

INTRODUCTION



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Those big ears hear nothing because they care less about us.

—Akan proverb

The narratives in this volume range over health concerns: physical, social, cultural, spiritual, financial, emotional, mental and environmental. They also reflect and refract the sociopolitical ecology in which vulnerable populations operate and, in addition, modulate both research and discourse ecologies. The narratives unearth an imbalance between the pivotal role played by the voices in the creation of wealth in the United States, the neglect, sometimes, of their unique health needs, and their plea to be heard in order to obtain optimal health.

An important theme that runs through the gamut of the narratives is the devastating incongruence between voice, ear and action. Society gives the impression that it is listening to the plight of vulnerable populations, but when push comes to shove, it refuses to hear and hence takes no action to better the lives and the lot of such populations. These vulnerable lives, we learned, will be changed for the better if society listened and acted accordingly.

The privilege of listening to the vulnerable populations' stories brings companionship between the participants and the chapter contributors. In particular, the researchers who contributed to this volume learned through the narratives about the researched population. This was done through relationships via intentional personal interactions and methodological strategies that helped to augment work on public health and medical discourse given the richness of the narratives in providing information about the health needs of the vulnerable populations and how they accessed healthcare. Specifically, the narratives provide the reader with the opportunity to learn about how vulnerable populations deal with their various dimensions of health and the ups and downs in their daily struggles to

seek optimal health. As we 'listen' to the hitherto-muted voices via the contributors' transcripts, we hear exasperation and squirming; we observe chortling and cheering, as well as enthusiasm and agonizing. Their voices give in and then cheer up, address themes of neglect by society, of societies' responsibility to care for the vulnerable and of the associated anger at a nation's blindness towards its citizens' sufferings. We also hear about the power of the human spirit to overcome adversity, and the love of family and healthcare providers, among others, in mitigating the negative and harmful effects of the problems encountered by the vulnerable populations. We learn about public hostility and stereotyping endured by vulnerable populations, such as the homeless, and their suggestions about how to deal with them.

To enable us to understand the stories told by our studied participants, we have, in the following chapters, placed the narrators at the centre-stage of the discourse ecology. This helps to avoid any form of marginalization and further muting of their voices. Context is provided for each narrative and care is taken not to distort the narrators' intended meanings. Indeed, the narrators provide explications of their ideas as well as questions posed to them by the researchers when necessary. Thus, not only are the narrators generous with their time, they are equally generous with the synthesis and analyses of the facts they provide.

Given that the narrators' own elucidation and explication of their lived experiences and social actions are grounded in their own experiences and thought processes, we believe that any attempt by the chapter contributors to undertake any further synthesis and analysis will be redundant and unnecessary; such contributor elucidations are therefore, for the most part, avoided. In effect, the storytellers are not mere narrators; their stories unearth, explain and discuss who they are, what they are going through, and ways of solving their problems. Thus, via metalanguage, they position the reader or society in a way that makes the content of their stories easy to comprehend.

Consequently, the narratives are presented in exactly the same content and style that the narrators told them. No syntactic, semantic or pragmatic changes or errors have been corrected and no content has been modified. The punctuation marks used correlate with narrators' phonetic output, such as pausing and prolongation, as carefully and as accurately as the authors are able to transcribe them. Given that all clarifications and explications of facts are carried out by the narrators themselves, sometimes on their own accord and at other times when prompted with a probe, it is fair to state that the data are authentic.

The contributors focused on specific individuals and spent time undertaking extensive interviews that enabled the studied participants to pre-

sent their stories in an unconstrained way. The interviews were conducted unidirectionally, thereby enabling the interviewees to also ask questions if they chose to. There was little to no interruption whenever the narrators had the floor or their turn.

The knowledge to be gained from this volume in general, and from the narratives in particular, has wide tentacles. There is health information, especially the narrators' accounts of how they view their physical, social, emotional, mental, environmental, financial and other forms of health. There is also information about how they accessed healthcare and its associated problems, society's attitude towards them and how that impacts their emotional and social lives and health, their support systems and networks, and their resilience in the face of discrimination, domination and exclusionist ideologies. The narrators' hidden concerns and wishes are rooted in objective reality, not in ignorance. They sometimes observe their negative and positive liberties (Berlin 1969; Obeng 2018, 2020) being intruded upon daily by the powers that be with no one ready to listen to them. Through their narratives, they seek a restoration of these liberties. This is despite the fact that government and/or other institutions 'hold them hostage' because of their being physically challenged, being homeless, being an immigrant or being a minority. They seek their positive liberty by asking to be allowed to participate in their own affairs and in the affairs of their communities.

