THE CONSTITUTION OF REPRODUCTIVE HEALTH(CARE): UNDERSTANDING THE COMMUNICATIVE TENSIONS OF ORGANIZATION, IDENTITY, AND GEOGRAPHY

A Dissertation

by

REBECCA ANN COSTANTINI

Submitted to the Office of Graduate and Professional Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

Chair of Committee,	Anna Wolfe
Committee Members,	Tasha Dubriwny
	Lu Tang
	Courtney Thompson
Head of Department,	Hart Blanton

August 2021

Major Subject: Communication

Copyright 2021 Rebecca Ann Costantini

ABSTRACT

Reproductive health(care) is a contentious issue, one that has been historically barred, limited, and regulated across the United States. Broadly defined, reproductive health is a state of well-being related to the reproductive systems, and reproductive healthcare is a spectrum of methods, resources, and services that contribute to the state of well-being related to the reproductive systems. However, reproductive health(care) can mean many things across different organizational contexts: justice, human health(care), women's health(care), rights, autonomy, choice. Ultimately, it is through the competing voices of the conversational gatekeepers of reproductive health(care) where can begin to recognize the messiness of what reproductive health(care) actually *is*.

The primary goal of this dissertation is to theorize *who* or *what* invokes and expresses the social realities of reproductive health(care) from an organizational communication perspective. Using the communicative constitution of organizations (CCO) framework, I set out to explore how reproductive health(care) is communicatively constituted through language, member identification, and sites. I did this by employing two methodologies: (1) semi-structured interviews and (2) intimate mapping. Collectively, the findings of this study showed that reproductive health(care) is not a solid, tangible entity. Rather, it is a vibrating assemblage of tension and conflict produced through discourse, member identification, and sites of affective, embodied experience.

This dissertation aims to bring awareness to how reproductive health(care) is constituted by organizations and organizational members that claim to support it. This project also begins to provide a foundation for organizations that maintain disparate understandings of reproductive

health(care) to break out of binaries (e.g., pro-life/pro-choice) and embrace the messiness that constitutes reproductive health(care). The findings of this dissertation also offer several practical implications for organizations and organizational members that not only do reproductive-related work, but also for those who craft policy, legislation, and contribute to the various conversations that affect and constrain reproductive health(care).

DEDICATION

To everyone who dissertated in the time of COVID-19.

ACKNOWLEDGEMENTS

This corpus of research has been a project-in-process for several years, even before my time at Texas A&M University. It would have not been at all possible without the supportive networks of people who were there for me at every stage of the process.

To start, I would like to recognize the members of this study, who voluntarily dedicated their time and energy to speak with me at the beginning of the COVID-19 pandemic. Your testimonies, stories, and experiences have propelled this study forward in every way, and I thank you, again, for your patience and enthusiasm as we navigated our virtual interviews together.

I am grateful for several current and former faculty members of William Paterson University of New Jersey, including Drs. Angie Yoo, Jen Owlett, Klive Oh, Sharmila Pixy Ferris, and Diana Peck, who sparked my initial research curiosities as a master's student. Additionally, I would like to thank Dr. Martha Witt, who was with me at the start of it all during my undergraduate years, and Susan Haggerty, who believed in my writing abilities more than a decade ago.

I am forever indebted to my dissertation committee, who have been gracious, supportive, and flexible throughout this entire process, motivating me to produce the best work I possibly can during an incredibly challenging time. To Anna Wolfe, thank you for taking a chance on me that day at Sweet Eugene's in 2018, when I first asked you to be my advisor. Your mentorship, compassion, and friendship over these last three and a half years have pushed me through this program (and dissertation) and energized me to expand my scholarship in ways that I would have never imagined possible. You taught me to never give up on interesting ideas, especially in the face of rejection and defeat. Most importantly, though, I am inspired by your genuine

commitment to the Communication discipline, your scholarship, and relentless dedication to making the world a more equitable place. Tasha Dubriwny and Lu Tang, you will always serve as formative influences in my academic career. I am moved by your dedication to your crafts and scholarship. Thank you for imparting your knowledge and providing guidance on all things health communication- and reproductive rights, health, and justice. And to Courtney Thompson, thank you for your unwavering patience and support during this dissertation process and our co-authored project. I appreciate you.

Additionally, I would like to extend warm thanks and gratitude to Drs. Kevin Barge, Srivi Ramasubramanian, Sandra Braman, and Jen Lueck, who I worked with in several research and assistantship capacities during the past four years. Your support, encouragement, and kindheartedness have propelled me forward in every way. You are all model scholars, teachers, and professionals.

Last, but not least, I would like to recognize my family and friends. To Brian, my spouse: you navigated this PhD journey with me while pursuing your PhD at the University of Houston. From reading draft after draft (after draft), to providing late night encouragement, I am thankful for the countless ways you showed me love during this process. You inspire me to be the best version of myself. To my Mom, Dad, my sister Gabriella, and my brother Victor—thank you for supporting me from afar, where you cheered me on when things got tough. I would also like to thank (in no particular order) Caitlin Williams, Kyle Colglazier, Shelby Landmark, Julia Medhurst-Bray, Luna Wu, Brittany Everett, and *countless* others, for your camaraderie and care. And to Asha Winfield, we've been through it all. Thank you for being there during *all* of the highs, lows, and everything in between.

CONTRIBUTORS AND FUNDING SOURCES

Contributors

This work was supervised by a dissertation committee consisting of Dr. Anna Wolfe, Dr. Tasha Dubriwny, and Dr. Lu Tang of the Department of Communication, as well as Dr. Courtney Thompson, Assistant Professor of the Department of Geography. The work conducted for this dissertation was completed independently by the student.

Funding Sources

This study was funded by a 2020 Summertime for Advancement in Research Dissertation Writing Fellowship and a Research Enhancement Grant from the Department of Communication at Texas A&M University.

TABLE OF CONTENTS

Page

ABSTRACT ii

DEDICATION iv

ACKNOWLEDGEMENTS v

CONTRIBUTORS AND FUNDING SOURCES vii

TABLE OF CONTENTS viii

LIST OF FIGURES x

LIST OF TABLES xi

CHAPTER I INTRODUCTION 1

CHAPTER II LITERATURE REVIEW 9

The Reproductive Frameworks 9
Tensions Between Frameworks 13
The Communicative Constitution of Organizations Approach 20
Summary and Presentation of Research Questions 26

CHAPTER III METHODOLOGY 31
Study Site: Texas 31
Changing Methodological Course 32
Researcher Positionality 34
Virtual Interviews 43
Intimate Mapping 54

CHAPTER IV THE COMMUNICATIVE CONSTITUTION OF REPRODUCTIVE HEALTH(CARE) 62
Reproductive Health(care) as Women's Health 63
Reproductive Health(care) as Human Health 70
Reproductive Health(care) as a Euphemism for Abortion 74
Summary: The Constitution of Reproductive Health(care) 80

Page

CHAPTER V "WHAT BUBBLES UP FROM THE GRASSROOTS?": THE CONSTITUTION OF MEMBERSHIP IDENTIFICATION IN REPRODUCTIVE HEALTH(CARE). 82
Figure 1: Equity 84
Figure 2: Care 87
Figure 3: Purpose 91
Figure 4: Scarcity 95
Summary: Membership Identification and Reproductive Health(care) 99

CHAPTER VI MAPPING THE INTIMATE: COMMUNICATIVELY CONSTITUTING REPRODUCTIVE HEALTH(CARE) AS A SITE 100
Conceptualizing Intimate Flows 101
Intimate Flows of Distance and Time 107
Intimate Flows of Barriers 113
Summary: Intimate Flows as Organization and Organizing 121

CHAPTER VII DISCUSSION & CONCLUSION 123
Reproductive Health(care) as Relational 125
Membership Identification and Reproductive Health(care) 128
Intimate Mapping and Reproductive Health(care) 129
Methodological Implications 132
Limitations 134
Future Directions 136
Conclusion 137

REFERENCES 140

APPENDIX A 163

APPENDIX B 165

APPENDIX C 166

LIST OF FIGURES

Figure 1 Distances to the Nearest Abortion Clinics and CPC Facilities in Texas 58

Figure 2 Intimate Flows of Texas' Reproductive Health(care) Landscape 102

Figure 3 Intimate Flow A 107

Figure 4 Intimate Flow B... 108

Figure 5 Intimate Flow C... 109

Figure 6 Intimate Flow D 110

Figure 7 Intimate Flow E... 112

Figure 8 Intimate Flow F 115

Figure 9 Intimate Flow G 115

Figure 10 Intimate Flow H 117

Figure 11 Intimate Flow I... 118

Figure 12 Intimate Flow J... 118

Figure 13 Intimate Flows of Texas' Reproductive Health(care) Landscape without Basemap 121

LIST OF TABLES

Table 1 Participant Demographics 49

CHAPTER I

INTRODUCTION

I drove down Texas State Highway 21 for the first time in August 2017, my entire life stuffed into two large suitcases in the backseat. I had landed at Austin-Bergstrom International Airport in the morning and was en route to College Station, my new home away from home for the next four years. It was a hot, sunny day, and the blue sky and farmland stretched parallel with the highway for miles. At some point during this trip, I took a detour onto a local farm road that led to a three-way intersection. Across the street from the intersection, positioned near the edge of the road, stood four homemade cardboard signs. Each sign was about half the size of a highway billboard and appeared to be nailed to makeshift wooden stilts. The message text on the signs was bolded in patriotic red, white, and blue font and set in large, capital letters. Multiple exclamation points punctuated the messages, almost as if they were yelling at the drivers stopped at the intersection. To this day, I can still see—and hear—two of the signs:

ATHEISTS, ABORTIONISTS, HOMOSEXUALS, AND OTHER PERVERTS WILL LOVE YOUR DEMOCRAT VOTE!!!

ABORTION IS A MURDEROUS CHOICE!!! VOTE: REPUBLICAN

These homemade signs and their messages are not new or controversial. However, what they do bring our attention to is how they animate values, ideas, and “matters of concern” around abortion, religiosity, sexuality, and politics. Even more curiously: who, or what, are the signs acting on behalf of? Who, or what, gives these signs agency?

From a communication-as-constitutive perspective, we can say that the road signs are

acting or are made to speak on behalf of something or someone. More specifically, the signs are comprised of the sociomaterial properties (cardboard, text, nails, wooden stilts, the labor it took to assemble the signs, attitudes, ideologies) made possible by the various interactants and figures who materialized them in the first place. They could range from religious or political leaders, activists, organizers, politicians, and community members. As such, the road signs are made possible through what Cooren (2012) calls the "effects of representation and materialization," which makes the road signs present through the "actions, performances, and conducts of various figures" (p. 6). The road signs are figures that are created to express certain actions, ideologies, and values of the humans that conjured them. Figures can take the form of printed text on cardboard (as described here), an expression or call to action, or they can be invoked by people in a conversation.

It is important to recognize that the road signs are one of *many* figures that materialize the social realities around abortion, religiosity, and sexuality in Texas (and beyond). This relational process is crucial because it is where "communication *makes a difference*" in producing and expressing these social realities on behalf of people (Cooren & Martine, 2016, p. 2 – original emphasis). Here, communication "*links or relates beings to each other*;" communication must materialize into something or someone to occur (Cooren, 2020, p. 2 – original emphasis). As communicative beings, social realities are the living matters (concerns, interests, facts, power, autonomy) that link us (as people) to things, situations, and matters of concern that are most significant to us (Cooren, 2015). This is a guiding principle of this dissertation.

The primary goal of this dissertation is to theorize *who* or *what* invokes and expresses the social realities of reproductive health(care) from an organizational communication perspective. Much like the previously described road signs, this dissertation is concerned with the

sociomaterial production of reproductive health(care). Using the communicative constitution of organizations (CCO) framework, I set out to explore how reproductive health(care) is actualized through language, membership identification, and sites.

Broadly defined, reproductive health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processing" (World Health Organization, 2021). Reproductive health*care* is "the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems" (United Nations Population Fund, 2009). I look to the World Health Organization (WHO) and United Nations Population Fund (UNFPA) for definitional direction because both agencies have set numerous historic precedents in the realm of reproductive health and reproductive healthcare over the course of their existence (e.g., 1994 International Conference on Population and Development Programme of Action, United Nations 2005 World Summit). Throughout this dissertation, I do not distinguish between reproductive health and reproductive healthcare (herein "reproductive health(care)"). Instead, I use both concepts simultaneously and interchangeably, recognizing reproductive health(care) as a *state* of being; a *mode* of care delivery/service; and a *collective* of organizations, agencies, and actors that support, sustain, and constrain the state and mode. For me, the state, mode, and collective of reproductive health(care) are inextricably linked and inform the social realities of each other. It is also worth noting that in this conceptualization of reproductive health(care), I do not consider abortion care to be a separate idea, concept, or service. Abortion is, at once, a reproductive health(care) service and contributes to the physical, mental, and social dimensions of one's reproductive well-being.

As I demonstrate in the chapters that follow, limited research exists around the

constitution of reproductive health(care) from an organizational communication perspective. There is a well-established trove of communication research that engages the constitution of organization(s) and organizing (Bisel, 2010; Cooren, 2012; Brummans et al., 2009; Cooren, 2012, 2015, 2018; Cooren et al., 2011; Chaput et al., 2011; Schoeneborn & Kuhn, 2019); space and place (Vásquez, 2016; Vásquez & Cooren, 2013; Wilhoit, 2016); and (socio)materiality (Ashcraft et al., 2009; Cooren, 2018, 2020). However, a specific focus on the constitutive forces that underlie reproductive health(care) and the various beings and objects that play a role in its constitution has yet to be staked. Even if we look across the disciplines that have situated their paradigmatic stances of organization and organizing within constitutive approaches—such as organization studies, critical management studies, rhetoric, and communication (broadly)—it is apparent that studies on reproductive health(care) as a constitutive entity have yet to be established.

Drawing from the CCO perspective offers a framework to (a) consider the role of (non)human agency in and (b) offer an initial set of questions around the constitution of reproductive health(care). As such, applying CCO theory might show us how reproductive health(care) is enacted and afforded agency in particular contexts. Like the road signs I saw (and heard) during my inaugural drive through Central Texas, I am curious about how language, member identification, and sites are figures that mobilize the sociomaterial production of reproductive health(care). In this way, this dissertation is as much about the constitutive relationships that link human and nonhuman beings as it is about organizational approaches, spatial considerations, public health, and rhetoric.

Reproductive health(care) is an historically contentious and taboo issue, one that has been barred, limited, and regulated on local, national, and international scales. During Donald

Trump's presidency from 2016-2020, there was a resurgence of anti-abortion legislation that attempted to dismantle reproductive health(care). The Global Gag Rule was reinstated, a policy that prevents international family planning organizations funded by the United States from using their resources to provide safe, legal abortion care or referrals for abortion (Center for Reproductive Rights, 2017). Language related to reproductive healthcare was censored across the United States' Department of Health and removed from the United Nations' records in 2019 (Howard, 2019). Additionally, the funding of abstinence-only education efforts and the promotion of faith-based denials of reproductive health services in U.S. workplaces has exponentially increased (Merelli, 2019). Several states, such as Idaho, Arizona, Arkansas, and Oklahoma, also have ongoing efforts to pass legislation called "fetal-heartbeat bills," which deems abortion care illegal at the sign of a heartbeat and criminalizes abortion providers (Murphy, 2021). Even post-Trump administration, a steady stream of legislation has been introduced in 2021 to limit reproductive health(care) through abortion restrictions and bans. A recent report published by Nash and Cross (2021) of the Guttmacher Institute identified over 500 abortion restrictions (including bans) that were introduced in 46 states between January 2021 through April 29, 2021.

I locate this dissertation in the South-Central region of the United States for several reasons, most notably because of the enduring historical and sociopolitical tensions caused by reproductive health(care) in this region. These tensions are in constant flux, determined and (re)shaped by several streams of figures and forces that constitute the social realities of reproductive health(care) in many South-Central states. Texas specifically has an interesting and precarious history with reproductive health(care). Texas is where *Roe v. Wade* (1973) first materialized, the landmark decision that extended the right to privacy to abortion decisions.

Since *Roe*, the Texas Legislature has instituted many abortion restrictions and reproductive health(care) rollbacks, beginning with the physician-only abortion care requirement instituted in the 1980s (Weitz & Kimport, 2015), additional Supreme Court cases—such as *Planned Parenthood v. Casey* (1992)—which explained that states cannot bar abortion care in ways that cause "undue burdens"—and the enforcement of parental consent for abortion procedures during the 1990s (Avow, 2021). The reproductive health-related barriers continued in steady waves during the early 2000s, starting with the "Women's Right to Know" Act (WRTK).

When the WRTK Act was passed in 2003, the legislation had dramatic effects on abortion availability across the state. Not only did it mandate a 24-hour waiting period before *any* abortion procedure, but it also required that abortions after 16 weeks must be performed in specific facilities that met certified and approved ambulatory surgical center requirements (Colman & Joyce, 2011). In 2005, the Texas Legislature began allocating funds to crisis pregnancy centers (CPCs) through the Alternatives to Abortion program, prevented the Department of Health and Human Services from contracting with health facilities that provided abortion, and instituted a 24-week abortion care ban (Avow, 2021). Subsequent legislation in the 2010s required physicians to perform ultrasounds on women considering abortion care in ambulatory surgical centers and banned abortion to the 20-week mark (Gerdts et al., 2016; Jones & Jerman, 2014). *Whole Woman's Health v. Hellerstedt* (2016) eventually invalidated the ambulatory surgical center requirements for performing abortion care, but additional restrictions were advanced between 2018-2020, such as fetal burial laws, medically unnecessary reporting requirements for abortion providers, and state-mandated orders that directed physicians to share misinformation with patients during mandatory sonograms (Avow, 2021). Additionally, the forced introduction of COVID-19 in 2020 layered extra complexity onto Texas' already

challenging reproductive health(care) landscape. I return to these complexities in Chapter III.

At the present writing of this dissertation, the Texas Legislature has considered 17 abortion restrictions in its 87th session (Nash & Cross, 2021). One of these restrictions is House Bill 1515/Senate Bill 8, a near-total six-week abortion ban. This restriction also creates a precedent for a private cause of action that allows "*anyone* the authority to file suit against abortion providers," regardless of their state residency or connection to the person seeking abortion care (Davis, 2021; Howard, 2021; Tuma, 2021). House Bill 1515/Senate Bill 8 is currently among the *most* restrictive abortion bans being deliberated in the United States (Najmabadi, 2021).

While it may seem that the landscape of people, objects, and things that constitutes reproductive health(care) in Texas are identifiable, I am primarily interested in what and/or who are seen as secondary or remain in the background. The *what* are the organizations (e.g., abortion funds, political advocacy initiatives), and the *who* are the organizers (e.g., workers, activists, helpline coordinators, community engagement specialists) that work in grassroots capacities often overshadowed by other powerful, mainstream actors and organizations.

The remainder of this dissertation is organized as follows. In Chapter II, I begin by looking to the dominant reproductive frameworks that shape understandings of reproductive health(care). Then, I discuss how CCO theory provides a helpful analytic framework that demonstrates how reproductive health(care) is constituted through discourse, member identification, and sites. I draw from semi-structured virtual interviews and intimate mapping as my primary methodologies. Semi-structured interviews offered a space to speak with reproductive workers of various levels, organizations, and organizing efforts. Through these interviews, I explored how the participants' language and membership identifications

materialize, animate, and support/constrain reproductive health(care) as an entity. Then, drawing from critical feminist geography and CCO theory, I developed an intimate map of reproductive health(care). The intimate map is a transdisciplinary endeavor that centers the meaning production and materiality of reproductive health(care) in Texas through the embodied experiences of the participants. I elaborate on these methodologies in Chapter III.

Chapters IV, V, and VI move through the results from the interviews and the intimate mapping. Chapter IV describes how reproductive health(care) is actualized as a contested space through the participants' language. More specifically, this chapter demonstrates how the participants situate reproductive health(care) as an entity that is simultaneously an aspect of women's health, an aspect of human health, and a euphemism for abortion. Then, Chapter V explores how and why the participants identify with reproductive health(care) organizations, specifically through their affiliations as organizational members and personal interests. Chapter VI takes a broader transdisciplinary approach. I establish an intimate mapping of Texas' reproductive health(care) landscape. This chapter shows how the participants' embodied experiences come together to constitute a site of the physical and sociopolitical landscape of reproductive health(care) in Texas. I conclude this dissertation with Chapter VII, which addresses the broader implications of this study for reproductive health(care) organizations and organizing efforts but also for the CCO framework and organizational communication scholarship. I also reflect on the cross-disciplinary project of joining critical geography and organizational communication into conversation. The joining of both disciplines offers new theoretical and methodological imperatives around mapping and constitutive approaches.

CHAPTER II

LITERATURE REVIEW

In this chapter, I draw from organizational communication, rhetoric, and health communication literatures to build a case for understanding how reproductive health(care) is constituted by several communicative forces. This review is presented in three sections. I begin by reviewing what reproductive health(care) is through the perspectives of three reproductive frameworks—rights, justice, health. I discuss the formative tensions that predominately exist between the reproductive rights and reproductive justice frameworks. The reproductive rights and reproductive justice frameworks are arguably the most popular reproductive frameworks. Both frameworks provide an important set of language, ideas, and values that inform public understandings of what reproductive health(care) is. Next, I transition my discussion into the Communicative Constitution of Organizations (CCO) framework. This section begins by with an overview of the CCO framework and how it has been applied in several organizational contexts. Then, I consider how one CCO approach in particular offers a framework to analyze how reproductive health(care) is communicatively constituted through various interactants. Based on this review, I conclude with a series of research questions that will help frame proceeding discussions around the constitutive properties that produce reproductive health(care). Specifically, I consider how *discourse*, *member identification*, and *sites* are central constitutive components that enact reproductive health(care).

The Reproductive Frameworks

The reproductive rights, justice, and health frameworks are three major perspectives that

inform the social realities of how reproductive health(care) is conceptualized at various levels (e.g., organizational, local, national) (National Resource Center on Domestic Violence, 2021). As such, these frameworks provide different approaches, discourse, and value-systems that shape conversations around *who* or *what* is most affected by the political, legal, and social forces that enable and constrain reproductive health(care) across race, class, gender, and sexuality. In the sections that follow, I demonstrate how reproductive health(care) is defined by each framework according to the matters of concern, language, and social issues that underscore them.

