeling sick afterwards.

Defining illness in itself is a cultural challenge that seems to vary in degrees from culture to culture. Probably interviewing and discussing is not the best way to find out this information; the best way would be to be in an actual situation, either in the home country or in a clinical situation. This research raises the issue of how difficult and also dangerous it is to assume 1). that interviewees actually tell you what the reality is, and 2). that the questions asked by the researcher can actually elicit the answer under research.

7. Conclusion and Recommendations

More research should be done on larger groups of Nigerians and other African language groups. Perhaps the method of interviewing should be accompanied with more visual materials, perhaps videos of particular medical situations in order to illicit the desired output. Perhaps there was a certain compensation on both the parts of the interviewer and interviewee: the interviewer trying to build a fast, superficial relationship and the interviewee wanting to please. Other information surfaced that may be of use: almost all of them admitted to having nightmares about their experience of travel to Italy. Although it was out of the scope of this research, Italian mental health workers would be well advised to be aware of future epidemics of Post-Traumatic Stress Disorder.

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