Their challenges (physical, emotional, social and financial, among others) are different and unique, yet one thesis is common: they want to be heard and given an opportunity to function as normal human beings and as authentic members of their communities. Whether it is being Black, suffering from ataxia, being hearing impaired, being homeless, being an immigrant or being a healthcare provider, these knowledgeable and very reasonable human beings reject 'otherness' and seek to be part of the mainstream and given an opportunity to contribute their quota to the gamut of society and to nation building, and not to be viewed as helpless freeloaders or, in some cases, privileged healthcare and social services providers.

The chapter summaries below prepare us for the informative narratives and elucidations in Chapters 1–5. The final chapter, the conclusion, provides a summary of the salient points of the volume and a brief conclusion.

Chapter Summaries

Chapter 1 by Hannah Kelling deals with the lived experiences of a homeless person, Mark, and of a person (a caregiver) who works with homeless

people, respectively. In first part of the chapter, Mark narrates his lived experiences as a homeless person of between two and five years, and how that makes him see Hannah as being of good fortune and privilege. He speaks about how he became homeless, something he described as being by choice since it afforded him an opportunity to see his son who lived with his (Mark's) divorced wife. Thus, as Kelling rightly hints, Mark's homelessness was motivated by choice, but even more so by his love for family and his willingness to be close to them, even if this would make him homeless. He explains his encounter with addiction to drugs and alcohol, being incarcerated every now and then, his wife's disrespect for him as a result of his homelessness and inability to hold a job, how desperation drives him and other homeless persons to deal in drugs in order to make money to stay afloat, and how he tries many times to put his life back together, as well as the hurdles he has faced as a result of unpaid bills among other things. Kelling's rendition of Mark's willingness to 'volunteer' information as being characteristic of someone whose words 'had been waiting just below the surface for a long time, waiting for the opportunity to come forward' testifies to the extent to which this hitherto imperceptive voice was looking for an opportunity to be heard with the view to finding a solution to his unique crisis.

Mark's narrative unveils a policy deficiency in Indiana: that of not having homeless shelters known to him in Orange County or in any other county in Southern Indiana, except perhaps in Evansville. His concern points to the need to inform and educate the homeless community in Southern Indiana about the presence of such facilities in order to lessen their burden and help them seek shelter if need be.

Mark shares his daily routines, his personal experience with housing officials and how his unique situation makes him unqualified to receive housing. His cynicism about the system, which he saw as rigged against the homeless, was made manifest – something that made him see the police, the city, county officials and everyone else for that matter as being in cahoots against him and his homeless friends. Indeed, he viewed the police as stalking and profiling the homeless. He ends his narrative with a call for structures to be put in place for everyone to own a house so as to enable them to function as normal human beings.

Mark's story no doubt opens up a pathway into an unspeakable but real situation in American social structure and organization, deviance and control, an unfair resource allocation, and how that ends up throwing some people off the visible grid or medium, thereby making the faces of the negatively affected, invisible and consequently their voices imperceptible.

The second narrative is that of Andrea, a caseworker with the Peace Shelter Center. Andrea narrates (to Hannah Kelling) her two-year experi-

ence regarding her normal work routine of assisting the homeless. Kelling describes Andrea as having a rare persona that conveys conflicting qualities of sweetness and toughness, as well as calmness and self-assurance in the midst of chaos and dissonance associated with her work.

Regarding her motivations for pursuing a career in casework and her own personal theories about why homelessness exists, Andrea delved into her previous experience of working for people with disabilities, managing group homes and working with clients who had very severe behavioural issues. She also spoke about her position in the Rapid Rehousing programme and how all this impacted her professional and personal lives. Andrea's love for personal interaction with the homeless, especially regarding their most vulnerable state, made her learn more about the people she and her social work colleagues assisted in particular and about homelessness in general. She describes the Center's target of serving a minimum of twenty people a day (even though some days they saw forty or more) and its provision of housing and/or financial assistance to enable people gain access to housing. Andrea's success as a caseworker at the Peace Center is captured by the strategy she adopted, a stance that emphasized the importance of and need for a carefully planned and administered empathy, as well as the fact that: 'Too little, and you fail to connect with your client. Too much, and you may unravel yourself.' Andrea thus calls for a balance between keeping one's sanity and professional etiquette, while at the same time making every effort to connect with one's clients.