The *reproductive rights framework* understands reproductive health(care) as reproductive freedom, or "the rights of individuals to decide freely, without governmental hindrance or coercion, whether or not to bear a child" (ACLU, 2021). More specifically, the reproductive rights framework was built around the basic premise that affords all people with the ability to "individually decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health" (Shalev, 1998). This framework uses language that emphasizes rights-based constructs, such as freedom, choice, privacy, and autonomy that informs its stance on reproductive health(care) (Thomsen, 2015). As such, organizations that operate within this framework use legislative initiatives and political campaigns and lobbying to advocate for legal rights and freedoms related to reproductive health(care).

The *reproductive justice framework*, however, does not solely revolve around issues of choice. The reproductive justice framework diverges from the reproductive rights framework in this way. According to the reproductive justice framework, reproductive health(care) must acknowledge securing access for those who are marginalized (Ross & Solinger, 2017). Reproductive health(care) must encompass "the human right to maintain personal bodily

autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong, 2021). The reproductive justice framework draws from a broader, all-encompassing continuum of reproductive health(care) concerns that affect diverse populations. This framework uses an intersectional lens, which "describes the structuring of gender through race and class to describe multiple forms of oppression that are simultaneous" (Ross, 2017, p. 210). It also expands to aspects that affect *all* reproductive bodies, including racial, food, and climate justice and prison abolition (Chrisler, 2012). Organizations that operate within a reproductive justice framework, then, are those dedicated to building networks of individuals and organizations to improve institutional policies and destabilize oppressive, racist, classist systems that impact the reproductive lives of marginalized communities.

From the perspective of the *reproductive health framework*, reproductive health(care) is primarily understood as a mode of service and resource delivery. Organizations that operate within this framework are those that support access to and the implementation of reproductive health*care*. This framework works to remedy reproductive health(care) disparities that are perpetuated by a series of access-driven factors, including limited access to abortion care and state and federally funded clinics (Frost, 2013; Haider et al., 2013; Ostrach & Cheyney, 2014; White et al., 2016), place and geographic positionality (Callaghan, 2014; Jerman et al., 2017; Jones & Jerman, 2013; Matsaganis & Golden, 2015), and misperceptions and information barriers (Golden & Pomerantz, 2015; Kavanaugh et al., 2019). However, while this framework works to address reproductive health(care) disparities, it does not necessarily address the systems that perpetuate these disparities (NCJW, 2021).

While the three reproductive frameworks predominately inform popular understandings of reproductive health(care), there are also other institutional entities that operate *outside* of these

frameworks that influence how reproductive health(care) is conceptualized. These entities include crisis pregnancy centers (CPCs)[1], also known as pregnancy resource centers, and other related organizations that do not recognize their work as inherently reproductive-related. Instead, they describe what their mission and values as driven by advocating for women and women's health. CPCs are nonprofit organizations offer targeted, free services and resources to women dealing with unintended pregnancies in order to prevent abortion (Bryant & Swartz, 2018). These organizations are motivated by value-systems and missions that are inextricably antiabortion and informed by religiosity, which is largely reflected in many of their organizational practices and materials (McVeigh et al., 2017; Swartzendruber & Lambert, 2018). While these organizations do not categorize their work as reproductive health(care)-related, the services and resources many CPCs offer are (e.g., sonograms, pregnancy tests).

For the purpose of this project, I consider reproductive rights, justice, and health organizations, and CPCs as existing within a *reproductive domain*. This reproductive domain is a collective space where these organizations' conversations, interactions, transactions, sensemaking, and meaning-making take place around reproductive health(care). This is because these organizations—regardless of their principles, frameworks, and values—(in)directly support reproductive health(care) in the work that they do and in the services and resources that they provide. For instance, ReproJust Collective and Eve Fund actively stake their work as reproductive-related by using language, such as "reproductive justice," and "reproductive health(care)," to describe their services, resources, and organizational missions. Other organizations, such as New Horizons Pregnancy Center and Parachute Pregnancy Center, do not

[1] Throughout this dissertation, I use *crisis pregnancy centers (CPCs)* to refer to organizations that position themselves *against* abortion, provide free services and resources to facilitate "women's health" and "pregnancy," and do not categorize their work as reproductive health(care)-related. In many cases, CPCs are called "pregnancy resource centers" (Bryant & Levi, 2012). For consistency, I choose to refer to these organizations here as CPCs.

explicitly use "reproductive" language to describe their work. However, their organizational websites suggest that they offer inherently reproductive-related services and resources, such as administering pregnancy tests, sonograms, and counseling services around abortion and pregnancy. Although some organizations might resist the language of "reproductive health(care)" and "reproductive domain," and even the idea of being grouped together, there is value in analyzing these organizations collectively because *all* of these organizations contribute to the meaningful sociomaterial production of reproductive health(care). As such, I am interested in the collective, contested space of the reproductive domain, not one particular organization.

Tensions Between Frameworks

Now that I have provided an overview of how the three reproductive frameworks and CPCs inform how reproductive health(care) is conceptualized and applied in different contexts, I turn my attention to the tensions that exist specifically between the reproductive rights and reproductive justice frameworks. Because both frameworks provide a set of language, ideas, and values that inform popular public understandings of reproductive health(care), it is important to understand how the friction between these frameworks materialized and contributes to the ongoing production of the social realities of reproductive health(care). First, I trace the impetus of the reproductive rights framework and how this framework was a catalyst for the emergence of the reproductive justice framework. Then, I examine how the divergences between frameworks materialize different realities of reproductive health(care).

Reproductive Rights Framework

The tenets of the reproductive rights framework, or movement, were originally staked by

activist initiatives on behalf of women for women to "take back" control of their bodies, decisions regarding their reproductive health, and abilities to reproduce from the government. In the context of the movement, reproductive rights are related to the choices involved in *when*, *where*, and *how* individuals oversee their reproductive health (Thomsen, 2013). Reproductive rights also encompass one's ability to abort or prevent unintended pregnancy by using accessible contraceptive methods (Russo & Steinberg, 2012). The reproductive rights movement is broadly based on these central tenets, which are articulated in "four rights-based principles" that inform the discourse and rhetoric the movement utilizes (Hoonton, 2005)—(1) *choice*, or the ability to choose when to have children; (2) *discretion*, or privacy, related to all reproductive decision-making; (3) *affirmative reproductive liberty*, where reproductive health decisions are free from government intervention; and (4) *personal autonomy*, or the freedom to make choices related to one's body and reproductive health(care).

It can be argued that the impetus for the reproductive rights framework was fueled by several events, including the abortion debates, subsequent Supreme Court cases and decisions that had lasting impacts on how reproductive healthcare was conceptualized, and the discursive and rhetorical strategies issued by pro-life and pro-choice groups that effectually marginalized and omitted considerations for women of color, among other minoritized groups, all together (Hayden, 2009; Railsback, 1984; Ross, 2017; Tonn, 1996). A major impetus for the framework focused on language and actions around *choice*.

Choice was—and arguably still is—a foundational principle of the reproductive rights movement. Broadly, choice underscores women's "inherent and inalienable right to limit their own reproduction" (Hayden, 2009, p. 117). Another central—and related—underpinning to the reproductive rights movement is the claim that *the personal is political* (Butler, 1988; Hayden,

2018). This claim suggests that personal experiences are not only organized and influenced by existing political structures (i.e., government entities, policies, and legislation), but personal experiences inform and shape the very same political structures (Butler, 1988). In this way, the personal *is* political because "it is [implicitly] conditioned by shared social structures" (Butler, 1988, p. 522). For second wave feminists, then, the combination of choice and *the personal is political* demonstrated that "cultural norms, policy, and social institutions" controlled and contoured every facet of women's lives and, therefore, could be defeated through "reforming efforts," ultimately providing women with even more opportunities and choices in the process (Hayden, 2018, p. 236). However, as Butler (1988) emphasizes, personal, subjective experience feeds into and influences political structures, norms, and cultural values and vice versa. Therefore, political structures and other related entities impact women's personal, subjective experiences and lives as much as their personal activities influence, uphold, or defy those same structures. Women's personal actions, which are influenced by cultural norms and political structures, also affect *other women*, namely those who are marginalized and minoritized by the very institutions and structures that are influenced and reinforced by non-minoritized women's actions (i.e., white women).

The reproductive rights movement's emphasis on choice and *the personal is political* was a tensional subject for those who were never afforded choices due to structural inequalities. Choice, then, is not a universally applicable concept for *all* people implicated in the abortion debates and broader reproductive rights movement. While the reproductive rights movement was a first attempt by women to articulate a collective "we," it was an attempt that failed to consider the needs and oppressive social structures that marginalized and minoritized people of color, people with disabilities, and members of the LGBTQIA+ community – not *just* women. Thus, a

new framework was articulated to represent and advocate for distinct aspect of the reproductive experiences of these communities.

Reproductive Justice Framework

Reproductive justice is a framework that was initially developed by Black activist-scholar women in the 1990s (Chrisler, 2012; Ross et al., 2017). Reproductive justice is an "interdisciplinary theory and practice that pays attention to nonbiological issues affecting reproductive bodies and parenting experiences in relation to the state and other authorities" (Ross et al., 2017, p. 167). More specifically, the reproductive justice framework offers a platform for activism and conceptualizing the diverse experiences of reproduction to "address women's diverse, intersectional, structural positionalities and their struggle for reproductive rights via a social justice commitment" (de Onís, 2015, p. 4). At its core, the reproductive justice framework is meant to support the lived experiences of *all* women, including

> homeless women, poor women, rural and inner-city women, refugees, incarcerated and trafficked women, women with physical disabilities, women with mental retardation and learning disabilities, ...women with HIV and other chronic illnesses and those who belong to the LGBTQ+ community (Chrisler, 2012, p. 8).

Reproductive justice also considers universal, global activist initiatives and contexts that acknowledge "the intersectionality of oppression; the problematic of dividing women into *us* and *them*; and the destructive nature of patriarchal structures that suppress, regulate, and/or control women's health, well-being, and social and economic rights" (Chrisler, 2012, p. 3; see also Ross et al., 2017; Ross & Solinger, 2017; Russo & Steinberg, 2012; Thomsen, 2013).

Reproductive justice provides a link between social justice problems and issues that, at

first glance, do not seem related to the reproductive rights framework but, in actuality, are relevant to several factors that shape reproductive politics and the reproductive health outcomes of marginalized and minoritized women (e.g., gentrification, immigration, incarceration) (Ross & Solinger, 2017). In this way, reproductive justice requires *affirmative reproductive liberty*, which calls for the government to "not unduly interfere with women's reproductive decision-making [because] the state has an obligation to help create the conditions for women to exercise their decisions without coercion and with social supports" (Ross et al., 2017, p. 169). Thus, the ultimate goal of the reproductive justice framework emphasizes societal conditions where reproductive (in)equalities are not (1) delimited to racial, class, and gender categories and (2) controlled by laws that sustain structural racism, inequality, and poor quality of (health)care.

Divergences Between Reproductive Rights and Reproductive Justice

The reproductive justice movement diverges from the reproductive rights movement in several pivotal ways. The reproductive rights movement relies on organizing and discourses that emphasize rights-based constructs, such as *freedom*, *choice*, and *privacy*, in the context of birth control and abortion (Thomsen, 2015). Reproductive rights advocates and activists often avoid speaking out when confronted with their problematic histories, ultimately "failing to recognize how white supremacist logic affects pro-choice organizations," and are unable to effectively galvanize as a mutual collective to overcome "white supremacist opponents" (Ross, 2017, p. 78). In addition, the reproductive rights movement continues to focus on the legalities of abortion rather than focusing on *all* women's access to reproductive healthcare services *and* safe, legal abortion (West, 2008). Historically, the reproductive rights movement represented the interests and concerns of white, middle-class women (Hayden, 2009; Ross, 2017). The reproductive

justice movement, on the other hand, addresses a broader, all-encompassing continuum of reproductive health concerns that affect diverse populations. In this way, the reproductive justice framework pushes the limits of reproductive rights' primary focus: abortion.

Thomsen (2013) contends that reproductive justice activists have challenged reproductive rights advocates to look *beyond* abortion as a singular issue. By solely focusing on abortion and rights-related issues, the reproductive rights movement has largely overlooked race and gender considerations, along with the damaging, lasting historical role "the birth control movement, coercive sterilization, contraceptive testing, and invasive reproductive technologies" had on women of color (Hoonton, 2005, p. 69). On the other end of the spectrum, reproductive rights advocates and organizations have pivoted their attention toward issues of "privacy, government intrusion, and health," effectively removing their advocacy interests from "liberation, rights, and justice" (Thomsen, 2013, p. 150).

Other differences between both frameworks materialize in the way that language is used. Most challenging for reproductive justice advocates is the reproductive rights movement's "conventional rhetorics" and vocabulary, most problematic of which revolves around the word *choice*. As previously mentioned, choice was a key tenet of the reproductive rights movement's agenda (Hayden, 2018). However, several issues underlie the movement's application of choice, which does not translate or align with the reproductive justice framework. Not only is choice a construct that applies to privileged populations and Western cultures, but it assumes that all women have the ability to choose and decide when, where, and how to have children (Chrisler, 2012). It also presupposes that all women have the economic and structural means to afford reproductive healthcare resources, including medical or counseling services, that are required for family planning checkups and routine activities (Chrisler, 2012; de Onís, 2015; Hayden, 2018;

Smith, 2005). So long as women can financially afford reproductive healthcare and other related resources, or if they are considered "legitimate choice-makers," then their reproductive choices are validated (Smith, 2005, p. 128). Choice, therefore, is informed by *economic rights* and does not necessarily reflect the economic realities of most women, particularly those who are marginalized and minoritized (Condit, 1994; Solinger, 2007). Moreover, choice presumes that women have *complete* autonomy and power over their reproductive decisions and, more literally, their bodies—that they "own [their bodies], control [them], and make decision about their [them], health, and relationships" (Chrisler, 2012, pp. 1-2). Choice also averts attention from institutional structures, mandates, and policies that inhibit women's reproductive freedom and the ways in which some women's choices perpetuate the very same structures, mandates, and policies that reinforce inherently misogynistic and racist norms (Butler, 1988; Hayden, 2018). Choice also contributes to a blatant disregard for structural (e.g., economic, social) issues, which ultimately manifests in accusing women of being responsible for the oppressions and inequalities that they experience (Hayden, 2018). Additionally, as de Onís (2015) explains, choice language does not resonate with certain communities of women who have never experienced choice in the ways that it is conceptualized by reproductive rights proponents.

Given the differences that exist between the reproductive rights and reproductive justice frameworks, misperceptions exist, particularly concerning reproductive justice. One of the primary misperceptions about the reproductive justice movement claims that activists and organizers envisioned replacing the reproductive rights framework all together (Leonard, 2017). However, reproductive justice is based on the merging of reproductive rights and social justice in order to address and represent the diverse, oppressed, lived reproductive (and beyond) experiences of women of color in a global, transnational context (Ross, 2017; Ross & Solinger,

2017; Solinger, 2007). The aim of the reproductive justice movement is to bring women of color to the fore, "moving [their] voices from the margins to the center of the discourse" (Leonard, 2017, p. 46). Therefore, the reproductive justice movement creators never intended to *replace* the reproductive rights framework; instead, reproductive justice is/was an intentional effort to "shed light on the combined forms of oppression that threaten [women of color's] bodily integrity and autonomy" (Leonard, 2017, p. 47). Ultimately, using the reproductive justice framework to understand reproductive health(care) requires moving beyond language and legalities and into the underlying causes of disparity, stigma, and marginalization.

The Communicative Constitution of Organizations Approach

In the previous sections, I discussed the various tensions that exist among the reproductive frameworks. I drew specific attention to the historical tensions between the reproductive rights and reproductive justice frameworks, two of the dominant reproductive frameworks. This overview provided a general basis of the various applications and definitional understandings of reproductive health(care) among each of the reproductive frameworks. It also showed how organizations that do not identify as doing "reproductive work" contribute to the social realities that influence reproductive health(care). Taken together, these organizations exist in a reproductive domain, a shared space where reproductive health(care) is conceptualized and expressed as an entity comprised of various competing relations. In this section, I introduce the Communicative Constitution of Organizations (CCO) approach, which offers an analytic framework to explore reproductive health(care) as a contested, tensional entity. I begin this discussion with an overview of CCO and the three dominant schools of thought that have contributed to CCO. Then, I position my approach to this dissertation in one of the three CCO

frameworks: the Montréal School of Organizational Communication.

CCO Framework

The Communicative Constitution of Organizations (CCO) approach centers communication as an open-ended, iterative process where communication materializes into something or someone in order to occur (Cooren, 2015, 2020). Adopting a CCO approach means studying how processes of communication manifest organizations' existences through the relations, interactions, and practices that take place between beings, both human and nonhuman (Cooren et al., 2013; Vásquez et al., 2018). As such, organizations are manifested *through* communication (Bisel, 2010). Organizations do not and cannot exist on their own volition.

CCO research is primarily divided among three schools of thought: the Four-Flows Model, Luhmann's Theory of Social Systems, and the Montréal School of Organizational Communication. Taken together, the CCO frameworks align with the overarching principle that organizations manifest, emerge, and are maintained through enduring communicative practices (Schoeneborn et al., 2019). But the frameworks also deviate in several ways, most notably in their development of *how* communication constitutes organizations (Schoeneborn et al., 2014). In what follows, I provide a brief overview of how each framework conceptualizes how organizations are constituted through communication.

For proponents of Luhmann's Theory of Social Systems, the organization is a social system comprised of decisions. As such, a Luhmannian perspective sees organizations as "precarious accomplishments" whose existences depend on the "continuous perpetuation and interconnection of decisions as communication events" (Schoeneborn & Vásquez, 2017, p. 9). The Four-Flows Model suggests that four interlocked, flawed, overlapping processes—or

flows—of communication manifest organization: membership negotiation, activity coordination, self-structuring, and institutional positioning. Schoeneborn and Blaschke (2014) provide a helpful overview of each flow: *membership negotiation* consists of the interactions that link individual members to each other; *self-structuring* are comprised of the interactions that enable people to represent themselves as part of the larger organization; *activity coordination* consists of organizational members negotiating and adapting to situation-specific expectations to make sense of how their contributions fit with one another's; and *institutional positioning* are the interactions that shape an organization's relation to its larger environment. It is only when these four flows come together does an organization begin to emerge (Schoeneborn & Vásquez, 2017). The Montréal School approach tends to encourage a relational ontology that centers the *interactions between* beings (Putnam & Mumby, 2014). This approach does not view organizations as systems, but rather as entities that are talked into existence and maintained through the interactions shared between humans and nonhuman beings. Thus, the Montréal School offers a compelling framework to realize the central goal of this dissertation: to identify the interactions between various beings that constitute reproductive health(care).

The Montréal School of Organizational Communication

An important underlying principle of the Montréal School approach centers the effects of how assuming the role of spokesperson of an organization—consciously/unconsciously, voluntarily/involuntarily—expresses the position of the organization (Cooren et al., 2011). Specifically, speaking on behalf of an organization demonstrates a simultaneous (a) alignment with the organization's principles, values, attitudes, ideas, ideologies, and interests and (b) enactment by the organization to do or say something (Cooren, 2012). But it is important to

recognize that it is not only human beings that express or speak on behalf of an organization. CCO scholarship demonstrates how various types and degrees of nonhuman figures fulfill this role, too, including organizational documents, texts, and marketing materials (Cooren, 2004; Costantini & Wolfe, 2021; Vásquez et al., 2016), leadership artifacts (Clifton et al., 2021) and space (Cnossen & Bencherki, 2018; Vásquez, 2016; Wilhoit, 2016). Thus, it is the interactional process that takes place between human and nonhuman beings where the organization is produced (Cooren, 2020). This takes us into an important discussion around the materiality and relationality of this very process.

Materiality concerns something or someone's "state of being material," which "consists of problematizing what sustains or supports its existence" (Cooren, 2015, p. 311). Regardless of whether we talk about physical material (documents, artifacts, buildings) or immaterial (ideas, matters of concern, values) beings, one being is not *more* material than the other (Cooren, 2012). Instead, what is important here is the relationality that links these beings. Relationality shows how various "matters" (concern, interest, power, design, facts) inform the basis of the social realities that constitute our ways of being (Cooren, 2015). It is also through this relational connection between beings that materializes an organization. According to Cooren (2015), these relations can be long-lasting, like the link between an organizational member's identification with their organization. Other relations are brief, such as a passing hallway interaction between colleagues. It is ultimately through the production, performance, and problematizing of these relations that contributes to the essence of an organization (Cooren, 2018).

The Montréal School approach positions an organization's existence as something that is achieved through communication, specifically how organizations are materialized through various speech acts. They can be "talked, written, and acted into existence" (Vásquez et al.,

2018, p. 418). In this way, communication is not restricted to an organization or the actors that manifested it but is, instead, located *in* communication *between* various beings (Boivin et al., 2017). An organization, therefore, can be studied at various levels of interaction. The Montréal School approach tends to center text and conversation as two primary forms of interaction.

Text refers to the language that is used to structure conversations through many forms—verbal, nonverbal, and written (Taylor & Van Every, 2000). It is primarily through the language of texts that gives agency to the identification, stabilization, and constitution of organizational forms, beings, and actors (Ashcraft et al., 2009). Texts are what Taylor and Van Every (2000) consider the surface of organization, the stable, material artifacts that provide the foundation of an organization.

Conversations are speech acts that give agency to texts (Cooren & Martine, 2016). It is through these interactions where people articulate and form shared connections and communicative collectives around an organization's purpose, values, and principles (Cooren & Martine, 2016). In this way, conversations are the site of organization, the place where communication is constructed, produced, and turned into action (Taylor & Van Every, 2000). Here, I draw from Ashcraft et al.'s (2009) notion of site, which refers to a "material place/space that influences the resources available for interaction" (p. 31). Sites are the "infrastructure to interaction," always in constant negotiation, (re)interpretation, and (re)configuration to create a place where organizational members "negotiate their contribution, their position, and their alignment" (Ashcraft et al., 2009, p. 31) with their organization and the larger environment through communication.

Taken together, these communication forms (text and conversation) demonstrate how text defines organization and conversation activates an organization (Ashcraft et al., 2009). For

instance, Planned Parenthood Federation of America's stance on reproductive health(care) as a "right" and "choice" is embodied in the various texts (e.g., policies, press releases, social media posts, organizers/activists, executive board) that speak on its behalf *through* conversations (e.g., television appearances, rallies, public demonstrations, livestream videos, internal organization meetings). These conversations, in turn, (re)affirm Planned Parenthood's texts. Taken together, the texts and conversations work in tandem to materialize Planned Parenthood's existence as an organizational entity. This process is called presentification.

Presentification actualizes organizations into existence through the tensions shared between texts and conversations (Brummans et al., 2009; Cooren 2015; Cooren et al., 2013). Through this process, the various actors and figures that speak on behalf of an organization must attribute their actions *to* the organization in order to presentify it as such (Bencherki & Cooren, 2011). If we revisit the example from the previous paragraph, it can be said that the organizers/activists and executive members who speak about reproductive health(care) as a "right" and "choice" on behalf of Planned Parenthood must attribute this action to Planned Parenthood in order to presentify the organization's existence. Costantini and Wolfe (2021) underscore the importance of presentification in the materialization of an organization's existence, particularly because "material manifestations of organizational being are the basic substance from which any organization can answer questions regarding who they are and why they are authorized to speak on behalf of certain issues, problems, or values" (p. 3). One such method that guides our understanding of how certain figures are authorized to speak on behalf of an organization is ventriloquism.

Cooren and colleagues conceptualized the ventriloquial approach to illustrate how organizations are made present through the interactions shared between humans and figures.

Traditionally, ventriloquists are expert puppeteers that make their puppets—or figures—do and/or say things on their behalf (Cooren et al., 2013). It is through this relational attachment that allows both the ventriloquist and ventriloquized to simultaneously operate in unison and as distinct actors (Cooren, 2012). A ventriloquial approach to communication demonstrates how humans position themselves (or are positioned) as being constrained or animated by different "things," or principles, values, interests, (aspects of) ideologies, norms, or experiences (Cooren et al., 2013). What is particularly compelling about the ventriloquial approach is that organizations are materialized *through* many human interactants and figures that express or speak on its behalf. It is through this lens that enables us to explore "the polyphonic or multivocal character" of the voices that are present in communicative acts (Cooren et al., 2013, p. 263). Based on the previous example, Planned Parenthood organizers/activists are ventriloquized *by* Planned Parenthood to speak on its behalf through the material things that they create (pamphlets, fliers, protest signs), or the demonstrations and canvassing efforts they participate in. It is through these communicative acts that Planned Parenthood is presentified as an organizational entity. At the same time, the organizers/activists position themselves to be ventriloquized through their organizational member identification, where their roles and actions are shaped, negotiated, and aligned with the values, principles, and ideologies of the organization (Cheney & Tompkins, 1987). As such, the ventriloquial approach allows us to look closely at the multiple communicative acts that take place at a given time and the various interactants and figures that contribute to their enactment.

Summary and Presentation of Research Questions

In this review, I have demonstrated how reproductive rights, justice, and health

organizations, as well as CPCs, exist in a collective space called the *reproductive domain*. The reproductive domain is a shared space where reproductive rights, justice, and health organizations, and CPCs' competing conversations, interactions, transactions, sensemaking, and meaning-making take place around reproductive health(care). These disparate understandings of reproductive health(care) raise several questions around how reproductive health(care) is constituted across the reproductive domain and at broader, societal level. CCO, particularly the Montréal School of Organizational Communication approach, offers one way to explore how various competing conceptualizations, positions, and value systems of various interactants and figures constitute reproductive health(care).

CCO scholarship provides extensive insights into how human and nonhuman actors animate and speak on behalf of organizations. However, no consideration has been given to the actors/figures that constitute reproductive health(care) from an organizational communication perspective. The value in investigating the constitution of reproductive health(care) lies in the tensional space of the reproductive domain, where organizations position what reproductive health(care) *is* and *means* according to their principles, ideologies, discourse, and frameworks. Based on this review, the CCO approach offers several exciting directions in the study of how reproductive health(care) is constituted.

First, CCO theory can demonstrate how various human interactants and figures from the reproductive domain animate texts and conversations to constitute reproductive health(care). As I previously explained, each organization within the reproductive domain locates their language around reproductive health(care) in different figures (i.e., value-systems, principles, histories). The reproductive rights framework locates reproductive health(care) in choice, rights, and legality. The reproductive justice framework situates reproductive health(care) in equitability,

access, and social justice. The reproductive health framework situates reproductive health(care) around service and resources. And CPCs do not directly recognize reproductive health(care). Instead, these organizations draw from language around women's health. As such, organizations that identify with particular reproductive frameworks enact texts and conversations in specific ways to realize principles, practices, values, and ideologies around reproductive health(care) that *matter* to each framework. As Vásquez et al. (2018) remind us:

> Texts are key in materializing and transporting matters of concern, making them endure from one communication event to another. Because of their material and symbolic nature, and their recursive interplay with conversation, texts can open and close the meanings and values given to matters of concerns. Hence, their production and consumption call for constant negotiations (p. 429).

Based on the example from the previous section, the organizers/activists, executive board, and spokesthings that express and speak on behalf of Planned Parenthood's position around reproductive health(care) are not only speaking on behalf of Planned Parenthood. They also speak on behalf of reproductive health(care) from the principles of the reproductive rights framework because the principles of this framework *matter* to Planned Parenthood.

Given that there are organizations that locate themselves within the other reproductive frameworks (health, justice), it follows that tensions arise when certain materializations of reproductive health(care) from one organization clash, or overlaps, with another. The texts and conversations *other* organizations enact to constitute reproductive health(care) are also located *between* the various interpretations that are simultaneously occurring within and across the reproductive frameworks (Boivin et al., 2017; Cooren et al., 2011). As such, reproductive health(care) *is* and *means* in constant negotiation, tension, and conflict within the reproductive

domain. It is not a static thing that exists in the world; rather, it is comprised of vibrating assemblages that compete to conceptualize and produce social realities around it. Thus, understanding how reproductive health(care) is communicatively constituted across the reproductive domain informs the first research question:

RQ1: How do organizational members in the reproductive domain communicatively constitute reproductive health(care)?

Second, it is important to explore how other interactants within the reproductive domain contribute to the constitution of reproductive health(care). Organizational members who identify and belong to organizations within the reproductive domain contribute to the social realities of how reproductive health(care) is materialized through their organization's principles, values, and ideologies. In this way, members are ventriloquized, or animated, to speak and/or act on behalf of their organizations' values, beliefs, concerns, and ideologies through their member identification.

Member identification is a process where an individual's roles and actions are (re)defined and (re)negotiated, informing *how* an individual situates themselves within an organization (Cheney & Tompkins, 1987). Identification is a "necessary social process" that fosters feelings of mutuality and relationality between individuals (Gossett, 2002, p. 386). Identification occurs through the enactment of different agents (e.g., emotions, language, ideas, values, texts, artifacts) (Chaput et al., 2011). These agents animate members to speak on behalf of their organizations which, in turn, "incarnates" or "presentifies" the organizations' very existence (Cooren, 2006). Through member identification, an organization is realized *through* its collective members. Therefore, how members from the reproductive domain position themselves to speak on behalf of their organizations' values, matters of concerns, principles, and ideologies will reveal how

their member identification is animated through figures that matter most to their organizations' existence. As such, I propose the following research question:

RQ2: How is member identification in the reproductive domain animated and constrained by the values, beliefs, ideologies, and positions of the members' organizations?

Lastly, the CCO approach invites organizational communication scholars to consider organizations as the "conflicted sites of human activity" (Trethewey & Ashcraft, 2004, p. 82). Sites are the "infrastructure to interaction," a place/space where organizational members negotiate their roles, purposes, and experiences to position themselves in their organizations (Ashcraft et al., 2009, p. 31). As such, understanding how members from the reproductive domain constitute reproductive health(care) as a site of tensional, embodied, affective work experiences can demonstrate how members make sense of their work within the context of their organizations and the larger landscape of the reproductive domain. It is this theorizing of reproductive health(care) as a site that can create modes of imagining that can visualize a tensional landscape of various communicative encounters. This thinking led to the third research question:

RQ3: How do members' reproductive work experiences constitute an affective, embodied landscape of reproductive health(care)?

CHAPTER III

METHODOLOGY

The research questions underpinning this dissertation called for an inductive, multimethod approach. From March 2020-July 2020, I conducted virtual interviews with 67 participants from a variety of roles and organization types in the reproductive domain. This dataset provided an overview of how the participants communicated about "reproductive health(care)" and how their member identification is informed by organizational values, ideologies, and practices. Then, I drew from the interview data to create an intimate map of the participants' deep stories. Here, I borrow Hochschild's (2017) concept of deep stories as "a narrative as *felt*…a story that *feels as if* it were true" (pp. ix, 16 – original emphasis). The deep stories are comprised of the complex, communicative, felt connections that exist within the participants' embodied experiences of their reproductive work. The intimate map is a transdisciplinary endeavor. It brings together communication and critical geography in an attempt to imagine and connect varying levels of communicative encounters.

Study Site: Texas

Newspaper columnist and Texas iconoclast Molly Ivins once said, "I learned two things growing up in Texas: (1) God loves you, and you're going to burn in hell forever. (2) Sex is the dirtiest and most dangerous thing you can possibly do, so save it for someone you love." The messages displayed on the homemade signs I encountered during my inaugural trip to College Station (i.e., *Abortion is a murderous choice!!! Vote: Republican*) unequivocally reaffirm Ivins' statement. Texas is an historic place where many legislative precedents around reproductive

health(care) have been set by religious ethics and rhetoric and an undying dedication to political conservatism and Lone Star State exceptionalism. As such, the tensions that exist between the Texas legislature and organizations within the reproductive domain (reproductive rights, justice, health organizations, CPCs) are a part of Texas' politically dynamic, shifting landscape of legislative discourse and diametric values that enable and constrain what reproductive health(care) means. *This* is why I chose Texas as the primary site for this study.

Changing Methodological Course

Prior to COVID-19, I planned to conduct an ethnographic analysis of Reproductive Parenthood Federation[2] (abortion clinic) and Pregnancy Care Line[2] (crisis pregnancy center) in Central Texas during the summer of 2020. The ethnographic analysis would have involved immersing myself in both organizations and their communities. I intended to collect photographic records of organizational space arrangements, observations of members' daily trajectories in their organizational spaces, informal conversation interviews with organizational members, and fieldnotes as a passive observer. But COVID-19 altered the political dynamic around abortion access and reproductive health across the United States, specifically in Texas, which deeply affected the original research design of this dissertation.

On March 23, 2020, during the first wave of COVID-19, Attorney General Ken Paxton declared abortion as a nonessential medical procedure, blocking Texans' access to abortion care (Justin, 2020a; Littlefield, 2021). Paxton's announcement followed an executive order that was issued by Governor Greg Abbott one day prior, directing healthcare facilities to suspend all procedures deemed "not medically necessary"—including abortion—or else "be met with the

[2] The names of the organizations have been changed.

full force of the law" (Justin, 2020b). Following the executive order and Paxton's announcement, the ban on abortion care was reversed and reinforced in a series of five legal "flip flops" between March and April 2020. Texas' COVID-19 abortion ban not only cancelled existing abortion procedures but forced those seeking abortion care to travel more than 600 miles outside of Texas and pay upwards of $2,400 for their procedures (Goldenstein, 2021; Lilith Fund, 2020). Although the ban expired on April 22, 2020, the continued complications of COVID-19 altered the ways organizations communicate about and provide reproductive health-related resources and services to their communities, who remain largely out-of-reach in rural areas of Texas.

The abortion ban, coupled with the continued effects of COVID-19, prompted me to reevaluate the original research questions and methodological design of my dissertation. Initially, I set out to understand how Reproductive Parenthood Federation, Pregnancy Care Line, and members from each organization (a) situate themselves discursively and geographically in relation to their communities and (b) how this situatedness affects resource (in)accessibility and reproductive health disparity across Central Texas. However, based on the initial COVID-19 research guidance issued by Texas A&M's Institutional Review Board (IRB) in March 2020, the vast majority of in-person interaction was prohibited to maintain the safety of researchers and participants. As a result, I quickly adapted my dissertation and identified organizations across Texas that claimed to (in)directly support reproductive health in the work that they do and services and resources they provide. This included organizations that openly staked their support for reproductive work on their organizational websites, such as Pro-Choice Texas, who actively "compiles research on the state of reproductive health care across Texas," and Virgo Fund, an abortion fund that works to "center marginalized people and communities historically underrepresented in mainstream reproductive justice movements." Other organizations, such as

Watford Pregnancy Center and Dworkin Pregnancy Alternatives, do not explicitly use "reproductive" or "reproductive health" to describe their work. Yet, their organizational websites reference reproductive-related services, such as administering pregnancy tests and serving women in crisis pregnancies—or "abortion-vulnerable women"—through educational efforts "about the consequences of sexual activity outside the bonds of marriage." Across all organizations, reproductive health-related services include—but are not limited to—screenings for sexually transmitted diseases, pregnancy tests, birth control/other contraceptives, abortion care, ultrasounds, and classes on sex education, abortion care, and parenting.

With the intention of virtually interviewing members from these organizations, I revisited this dissertation's theoretical framework and recrafted my research questions. These research questions—the present questions of this dissertation—explore how members communicate about reproductive health, their work, and how this communication constitutes their organizational membership identification and the spatial implications of their organizations' existences. The revised research questions and methods provided flexibility to speak with my participants virtually while following Texas A&M's IRB COVID-19 research protocols. I provide an in-depth overview of my processes and procedures around virtual interviews later in this chapter.

Researcher Positionality

My proclivities as a critical qualitative scholar are largely guided by my interest in contested organizations, namely how these organization types are socially constructed and constituted through their dubious existences. I consider contested organizations to be sociopolitical disruptors, namely in the ways that their organizational presences are strategically made palpable or hidden.

Within organizational communication scholarship, a critical approach aims to reveal, interrupt, and transform the oppressive dimensions and dynamics of power (Mumby, 2000; Taylor & Trujillo, 2001). My work aims to identify how these power dynamics are materialized through the constitutive relationships of (non)human actors that mobilize, presentify, and actualize organizations (Cooren, 2018, 2012). More specifically, a critical approach evaluates how power and politics are materialized in the everyday communicative process through which meaning and identity formation occur (Mumby, 2000). From this perspective, organizations are sites where meaning and identity are co-produced through the ebb and flow of sociomaterial production (Putnam & Nicotera, 2009).

In a broader sense, qualitative research is comprised of many methodological approaches and paradigms that identify the nuances and processes of everyday, social life (Cresswell & Poth, 2016; Tracy, 2019). To create qualitative research, we must engage in what Saldaña (2014) calls *thinking qualitatively*, or the practice of applying a variety of "thinking methods and mental operations" to analyze information, make decisions, and solve problems (p. 3). This is also made evident in Aspers and Corte's (2019) search for a core meaning of what constitutes *qualitative* research. After concluding their systematic analysis, Aspers and Corte (2019) forward that qualitative research is an iterative process that involves two enduring criteria: "(i) how to do things—namely, generating and analyzing empirical material, in an iterative process in which one gets closed to making distinctions, and (ii) the outcome—improved understanding novel to the scholarly community" (p. 155). Qualitative researchers use an iterative, back-and-forth approach that involves revisiting research questions, theoretical frameworks, and the data to explore research problems rather than attempting to fill research gaps (Tracy, 2019, 2021).

From the perspective of organizational communication scholarship, qualitative

approaches “focus on the complex ways in which routine organization shapes people’s lives and, reciprocally, how members’ communication practices constitute organizing” (Putnam & Mumby, 2014, p. 6). And although qualitative research has been criticized for its lack of statistical generalizability, objectivity, and replicability (Ritchie et al., 2013; Tracy, 2021), rigorous guidelines for creating good, credible, and meaningful qualitative research exist in the current literature. For this project, I specifically looked to Sarah Tracy’s (2010) “eight big-tent criteria” to inform my dissertation design and the phronetic iterative approach (2018) to guide my analysis efforts as I transcribed and coded my virtual, video- and audio-recorded interviews.

My general orientation as a qualitative researcher also positions my scholarship in a critical-interpretive lens, one that maintains that reality is socially constructed, and meaning is derived from the social systems, interactions, and relationships that are (re)produced within this reality (Deetz, 1982). From an organizational communication perspective, critical-interpretivism recognizes communication as “the way by which organizing and disorganizing take place” (Cooren & Martine, 2016, p. 2). As such, communication is characterized by how the socially constructed realities of organizations and organizational actions uphold, perpetuate, and disrupt power relations through the discourse and interactions of human and nonhuman figures (Cooren et al., 2006; Papa et al., 2008). In this way, critical-interpretivism examines how certain networks, organizations, and groups are privileged to mobilize and constitute discourse, power, and meaning-making.

The critical-interpretive lens I draw from is also deeply influenced by (a) a feminist approach of organizations and organizing (see, e.g., Buzzanell, 1994, 2021) and (b) feminist principles around organizing, collecting, and analyzing data (D’Ignazio & Klein, 2020). Aligning with a feminist perspective requires one to engage in and accept discomfort and denounce the

"glossy, marketized, and neoliberal" feminism that "deny[ies] the violence of nationalism, capitalism, and imperialism" (Görkariksel et al., 2021, p. 1). Görkariksel et al. (2021) continue:

> Claiming the title of feminist proclaims a willingness to accept or provoke discomfort in order to question and destabilize the status quo while simultaneously acknowledging that the arrangement of this discomfort is uneven and falls along lines of power and privilege.

Similar to Görkariksel et al.'s (2021) imperatives, feminist approaches within organizational communication also focus on interrogating power and privilege by identifying the "patriarchal and misogynistic elements of organizational structure and culture" (Taylor & Trujillo, 2001, p. 13). However, recent conversations around feminist organizing and, more generally, organizational communication scholarship, have brought attention to the subdiscipline's historically white, Western-dominated, postcolonial theorizing that upholds these very problematic patriarchal, misogynistic, and racist structures (see, e.g., Buzzanell, 2021; Hanchey, 2020; Jensen et al., 2020). For instance, the #ToneUpOrgComm Collective recently published a manifestx calling out the subdiscipline's complicity and "narcissism of whiteness" (Cruz et al., 2020, p. 152). The Collective outlined priorities for a renewed, intersectional organizational communication subdiscipline that "embraces fiery language, is undisciplined, arises in relation, destabilizes white righteousness, and will not be silent" (Cruz et al., 2020, p. 152). While problematic perspectives and methods are beginning to be reckoned with more intentionally, they have continually pushed the lived experiences and voices of Black, Indigenous, People of Color (BIPOC), LGBTQIA+ communities to the periphery (Broadfoot & Munshi, 2007; Cruz, 2015, 2017). This is also true of the reproductive frameworks, which, at their core, are guided by the principles of feminist organizing and social justice.

Reproductive justice organizations and organizing efforts, in particular, hold traditionally

white-dominated reproductive spaces responsible through the identification and dismantling of the very social systems that have historically limited autonomy, choice, and healthcare access for BIPOC and LGBTQIA+ folx. Similar to scholarship around organization and organizing, engaging in reproductive-related research from a justice-oriented perspective, then, must address the lived experiences of voices that are oftentimes silenced by oppressive forces (Ross, 2017; Ross & Solinger, 2017; Solinger, 2007). For these reasons, centering this project in a critical-interpretivist feminist approach required engaging in an iterative process of reflexivity.

Reflexive Practices

Reflexivity is a process that situates "our structural position within a complex terrain of power relations" to understand how our identities influence the production of knowledge in all stages of the research process, including participant interactions and the power dynamics that exist through institutional affiliations (Vasudevan, 2021, p. 29). Reflexivity recognizes that "all knowledge is produced in specific circumstances and that those circumstances shape it in some way" (Rose, 1993, p. 305). As such, practicing reflexivity offers the researcher(s) with a platform to reflect on their positionalities and the power relationships that exist within the researcher-participant dynamic, as expressed by Falconer et al. (2002):

> First, rather than targeting difference *per se*, a full reflexivity helps one to understand how identity is constituted during the research process itself...Second, by providing an additional, positioned view of the researcher, a fuller reflexivity helps to make the researcher's positionality vis-à-vis the research more clear...Finally, this approach may help to share power with the participant more equitably than is possible with other methodologies, and validates the participant more fully as a knower (p. 114).

Throughout every stage of this project, I attempted to practice reflexivity through analytic notetaking and active reflection on my positionalities as a researcher, participant, and co-constructor of knowledge. I also reflected on the awkwardness and discomfort that materialized in some of my conversations, which often left me questioning my role in documenting the nuanced stories and experiences of reproductive health work in Texas. I often wondered, *Why did I choose this context?* and *Why am* I *positioned to hear and document these accounts?*

Engaging in reflexivity was particularly critical for this dissertation for several reasons. First, the earliest iteration of the list of organizations I identified for this study was derived from my situated knowledge and experience as a student fellow with Pro-Choice Texas, which identifies as a reproductive rights organization. Initially, I catalogued reproductive rights, justice, and health organizations that were a part of Pro-Choice Texas' network. Then, I drew from Pro-Choice Texas' language to search for CPCs, which included "pregnancy resource centers," "fake women's health centers," "fake clinics." This language was largely drawn from Pro-Choice Texas' ongoing research effort to expose "fake clinics" (i.e., CPCs) across Texas. Although I originally used Pro-Choice Texas' language as a starting point, I recognize that it was deeply influenced by its values, mission, and perspectives.

Second, this project centers around understanding communicative, meaning-making experiences informing realities about reproductive health(care) that are oftentimes grounded in sticky value systems and frameworks. As such, there are ethical considerations that affect the biases, assumptions, and values that informed *my* orientation to this project and the ways the participants understand and approach reproductive health(care). Vasudevan (2021) discusses understanding this orientation through reflexivity as a practice enmeshed with *materialist relationality*. This approach acknowledges our duty, as scholars, to recognize how we are (a)

already interlocked with various forms of suffering (e.g., racial, gender, classist) but also (b) positioned to engage our research in ways that builds solidarity through our work:

> As scholars, we are materially connected to racialized suffering in excess of our identities. Orientations, 'how bodies are directed towards things,' *matter* for liberatory research—both in terms of what is most significant and in the sense of physical substance. Within this framework, reflexivity can engender change when we orient toward building solidarity across the oppressive cleavages that unevenly produce suffering (p. 30).

As a pro-abortion, nonreligious feminist who was previously affiliated with a reproductive rights organization and is currently a graduate student of a powerful, wealthy, conservative research institution, my interactions with participants were affected in ways that determined access to other organizational members or additional organizations within their networks. Yet, I remained acutely aware of how my appearance and identity as a white, educated, cisgender woman also affected how I was received by certain organizational members. My identities fostered skepticism among participants who have experienced trauma through their reproductive work while, at the same time, created opportunities to start conversations that would have otherwise never began. The tensionality of my identities was something I grappled with throughout this dissertation process (and beyond), particularly during my initial recruitment efforts.