Using her own lived experience with family members who went through addiction and housing uncertainty and how that impacted her, Andrea elucidates such problems as clients' pride or unwillingness to share the unique stories leading to their homelessness. She also explains the Peace Center's inability to deal with detoxification, which results in referring clients to other relevant centres. All the above, Andrea's notes, are some of the barriers that the centre had to deal with. She notes how empathy causes burnout in social workers and case managers, and the need to sometimes resort to sympathy rather than empathy. She elucidates the complexities associated with health insurance and how co-pays and high-premium payments all negatively impact the homeless community, as well as how, on some occasions, different individuals and agencies help mitigate and solve this problem for the homeless. She also discusses how huge medical bills, wanton arrests of the homeless by law-enforcement officers, and a lack of effective and efficient support systems contribute to housing instability, leading to homelessness. Furthermore, she explains the preponderance of mental health issues among the homeless population and how this is viewed and dealt with. She ends by calling on other caseworkers and society to provide emotional support to this community

and to help them with navigating the complex healthcare services that may be available to them.

Chapter 2 by Cassie Kresnye deals with two individuals, Nancy and Lisa, both of whom suffer from ataxia; a condition associated with poor coordination and unsteadiness due to the brain's failure to regulate posture as well as the strength and direction of limb movements. In the first narrative, Kresnye 'invites' her readers into the lived experience of Nancy with regard to the debilitating effects of the disease on her balance and the way she walks, especially her inability to walk straight, her unpredictable falls and how her use of Rollator and a cane sometimes help mitigate her falls. Nancy educates Kresnye (and hence the readers of this volume) on the time of her diagnosis with ataxia, the causes of the disease, the various texts, contexts and steps that went into her diagnosis of the disease, and the fact that the disease can be managed, not cured. She also discusses the various physical and neurological activities associated with the disease, her participation in drug and medical procedure trials and studies aimed at helping her get well, as well as support groups in which she had had to participate in order to stay healthy. Nancy expounded the extent to which age and other environmental factors (such as the home environment, crowded environments, etc.) impacted her ability to participate in the much-needed physical and neurological activities aimed at helping her manage the disease. She also allows us into her personal experience with her mother's own fight with ataxia and how she dealt with her own diagnosis regarding disease management. She also educates us about how she broke the bad news to her immediate family (her husband, daughter and son) and how the family jointly dealt with the emotional valence and social trauma associated with such bad news. She also shared how the family worked with medical personnel to manage the disease itself.

There is no doubt that Nancy's story is emblematic of someone with courage and determination to survive, and even overcome adversity. She turned her unique situation into a teachable construct by assisting society in understanding the disease and in helping others to get an education. It is not surprising that she ends the interview with the expression: 'There's a lot of hope.' Indeed, there is a lot of hope if her voice, a voice that explicates her unique personal experience, is listened to and if her concerns are dealt with.

The object of the second part of Chapter 2 is Kresnye's presentation of her interaction with Lisa, a woman in her fifties who is also an ataxia patient, and her elucidation and elaboration of Lisa's lived experience with the disease. Lisa discusses who her caregivers were (with her husband being the main one) and the steps and health issues (such as blaming her lack of coordination on her knee and hence having the doctors do the knee

surgery that she went through before learning she had ataxia. She takes us through her childhood experiences, her adulthood journey and the eventual diagnosis of the disease. She also discusses her experiences with different doctors in various specialized areas, especially those in neurology, and the various tests and procedures that were recommended to her. Furthermore, she takes us through the various support groups she learned about and those in which she got involved, as well as the impact they had had on her disease management. Her use of metaphors such as 'I like to think ataxia is like a broken arm' points to her linguistic and communicative prowess in explicating the labelling, finger-pointing and sometimes avoidance that people suffering from various diseases must deal with daily. She informs us how joining support groups and leaving one's ecology to interact with others in different ecologies helped her to deal with her disease. In particular, she explains how knowledge and entertainment that are shared and enjoyed in the various support groups helped to lift the burden of stress and entrapment associated with staying in a solitary ecology where one is ensnared in the same place without respite.

Lisa also talks about her real fears, such as the possibility of falling down stairs or of going to crowded places and how she deals with them. Her story, like that of Nancy, is one of a test and contest of willpower, of survival and of an understanding that there is hope at the end of the struggles and difficult tunnels that ataxia sufferers must navigate.