When I contacted members from CPCs, I took the approach Kelly (2014) used during their fieldwork observing CPC members. Kelly (2014) explained that they were open with CPC members about their positionalities due to ethical implications: "Out of ethical concerns, I informed the center director that I identify as pro-choice, feminist, and nonevangelical when asking for permission to conduct research in the center" (p. 428). While I did not openly reveal

my pro-abortion, nonreligious positionalities in my recruitment e-mails and communications, I was open about the intentions of my dissertation and used phrases, such as "reproductive health," when describing my project. But tension surfaced around my use of "reproductive health," specifically among CPC members. I was oftentimes asked, *What is your understanding of reproductive health* (or women's health)*?* and *Are you* really *talking about abortion?*. I engaged in these conversations as they unfolded, never denying an interaction or moment of clarification that highlighted my positionalities or the purpose and goals of my dissertation.

After learning more about my dissertation and research interests, CPC members either stopped responding to my e-mails or declined to participate in my study. "My gut is telling me not to do it," one CPC director responded. A client services director from another CPC said, "In this climate we have to take whatever measures we can to protect our organization. We don't feel that with this particular opportunity we can guarantee that what we share will not be misstated or misrepresented." Upon calling a CPC to retrieve an e-mail address, I spoke with a front desk administrator, who exclaimed: "No secrets here, not that we're hiding anything! It's nothing personal, but pregnancy resource centers have to protect themselves." After multiple back-and-forth correspondences, an executive director of a Pregnancy Care Line center replied, "It looks like your research goal is to explore factors that contribute to disparities in awareness/access to reproductive health care, right? It doesn't seem that what we offer as a pregnancy resource center adds to the investigation of that question." This was a common response among many CPC members I contacted. These members were not only skeptical of me, but they also separated themselves from reproductive health(care), differentiating their services and resources from anything reproductive-related. In total, I received more than 40 declines from CPC members. As such, I shifted my recruitment strategy by engaging in meaningful code switching as a way to

establish rapport and connection with CPC members.

Meaningful code switching is described by Gist-Mackey and Kingsford (2020) as a process where researchers relate to participants in familiar, empathetic, and vulnerable ways. For example, in my revised recruitment e-mail to CPC members, I used familiar identifiers, such as "women's health," "wellness," and "pregnancy," to signal my approachability and openness as a researcher and, ultimately, a person with a vested interest in starting conversations with the CPC community (see *Appendix B*). The purpose of recrafting the recruitment strategy in this way was to create meaningful, accessible connections with CPC members who oftentimes voiced concerns about being misrepresented and misquoted in interviews and by media outlets. However, I struggled with the ethical implications of engaging in code switching but felt it was necessary to establish a connection with CPC members. Because interviews are oftentimes one-off interactions that do not allow for the development of ongoing relationships with participants (Gist-Mackey & Kingsford, 2020), code switching enabled me to develop connections with CPC members before and during the interviews. In this case, it led to 39 interviews.

Members from reproductive rights, justice, and health organizations also questioned my initial contact efforts. Many of these members were uncertain about the primary motivation behind my study due to my affiliation with an historically conservative university. One member of an abortion fund said:

> I guess my concern would just be, is that A&M is known as being kind of a conservative school, and this is a very politically sensitive subject, as you mentioned. I get it, I went to a Catholic university, but I don't want to be part of a study that's, you know, used to politically attack reproductive justice.

However, my research agenda around reproductive health(care), my knowledge of the three

reproductive frameworks, and previous involvement with Pro-Choice Texas served as a bridge that connected me to a network of organizational members that shared similar ties.

In the sections that follow, I delve more deeply into the study methodologies I used to explore how members who work in the reproductive domain communicate about reproductive health and their work and the spatial consequences of reproductive health access in Texas. First, I conducted virtual interviews with a range of organizational members to gauge (a) how they understand and talk about reproductive health(care) and (b) how their member identification is constituted by their perceptions of their work and larger organizational roles. Then, using Esri's ArcMap and Canva, I created an intimate map that articulates the participants' embodied experiences around reproductive health(care).

Virtual Interviews

As my dissertation evolved during COVID-19, I turned to Zoom, a videoconferencing platform, to conduct my interviews. Research around the methodological effectiveness of virtual interviewing through Zoom has remained largely underdeveloped (Gray et al., 2020). In the limited research that does exist around the platform, Archibald et al. (2019) report that Zoom is better equipped as a data collection platform than other videoconferencing programs due to its secure recording and storage of sessions that do not rely on outside systems or vendors.

In general, videoconferencing platforms are useful data collection tools for qualitative research, specifically interviews. For instance, there is evidence demonstrating that the quality of virtual interviews versus face-to-face interviews is relatively similar (Deakin & Wakefield, 2013). Virtual interviewing is also cost effective and conducive for those who are geographically dispersed (Hanna, 2012). Participants even tend to be more forthcoming and expressive during

interviews hosted in online environments (Gray et al., 2020) and are able to participate in the comfort of their own spaces (Hanna, 2012; Howlett, 2020). Based on the complexity and ambiguity that currently surrounds COVID-19, there is a strong suggestion that qualitative researchers will continue to rely on Zoom and other videoconferencing platforms as data collection sites for the foreseeable future.

Virtual interviews involve layers of distinct consideration, planning, and logistics, such as arranging interview spaces, lighting, accounting for the quality of video recording devices, and anticipating technical difficulties (i.e., internet connectivity issues). For the duration of my interviews, I positioned myself in a well-lit corner of my kitchen, in front of a plain, white wall. My participants conferenced in from several interesting spaces, including offices, dining rooms, backyards, front porches, bedrooms, sound booths, living rooms, and even their cars. Some had their cameras focused on their faces, others' cameras were either positioned in ways that concealed their faces or turned off completely. Almost no one used Zoom backgrounds, or artificial backdrops that conceal a person's space. Internet connectivity and sounds issues were sporadic. Screen freezing also occurred spontaneously, and Zoom connections had to be reestablished.

I used my Texas A&M Zoom enterprise account as the primary platform for my virtual interviews for several reasons. First, Zoom enterprise accounts offer closed captioning functionality for all participants to facilitate accessible meeting conversations (Zoom Video Communications Inc., 2021). From these closed captions, Zoom produces a transcript text file (.txt) with timestamps—albeit messy—of the entire meeting, which eliminates the need for a third-party transcriptionist. Zoom also provides security measures to protect the confidentiality of the meeting participants (Gray et al., 2020) and recorded sessions (Archibald et al., 2019).

Most importantly, Zoom provides flexibility to speak with people from their own spaces, wherever that may be (Hanna, 2012). Other additional best practices when using Zoom for qualitative data collection include establishing a backup plan, planning for technical difficulties, and anticipating distractions on both sides of the screen (i.e., external noises, background conversations).

During my interviews, there were several distractions that interrupted the flow of conversation. Jenny, a board member of Magdala Maternity Home, muted her microphone several times to attend to screaming children. Lisa, an executive director of Crisis Pregnancy Medical Center, excused herself from her computer and walked away for a few minutes at a time. Upon hearing a phone ring, Monica, executive director of Watford Pregnancy Center, motioned to an out-of-sight space. "That's our phone," she said. "I'm the only one to get it, so." She shrugged and left the screen, disappearing into an out-of-view room. Others were distracted by incoming e-mails, phone calls, barking animals, cooking or eating meals, and chatter from other people occupying their spaces. These distractions were expected and welcomed during the interview process, which took place at the beginning of the COVID-19 lockdown. I made sure to meet the participants where they were; everyone was free to join their interview session in any way they were able or felt comfortable.

Aside from the additional complexities that virtual interviews present, interviewing was a critical method for this dissertation. Interviews are interpretively active meaning-making occasions, which makes interview data a collaborative effort between the interviewer and interviewee (Holstein & Gubrium, 2003). The interview as an inter*active* process attends to the ways that knowledge is assembled through talk or knowledge sharing. Interviews are also dynamic *meaning-making occasions*, focusing on how meaning is interpreted and constructed,

the circumstances of construction, and the meaningful linkages that are assembled for the interview occasion (Holstein & Gubrium, 2003; Tracy, 2013). Overall, interviews are "a complex, messy, and necessarily partial process" that also serve as sites for "story-telling, performance, and partial truths" (Blithe & Wolfe, 2017, pp. 169-170). As such, interview data is not only created through the (im)materiality of participants' and researchers' talk and sensemaking experiences, but also through the technologies that are used to facilitate and capture these virtual, dialogic interactions.

My choice to use Zoom as the primary technology to record the interviews became enmeshed and implicated in the processes of producing—and ultimately analyzing—the data (Ellingson & Sotirin, 2020). Unlike face-to-face interviews, where we are only left with audio recordings as interview artifacts, using Zoom produced *video* artifacts that enabled me to relive each interview occasion. Reexperiencing the interviews through these video artifacts enabled me to (re)observe facial expressions and other nonverbal cues, disruptions, back-and-forth candor between myself and the participants, and how the participants were situated in their spaces, communicative details that are otherwise lost or invisible in audio artifacts. And I watched the videos several times, approaching each interview with a view of reality that is akin to a mirror's surface: skewed, changed, distorted. Much like a mirror's reflection, each video artifact is both derivative and reflective of its original interview occasion. As such, each interview will be approached and interpreted differently at every engagement.

There was a notable *generative messiness* (coined by Ellingson & Sotirin, 2020) to the Zoom interviews, specifically through the process of how the participants and I made sense of conversational turn-taking in virtual spaces, shared stories, encountered disruptions, navigated emotions around COVID-19, and negotiated power relations. For this study, virtual interviews

offered opportunities to engage the participants in questions about their organizational knowledges, their work, and how they communicate about—and ultimately make sense of—reproductive health(care). The interviews also provided the participants with a space to articulate emotion, particularly feelings of frustration and anger toward the various oppressive, systemic barriers that hinder their work. From a broader perspective, the virtual interviews are representative of specific sociohistorical moments in time and demonstrate "how digitally recorded data continually omit, add, and transform" (Ellingson & Sotirin, 2020, p. 44) to the larger, lively complex data landscape they belong to.

Process

As I previously discussed, my initial contact list of organizations was informed by Pro-Choice Texas' network and their existing research around CPCs. But because I was interested in capturing a broader range of perspectives that exist within the reproductive domain, I identified abortion clinics, abortion funds, and CPCs through open records requests from the Texas Health and Human Services Commission and manual internet searches. This search yielded 227 operating organizations at the time of data collection. To keep track of my e-mail correspondences, I created an Excel spreadsheet containing the following eleven columns: (a) Organization Name; (b) Organization Category (e.g., CPC, abortion clinic, abortion fund, etc.); (c) Initial Date Contacted; (d) Person(s) Contacted; (e) Contact Information; (f) Response (*from whom?*); (g) Introductory Meeting? (*yes/no*); (h) Follow-up with Supplemental Information (e.g., informed consent sheet, project abstract); (i) Last Contact Date; (j) Agreed to Participate in Study? (*yes/no*); (k) Other Notes (e.g., follow-up items, participants' side commentary, miscellaneous information). Since I scheduled interviews at the beginning of the COVID-19

pandemic, all correspondences about my study were communicated through e-mail or phone. However, as I discussed earlier in this chapter, my recruitment strategy varied, depending on the organizations I contacted. From the 227 organizations I identified, 30 were reproductive rights, justice, and health organizations, and 197 were CPCs. As a result of my recruitment efforts, I conducted 67 interviews—28 with reproductive rights, justice, and health members and 39 with CPC members. These numbers are reflective of Texas' legislative landscape, which allocates substantial funds to CPCs while limiting reproductive health(care)-oriented organizations (Tuma, 2015).

The participants represented a range of age groups and were predominately white (68%), female identifying (91%), and college educated (bachelor's, 44%; master's, 23%) (see *Table 1*). Religiosity was also high among the participants, half of whom identified as Christian (50%). The participants' demographic profile was unsurprising, almost expected, as those who have historically dominated reproductive work and spaces are mainly white women (see, e.g., Hayden, 2009; Nelson, 2003; Ross, 2017). Although *saturation* is a post-positivist notion (Tracy, 2021), I found that my participants exhausted all new themes and concepts that emerged from how the participants understood and talked about reproductive health and their work.

Many of the participants from the rights, justice, and health organizations were regional program organizers, helpline managers, volunteers, community organizers, and political advocacy strategists. In contrast, most participants from CPCs held managerial- or executive-level positions, such as branch directors, program directors, education directors, and advisory board members. I initially intended to interview volunteers and entry-level members but, instead, was redirected to people in higher-level positions. They were the decision-makers and, from my communication with CPC members, had the final say in whether their staff participated in my

	Percentage	# of Participants
Age (years)		
18-24	8%	6
25-34	26%	18
35-44	22%	15
45-54	16%	11
55-64	14%	10
65-74	10%	7
Gender*		
Female	91%	61
Male	5%	4
Nonbinary	2%	2
Racial Identity*		
American Indian or Alaska Native	4%	3
Asian Indian	1%	1
Black or African American	10%	7
Filipino	1%	1
Hispanic, Latino, or Spanish origin	22%	15
Middle Eastern or North African	1%	1
Other Asian	1%	1
White	68%	46
Education		
Associate degree	4%	3
Bachelor's degree	44%	30
Master's degree	23%	16
Doctorate degree	2%	2
High school graduate, diploma, or the equivalent (e.g., GED)	4%	3
Professional degree	1%	1
Trade/technical/vocational training	1%	1
Some college credit, no degree	16%	11
Religion		
Agnostic	5%	4
Atheist	7%	5
Christian	50%	34
Jewish	1%	1
Muslim	1%	1
Other	10%	7
Roman Catholic	13%	9
Spiritual, but not committed to a particular faith.	8%	6

Table 1. Participant Demographics

study. Some of these members also felt that they had to directly supervise my interactions with other staff members, such as Michelle, the executive director of Pregnancy Care Line: "I don't feel comfortable passing this off to anyone else, and I just cannot oversee it." This need to

* Participants were provided with the options to self-identify their gender and select multiple racial identities.

oversee my conversations was also evident in the six dyadic interviews requested by CPC members, where manager-level members were present during my interviews with staff. I discuss the dynamic of the dyadic interviews in the section that follows.

Procedure

Upon confirming their initial participation through e-mail, I sent each participant a short Qualtrics survey, which asked five demographic questions about their age, gender and racial identities, education level, and religiosity (see *Table 1*). Participants also had the opportunity to choose an identifying pseudonym. Selecting a pseudonym was important for the majority of my participants, who recognized that the reproductive domain is a relatively small space where familiarity with organizations and members is high. Even beyond the demographic survey, the use of pseudonyms was an ongoing conversation I had with participants to ensure the protection of their identities, work, and organizations (Guenther, 2004). Overall, the purpose of the demographic survey was to piece together the landscape of participants and perspectives that were represented—or absent—in this study.

At the beginning of each virtual interview, I reviewed the informed consent form with participants. Then, I asked the following three questions prior to starting the session: *Do you have any remaining questions about this study?*, *Do you consent to being recorded?*, and *Do you consent to being a part of this interview?*. Participants were required to provide an audible "yes" or "no" when consenting to participate, since the logistics of virtually signing a consent form at the beginning of every interview can be complex and time consuming.

The interview protocol began with general questions about the participants' work, which included questions, such as "Tell me about your position(s). What are your responsibilities?"

and, “Why did you choose to work at your organization?” (see *Appendix A*). As we moved into questions about how the participants talk about reproductive health, issues around reproductive health in the communities they serve, and the barriers that keep them from delivering services and resources, two types of interview experiences emerged. Some participants spoke openly and exhaustively about their work, sharing in-depth details about how they conceptualize reproductive health, strengths and weaknesses of their organizations, and reflecting deeply on what it means to be involved in reproductive-related work during a global pandemic in Texas and, more broadly, the South-Central Region of the United States. Many of these participants also shared how traumatic life experiences led them to their current work. In these cases, I asked follow-up questions but let the participants take an active lead in the conversations. Other participants provided brief answers, or had difficulties locating language around “reproductive health(care),” which I explore in Chapter IV. These participants used their existing knowledges around “women’s health” to elaborate on their work, organizations, and how they serve their communities. In these cases, I used the interview protocol as a structured guide to lead the participants through our discussions.

The six dyadic interviews I conducted with CPC members presented unique challenges. In certain research settings, dyadic interviews can be beneficial. Dyadic interviews are conducive to synchronous online formats and allow the participants to co-construct thoughts and conversation points during the session (Morgan et al., 2013). However, there are drawbacks. First, a participant may self-censor their contributions or conceal information based on the other participant’s responses (Eisikovits & Koren, 2010). There are also ethical implications around participants revealing potentially sensitive information, which may affect the dynamic of their work relationship and have long-lasting consequences beyond the parameters of the interview

(Forbat & Henderson, 2003). These tensions were palpable between my participants throughout the dyadic interviews. For instance, during an interview with a board member and program director of a maternity home, the board member regularly interrupted the program director, correcting their answers and adding additional, unsolicited input. This resulted in several instances where the program director deferred to the board member to answer my questions. A similar situation occurred during an interview between a CPC staff member and executive director. Although I continually asked the staff member questions, they became progressively quieter throughout the interview, eventually disappearing from the conversation.

All interviews were recorded through Zoom. I also took analytic notes during each interview and archived the notes in the Excel spreadsheet tracker previously discussed. These notes served as critical reminders during the transcription process of what occurred during each interview, such as distractions and side commentaries. Interviews ranged in length from 30 to 75 minutes and yielded more than 600 pages of single-spaced data.

Analysis

The organization and analysis of my interview data was guided by Tracy's (2013, 2019) iterative approach and Nathues et al. (2020) and Castor and Saludadez's (2019) ventriloquial analyses processes. Tracy's (2013, 2019) iterative approach involves moving back and forth between theory, existing research questions, and the data. During this process, research questions are refined as the data is revisited multiple times. I attempted to transcribe and code the interviews shortly after conducting them, but the volume of interviews and mounting complications of COVID-19 resulted in a slower process.

The coding process confirmed some of my preconceived notions as I moved through the

interviews but also called attention to themes that I did not initially consider when crafting my interview protocol. For instance, I did not anticipate how euphemistic language animated the participants' understandings of reproductive health(care). I saw this develop as a recurring pattern the first set of interviews. In subsequent interviews, I asked participants about this euphemistic language.

I conducted a first round of open coding on 20% of my interview data that represented a range of voices, perspectives, and organizations across my larger dataset. This process generated 1,058 open codes. During the open coding process, I coded segments of text that spoke to each of my research questions. This included coding entire paragraphs, sentences, phrases, and words. I also kept a running list of notes and commentary that documented my interactions with the participants and other significant moments that either occurred during the interviews or in e-mail correspondences. Originally, I began my coding efforts in NVivo, but the platform became too cumbersome for the amount of codes I had developed. I turned to a manual analysis approach and used the track changes functionalities (i.e., commenting, highlighting) in Microsoft Word.

From the initial open codes, I identified 19 secondary codes and created a preliminary codebook to test additional data. Then, I proceeded with subsequent rounds of analysis, which involved revisiting my research questions, theoretical framework, and data—a process that helped to refine my codes and develop larger themes. These larger themes, which I explore in the proceeding chapters, provided a framework to explore my research questions and data in-depth. These themes largely speak to how *discourse*, *member identification*, and *sites* of affective, embodied experiences constitute reproductive health(care).

I conducted a ventriloquial analysis in tandem with the iterative approach to observe how multiple, conflicting voices that contributed to each theme. I drew from Nathues et al. (2020) and

Castor and Saludadez (2019) ventriloquial analysis processes, which both offer similar frameworks that involve the following steps: (1) identify interactants and figures; (2) record and/or document the interactions; (3) organize the interactions into categories or groups; and (4) analyze the ventriloquial activities by providing specific exemplars. Following this process, I drew from the recorded interviews with organizational members working within the reproductive domain. Then, from these interviews, I identified figures that constituted reproductive health(care) through discourse, membership identification, and embodied, affective experiences. As such, I inferred that these figures were made to produce specific interpretations and understandings of reproductive health(care) on behalf of their organizations.

Intimate Mapping

When I first began this study, I intended to conduct a series of spatial analyses using Esri's ArcGIS. However, I shifted my focus to critical feminist geography. This methodological pivot was important because critical feminist geographic perspectives, such as intimate mapping, "involve a proximity that renders tangible the intimacies and economies of the body," as well as other affective sites that are not necessarily afforded by geographic information systems (Mountz & Hyndman, 2006, p. 450). These perspectives also align with my identity as a critical-qualitative feminist scholar. Additionally, this methodological shift provided connection points to CCO scholarship. CCO theory provides a productive framework to show how organization is performed *through* communication (Cooren, 2006) and the various tensions that result from the expression of human and nonhuman beings (e.g., affective sites) that provide insight into how things are enacted (Cooren et al., 2013). Bringing critical feminist geography and CCO into conversation offers a useful, cross-disciplinary framework to understand how

various human and nonhuman beings swirl in tension to constitute reproductive health(care) as an embodied, communicative site. As such, the second and final method I used explored how the flows of communicative, sociomaterial, and political tensions constituted an intimate mapping of Texas' reproductive health(care) landscape. I drew from Pratt and Rosner's (2006) and Whitesell and Faria's (2019) conceptualizations of global intimate mapping to create an intimate map that pays particular attention to the nuanced tensions of space and place within a smaller, zoomed-in landscape.

Global intimate maps are alternative visualizations of space with the goal of "accounting for power-laden, political, and emotional site markings and encounters" (Whitesell & Faria, 2019, p. 1278). They are a response to traditional maps that tend to erase or omit stories that play an active role in "socially construct[ing] public spaces through their actions and constantly (re)define boundaries in such places" (Bagheri, 2014, p. 1297). In this way, global intimate mapping techniques can be considered counter-mapping efforts that resist traditional forms of visualization, scale, and distancing and, instead, center a sensorial approach comprised of "sound, smell, taste; the ways bodies and objects meet and touch; zones of contact and the formations they generate" (Pratt & Rosner, 2006, p. 17). Intimate mapping crystallizes these affective, sensorial experiences, blending the divide between viewer-viewed, mapmaker-participants, communicator-communicated (Whitesell & Faria, 2019). These affective experiences, in turn, co-constitute the discursive and sociomaterial flows that shape the space in which they exist.

Intimate mapping techniques are deeply informed by a critical-interpretive feminist and geographic commitment to identify spaces of power and privilege and "challenge gender-based oppositions by upending hierarchies of space and scale" (Pratt & Rosner, 2006, p. 16). Intimate

mapping can offer communication scholars—and beyond—a methodological framework and practice that simultaneously (a) encourages interdisciplinary connection, (b) disrupts positivist, masculinist knowledges of geography (Rose, 1993), (c) materializes networks of communicative, sociopolitical, affective sites in everyday spaces (Whitesell & Faria, 2019), and (d) captures embodied experiences of unseen voices. For this study, an intimate mapping approach brings the underlying, unseen tensions and testimonies that constitute Texas' reproductive landscape to the fore that otherwise remain invisible or secondary in traditional mapping approaches. The approach is also reflexive and considers the implications of the tools, symbols, and technologies used by the researcher to create and conceptualize their maps (Casti, 2015). From an organizational communication perspective, an intimate mapping approach can hold understandings of organization and organizing in tension while making space for other methodological approaches to (re)imagine and animate these concepts. This approach also offers a method to visualize the relationality and the complexities that exist between bodies, objects/artifacts, and sites (Ashcraft et al., 2009) that ultimately contribute to the basis of the mapping.

For this study, I position my intimate map as a communicative visualization, artifact, and site that materializes the relational milieu of discourse, borders and barriers, emotions, and sociopolitical tensions to explore the first-hand knowledges, spatial stories, and organizing efforts of Texas' reproductive workers. In the sections that follow, I discuss the intimate map creation process and conclude with a brief overview of the questions and methodological tensions that inspired my interest in pursuing mapping as a method for this study and, more broadly, advocating for its use in organizational communication scholarship.

Intimately Mapping Texas' Reproductive Landscape

The intimate map I created for this study centers the voices of my participants, particularly those who articulated how space and place hinders the delivery of and access to reproductive health(care) in Texas. The local intimate map is based on the 67 virtual interviews I conducted between March-July 2020. While I did not explicitly ask questions related to space, place, locality, and distance during the interviews, spatial considerations surfaced during my conversations with participants about reproductive health(care) disparity and barriers and providing service to underserved populations.

The majority of the participants who discussed how their work is affected by the difficulties of locality and distance were predominately from reproductive rights, justice, and health organizations. The voices of participants from CPCs were largely absent from these discussions. These findings were not entirely surprising for several reasons. In their study on abortion clinic and CPC distribution in Texas, Costantini and Thompson (2021) demonstrate that abortion clinics in Texas are predominately located in urban areas and have a diminished presence in rural areas (see *Figure 1*). However, there is a higher concentration of CPCs across rural areas in Texas, and many more CPCs than abortion clinics in general (see *Figure 1*). Because CPCs have a dominant presence across Texas, it follows that issues and barriers related to locality, distance, and travel do not necessarily constrain their work or hinder their services and care delivery. Locality is not an issue for CPCs. On the other hand, abortion clinics' locations are limited in the ways they are able to serve communities outside of where they are located (i.e., rural areas). For these organizations—and others that fall within the reproductive rights, justice, and health frameworks—distance and locality are barriers that affect how service and care are delivered and accessed by rural clients.

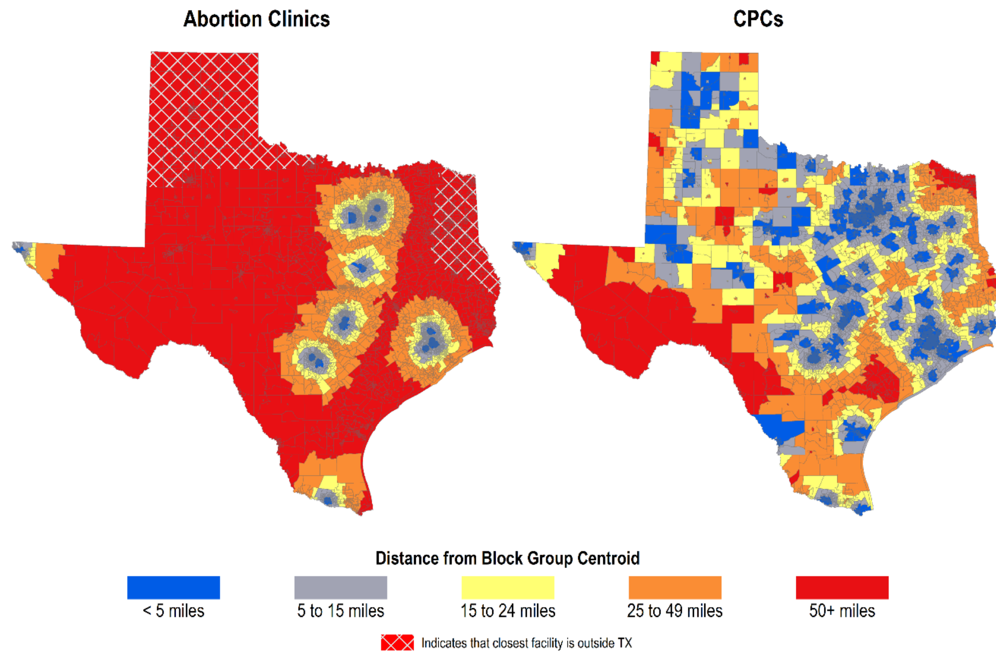

Figure 1. Distances to the Nearest Abortion Clinics and CPC Facilities in Texas (Costantini & Thompson, 2021)

At the beginning of my map creation process, I reexamined the interview data and identifying all interviewees' references to space and place, including travel restrictions, barriers, and borders; transportation and driving distances; maps or mapping; specific areas or regions in Texas and surrounding states; and locality, policy, and undocumented populations. Then, I created a choropleth map in Esri's ArcMap using 2009 population estimates data from the Texas Demographic Center. Choropleth maps are thematic maps. Choropleth maps represent statistical information through shading or symbology "in proportion to the measurement of the statistical variable being displayed on the map" (Fourie, 2021). I used population estimates to showcase population density across the state of Texas because the data showcases stark contrasts between populated areas in Texas, specifically between major city centers and the surrounding areas. Then, drawing from my interview data, spatial stories from 12 participants spoke to varying encounters, interactions, and experiences—both personal and professional—in relation to their

reproductive work. Spatial stories are what de Certeau (2001) categorizes as "every day [stories that] traverse and organize places; they select and link them together; they make sentences and itineraries out of them. They are spatial trajectories" (p. 115). As I will discuss in Chapter VI, spatial stories are the directional intimate flows that simultaneously guide us through and constitute the intimate map.

I turned to Canva, a design platform, to position each spatial story onto the map according to its contents. For instance, if a spatial story referenced words such as, "barriers" or "borders," I contorted the words of the story into the shape of a border or barrier within the referenced region in an attempt to visualize the story. Words or expressions within the participants' stories that referenced geographic and/or directional information, space, place, and/or cities were bolded and underlined to call attention to these details.

The intimate map presented in this study situates the lived experiences of members from this study. At the same time, the map implicates my experiences as a person who occupies and moves through the same reproductive health(care) spaces as my participants but, perhaps, differently. And I recognize that I move through privileged spaces (e.g., academia, research) that shape my experiences in the reproductive space in specific ways. The intimate map becomes a space where I am implicated—alongside my participants—as an integral part of the map's existence, meaning, aesthetic, politics, and purpose. Therefore, the intimate map works to disrupt traditional understandings of scale, distance, space, and place that "often work to homogenize and erase individual experience" (Whitesell & Faria, 2019, p. 1282). Most importantly, the map visually and discursively scaffolds the embodied stories of my participants to an already existing landscape of (un)told reproductive health(care) experiences.

Notes on a "New" Methodological Pathway

Organization studies scholars have set a methodological precedent for analyzing spatial practices in the study of organizations and organizing (see, e.g., Best & Hindmarsh, 2019; Nash, 2020; Wilhoit, 2016). However, Costantini and Thompson (2021) call on scholars of organization and organizing who develop and draw from spatial concepts to articulate what notions of organization and organizing looks like through the practice of mapping. Costantini and Thompson (2021) pose the following questions:

> Space is many things across the organization studies literature—conduits, boundaries, channels, discursive, networks, constituted, constructed, bounded, embodied, performative, relational, built, socially produced. From these conceptualizations, what does space actually look like? How might we map these spatial considerations? … How might we begin to use geospatial principles to visualize discourses and the sociomaterial, affective aspects of space? (p. 25).

I consider the questions raised by Costantini and Thompson's (2021) in this study, specifically how organizational communication scholars might begin to use mapping techniques to locate a visualization of space has in our understandings of organization and organizing. Mapping is a method organizational communication researchers rarely use; therefore, mapping could be considered a novel endeavor to the organizational communication subfield and the Communication discipline more broadly. But Hanchey (2020) discusses the dangers of classifying scholarship as novel or groundbreaking, defining these ideas as "traps" or "another way that scholars of color, scholars from the Global South, as well as queer and trans* scholars, are relegated to the boundaries of communication studies subdisciplines" (p. 123). The epistemologies and ontologies of *maps* and *mapping* have deep, expansive roots in Indigenous

and anti-colonial cartographies and have been explored by scholars across a wide range of (sub)disciplines and paradigmatic commitments. My goal is not to claim maps or mapping as new, groundbreaking knowledge, artifacts, or methods, or to gloss over work that has been forwarded by voices that have come long before me. Instead, my aim is to encourage organizational communication scholars to resist the kneejerk reaction urge of methodological dismissal and, instead, recognize mapping as both a (a) productive interdisciplinary methodological and analytical practice and (b) form of communicative visualization.

Just as Doreen Massey (2005) once called for *space* to be uprooted from "that constellation of concepts in which it has so often been embedded and to settle it among another set of ideas where it releases a more challenging political landscape" (p. 13), I call organizational communication scholars to do the same in lifting organization and organizing from their "constellation of concepts," to situate them within a different, creative, and new methodological pathway: mapping.

CHAPTER IV

THE COMMUNCATIVE CONSTITUTION OF REPRODUCTIVE HEALTH(CARE)

In this chapter, I explore how members from the reproductive domain play a critical role in communicatively constituting reproductive health(care). Specifically, this chapter seeks to answer the following research question: *How do organizational members in the reproductive domain communicatively constitute reproductive health(care)?*

From the perspective of relationality, Costantini and Wolfe (2021) tell us that "we are challenged to squint at apparently solid structures in order to make out the vibrating relations that make them seem so tangible" (p. 23). At a distance, reproductive health(care) appears to exist as a solid structure in the world. Its seemingly tangible existence is augmented by its frictional positioning between rigid, binary forces: pro-life/pro-choice and anti-abortion and abortion-rights advocacy. However, upon closer look, reproductive health(care) is materialized by the "vibrating relations" that occur *between* the binary forces. These relations are a collection of messy, disparate (inter)actions and transactions that exist in perpetual negotiation, tension, and contradiction (Cooren & Martine, 2016). Ultimately, reproductive health(care) is a buzzing hive of activity that transcends binary categories. It is constituted by a vibrating assemblage of organizations, organizational members, value-systems, perspectives, competition, and conflict that produce reproductive health(care) as such.

This chapter is primarily concerned with how organizational members from the reproductive domain invoke various texts, policies, stories, values, and ideologies in their constitution of reproductive health(care) on *behalf* of their organizations. As I discussed in Chapter II, the reproductive domain is a collective space where reproductive rights, justice, and

health organizations, and CPCs' conversations, interactions, transactions, sensemaking, and meaning-making express and constitute reproductive health(care). The organizations within the reproductive domain are in competition to claim what reproductive health(care) is in this *shared* space. The effects of this are made palpable in the ways that certain articulations of reproductive health(care) are vocalized while others are silenced or excluded.

By drawing from the tenets of relational ontology (Cooren 2018, 2020), I demonstrate how members of the reproductive domain draw upon through three clusters of discourse to produce "reproductive health(care) as: *an aspect of women's health*, *an aspect of human health*, and *a euphemism for abortion*. The discourse clusters contribute to the simultaneous messiness and strategic application to invoke organizational goals, missions, principles, and values across the reproductive domain. Therefore, it is through the perspectives of the conversational gatekeepers of reproductive health(care) where we can begin to recognize how communication constitutes the sociomaterial production of reproductive health(care).

Reproductive Health(care) as Women's Health

During my initial recruitment efforts for this dissertation, members from several organizations claimed that their organizations were not relevant to the primary aims of my study because:

> *We are both swamped given everything going on in the world and given the politicized nature of what we do we just don't think it's prudent to participate.*

> *I will be honest that I have been burned from those that have their own pro-choice agendas and that has concerned me and alerted me in doing any interviews like this.*

In this climate we have to take whatever measures we can to protect our organization. We don't feel that with this particular opportunity we can guarantee that what we share will not be misstated or misrepresented.

With the current healthcare climate, I am sorry but we do not have the bandwidth to assist you with your dissertation.

I am not sure why you are contacting us for information when there are several pregnancy centers closer to you who are doing the very same thing as we do.

It looks like she's studying women's access to reproductive healthcare and wants to ask staff about their understanding of reproductive healthcare and their views of the types of boundaries in place to access it. It looks as though [our] *identity would remain provate* [sic]*, but the thesis is a little vague, and her bio shows she works for Pro-Choice Texas. I can politely decline, but I wanted to let you know about it in case you are interested.*

These e-mail correspondences provide important insight around how organizations subscribe to rigid binary systems that produce disparate understandings of what does (and does not) constitute reproductive health(care). Based on these e-mail exchanges, many of these organizational members did not see themselves as relevant contributors to my study. For them, my study fell outside of the realm of their conversations, organizational practices, and language. To these organizational members, what they do exists outside of the scope of reproductive health(care). These members focus on *women's health*, not reproductive health(care).

"Women's health" was used to describe the focus of their work in addressing clients' mental, physical, and emotional well-being. My interview with Megan, an OB/GYN and volunteer at Parachute Pregnancy Center illuminated several interesting points around the "semantics" of this language:

> So, where women's health is, in my opinion, referring to the whole body, and not just the reproductive system. And so, I think that, but also think that we have to give people, you know, a little bit of slack and not get too caught up in the words and the semantics of everything. Sometimes, I think, we can get a little too caught up in all of that, but I think as long as everyone has a general understanding of what's being said, then, yes, I do think that they can be interchangeable. I try not to get too hung up on, you know, what people call it.

Megan initially makes the distinction between women's health and reproduction, claiming that women's health is *more* than reproduction and encompasses a holistic approach—"the whole body." Interestingly, Megan also acknowledges "how words and the semantics of everything" influence how reproductive health(care) is communicatively constituted by different people and organizations outside of her organization. As an OB/GYN and volunteer at Parachute Pregnancy Center, Megan draws from her outside technical expertise of obstetrics and gynecology but is simultaneously constrained by her organization's values, mission, and ideologies, which revolve around women's health and centering a holistic approach. This tension is apparent in Megan's comment about the particularities of the "words and semantics" used to describe reproductive health(care). In this way, Megan indirectly describes the messiness of reproductive health(care) that makes it difficult—almost *impossible*—to address the language used to conceptualize it. But Megan's comment, "as long as everyone has a general understanding of what's being said,"

brings our attention to how women's health and reproductive health(care) are taken for granted concepts that are constituted in dissimilar ways according to many different people for different reasons. This very logic directly contributes to the disparate communicative production and meaning of reproductive health(care).

Like Megan, other participants made distinctions between "women's health" and "reproductive health(care)," oftentimes using language that invoked the idea of the *whole woman*, which is comprised of physical, emotional, and spiritual well-being. Cathy, a sonographer from Choose Hope, a CPC, explained, "We are not, we are not parts of the body, especially as women, I think we are very much, emotionally, spiritually, physically aware of all of that." For Hannah, the executive director of Clear Valley Pregnancy Resource Center, differences between "reproductive health(care)" and "women's health" materialize in the way services and resource are centered: "You know you need to get your pap smears or whatever. Well, it's not just that, you know, there, there are other issues that need to be looked at as well in women's health." The social realities of women's health seem to compete with reproductive health(care). The physical, social, and emotional well-being of women's health is often centered as all-encompassing and broad, while reproduction plays a limited, specific role in women's health.

Karen, a client advocate of New Horizons Pregnancy Resource Center, reiterated other participants' sentiments by clarifying the differences between women's health and reproductive health(care). These differences are detected through the language Karen used to simultaneously bolster women's health as a holistic approach while dismissing reproductive health(care):

> Yeah, it's just not reproductive health, though. Right now, it's everything—their physical health, their mental health, emotional health. It's just not reproductive health. I don't

> think I would use what that just for women's health, it's more of a broader picture right? More holistic.

For Karen, women's health and reproductive health(care) are diametrically opposed. Here, reproductive health(care) conjures an acutely nuanced and unrelated perspective devoid of considering the broader picture of holistic services and resources that women's health offers. Karen constitutes reproductive health(care) as different, dissimilar, not a part of the "broader picture" of women's health. There was even a palpable tension when Karen verbally articulated the phrase "reproductive health(care)," almost as if the language itself was iniquitous and offensive. Holly, a client consultant from Birth Blessing Pregnancy Center, shares Karen's sentiments:

> When I think of women's health, I think it's, it's a lot broader than just the reproductive health. I don't know if that's weird, weird for me to think that, but in my mind, I'm like, I think, yeah, I think that it's more than just reproductive aspects of that, you know, like I think mental health plays into that and physical. That's not related to that part of your health. I don't know, I don't know if that makes sense.

Holly's commentary reveals her uncertainty around reproductive health(care) and women's health. This is apparent through her admission of uncertainty and feeling strange when describing the differences between both concepts. The language Holly uses suggests that there is a distinction that exists between womanhood and reproduction. Here, Holly reduces women's health to parts, effectually saying that reproductive health(care) is a separate consideration that is not tied to other aspects of women's health. Interviewees, such as Holly and Karen, tended to contrast their "holistic" approach to health and well-being to the relatively limited role of "reproductive health(care)," which they constitute as limited to the physical functionality of

reproductive organs toward the goal of child-bearing. These discourses assume the existence of an essential category of "women" that is homogeneous enough to warrant care that is distinct from out-group members, such as men. While relying on this binary opposition between men and women, a focus on reproductive functionality tends to assume heterosexual relations and an ideology of natalism as the "natural" purpose of the reproductive system. As such, transgender and gender-fluid folx are effectively erased in the conversations around women's health.

Other participants struggled to understand what reproductive health(care) is or meant to them, often grounding their stories and experiences in knowledges informed by the media or personal interpretations. Interestingly, while these participants could not locate the language to mobilize reproductive health(care), some were aware of its politicized and controversial nature.

During my interview with Barbara, a client advocate from New Horizons Pregnancy Resource Center, I asked her to describe her understanding of reproductive health(care) and ultimately what it meant to her as a client advocate. As a client advocate, Barbara is primarily responsible for communicating information to her clients in crisis pregnancy situations about a range of services and options, including abortion, parenting, and adoption. Barbara admitted that she had only ever heard reproductive health(care) referred to as reproductive rights "on the news." "That's how its portrayed in the news, you know, reproductive rights," Barbara said, shaking her head. "I don't know. No, I don't see it in our everyday language. Maybe it's an urban versus rural bit?" Barbara's response constitutes reproductive health(care) twofold. First, she associates it with reproductive rights, which is informed by her media and news consumption. Then, she frames reproductive health(care) as a term that might be used more often in urban regions as opposed to rural regions. Barbara's commentary reveals a slippage in how reproductive health(care) is constituted across the reproductive domain. While a member of a

CPC, Barbara draws from language (i.e., reproductive rights) that is rooted in different values and hierarchies. Although her organization does not explicitly use the language "reproductive health(care)," Barbara situates reproductive health(care) as related to reproductive rights based on her experiences and memories of news media. But Barbara's association constitutes reproductive health(care) as something that is controversial and political, which is informed by her position as a client advocate and her personal experiences.

On the other hand, Yvonne, founder and president of Watford Pregnancy Center, acknowledged her familiarity with reproductive health(care) but expressed confusion around its various "names:"

> In the healthcare field you will find people using different names for [reproductive health(care)]. Our organization, I consider it just healthcare. Healthcare is more of a, the word I prefer to use. I've heard of reproductive health(care), but I'm not really too sure what that means, even as a nurse, you know?

Through Yvonne's story, reproductive health(care) is constituted as an enigma, something that is undefinable to her, "even as a nurse." But most interesting is that Yvonne does demonstrate an awareness of multiple "names" that reproductive health(care) is referred to. So, if reproductive health(care) is not a medical term that a nurse would know and be able to define, what is it? Like Barbara, Yvonne constitutes reproductive health(care) as something that is political and separate from *healthcare*, which is the word she prefers to use. For Yvonne, this move reaffirms binaries that actively divide healthcare from the politicized nature of reproductive health(care). "Just healthcare" is constituted as a more neutralized phrasing and more of a practical application.

Reproductive Health(care) as Human Health

In contrast to the first cluster of discourses, "reproductive health(care)" as human health conceives of "women's health" as ignoring reproductive health(care) needs beyond cisgender women's efforts of reproduction and child-bearing. From the reproductive rights and reproductive justice framework, in particular, all people—regardless of gender identity, fertility, sexual activity—have needs related to reproductive health(care). These discourses assume gender identity exists on a spectrum, rather than a binary, and that identity can be fluid over time, related to sexuality in various ways. Regardless of gender identity and/or sexuality, all humans have reproductive health(care) needs. As Erika (organizing program manager, Eve Fund) viscerally explained:

> When you say 'women's health,' you're assuming, it comes with a lot of assumptions, is basically what it is, right? It's assuming that people are women, they primarily want to get pregnant. So, like me, as a queer person who, you know, I don't worry about, like, I have other reproductive health needs that, you know, my street sister would have, and we both have different needs and, like, somebody who's trans, you know? So, it leaves out a lot of people.
>
> I think we need to stop doing it as a movement, and I think we're doing better about that, um, but I think our legislators, their staff folks, and, and, it does not surprise me the antis are also using this, because, you know, I mean they fucking did a very good job of gendering this whole fight and of making this, painting this as, like, a woman's issue, as only a woman's issue. A good majority of them are women, but it's not everybody.

Erika's reaction is in direct conversation with Holly's response on page 67. While Holly

expressed feeling strange about distinguishing between womanhood and reproduction, here, Erika is frustrated at the conflation between the language of womanhood and reproduction. Erika acknowledged that her organization, as well as other partner reproductive rights, justice, and health organizations, are actively working to produce understandings of reproductive health(care) as human health through language that is accessible, equitable, and inclusive. But tension surfaced around how other organizations in across the reproductive domain use language, such as "women's health," to materialize reproductive health(care). Specifically, Erika's commentary demonstrates that her/her organization's conceptualization of reproductive health(care) is in contention with how reproductive health(care) is constituted through the values, ideologies, and positions of political leaders, legislative officials, and members of CPCs who use "women's health" to mobilize reproductive health(care). This, in turn, consequentially genders the discourse around reproductive health(care), which adversely influences the social realities of reproductive health(care) for the LGBTQIA+ community. Ultimately, they are excluded from the language.

Several other participants drew from their organizations' positions on gender neutral language to demonstrate how reproductive health(care) is constituted as human health. Alex, a helpline manager Virgo Fund, echoed Erika's testimony, highlighting how their organization uses gender neutral language in all forms of communication in efforts to include transgender and non-binary folx. To Alex, gendered language that is used to describe reproductive health(care) is "very violent" because it effectually glosses over the existence and lived experiences of a community that has been subjected to "so much history of violence."