In the first part of Chapter 3, Mackenzie Jones presents the narrative of Trip, a gastroenterologist whose passion was to provide healthcare to his patients. Trip happened to be Jones' doctor, so getting him to participate in the interview was not very difficult; in fact, it was Trip who encouraged Jones to share her interests and goals for 'changing the world', so Jones' interest in patients with communication disorders such as deaf/hard-of-hearing populations coincided directly into Trip's clinical interest, since he was caring for patients, some of whom had communication disorders. Trip could fingerspell his name and was also vaguely familiar with American Sign Language (ASL).

Jones notes that her goal when interviewing Trip was to understand the communication strategies actually used in a hospital or a doctor's office when a patient is deaf and to explore the experience of a physician who may not be used to working with Deaf people on a regular basis. Jones prefaces her presentation of the narrative by elucidating the rationale behind establishing the Americans with Disabilities Act (ADA) and what Titles II and III say about nondiscrimination against those with communication disorders, as well as the need for government-run and nongovernmental organizations to consider their preferences for communication aids in order to ensure the highest quality of care. She disambiguates the

expressions ‘Deaf’, ‘deaf’ and ‘hard of hearing’ by helping her readers to understand ‘deaf’ and ‘hard of hearing’ (the medical condition) and ‘Deaf’ (the culture of the Deaf world).

In the interview itself, Trip mentions his background growing up in a home with a doctor parent – a situation that drew him into medicine and subsequently impacted his choice of specialization/residency. He also mentions how he was introduced to ASL and talks about there being someone who knows ASL (an interpreter) and who helped with translation/interpretation at the clinic. He describes ‘generic’ classes that he took in Medical School on working with patients with disabilities, which were mainly done without actual patients being brought into class to help give them hands-on experience. He lucidly describes his strategies with hearing impaired patients; these include raising his voice, sitting in front of them for them to read his lips and using ASL if necessary. He also explains how letters are often used as modes of communication to refer patients to other specialists and to invite the clients back if the need arises to explain specific conditions to them in follow-up sessions. He notes the difficulties nurses and other personnel have in communicating with them and mentions the frequency of encounter with hearing-impaired clients. He also cites specific cases where procedures have to be carried out on his patients and the overall communicative events that take place before and after surgery with such clients. He notes also how a Video Relay System (VRS) and computer monitors on rolling tables are used for interpreters in the hospital if they (the doctors/hospitals) are the ones who provide the interpreter. Also, he acknowledges the fact that more can be done to improve the communication between hard-of-hearing patients and their healthcare providers at the hospitals. Jones calls for improvements in communicative modes in the medical discourse ecology to ensure effective communication and patient-physician satisfaction.

The object of the second section of Jones’ chapter is a presentation and an elucidation of the narrative of Adam, a deaf (hearing-impaired) patient who is a professor of ASL. Jones elucidates how Adam uses cordial interlocution with his students to set the scene for his class each morning. She recalls how Adam helped her improve her ASL and her understanding of the culture of the Deaf community. She also explains how he assisted her in finding an interpreter during data collection and synthesis. In particular, the Jones–Adam interaction provides insights into techniques in collecting data from the Deaf community and into how an interpreter functions within the deaf discourse ecology.

According to Jones, Adam’s story provides instances of positive and negative interactions with healthcare providers. It also provides ideas for providing and ensuring a more equitable healthcare system. Furthermore,

given that Adam used ASL, Jones draws our attention to the fact that the narrative transcripts are based on the interpreter's rendition of Adam's ASL. Also, taking into consideration the problems associated with translation in general and ASL in particular, she acknowledges the possibility of some communicative facets being lost in translation and interpretation.

In the narrative itself, Adam explicates his encounter with doctors, how communicative frames are established and employed in the management of the health discourse, the problems encountered with sound and prosody articulation (production), including various forms of lip aperture and interpretation, and solutions found to ensure the achievement of successful health communication outcomes and goals.

Adam also provides us with a glimpse of the nature of the discourse at the doctor's office reception and how trust and authenticity are established between a client and the office staff before a client is allowed into a doctor's office. He alludes to the fact that it is the fight for civil rights that has led to the establishment of Deaf people being afforded the right to see doctors.