Jess GB, a board member of The Back Fund, also reaffirmed Erika and Alex's sentiments, clarifying that her organization tries to be as inclusive as possible in the language

they invoke around reproductive health(care), especially when speaking with callers seeking their services. For this reason, Jess GB indicated that she upholds this organizational principle by actively avoiding language, such as "women's health" and "women's rights," when referring to reproductive health(care). Elena, a policy and advocacy strategist for Repro Union Collaborative, also pointed out that in her role, using women's health and reproductive health(care) interchangeably is counterproductive because "reproductive health(care) encompasses *more* than just women." For Jess GB and Elena, reproductive health(care) is constituted as human health through action, namely through their member roles and responsibilities within their organizations.

However, not all organizations take care to monitor their language around reproductive health(care). In particular, there are several reproductive rights organizations that support the LGBTQIA+ community and other marginalized populations yet still proceed to use gendered language to constitute reproductive health(care). Maria (community outreach specialist, Northpoint Reproductive Health) provides one such example:

> We've always served trans patients, but now it's like, like *We are in the market for you*, but still calling it 'women's healthcare' and a 'women's right to choose.' And that really disturbs me, and I've advocated for while I'm here, like, telling my team and my managers, like, sending them articles about like, why being trans inclusive is important. So, I see that a lot in Northpoint Reproductive Health and, of course, a lot of the supporters. They also say it. And I do consider like part of my job to like make sure it is as inclusive as it can be.

What is interesting about Maria's experience is that she explicitly stakes a responsibility and obligation for (re)educating the organization and her team members about dismantling such exclusionary language. In this way, she is speaking out *against* her organization in favor of a

more inclusive language to materialize reproductive health(care). Also notable in Maria's experience is that how her organization constitutes reproductive health(care) in a gendered way also spills over, by extension, to its supporters and extended public network. The discourse that Northpoint Reproductive Health uses is repurposed in the public sphere, perpetuating counterproductive ways of conceptualizing reproductive health(care) further contribute to the confusion and messiness of the concept. Dru, a political strategist for Repro Union Collaborative, elucidates this issue further through their explanation of something called "the word salad issue:"

> I think that we, as the reproductive rights movement and health and justice movement, I guess is what it would be if we're going to be really accurate, and also as progressive movements as a whole, have a tendency to make things really opaque, right? Like, I think that it's, I think having, I think language is important, and having specific names for things is important, but I think there's also a situation that's a hurdle, right, like this word salad issue I think is pretty new. So, like, in 2010, I guess it was 2011, January 2011, when I started, this wasn't an issue, right, like we talked about abortion, we talked about women's health, we talked about reproductive rights to a certain extent, but we mostly talked about women's health, and there was a shift of, like, 'women's health' as a euphemism for 'abortion'.

Dru's explanation of "the word salad issue" offers a connection point related to how euphemisms were folded into the language of their organization, but also within the broader language of reproductive rights, justice, and health organizations. Dru admits that organizations that operate within the three reproductive frameworks are not always clear in the ways they constitute reproductive health(care) through their language, missions, values, and ideologies. In the context of Dru's organization, "women's health," "abortion," and "reproductive rights" were, at one

point, understood as separate concepts. However, Dru observed a shift occur during their first months working at their organization. The hurdle Dru references—"the word salad issue"—was a result of the shift, which ultimately led to the establishment and acceptance of euphemistic language. Once separate entities, "women's health" evolved into "reproductive health(care)," which morphed into "abortion." Dru's account is one of many that has consistently emphasized the cyclical nature of how reproductive health(care) is constituted and the adverse effects it has on organizational and societal understandings of the concept.

Reproductive Health(care) as a Euphemism for Abortion

Women's health and reproductive health(care) are both insufficient terms insofar as they are used, at times, to obscure the fact that people are actually talking about abortion. Eisenberg (1984) reminds us that strategic ambiguity is a maneuver that "allows for multiple interpretations to exist among people who contend that they are attending to the same message" (p. 231). Strategic ambiguity utilizes equivocality (openness to interpretation), which can promote unified diversity while also allowing for plausible deniability and the pursuit of conflicting goals. As such, reproductive health(care) is applied as a euphemism for abortion through the use of strategic ambiguity.

Briefly, *euphemism* refers to a word, phrase, or expression that is used as a replacement for those that are blunt or unpleasant. Gómez (2009) characterizes euphemism as a substitution process, more specifically "the cognitive process of conceptualization of a forbidden reality" (p. 738). Euphemisms are a communicative form often used to save face (Allan & Burridge, 1991; McGlone & Batchelor, 2003), conceal, and provide palatable ways of discussing the unspeakable (Vickers, 2002). However, not all euphemisms are used to hide the unspeakable or "forbidden"

subjects. Employing euphemistic language is also a strategic linguistic maneuver to refer to such topics—such as abortion—in plain sight.

Google Ngram Viewer, an online search engine that shows language frequencies across time, provides an interesting history of the application and evolution of the word *abortion*, extending as far back as 1500 AD. An exploratory review of papers, texts, and articles dated 1500-1785 shows that abortion was previously defined as "miscarriage." Take, for example, an entry in *The Storehouse of Physical Practice: Being a General Treatise of the Causes and Signs of All Diseases Afflicting the Human Body* (1695): "ABORTION, Miscarriage in Women; the bringing forth of a Child or Foetus [sic] before its due time, fo that 'tis in no capacity to live." At present, there are *many* definitions, interpretations, and differences that are used to describe what we mean by abortion. Abortion is "the removal of pregnancy tissue, products of conception, or the fetus and placenta (afterbirth) from the uterus" (Harvard Health Publishing, 2019). According to Planned Parenthood (2021), abortion is "a safe and legal way to end a pregnancy." For SisterSong (2021), a reproductive justice organization, abortion is "about access, not choice" because "mainstream movements have focused on keeping abortion legal as an individual choice. That is necessary, but not enough." A crisis pregnancy center located in Central Texas offers several definitions of abortion procedures, cautioning readers that abortions "should only be performed on women who have a viable (capable of living) pregnancy."

In the span of several centuries, we can observe how language around abortion has evolved from miscarriage to termination, removal, choice, and access. The differences in this language also bring our attention to the application of its uses, specifically through the strategic ambiguity of euphemism. For instance, feminist activists during the 1970s developed the phrase "menstrual extraction" to simultaneously describe performing early abortions and passing

menstrual periods (Chalker & Downer, 1996). As such, "menstrual extraction" had convenient and strategic uses as a euphemism for abortion because it was unclear if a menstrual extraction resulted in an abortion or was the completion of menstruation (Murphy, 2012). In the same way, the phrase "termination of pregnancy" is the standard medical term for abortion but is also strategically used as a euphemism for abortion. The reproductive frameworks have also become synonymous with abortion care, as I will demonstrate in the sections that follow.

The evolution of the euphemistic language strategically used to materialize abortion provides a productive starting point to understand the strategic application of reproductive health(care) as a euphemism. From my conversations with some participants, euphemisms were often invoked to describe abortion depending on what a situation called for—from preparing and informing political candidates, to speaking with clients seeking abortion care. Jess, an organizer for Pro-Choice Texas, cited that in her work as a political organizer, she found that political candidates often have trouble using the word abortion in speeches and communications in fear of a backlash from their constituents. Therefore, candidates use euphemistic expressions to enact references to abortion:

> Candidates have a really hard time just straight up using the word abortion. They'll definitely use euphemisms, like women's healthcare or, you know, reproductive health whatever is someone's right to choose. And, and I think we, we tell them that when they use these euphemisms, voters know what they're talking about, right? When you say, 'women's healthcare,' people automatically think of abortion, right, so you might as well just use the word.

Caroline, political director of Pro-Choice Texas, echoed her colleague's sentiments:

> I feel like there's a lot of euphemisms that politicians in Texas use, like, reproductive

> choice or women's health or, you know…there's a lot of ways that people navigate around the word abortion.

In these examples, political candidates' applications of euphemistic terms to describe abortion is meant to blunt the negative effects associated with the word "abortion." But what is also interesting about both Jess and Caroline's observations is that the euphemisms around abortion are *known* euphemisms; they are public knowledge. But even though these euphemisms are known, political candidates, organizational members within the reproductive domain, and the public continue to use reproductive health(care)-related language as a euphemism to conceal the negative connotations—the historical baggage—that constitutes abortion. Erika (organizing program manager, Eve Fund) expressed frustration toward this issue:

> Using the word abortion is the main thing, like, always using the word abortion, not using, you know, fun little fillers like 'women's health' or 'reproductive health' or 'reproductive justice,' which even some people have been using in place for abortion and that's also like, no, just say 'abortion,' because we need to need synchronize it.

Erika's call to "synchronize abortion" is a call to action coordinate a unified front around identifying and dismantling euphemisms. It is also a larger call to reproductive rights, justice, and health organizations to collectively assess the language that is used to constitute abortion in order to stop using what Erika calls "fun little fillers." This call is taken up by many of the participants I spoke with, most of whom are members from reproductive rights, justice, and health organizations. However, these perspectives vary, depending on the organizational role one fulfills and the organization they belong to.

A participant who chose to be identified as RIGHT2CHOOSE (front desk receptionist, OneClick Reproductive Services) cited that people who call their clinic specifically seeking

abortion services oftentimes use euphemistic language to invoke abortion:

> Termination, that's a pretty common one. 'Get rid of the pregnancy.' A lot of them will refer to it as, like, 'I want to get the miscarriage pill.' They say some other things, like, 'I want you to remove the baby.' Just, I think women really just don't want to say the word 'abortion', because it's…I don't know what the word 'abortion', what it does to women. But those are the biggest ones I would say…termination is probably the most common.

RIGHT2CHOOSE was on the cusp of clarifying why people who call to schedule abortion procedures are hesitant to use the word "abortion." Instead, RIGHT2CHOOSE recognized that the word "does something to women," or negatively affects them. In a way, the word "abortion" has agency over callers. This agency prevents them from finding the language to articulate what abortion is. This occurrence RIGHT2CHOOSE describes is indicative of how organizational members, organizations, and the broader public sphere constitute abortion, oftentimes replacing the word with more "palatable"—sometimes misleading—expressions. The application of euphemistic terms to describe "abortion" are manifested in the ways RIGHT2CHOOSE's clients ask for the procedure—"I want to get the miscarriage pill," "get rid of the pregnancy," "termination."

At the same time, some participants indicated that their organizations encourage the use of euphemisms around abortion. Maleeha (community organizer, ACCESS Fund) noted that referring to abortion as "reproductive health(care)" is common in her organization: "A lot of people tend to think it's just the right to an abortion, the right to access abortion." This is a point of contention for Maleeha, a community organizer, because she serves as a gatekeeper between her organization and the community she serves. So, when Maleeha's organization uses "reproductive health(care)" to refer to "abortion," Maleeha must make choices between aligning

with her organization's language—and, more specifically, its position—for the sake of avoiding unclear communication around reproductive health(care).

On the other hand, other participants embraced euphemistic language as a rhetorical strategy. For instance, VH, a freelance volunteer marketing coordinator for several abortion clinics across Texas, uses euphemistic language often in her role. VH described her role as "telling the story" of the abortion clinics she freelances for. When VH creates marketing materials for these organizations, she positions herself as speaking on behalf of the organizations. In this way, VH *is* the organizations, and the organizations are VH. However, when VH has face-to-face conversations, she uses "women's reproductive health:"

> I find in my marketing, it's abortion. If it's the pill, abortion. Surgical abortion, abortion. Because that's the only word women are looking for. They're not looking for, we once in a while have somebody look for 'termination of pregnancy.' So, in the marketing, when I talk about people's rights and all those kinds of things, I tend to go towards women's reproductive health. And the reason for that is, even if a woman thinks she's having an abortion, she needs to have the right to maybe not. And so, I think it's more from that aspect that I discuss it as women's reproductive health, as opposed to abortion, because abortion is a finalized finite, finite thing. Whereas, if a woman walks into our door, they need to know they can change their mind at any second.

VH's interchangeable uses of language are both strategic and problematic. On the one hand, when crafting online marketing materials, VH uses "abortion" because "that's the only word women are looking for;" it is the primary service her organization provides as an abortion clinic. However, when VH "talks about people's rights," the word "abortion" is substituted with "women's reproductive health" because using "women's reproductive health" is a phrase that

encompasses a wide range of services and resources that extend beyond abortion. According to VH, "women's reproductive health" embodies choice and signals to people that they can change their minds about abortion at any time, that there are other options. As such, VH uses the phrase "women's reproductive health" to refer to abortion when speaking to clients—or prospective clients—face-to-face to blunt the potential negative reactions or consequences.

Both Maleeha (community organizer, ACCESS Fund) and VH's (volunteer, various abortion clinics) experiences or invokes reproductive health(care) as a euphemism for abortion within their organizations is in direct contention with other participants, who urgently expressed the need to stop using euphemistic terms—such as reproductive health(care)—to constitute abortion. It is clear that some organizations continue to use "reproductive health(care)" to refer to abortion as a way to relay information to the public, similar to how the political candidates Jess (organizer, Pro-Choice Texas) and Caroline (political director, Pro-Choice Texas) work with avoid using "abortion" in their speeches and communication efforts. In other instances, reproductive health(care) is used to make abortion more palatable for people who are seeking abortion procedures. For some participants, constituting abortion in this way provided a sense of choice and autonomy for clients who may (or may not) necessarily choose to have an abortion.

Summary: The Constitution of Reproductive Health(care)

This chapter attempted to answer the question, "How do organizational members in the reproductive domain communicatively constitute reproductive health(care)?." Reproductive health(care) is materialized by the "vibrating relations" shared between organizations, organizational members, value-systems, perspectives, competition, and conflict that produce reproductive health(care) as a buzzing hive of activity. This was demonstrated in how members

of the reproductive domain conceptualize reproductive health(care) as a simultaneous aspect of *women's health*, *human health*, and *a euphemism for abortion*. The existence of several competing, disparate discourses that constitute reproductive health(care) bring several issues to the forefront, most notably how reproductive health(care) is constituted by organizational members at a service-level. How can members of the reproductive domain serve their communities when they themselves draw from different language to locate understandings of reproductive health(care)? What is lost in the binaries of language, and how do these binaries prevent information and care from being delivered to communities that are marginalized and underserved? These are questions that must be addressed in order to further unpack how reproductive health(care) is constituted by organizational members of the reproductive domain.

CHAPTER V

"WHAT BUBBLES UP FROM THE GRASSROOTS?": THE CONSTITUTION OF MEMBERSHIP IDENTIFICATION IN REPRODUCTIVE HEALTH(CARE)

> I had a medical abortion. Was 20, nearly 22 weeks. I started kind of telling my story, and then Wendy Davis' filibuster really ignited everyone and ignited me. So, I became a lot more of an activist, besides just, like, a storyteller. And it was looking for ways that I could contribute in Texas, and Pro-Choice Texas was really the one that makes the most sense in terms of trying to make a difference in the legislative process, which is where I really, really, really was mad. I wanted to change the roles. I had done advocacy work and I had contributed to articles and I had shared my story and I'd staged protests and things like that but getting involved as a board member felt like a more structured way for me to help. And I felt more amplified.

As Jeni and I continued our Zoom interview, I carefully considered the language she used to describe her work: *telling my story*, *ignited*, *activist*, *storyteller*, *contribute*, *trying to make a difference*, *change the roles*, *getting involved*, *structured*, *amplified*. How do these figures mobilize Jeni's identification with her organization? What links Jeni's identification with Pro-Choice Texas as a former board member?

There are many ways people define their identities, but one enduring way is through their work (Tracy & Trethewey, 2005). Identity is a concept in the organizational communication scholarship that has been explicated in various research contexts and theoretical paradigms. For the purposes of this chapter, identity is cultivated through questions, such as *Who am I?* and *How*

should I act? (Alvesson et al., 2008; Alvesson & Willmott, 2002). It is the "conception of the self reflexively and discursively understood *by* the self" (Kuhn, 2006, p. 1340 – emphasis added). More specifically, it is a communicative sensemaking process that helps individuals understand and realize who they are in relation to the world around them (Larson, 2017; Wieland, 2010). Member identification, then, is a sustained process in which an individual's roles and actions are (re)defined and (re)negotiated, informing *how* an individual situates themselves within an organization (Cheney & Tompkins, 1987).

Drawing from the ventriloquial approach provides an analytic framework to analyze how one's member identification is animated and constrained by their organizations' values, beliefs, ideologies, and positions (Chaput et al., 2011). As Cooren et al. (2013) explain:

> Human interactants position themselves (or are positioned) as being constrained or animated by different principles, values, interests, (aspects of) ideologies, norms or experiences, which operate as 'figures' that are made to speech to accomplish particular goals or serve particular interests (p. 256).

As such, I found that the participants' member identification with their organizations was ventriloquized by four value figures central to their organizations' existences: *equity*, *care*, *purpose*, and *scarcity*. In the remainder of this chapter, I will define each of these four figures and demonstrate how member identity is constituted through the ventriloquial relations that link each value figure with their human interactants (i.e., the participants). Therefore, I seek to answer the following research question: *How is member identification in the reproductive domain animated and constrained by the values, beliefs, ideologies, and positions of the members' organizations?*

Figure 1: Equity

Among the figures that animated the participants' membership identification, *equity* was especially crucial in determining how services, funds, and resources were delegated to their clients. Equity was described as an effort to transform the spaces where the participants do their work while simultaneously creating spaces for the people they serve. The participants in this study frequently described their work as a force of change, or transformative work that is shaped by difference, creativity, and "pushing the boundaries." For instance, Jess GB, a board member of a grassroots abortion fund called The Back Fund, commented on how she fosters equity by holding unequitable systems accountable in her role as a board member:

> I have to remind myself that if we don't believe in the systems that are in place for them to be fair and equitable, right? So, we see our role as making sure that funds get distributed in an equitable way to people who really need them.

As demonstrated in this example, Jess GB's member identification is materialized through her performance of holding inequitable systems accountable on *behalf* of The Back Fund. She does this by ensuring that the funds her offered by her organization for abortion care are "distributed equitably." As such, equitability animates Jess GB's member identity in ways that determine how funds are fairly distributed to clients. Ultimately, what "fair" means is ventriloquized the by the values and position of The Back Fund that speak through Jess GB.

Pamela, a co-founder and director of ReproJust Collective, also discussed the importance of invoking equitability in the form of accountability in a way that ensures her organization is a "model organization:"

> Holding everybody accountable to the reproductive justice framework means holding ourselves accountable, our internal practices. Are we practicing what we preach? Are we

> creating an organization that, that people can look at and say it's consistent with reproductive justice values?

In this example, Pamela's membership identification presents us with an interesting situation. First, as a co-founder of ReproJust Collective, Pamela is at once a member of ReproJust Collective and someone who materialized the organization into existence. Thus, Pamela's membership identification is animated by the values she initially used to establish ReproJust Collective, values that are steeped in the reproductive justice framework. As I discussed in Chapter II, the reproductive justice framework is premised on values of equity, social justice, and access. So, while Pamela—in her role as co-founder and director of ReproJust Collective—is animated by values of reproductive justice, she also performs these values in a way that mobilizes ReproJust Collective as a "model organization." In other words, through Pamela, ReproJust Collective shows *other* organizations how to exist within, mobilize, and operate the values of the reproductive justice framework.

Other participants' member identification was enacted in similar ways according to their organizations' values, mission, and ideologies. Similar to Pamela, upholding principles of reproductive freedom and reproductive justice were especially important principles that animated Dee's member identity as a policy director of The Ayanna Center, a reproductive justice organization focused on addressing social (in)justice and disparity:

> If we can actively engage and transform how Black women engage with their own reproductive health thereby changing the systems that impact reproductive health, then all women and all folk will experience reproductive freedom, and reproductive oppression will end.

Here, Dee's member identification is aligned with The Ayanna Center's central mission, which

revolves around engaging and transforming how Black women understand reproductive health(care). To do this, Dee works on behalf of her organization to challenge the oppressive systems that constrain reproductive health(care) access for Black women. More specifically, Dee's member identification is aligned with their organization's mission to fundamentally alter the social realities of reproductive health(care) for Black women. In this way, Dee animates several matters of concern of The Ayanna Center through her role and responsibilities as a policy director. At the same time, The Ayanna Center animates Dee to speak on its behalf.

Participants' member identification was also invoked by similar principles of equity, specifically through efforts to erase stigmas around reproductive health(care), inviting marginalized folx into discussions, and uplifting similar organizations and ideas in ways that creates unity and dialogue. Participants like Sonja, the faith and outreach coordinator, helped to contextualize what this looks like through her work at Choice Action Network. Through her congregational initiatives, we see how equitability ventriloquizes Sonja's member identification through initiatives that focus on bringing people together in conversations that recognizes difference:

> Our congregational initiative is an initiative to bring all people to the table and create and hold space where you can share and tell your story, because unless I can hear the stories of other people who think differently than me in a shame-free, judgment-free, stigma-free arena, I'm not going to be changed or transformed, either. So, I think it is an effort to, to bring people together as opposed to separating people. It's really about bringing us together, as opposed to separating us into different camps.

Sonja's commentary shows us that equitability mobilizes her member identification in several ways. Choice Action Network's various congregational initiatives that bring people together into

conversation. Choice Action Network creates a space, "a shame-free, judgment-free, stigma-free arena," where inclusivity, openness, and community are figures that speak on its behalf to bring people together. Choice Action Network accomplishes this by ventriloquizing Sonja. As such, Sonja simultaneously (a) speaks on behalf of the organization's values and (b) is animated by these very values by physically gathering groups of people in efforts to promote acceptance and difference among religious denominations, political leanings, and value-systems.

Figure 2: Care

The second figure that mobilized the participants' member identification is *care*. Care was characterized by the participants as both *immaterial* (e.g., social support, love, encouragement, emotional support, spiritual) and *material* (e.g., resources, services, monetary support, sustenance). Depending on the participants' roles and organizational affiliations, care animated the participants' member identification in different ways.

Cayman, an advisory board member for Parachute Pregnancy Center, expressed the importance of religion and spirituality as key properties of enacting care: "We do the best to spread our word and the word of God. I feel like that's going to help us make the best impact on our community." Here, care materializes Cayman's membership identification through his organization's religious values, which actively invoke care through "the word of God." Interestingly, the "word of God" as a form of text enables Parachute Pregnancy Center to be "identified, stabilized, and constituted" (Cooren & Martine, 2016, p. 6) as an organizational form that mobilizes care in a very particular way.

The immaterial properties of care animated other participants' member identification in similar ways. This was articulated by the participants' discussions around helping their clients

“get back out into society” and “giving power.” Tricia, a board member of Magdala Maternity Home, explains:

> We want to give these women a hand up so that they can be successful in their roles as mothers and as women. And not just give them, not just throw money at them. Like, give them a hand up so that they have the tools that they need to, to be all they can be. Our home is 100% free to them. Like they, they don’t have to have any money to partake of our services.

“Giving women a hand up” is a phrase that reveals an interesting care dynamic enacted here by both Tricia and her organization. Tricia’s member identification is informed by a particular understanding of “care.” Care is given agency through the metaphoric language of “giving a hand up.” In *Feeding the Other: Whiteness, Privilege, and Neoliberal Stigma in Food Pantries*, de Souza (2019) shows how “hand up and not hand out” language demonstrates that care and assistance are not *just* given out; care and assistance are *earned*. “Free” does not imply freedom. This is true of Magdala Maternity Home, where women are required to complete tasks, chores, and classes to *earn* (a) their place at the organization, (b) social support from the organization, and (c) the “tools” the organization offers to be successful in life. These conditions are animated by the very values-system and positioning of care Magdala Maternity Home center which, in turn, speak through Tricia.

Participants’ member identification was animated by other similar instances of immaterial care, specifically through actions and language that conjured emotional/social support and love for clients. Vonetta, executive director of SacredCrop Center—a CPC—underscores the importance of providing an emotional support system for her clients:

> When we see, unfortunately, a decline in the family structure, there’s so many single

young women that need a support system. We're able to help them make wise decisions, so that can make a good decision knowing facts.

"Decline in the family structure," "single young women," "help them make wise decisions," and "knowing facts" demonstrates how care is positioned by Vonetta as the executive director and chief spokesperson of SacredCrop Center, but also how SacredCrop Center animates Vonetta to speak on behalf of the value-systems it supports. These value-systems are materialized through Vonetta's language. Because the heteronormative family structure is declining, the social support (or care) Vonetta and SacredCrop Center offer is underscored by these value systems.

Care materialized Sandra's member identification as a branch director of Helpline Pregnancy Center materialized through the physical "loving" she provides to clients: "Loving on these women that many times will respond to me and say that they've never been told, 'I love you' They've never been told, 'Hey, I believe in you.'" Throughout our conversation, Sandra's acts of "loving" were underscored by her organization's values of providing emotional support and care for vulnerable women. Sandra's member identification as a branch director, then, is deeply informed by Helpline Pregnancy Center's matters of concern (i.e., vulnerable women).

Care animated other participants' member identification in similar ways, specifically through the metaphor of "walking with" clients. Participants do not physically walk with clients; rather, walking symbolizes emotional support. This language was invoked the by participants in several different applications: "walking with you throughout, whatever your journey and may be" (Natalya, family support specialist, Fellowship Community Charity); "they are not going to walk through whatever issues alone" (Cathy, sonographer, Choose Hope); "we might keep up with her and walk through her…through her journey with her" (Heather, executive director, Northlight Collective). In these examples, participants' member identification is made present

through the metaphoric action of walking with clients. But it is not only the participants who "walk" with the clients; their organizations are also present, ventriloquizing the participants to provide this care through the metaphoric act of "walking with" clients.

In contrast, care materialized other participants' member identification through acts of providing clients with reproductive health(care) resources and access. Miranda, a Northpoint Reproductive Health clinic escort/trainer and ACCESS Fund board member, comments that *care*, as a method of service delivery, is included in one of her organization's slogans:

> One of their slogans or campaigns is *Care, no matter what*, and that really rings true, especially [because] they help people who don't have insurance or any other way to access birth control or testing or screening of any kind.

Here, the slogan *Care, no matter what* ventriloquizes Miranda's member identification as a clinic escort/trainer and spokesperson of the organization to provide care under any and all conditions. This slogan animates Miranda to invoke care as a core organizational value but to also perform care by providing services and resources to clients. This is also true for Amanda, a core member of Terra Firma Collective**,** an organization that supports abortion care patients with transportation, accommodation, and abortion doula services. For Amanda, care looks like:

> Supportive, transportation, and practical support to anyone trying to get an abortion in Central Texas. So, making sure that nobody is that, making sure that logistical issues don't prevent anyone from accessing abortions. So, childcare rides, a place to stay and work.

Again, we see care materialize as a physical service, or resource, that animates Amanda's membership identification with Terra Firma Collective. In this case, care manifests in the transportation, logistics, "childcare" and other "practical support" to help clients access abortion

care. It could be said that this physical, material care underscores how the Terra Firma Collective animates care. Amanda is one such example of this. Terra Firma Collective animates care as a core value that is upheld by organizational members, such as a member, who actively fulfill care in the form of driving clients to abortion procedures and arranging childcare (if needed).

Figure 3: Purpose

The third figure that animated the participants' member identification was *purpose*. Participants shared that serving a purpose and/or mission is an underlying force that actively informs their work and the reasons they do their work. Molloy and Foust (2016) describe this phenomenon as *work calling*, which suggests that work is meaningful and a catalyst for societal change, more than any job (e.g., source of income) or a career (e.g., occupational opportunities and trajectory) would be. More specifically, *work calling* imbues significance

> in one's work, brought to awareness through a process of being compelled or a moment of reckoning instigated by a higher power or the internal self and enacted through the integration of the individual's passion and skill-set in ways that positively contribute to society through one's work (p. 351).

Barb, co-founder and board member of the Archangel Maternity Project and Nazarene Maternity Home, mobilizes the meaning of purpose when she said, "I'll do anything I have to do." Similarly, Pamela (co-founder/co-director, ReproJust Collective) articulated: "We are willing to do whatever it takes." Thus, for the participants, member identification is animated by feelings that of responding to a higher power or sense of purpose.

One way the participants' member identification was animated by purpose was through religious/spiritual connections, or an *ephemeral higher calling*. For example, Christy, a teacher at

Your Choice Pregnancy Centers & Educational Programs, shares one such experience as a participant in a post-abortion class:

> We got to a part in the study that talked about truth, truth of what an embryo is, and truth of who we are and who God is. And the truth of God's word. And there was a new awakening in me and a desire that I knew that no matter how much healing I thought I had had that there was so much more to come. I knew then that I wanted to be a part of this ministry and lead other women in healing.

Here, Christy appears to be animated by feelings of hope and purposefulness when she speaks about her "new awakening" and "desire" to help "women in healing" from abortion experiences. This awakening compelled Christy's sense of purpose and mission as a teacher at Your Choice Pregnancy Centers & Educational Programs to promote "truth" and "God's word" on behalf of her organization. Christy's experience provides an interesting example of how purpose plays a strong role in animating one's sense of member identification with an organization. Because of a past transformative Christy had during a post-abortion class, she felt a strong calling and sense of urgency to become a spokesperson for these issues. As such, Christy positions herself as a teacher and spokesperson to speak on behalf of the organization through the classes she teaches and the women she interacts with. Through these interactions, Christy supports Your Choice Pregnancy Centers & Educational Programs' vision, thus reaffirming its existence as an organizational entity.

In a similar way, Barb, co-founder and board member of the Archangel Maternity Project and Nazarene Maternity Home, positions her member identification as an agent of "God" and "Christ:"

> I'm doing God's work. Mothers see us through seeing Christ *through* us. It's very

> important. Protecting and, you know, protecting the unborn and being there as their mother, so to speak.

Here, Barb speaks on behalf of “God” when she says she’s “doing God’s work,” which involves “protecting the unborn.” But most interesting is Barb’s declaration, “Mothers see us through seeing Christ *through* us.” At first glance, this statement indicates that the clients (“mothers”) Barb serves must have a familiarity and recognition of Christ in order to understand how Barb and her organization *see* Christ. This statement seems confusing but has compelling implications for how purpose animates member identification. First, Barb’s purpose is animated through her dedication to the unborn and God. Barb indirectly positions herself an authorized spokesperson who simultaneously speaks on behalf of her organization, God, and the unborn as their “mother figure.” As such, in order for Barb to help clients, her clients must first (a) possess an understanding of God/Christ and then (b) accept Barb’s personification of God/Christ. But, at the same time, it can be said that Barb is being ventriloquized by her organization to materialize this very specific manifestation of God/Christ in the name of “protecting the unborn.”

Similar agentic language—“met with God” and “God calling me”—also animated other participants’ member identification, as illustrated in Karen’s (client advocate, New Horizons Pregnancy Center) sentiment; “I, you know, just felt like it was God calling me.” This language enacts a perceived higher purpose that animates the participants’ member identification, where God/Christ “tells” and “calls” people to do work on their behalf (Scott, 2007). In this way, people feel that they are called into their work by God because of the relationships, affiliations, or connections they perceive to have with this being (McNamee, 2011). This has interesting implications from a CCO perspective. According to Cooren (2020),

> Whenever one attempts to define what something or who someone is, one always has to

> identify *through what* or *whom* this figure presents, embodies, materializes itself/him-self or herself (p. 11).

In the previous examples, the participants attempt to materialize God's existence through their perceived understandings of what God represents to them. To do this, the participants' draw on their value-systems, religiosity/spirituality, experiences—their overarching social realities—to "locate" their purpose *in* God as a concept and religious authority figure. The participants' purpose, as mobilized through this omniscient being, ultimately animates the participants' membership identification with their organizations because their organizations *also* locate themselves (i.e., values, mission, ideologies) in/through God.

Other participants also described being guided and motivated ephemeral purpose, except this calling was animated by an urgent "boots on the ground," access-driven focus, such as increasing and supporting legislative initiatives that promote abortion access and reproductive health. Maleeha, a community organizer at ACCESS Fund, described how her own experiences—in this case, an abortion experience—inspired her to join the cause to speak on behalf of abortion access:

> I ended up going to Colorado Springs to have medication abortion, and it was just a one big mess. So, for that reason, I was like, *What in the world, why is it so difficult*? So, that's what got me involved with the cause. I was surrounded by a whole bunch of other people like me, and that's where I was introduced to ACCESS Fund, along with Northpoint Reproductive Health…it just felt like this was my calling.

Aimee, executive director of Pro-Choice Texas, also shared a personal experience that brought her to her work, explaining how a personal connection to the reproductive health space galvanized a sense of purpose and duty to secure access to abortion care for her community:

> I became interested in abortion rights in general because my dad was an abortion provider in Texas, and I admired his work, and I wanted to do something that helped the community in Texas, to help them access the care that they needed. I wanted to do something that made an impact.

These access-driven higher callings oftentimes involved the participants expressing their desires to see their roles become obsolete as a result of the successfully completing work they were called to do. Alex (helpline manager, Virgo Fund) shares, "I think one of the goals for us is to basically work ourselves out of a job. We always say that, and people think we're joking, but we're like *no*. We're really trying to not have jobs. That's the whole point, you know? The point is to not be in this cycle." The *cycle* Alex refers to is the external structural, societal barriers and challenges that prevent her, along with other participants, work from advancing or reaching beyond the borders of their communities.

Figure 4: Scarcity

The last figure that animated the participants' membership identification was *scarcity*. For the participants, scarcity manifested as "lack of" somethings or someones. Specifically, scarcity took the form *diminished capacity*, *lack of funding*, and *limiting legislation* that affect the participants' day-to-day work and, more broadly, constrained their member identification with their organizations. Scarcity was further exacerbated by the effects of COVID-19, as demonstrated in some of the participants experiences that follow.

Participants characterized *diminished capacity* as a lack of staff and "maxing out" volunteers and resources to serve the needs of their communities. For Jess GB (board member, The Back Fund), this was especially apparent at the beginning of COVID-19:

> It's really worth noting that we're all in crisis right now. Because we're an all-volunteer board, and even if we weren't an all-volunteer board, we're all being called on to care for our communities in expanded ways. It's…we have a limited capacity to be able to respond to those as well.

As demonstrated here, diminished capacity weighs heavily on under-resourced organizations and contingent staff, who may have access to limited resources or are unable to dedicate as many hours to their tasks as full-time staff due to other obligations (Gossett, 2002).

Aimee (executive director, Pro-Choice Texas) shared that organizations with limited resources "try to prioritize the outward-facing work," or work that prioritizes community-level needs first, such as outreach initiatives, community engagement, and campaign work. She elaborates on how this contributes to the frequency of burnout that occurs across reproductive work:

> To our detriment, I think that has caused the movement to have a lot of high turnover with people doing this work. People burnout pretty quickly, and I think that that's a reason why we haven't been as successful over the past four decades advocating for [abortion access] because people get burned out.

Burnout is also demonstrated in Miranda's (clinic escort/trainer, Northpoint Reproductive Health; board member, ACCESS Fund) account of answering Facebook messages about resource access: "People just don't know where to begin to look. I get a lot of private messages on Facebook like, 'Hey, my friend is in need. Can you tell us who to talk to, or where to go?'" Miranda goes on to share that misinformation about abortion online not only overshadows the work she is doing in her community but is also unwieldy to manage in an organization comprised of 10-15 members who are already stretched thin.

Diminished capacity is also heavily influenced by *lack of funds*. "There's not enough money," Shae (hotline coordinator, Eve Fund) says. "We would need millions and millions of dollars to fund every person's [abortion] procedure completely. More often than not, we're not funding people because we just don't have the budget for it." Many participants shared Shae's frustration about funding, oftentimes articulating how limited funds hinder their abilities to immediate provide services and care to their community. B (policy and advocacy strategist, Repro Union Collaborative) explains, "Abortions are freaking expensive, you know? And that's why *all hail the abortion funds*, but there's only so much the abortion funds have capability for doing." ACCESS Fund clinic escort and volunteer, Maryn, underscores this when she says, "Finances are always *huge*. We can never fund every single person that calls, right? And I hate that." Here, both B and Maryn acknowledge the work abortion funds do, but the compounded effects of abortion costs and the limitations abortion funds face when disbursing money inhibit these organizations' reach. Additionally, many participants shared that funds are limited and largely dependent on community donations, grants, and fundraisers. Charlie, board president of Magdala Maternity Home, emphasizes this about his organization: "This is an organization that exists on donations, and our donors are incredibly important."

Although lack of funds presents several challenges to many of the participants' work, Rae (executive director, ACCESS Fund) articulates a "double-edged situation:"

> I think that abortion funds have often flown under the radar, which is great for us, and also bad, right? So, there's a limit to the funding you get when you're flying under the radar. There's a limit to your capacity as an organization to provide the services when you're flying under the radar. That also means that less people are receiving our help, which, for us, is okay because we don't have the money, right? So, like, we're already

> and always have been turning people away, because we don't have the money. So, it's like, even if we had a higher profile, we wouldn't be able to serve the people coming in because we have limited resources.

Rae continued to explain that organizations, such as abortion funds, have historically kept "low profiles" to avoid the adverse, political attention larger, mainstream organizations face. For Rae, operating "under the radar" is both an opportunity and an obstacle. Rae recognizes the diminished capacity of their organization when they describe the limited funds available for disbursement to clients. However, Rae acknowledges that if their organization maintained a higher profile, they would be serving even less amounts of clients because of the organization's limited resources. In either situation, limited resources—including staffing and funding—remains a constant in every participant's work.

Elsewhere, *limiting legislation* presented itself as a form of scarcity participants' work. This is especially salient for those who grappled with and worked through the Texas abortion bans that occurred between March and April 2020 as a result Attorney General Ken Paxton declaring abortion as a "nonessential procedure" at the beginning of COVID-19. As Jess, an organizer for Pro-Choice Texas, stated:

> There're so many restrictions. 24-hour waiting period. There's the ultrasound. People don't know how hard it is to access an abortion because there's layer upon layer upon layer of complicated shit that's in the way. So, even if you do understand all the restrictions, you might not understand that actually they're [Texas government] making it harder and less safe from people access care.

Other participants echoed Jess' frustrations around Texas' abortion restrictions in their work. Shae (hotline coordinator, Eve Fund), explains:

> We want people to be able to get an abortion whenever they need one, and so there's a lot of laws in Texas that prevent that. A lot of things that don't make sense that have been put into policy that are keeping people from being able to get their abortion.

RIGHT2CHOOSE, a member of OneClick Reproductive Services, describes the restrictions as "constant hurdles" that they and their organization "bend over backwards for," but for a good cause. "We're more than happy to do it. Whatever it takes, we have to keep providing the care that is needed." Many participants, such as policy and advocacy strategist, Elena, explained that through their work, they try to "address the challenges to abortion, both through policy and advocacy and through our legal department," but the compounding effects of scarcity make it difficult and, at times, nearly impossible to manage.

Summary: Membership Identification and Reproductive Health(care)

In this chapter, I set out to understand why and how organizational members identify with their reproductive health(care) organizations. I found that when the participants were asked to account for their affiliation with their organizations, they spoke through and/or on behalf of four value figures: *equity*, *care*, *purpose*, *scarcity*. As such, the participants' member identification was presentified through the animation of these value figures. Through this process, participants' imperfect identifications were revealed, displaying the participants' frustrations, aggravation, and other general emotions toward their organizations. As such, the participants' alignment with their organizations were, at once, messy, clashing, and complementary, each revealing a series of relational tensions present between the figures.

CHAPTER VI

MAPPING THE INTIMATE: COMMUNICATIVELY CONSTITUTING REPRODUCTIVE HEALTH(CARE) AS A SITE

The findings presented in the previous two chapters explored how language and membership identification animated my participants' understandings of reproductive health(care). This final analysis chapter takes a broader, transdisciplinary approach. It considers the larger communicative and sociopolitical forces that constitute Texas' reproductive landscape through a project of mapping. Drawing from Pratt and Rosner (2006), Mountz and Hyndman (2006), Whitesell and Faria (2019), and the communicative constitution of organizations (CCO) perspective, I bring together perspectives from critical feminist geography and relational ontology to develop an intimate map of Texas. This intimate map is a cross-disciplinary endeavor that aims to simultaneously (a) disrupt traditional understandings of distance, scale, space, and place, (b) embody participants' experiences, and (c) center the meaning production and materiality of reproductive health(care) in Texas. As such, this chapter seeks to answer the following research question: *How do members' reproductive work experiences constitute an affective, embodied landscape of reproductive health(care)?*

In what follows, I explore how an intimate mapping communicatively constitutes Texas' reproductive landscape. My use of the word *landscape* is derived from human geography (see, e.g., Adams et al., 2001; Tuan, 1997). Landscape is "both an actual, physical place and a figurative site of ongoing sociopolitical discourses concerning the relations between community, self, and place" (Olwig, 2001, p. 94). More specifically, landscape is a "common place that has a history and meaning, incarnating the experiences and aspirations of a people" (Tuan, 1997). As

such, this chapter shows how Texas' reproductive landscape is constituted by a phenomenon called *intimate flows*. I show how the intimate flows link the physical and sociopolitical landscapes within Texas and the communicative experiences of reproductive rights, justice, and health workers. I recognize the intimate mapping as one of many artifacts that realizes Texas' reproductive landscape. The analysis primarily focuses on the affective and generative processes through which the intimate map is produced, read, interpreted, and enacted through the intimate flows.

Conceptualizing Intimate Flows

To illustrate the constitutive forces that underlie Texas' reproductive landscape, I locate my analysis in an intimate mapping (see *Figure 2*). The intimate map is comprised of intimate flows, which are overlaid within and around a regional basemap of Texas and the South-Central United States. These intimate flows consist of the participants' words and capture embodied experiences, spatial stories, ideas, passions, and complexities surrounding the participants' reproductive work. As such, intimate flows organize, generate, trouble, and complicate the materiality of the landscape in which they are situated. I borrow the language around flows from both critical geography and CCO approaches.

First, I draw inspiration from Pratt and Rosner (2006) and conceptualize intimate flows as communicative forms that are unruly, unending, "immediate, sensual, not yet stabilized within a fixed interpretation" (p. 18). Intimate flows are neither fully permanent nor temporary; they are always in flux. They take us into different visual and interpretative experiences, moving us beyond traditional understandings of meaning-making. From an organizational communication perspective, CCO thinking also conceptualizes flows in a similar way. Flows are conceptualized

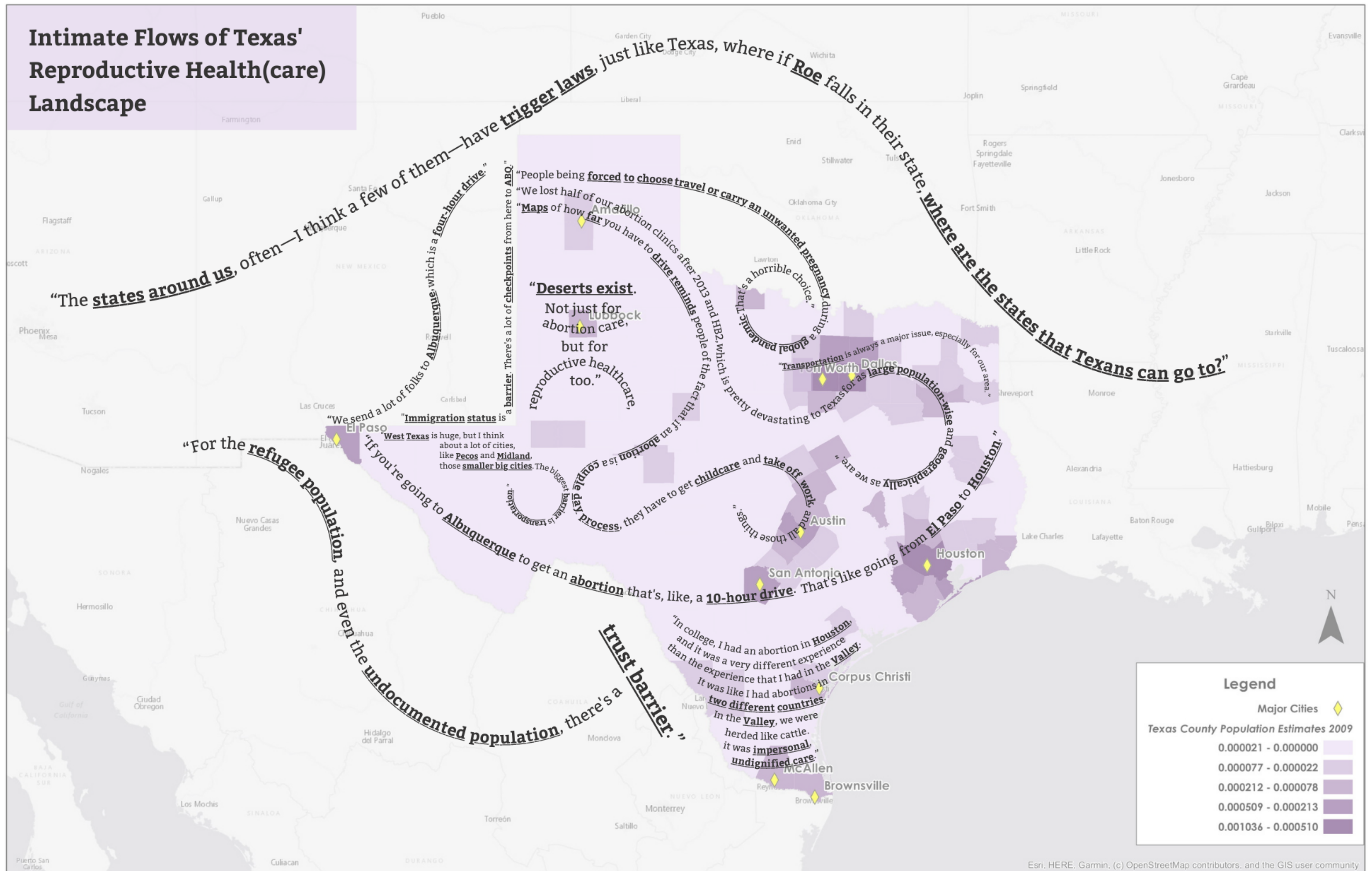

Figure 2. Intimate Flows of Texas' Reproductive Health(care) Landscape

"as ongoing and precarious *flows of practice*" (Schoeneborn et al., 2019, p. 485). Here, flows are fluid, meaning-making process that link or relate various elements that contribute to the materialization of organization (Bencherki, 2016). This way of conceiving intimate flows using language from critical geography and CCO theory will help to guide our understanding of the materiality of the flows and their constitutive potential.