Moreover, he provides an account of his childhood, how his parents detected he was hearing impaired and the steps they took to educate him. He also provides a fascinating insight into the linguistic structure of, and communicative strategies, in ASL and explains clearly why ASL is not English, but a unique language with its own unique syntax and pragmatics. He elucidates this further by explaining the centrality of facial expressions, gestures (body language, lip aperture, hand shapes, hand movements and fingerspelling), gaze and proximity in ASL interactions. He speaks about his college days, pointing out his initial majors of interest and how he settled on a B.S. in construction management. He also provides an insight into his search for employment and how that took him to New York, where Deaf people are viewed as high risk, despite the Americans with Disabilities Act, which protects people like him from employment discrimination. He eventually ended up as a professor of ASL after completing a master's degree.

Furthermore, Adam talks about support from his parents and siblings when he was growing up, and how he wished advocacy had been part of his early education. He also mentions the challenges he experiences as an adult, including healthcare affordability, the fact that he had to live on social security at some point, not having health insurance, and the negative attitude and stigma attached to being deaf. He describes the 'horrible' and 'horrendous' nature of certain hospitals due to doctors and nurses not responding immediately to requests and the absence of interpreters at some clinics. He also explains how hospitals now use VRS (to provide an equivalent to telephone services for deaf and hard-of-hearing people) and Video Remote Interpreting (to provide interpreting services for many

languages) to ensure effective communication between doctors/nurses and their hard-of-hearing clients. He notes that he prefers family members acting as interpreters rather than the use of technology or hospital interpreters if a deaf person's illness is severe, given the emotions associated with illness. He recommends ASL language and Deaf culture training for doctors to create awareness of their unique situation, to increase the doctors' understanding of the Deaf culture and consequently increase the doctors' efficiency in working with the Deaf community.

In Chapter 4, Dema Kittaneh presents the narrative of a Jordanian immigrant Amy living in the United States and shows how her status impacts her health. She prefaces the narrative with a brief review of the literature on migration in general and emigration into the United States in particular. Specifically, she explicates such problems as difficulties speaking and learning English, raising children and helping them succeed in schools, securing work, securing housing, accessing social and economic services, using transportation, and overcoming cultural barriers. She draws on the work of Garrett (2006), who also examines problems of migration and discusses the facts about immigrants being vulnerable due to increased risk for poor physical, psychological and social health outcomes, as well as inadequate healthcare (see also Aday 2001; Flaskerud and Winslow 1998). Amy, a fifty-year-old former Jordanian banker, came to the United States at the age of twenty-three by chance and became an immigrant without the intention of permanently settling in the country. Amy, according to Kittaneh, went from being a banker in her home country to becoming a housewife and mother of three after settling in the United States, a situation that, according to Kittaneh, negatively impacted her physical, mental, social, financial and spiritual health.

Amy, Kittaneh notes, spoke about the open-mindedness and educated status of the people of Bloomington, Indiana, and the large and growing presence of international students and transnational people making it a hospitable place to live. Also, Kittaneh quotes Amy as speaking about the 'lazy' lifestyle in the United States, which she felt could potentially affect her children in the long run. She saw as problematic the practice whereby people refrained from cooking and ate mainly from restaurants, something that she thought negatively affected their health. In terms of physical health, Kittaneh quotes Amy as noting that Bloomington has gyms, the YMCA (to which she signed her children up to be members), swimming pools, parks and everything needed for one to maintain good physical health, and consequently to become confident as well as being part of the community. Amy's children volunteered in such organizations as Habitat for Humanity, Riley Hospital and Key Club as part of being authentic members of the Bloomington community.

On the kind of activities that influenced Amy, Kittaneh points to the fact that despite taking a walk with her husband on a regular basis, Amy gained weight because after childbirth she resorted to eating fast food, sitting and watching TV. An important fact brought up in Amy's narrative was that whereas in Jordan people 'monitor' one another's weight and appearance and openly question individuals if they notice any dramatic changes such as excessive weight gain, in the US people mind their own business and refrain from openly commenting on the bodily appearance of others. This cultural difference, Amy notes, may have contributed to her gaining weight, since no one drew her attention to it. According to Kittaneh, upon Amy's return to Jordan, she was openly criticized for not taking care of her body and becoming obese, which made her feel embarrassed. The fact that she was diagnosed as prediabetic as well as her motivation to be healthy made her determined to lose weight. Among other steps, he cut out junk food, mainly ate home-cooked meals and took daily walks in order to lose weight.

Amy credited the US health system with providing customized strategies for keeping people healthy by referring them to a dietician for help. In her case, she also had lap-band surgery and lost 70 pounds. An important message she has for others is for them to take their health into their own hands and work to improve it. The issue of health insurance in general, and the fact that most poor or poorly paid individuals have no health insurance in particular, came up in her narrative. She elucidates how the Affordable Care Act (Obamacare) came as a reprieve for her family. She praises Bloomington doctors for being nice, nondiscriminatory and professional without necessarily looking at how much money one has. Her narrative, Kittaneh notes, also touches on her husband's health problems, which include being overweight, having high cholesterol, cardiovascular problems, diabetes and high blood pressure, as well as suffering two heart attacks. Obamacare, she re-emphasizes, met their health needs.

Amy's narrative ends on a positive note about her family's improved financial health, which involved her and her husband starting a new grocery business and feeling successful despite the physical burden of working from 10:30 AM to 7:30 PM each day. The narrative ends with an emphasis on how the physical, financial and social dimensions of her health have improved and with a suggestion made to public health professionals to advocate for health policies that can help improve the health of vulnerable populations.

In the second section of the chapter, Kittaneh writes about the health experiences of another immigrant, Hama, who hailed from northern Nigeria and who, like Amy, was a housewife. Hama emigrated to the United States at the age of nineteen as a result of getting married and had lived in

Bloomington for twenty-two years by the time the interview took place. She had five children, aged 21, 19, 14, 11 and 4 months. Kittaneh discusses the attempt by Hama's family to move back to Nigeria in 2015 and how the activities of the terrorist group Boko Haram made it impossible for them to live peacefully, and consequently forced them to move back to the United States after only six months in Nigeria.

Hama spoke about her financial health, especially about being able to work and make some money. Her ability to work gave her confidence and satisfaction for the first time in life. However, she quit working after becoming pregnant. She also recounts that in the 1970s because of discrimination her husband could not find a job. However, things have changed over the years, making it easier for him in this respect. She noted further that the change in attitude towards Black people in Bloomington has improved her family's financial health, making it possible for them to pay for accommodation, health and food, and to even have some savings.

Hama had no medical issues and praised the US environmental health system as well as the overall medical system compared to that of Nigeria – something that she said had benefited her children. For example, an observation of Kittaneh's transcripts indicates the absence of malaria in the United States as being a big difference between healthcare access in the United States and Nigeria. Hama condemns the Nigerian medical system, sometimes harshly. It is important to note that even though some of her examples – such as the same medication (including dosage) being given to adults and children – could be called into question, the fact that she makes this observation is noteworthy. In particular, we observe from Kittaneh's transcripts how Hama speaks about the persistent use of injections to treat people suffering from all kinds of illnesses and how nurses instead of doctors prescribe medication. Hama notes that she was unhappy with this state of affairs in Nigeria. Her narrative briefly touched on dental healthcare in the United States and how her children had benefited from it. She notes that moving to the United State has been a positive move for her in terms of her health, and she credits her good health to her engagement in physical activity, especially exercising (walking).

In terms of safety, Hama considered Nigeria to be safer than the United States (Bloomington) in terms of taking a walk, since most of the people you meet when you take a walk in Nigeria are known to you. She attributes the relative safety in Bloomington to people abiding by the rules set by the city.

Regarding the social and emotional health of her children, Hama notes that her children were not affected negatively either emotionally or socially, except for one incident that involved other children telling her daughter to take off her Hijab (headscarf), something that made her

daughter feel awkward. This apparent bullying stopped after her daughter's involvement in a TV programme. On the subject of physical health, Hama mentions that such activities as swimming, running and playing basketball help to keep her children fit.

On education, Hama spoke about the poor educational system in northern Nigeria brought about by teachers' incompetence in English, the official language of instruction. She also spoke about her difficulty in understanding American English when she first came to the United States. She commended and attributed her children's educational success to her husband, who she said was dedicated to the children's education, assisted them with their homework and also helped them to read and learn English.

In relation to her marriage, Hama spoke about the socioemotional advantage of living in the United States, since wives and husbands support each other, unlike in Nigeria, where the husband barely comes home and the wife is stuck with the children at home, a situation that negatively affects the wife and children's emotional and social health.

On the subject of spiritual health, Kittaneh quotes Hama as saying that she does things that are consistent with her religion, but not necessarily with her Hausa (Nigerian) culture. Unlike her husband, who adapted to American culture because his friends were African American, she had only Arab friends, thus making it difficult for her to understand and adopt such American cultural mores as those relating to birthday celebrations.

Another aspect of socioemotional health noted by Hama related to clothing or lack thereof, especially seeing American women as 'naked' because of how little they wear. This, she noted, made her angry with her husband, leading her to question his integrity. Specifically, she blamed her husband for taking her for a walk in order to give himself the opportunity to watch 'naked' women. She barred him from watching TV because of what she perceived as 'naked' women on TV. Eventually, she came to accept American clothing culture, despite the exception she took to some of the cultural mores.

In Chapter 5, Kourtney Ayanna Dorqual Byrd examines issues of identity of two Black graduate students, an Afro-Caribbean female and an African American male at Indiana University-Bloomington. Specifically, she collected narratives that revealed how the Black identity of graduate students impacts their health. Via these narratives, she stresses the negative emotional health about being Black in the United States. She notes that Black people in general, and Afro-Caribbean and African Americans in particular, face racial stressors in their daily lives and that these stressors negatively influence their physical, emotional, spiritual and mental health, as well as undermining their attitudes towards their racial identity.

Byrd cites statistics from the US Commission on Civil Rights (2010) and from Indiana University-Bloomington, which showed the relative low enrolment of Black people in higher education (colleges and universities) due to their Black identity.

Byrd prefaces her research participants' narrative with a brief discussion of the Black Graduate Student Association, an organization at Indiana University-Bloomington that is dedicated to promoting and championing the academic, professional, mental and social wellbeing of Black graduate and professional students. Byrd's Black identity group membership made her entry into the researched participants' lives much easier. Even though over thirty people responded to her recruitment email, she selected the first two responders as participants in the study. She uses qualitative methods of research (narrative methodology via interviewing) to understand and present the kind of life experiences that influence one's health and to discover any potential information that will help improve not just the respondents' health, but also that of Black America in general. The only qualification for participating in Byrd's study was, besides being Black and a graduate student or student in the professional school, being eighteen years of age or older. Using two semi-structured interviews, Byrd spoke with each interviewee for between 15 and 30 minutes. She asked about the kind of activities that influenced the respondents' health and about the strategies that helped them deal with any problems that influenced or helped to improve their health. On the question of the activities that influenced her health, Respondent 1 (Interviewee-1) mentioned: (a) sleeping (which she said influenced her thinking –the more sleep she had, the better she could think); (b) hanging out with people in the community for upliftment of one's spirit; (c) being in solitude to refresh one's self; and (d) eating (where she notes that eating the wrong food did not connect body with mind and spirit and also negatively impacted her output).

On the body–mind–soul connection, the respondent noted that she had very bad migraines and that the dining hall food made these worse, since the food was not made with 'love and care'. The food, she noted, lacked the energy that should be there for those who eat it. She would have preferred home-cooked meals made with love and care. She did not see the meals served in the dining halls as 'real' meals; they were not spiritually fulfilling and so caused her to have headaches, to be frustrated and consequently to have a negative impact on her soul. Her energy 'feels off', she noted. She wanted 'cultural' food and spicy food that did not make her sick.

The interviewee reaffirms her need for space (not a shared area that she viewed as often being dirty, filthy and disgusting) to enable her to bake her food and to cook what she considered real food (food that is

'well' and tastes good). She saw baking, aromatherapy and painting as being therapeutic for her because they helped her relax and release tension. Having space to think about herself also relaxed her. Cooking, painting, yoga, going to the gym and cleaning, among other activities, provided extra support for her relaxation and releasing of inner stress (tension). She considers water, sun and being in the community as rejuvenating her body, mind and spirit.

On racial identity, Interviewee 1 talks about being Black, being a woman, being queer and being Afro-Caribbean. She talks about how, in accessing healthcare, her self-work and identity are not seen as a priority unless one was really sick or even dying. She notes that Black people are expected to do more than anyone else to the extent that even if they are sick, they must show up for class to avoid falling into stereotypes set for Black people. For Black students, this situation creates physical presence in the classroom, but emotional and spiritual absence from the classroom – what she refers to as post-traumatic slave syndrome.

To help other people improve upon their health, Interviewee 1 talks about getting to know the constituents and determinants of health and knowing what kind of activity is good for the body. She ends with an important message; 'One cannot be well if one does not know oneself . . . and whether one is willing to sacrifice' to get well.

The object of the second narrative in Byrd's chapter is a presentation and a brief explication of the life story of the second interviewee (Interviewee 2). Interviewee 2 defined health as an equilibrium (a state of wellness where everything is in proper alignment and function) and effectiveness in meeting one's needs, and the insurance that one is in the appropriate blood pressure range. He categorizes health as mental health, physical health and the overall wellbeing of an individual.

On the list of activities that influence his health by maintaining balance, Interviewee 2 sees the amount of work and physical activity one has to do as being the most important determinant of maintaining good health. Specifically, he notes that one's capacity to exercise and to eat right and have a job are the most important determinants of activities needed to measure one's state of health.

On how his Black identity impacted his health, Interviewee 2 stresses the negative emotional health about being Black in the United States by noting that Black Americans face racial stressors in their daily lives and that these stressors negatively influence their physical and mental health, as well as undermining their attitudes towards their racial identity.

An important difference between Interviewee 1 and Interviewee 2 is that Interviewee 2 took every opportunity that came his way to ask Byrd questions about her health. For example, he asks Byrd if she had the lux-

ury of free time to work out, an expendable or disposable income to have a gym membership, enough money to purchase health food options and whether she lived in a 'food desert', given that the above-mentioned factors affect one's health. He speaks of work that involves several hours of sitting as going against physical activity and hence physical health, while high-intensity and stressful tasks such as studying as negatively impacting both physical and mental health, as well as one's overall wellbeing. Other activities that influence health, Interviewee 2 argues, are maintaining balance, having enough sleep, not overexerting one's self and managing one's time efficiently, as well as identifying role models and following their health-related guidance. Also mentioned by Interviewee 2 are: (a) seeing a dietician and a mental health therapist; (b) maintaining one's mental and spiritual health; (c) connecting with people who share one's interests and who can talk about the stress they themselves are going through and consequently help one deal with stress; (d) building habits and behaviours necessary for creating long-term optimal health; and (e) reassuring and sustaining ecologies that help nurture and sustain the best possible health outcomes.

Intl-2 laments divisions in the Black community and things that members of the community ought to do to improve their health, but that they are not doing presently. He also explicates perceived and intended identities as well as intersectionality (which he notes was born out of Black feminism and Black womanism) and notes that, if unbalanced, the different identities create distance and barriers. He calls on Black people to choose their most salient identity marker rather than having it imposed on them. This, he notes, is because relegating some of one's identity to the background or leaving out aspects of one's identity leads to unhealthy coping mechanisms, which thus negatively impact one's mental, emotional, spiritual and physical health, given the fact that they could lead to overeating, unhealthy engagement in sex, and overcommitting, among other things.

Regarding suggestions about improving one's health, Interviewee 2 talks about identifying and being aware of one's mental, emotional, spiritual, physical and intellectual health, and what these involve. He also advises people to see a therapist (to see how one is doing mentally), an advisor (about time management) and a dietician (to find out whether what one is eating is right). He ends by recommending Indiana University-Bloomington's Counseling and Psychological Services to Black students, since the people who work there are Black and understand their unique needs.

The conclusion involves a summary of the main points raised in the volume and a few concluding remarks followed by recommendations of our own. We highlight how the interdisciplinary nature of the volume and the entwining of the various disciplines help us understand the plight of

vulnerable populations. We also bring out common themes in the narratives – in particular, their provision of a glimpse into the lived experiences of the studied participants, and vulnerable populations in general, from their unique perspectives and spaces. We also emphasize another theme: that of people finding strategies to deal with their unique social and psychological situations and with the physical, social, financial, emotional and environmental dimensions of their health. We note that the content, context and co-text of the narrators’ stories are pathways to strong, enduring and successful survival and character-building blocks. Also noted is how the narrators’ ability to build supportive families impacts their person, personality, mind, soul and spirit. The homeless, for example, bond with one another as a family and support one another; this helps them deal with some of the physical and emotional difficulties they face on the street.

An important conclusion we draw is that society, government, social work actors, healthcare providers and all stakeholders must pay attention to the participants’ narratives because the stories reveal voids in the lives of the participants that need to be filled in order for them to live as normal human beings.

Finally, we highlight the entwining of language, power, ideology, justice, healthcare access and healthcare delivery. We also draw attention to moral lessons, such as the need to provide physical and infrastructural resources for vulnerable populations and the need to provide the deaf with interpreters, as well as to recognize their fight to be heard. We also highlight the struggle of vulnerable populations against racism and xenophobia, and their battle against other forms of discrimination. We point out that in order for society to live up to expectations, the words, ‘Life, Liberty, and the pursuit of Happiness’ in Thomas Jefferson’s Independence Declaration must be seen as relevant, even required, in order to meet the challenge in ensuring optimal health and safety for one and all.

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