Speaking about the materiality of some*thing* refers to what the thing is made of, its intangible and tangible properties (Cooren et al., 2012). It also refers to the relations that exist between these substances, or the connections that link these other beings and things (Cooren & Caïdor, 2019). Some relations are enduring, such as the link connecting reproductive health, rights, and justice workers to their organizations through work agreements, or the link between reproductive organizers and the sites where they organize (e.g., Texas). Other relations are fleeting, such an organizational affiliation or position. It is ultimately through the production, performance, and problematizing of these relations that contribute to their existence (Cooren, 2015, 2018).

In their conceptualization of materiality, Ashcraft et al. (2009) forward three categories of materiality: sites, artifacts/objects, and bodies. For the purposes of this dissertation, the materiality of the intimate flows is informed by two of Ashcraft et al.'s (2009) categories: *sites* (Texas' landscape, participants' locations in Texas) and *artifacts/objects* that manifest the intimate flows (participants' language, work, personal testimonies, attitudes). Thus, the materiality of the intimate flows ultimately (re)produces an assemblage of relational flows that constitutes reproductive health(care).

Assemblages are characterized as "constellations or arrangements" that imply the existence of a grouping or relational network (Putnam, 2019, p. 32). Bennett (2010) provides a

helpful conceptualization:

> Assemblages are living, throbbing confederations that are able to function despite the persistent presence of energies that confound them from within. They have uneven topographies, because some of the points at which various affects and bodies cross paths are more heavily trafficked than others, and so power is not distributed equally across its surface. Assemblages are not governed by any central head: no one materiality or type of material has sufficient competence to determine consistency and trajectory or impact of the group….An assemblage thus not only has a distinctive history of formation but a finite span of life (p. 24).

Specifically, assemblages are not necessarily "organize wholes" but are "the differences of the parts that are subsumed into a higher unity" (Phillips, 2006). Each "part" of an assemblage is a "vital force" (Bennett, 2010) in the agency of its existence. These "parts" also offer us a way to decode how multiple tensions among "hybrid agents" contribute to the complexities of how the whole is "assembled, disassembled, and (re)arranged" (Putnam, 2019, p. 33). Using this framework, I situate intimate flows ("parts") as links that guide our understandings of the various stories, experiences, feelings/emotions, work experiences, personal experiences ("hybrid agents") that shape Texas' reproductive landscape ("the whole").

This chapter frames intimate flows as parts of an assemblage that are actualized, organized, and held together by the ideas, thoughts, experiences, and tensions that produces and problematizes the existence of Texas' reproductive landscape. As such, the existence of the intimate flows is not necessarily limited to their physical location on the intimate map presented here. They can materialize through a discussion during a dissertation defense, or through a map visualization (see *Figure 2*). This dissertation provides one of numerous ways to conceptualize

intimate flows.

Each of the 12 flows presented in this chapter produced a series of precedent-setting stories that added to an already existing collective, storied network of flows. As such, I chose not to identify the intimate flows with the participants who offered them during my interviews. I recognize the intimate flows as fragments of what Phillips (2006) calls “a higher unity.” The intimate flows are a part of the *collective* experiences that materialize the intimate map and, more broadly, Texas’ reproductive landscape. The flows connect us to our *every* level and component of our social realities. As Cooren (2018, p. 282) notes, the application of “our” must be understood relationally, in the context of the collective, because “these characteristics that seem to be ours never are absolutely ours.”

Situating the Intimate Flows

As I emphasized in Chapter III, each intimate flow is overlaid onto the map in ways that speak to the affective areas or regions they reference. The flows are positioned according to the trajectories of their content and references to space, places, barriers, and borders. The size and shape of each intimate flow is indicative of the details it contains. For instance, an intimate flow that references distances between cities across the state of Texas will appear much larger and more pronounced on the map than an intimate flow specific to one area or region of Texas. The purpose of this stylistic choice is to demonstrate the effect of distance.

The intimate mapping articulates many of the sociopolitical, communicative, and geographic obstacles that constitute reproductive work and reproductive health(care) access in Texas. Chapter III discussed several of these obstacles, most notably policies and sociopolitical tensions that have restricted and limited reproductive health(care) access in the state. The effects

of these reproductive health(care) obstacles that have accrued over the years as a result of political, value-laden tensions deeply affect those who conduct and organize reproductive work in Texas. Yet, these affective experiences often remain elusive and unarticulated on the landscape or are excluded from the mainstream. The intimate mapping of Texas brings these experiences to light. More specifically, the intimate flows communicatively demonstrate how the materiality of policies/legislation, barriers, disparity, and first-hand personal and professional experiences maintain, structure, and (re)shape what it means to do reproductive work in Texas, to be a part of an historically challenging reproductive landscape.

The intimate map is meant to serve as a guide through the intimate flows. I consider the intimate flows as organization and organizing heuristics that guide, challenge, and mobilize our interpretations of what reproductive health(care) *is* in the context of Texas. In the proceeding sections, I show how the intimate flows—and, more broadly, the intimate map—play a role in constituting Texas' reproductive landscape. I loosely catalog the intimate flows into the following "intimate collections:" *Intimate Flows of Distance and Time* and *Intimate Flows of Barriers*. Intimate collections simply refer to my groupings of intimate flows based on their contents. I recognize that these collections overlap. Distance and time are forms of barriers and vice versa. However, for the sake of this analysis, I have ordered the intimate flows in this way. It made sense to make this analytical move because it is how I interpreted and positioned the intimate flows on the map at the time of this analysis. I encourage readers not to think of the intimate map as a static, authoritative representation of Texas' reproductive landscape. Instead, I invite you to *feel*, sit with, and experience the intimate flows.

Intimate Flows of Distance and Time

The intimate map in *Figure 2* communicates various connections between places, attempting to capture a range of emotions and experiences that flow out of, intervene, curl, border, bend, and wrap around Texas and its surrounding places. Among the 12 intimate flows, the first "intimate collection" centers its focus on *distance* and *time*. Distance and time surfaced as frequent spatial considerations that shaped the participants' reproductive work and were often interconnected in many of the intimate flows. Both concepts simultaneously referred to traveling extreme distances across, within, and outside of Texas; car miles; mobility and access to transportation; and durations (i.e., hours, processes). These intimate flows also illustrate the complexities of time off, or "borrowed time," which refers to dedicating organizing power to help clients arrange childcare and negotiate time off from work. In this sense, time off/borrowed time effects distances that must be traveled in order to receive reproductive healthcare. Oftentimes, I found that intimate flows of distance and time projected exasperation, urgency, and frustration—feelings and emotions that materialize the adverse effects of distance and time within Texas' reproductive landscape. Consider Intimate Flow A (see *Figure 3*), which is overlaid across the bottom half of Texas:

> *If you're going to Albuquerque to get an abortion that's, like, a 10-hour drive. That's like going from El Paso to Houston*.

Figure 3. Intimate Flow A

At first glance, Intimate Flow A demonstrates the difficulties that distance presents when seeking abortion care within and around Texas. Upon closer look, however, this flow uses the distance between two major cities on opposite ends of Texas as a specific reference to the extreme lengths of time it takes to travel, by car, *outside* of Texas to receive abortion care. The following intimate flows also bring attention to the problematic nature of Texas' size and the adverse effects it has on reproductive health(care) organizing and delivery. Intimate Flow B (*Figure 4*), is situated toward the bottom of Texas' Panhandle. The curvatures in "abortion care" and "reproductive healthcare" brings our attention to the empty space around the flow. This flow brings our attention to the vastness of Texas and the medical deserts that stretch across Texas' landscape—specifically in the Panhandle. The flow reaches out, almost grasps, at the empty space that surrounds it:

Deserts exist. Not just for abortion care but for reproductive healthcare, too.

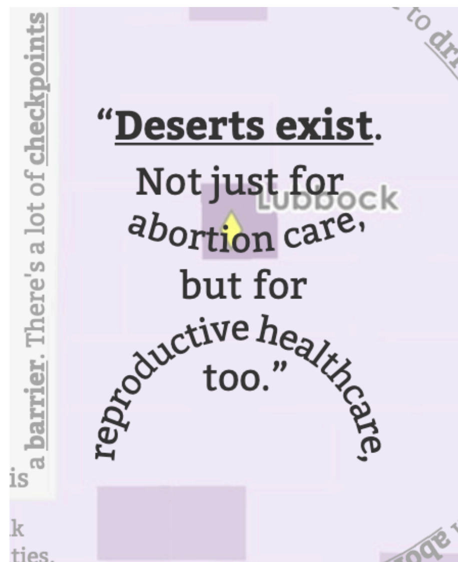

Figure 4. Intimate Flow B

Intimate Flow C (see *Figure 5*) is positioned next to El Paso, stretching through and circling

around West Texas. Similar to Intimate Flow B, Intimate Flow C also curves outward into the vastness of West Texas. The flow’s text is largely gathered near El Paso but elongates, stretching out to the areas where Pecos and Midland are situated:

> *West Texas is huge, but I think about a lot of cities, like Pecos and Midland, those smaller big cities. The biggest barrier is transportation.*

Figure 5. Intimate Flow C

Embedded within both of these intimate flows—among others—are the underlying logistical complexities that reproductive rights, justice, and health organizers, community managers, helpline specialists, and others must consider when providing care to specific regions of Texas. Rural regions, in particular, present particular complexities. It is well-known that people in rural communities must travel farther distances and oftentimes do not have readily available access to public transportation to access healthcare (Arcury et al., 2005). Thus, Intimate Flow B and Intimate Flow C speak in the name of the difficulties that repro workers face when organizing reproductive health(care) for clients who are located in areas of Texas that are considered rural medical deserts. Centering the claims “deserts exist” and “West Texas is huge” precisely means that these considerations materialize distance- and time-related barriers that actively shape reproductive work and Texas’ reproductive landscape. More specifically, these intimate flows

add to the already layered stories and experiences of the past, present, and future repro workers that have (re)shaped understandings of Texas' reproductive landscape and what it means to carry out and *do* repro work in the state. Also demonstrating this affect is the basemap of the intimate map, which contains population totals by county. The areas shaded in light purple, for instance, draw our attention to the underpopulated areas of Texas, which are largely located in West Texas and outside of the major city centers.

Intimate Flow B and Intimate Flow C hinted at the limitations of repro workers' organizing capacities, resources, funds, and general reach to communities that are situated outside of major cities, or on the peripheries of Texas. Most interesting are the flows that specifically articulate the varying understandings of reproductive health(care) that exist within these regions. This is best illustrated in Intimate Flow D (see *Figure* 6) positioned at the bottom of the map, situated in a cone-like formation in South Texas:

> *In college, I had an abortion in Houston, and it was a very different experience than the experience I had in the Valley. It was like I had abortions in two different countries. In the Valley, we were herded like cattle. It was impersonal, undignified care.*

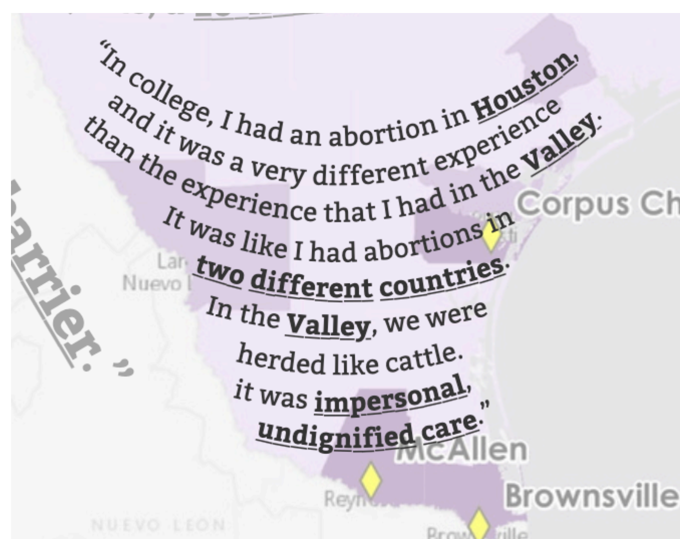

Figure 6. Intimate Flow D

"It was like I had an abortion in two different countries" and "we were herded like cattle" are provocative and powerful statements that materialize the striking differences that exist around reproductive health(care) and, more specifically, abortion care in the two regions of Texas it centers. This intimate flow illustrates one of several personal stories told by a reproductive justice organizer from the Rio Grande Valley (i.e., the Valley) about their abortion care experiences from the Valley and Houston. The intimate flow offers a window into understanding how both reproductive health(care) and abortion care in the Valley are controversial, rarely discussed, and have since been limited by restrictive legislation that shuttered abortion clinics and related reproductive health(care)-related services (Jervis, 2014; Tan & Leal, 2012). At the same time, the intimate flow also centers the distances between two different regions of Texas ("two different countries"). The Valley and Houston—which is situated in East Texas—are roughly five hours (or 350 miles) apart. Ultimately, this intimate flow materializes how conceptualizations of reproductive health(care) and abortion care in two relatively close regions in Texas produce fissures in the state's reproductive landscape. This is also visually demonstrated in the intimate flow's contents and shape. The flow brings our attention to the tensions surrounding reproductive health(care) and abortion care in the Valley through its (a) exasperated, defeated tone of its wording and phrasing and (b) its narrowing and diminishing form. As the intimate flow reaches South Texas' tip, it narrows becoming almost nonexistent.

Both the content and formation of the previous intimate flow is indicative of the challenges that arise from organizing and providing reproductive health(care) in spaces that resist, challenge, dismiss, or forget the complexities that are involved in arranging such care. These limitations are further articulated in Intimate Flow E (see *Figure 7*), which begins at the top of Texas' Panhandle and weaves through the center of the state, ultimately curling around

Austin:

Maps of how far you have to drive reminds people of the fact that if an abortion is a couple day process, they have to get childcare and take off work and all those things.

Figure 7. Intimate Flow E

The significance of this flow is meant to bring attention to the distances between the Panhandle and Austin. The flow's contorted text is meant to mimic the limitations and barriers articulated in flow that require clients and reproductive workers alike to adapt to situations that require forced flexibility when seeking or coordinating reproductive health(care) (i.e., driving, distance, seeking childcare, taking off from work).

Similar to the preceding intimate flows, Intimate Flow E demonstrates the organizing power it takes for reproductive rights, health, and justice workers to not only help clients arrange

travel, care, and funds across and within state lines. It also is suggestive of the complexities involved in navigating the stigma associated with receiving such care and the various legislative barriers that inform where and when care is received. Interestingly, the intimate flow itself serves as a visual reminder of these complexities. The flow's reference to "maps" as "reminders," for example, brings our attention to how physical artifacts, documents, and/or evidence are often needed to *visually remind* people about the layered complexities distance and time present when seeking reproductive health(care) in Texas.

In general, maps are communicative devices that help to reduce uncertainty and complexity "to produce an effective abstraction of some set of spaces and relations" (Wainright & Bryan, 2009, p. 155). This is critical because, as Wilson (2015) points out, "the map artifact draws one in, causing one to actually lean in and trace the contours of place" (p. 13). In this way, Intimate Flow F shows us how maps that materialize distance and time are meant to humanize the emotional weight and hefty logistics of seeking reproductive healthcare in Texas. This intimate flow, then, serves as a reminder of how the complexities of reproductive health(care) in Texas are oftentimes disregarded or erased without the aid of maps, or other visuals, that demonstrate the distances and time it takes to arrange and receive care. This erasure or disregard for distance and time oftentimes occurs because it is those who animate the discussions around reproductive health(care) that are already readily attuned to these issues. More specifically, it is the workers from reproductive health, rights, and justice organizations who position themselves to speak on behalf of these matters.

Intimate Flows of Barriers

The second "intimate collection" brings together intimate flows that consider how

barriers constitute Texas' reproductive landscape. The sociopolitical context that repro health, justice, and rights workers are faced with provides insights into how their organizing capacities and work are relational accomplishments affected by various types of barriers. Many of the intimate flows within this collection position barriers as both physical and invisible boundaries that block, border, limit, restrict, prevent, barricade, discipline, police, and hinder reproductive health(care) access in and around Texas. Such effects can be heard and felt when the intimate flows invoke words and phrases, such as "trust barrier," "forced to choose travel or carry an unwanted pregnancy," "immigration status," "barriers," "checkpoints," and "trigger laws."

When we first glance at the intimate map in *Figure 2*, many of the intimate flows that reference barriers swirl around or are positioned directly on a border(s). The purpose of this positioning is twofold. It demonstrates the materialization of barriers in the forms of borders and policy that impact reproductive health(care) access for those within Texas and directly around the state. The positioning of these intimate flows also brings attention to the areas where reproductive health(care) is most tensional according to the trajectories, words, and spatial information of the intimate flows. Take, for instance, Intimate Flow F (see *Figure 8*) positioned at a 90-degree angle on the Texas-New Mexico border. The intentionality of this intimate flow's shape is meant to draw our attention to the physical borders and barriers that exist throughout Texas and outside of Texas. The 90-degree angle represents the severity and rigidity of borders and barriers and how they enable and constrain who has access to reproductive health(care) and when and where they can receive such access.

Immigration status is a barrier. There's a lot of checkpoints from here to Albuquerque.

Figure 8. Intimate Flow F

Similar to Intimate Flow F, Intimate Flow G (see *Figure 9*) visually displays the effects of borders. This flow stretches from the bottom of New Mexico through Mexico and up to the border of South Texas.

For the refugee population and the undocumented population, there's a trust barrier.

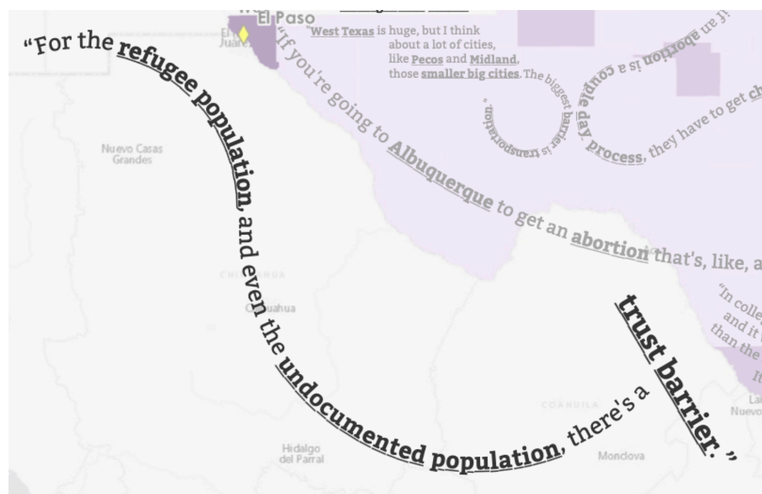

Figure 9. Intimate Flow G

Both Intimate Flow F and Intimate Flow G materialize *barriers* in two distinct, yet relational, ways. Intimate Flow F brings our attention to the Texas-New Mexico border. At first glance, the intimate flow reveals many things about reproductive work in this border region of Texas and New Mexico. And what do I mean when I say *border* here? Border refers to the international, national, regional, and cultural divide that geographically and socio-politically separates people, ideas, and experiences (Mohanty, 2003). Border is often synonymous with alien, foreignness, non-American, other, and "immigration status," as referenced in Intimate Flow G.

In the context of Intimate Flow F, immigration status is materialized as a reproductive health(care) barrier that gatekeeps care—whether care is received, or whether one is worthy of receiving care. Immigration status is both determined by *tangibility* (i.e., physical documents that *show* status, checkpoints that validate said status) and *intangibility* (i.e., good versus bad standing, importance) that validates one's existence. Intimate Flow G also brings our attention to an additional intangible issue: "trust barriers." Trust barriers affect the ways repro workers relate to the communities they provide and organize care. Trust implies a certain level of belief, confidence, acceptance, and a willingness to provide help and care, to keep information—such as "immigration status"—confidential. In this respect, Intimate Flow F (*immigration status*, *checkpoints*) materializes the effects of the Intimate Flow G (*trust barriers*). As such, the tensions produced by immigration status and trust barriers complicate the ways that reproductive health, justice, and rights organizations on Texas' border—and near border areas—deliver and organize care for vulnerable, policed populations. It also complicates how relationships are built between repro workers, their organizations, and these communities. As I discussed earlier in this section, this is visually demonstrated in the formations of both intimate flows. Intimate Flow F begins near El Paso and travels up Texas' Panhandle, forming a border-like configuration.

Intimate Flow G begins at the tip of New Mexico, stretches down through Mexico, and ends at the border of South Texas.

While the preceding intimate flows materialized barriers in the form of immigration status, checkpoints, and trust issues, other intimate flows invoked barriers through policy and legislation that deeply shape Texas' reproductive health(care) landscape. As previously discussed in Chapter III, Texas has a history of introducing anti-abortion and -reproductive health(care) legislation that has restricted access and availability to care, as well as physically closed clinic spaces. Consider the following series of intimate flows, which address these barriers. Intimate Flow H (see *Figure 10*) stretches from the top of Texas' Panhandle, passing near Dallas and swirling through East Texas:

> *We lost half of our abortion clinics after 2013 and HB2, which is pretty devastating to Texas for as large population-wise and geographically as we are.*

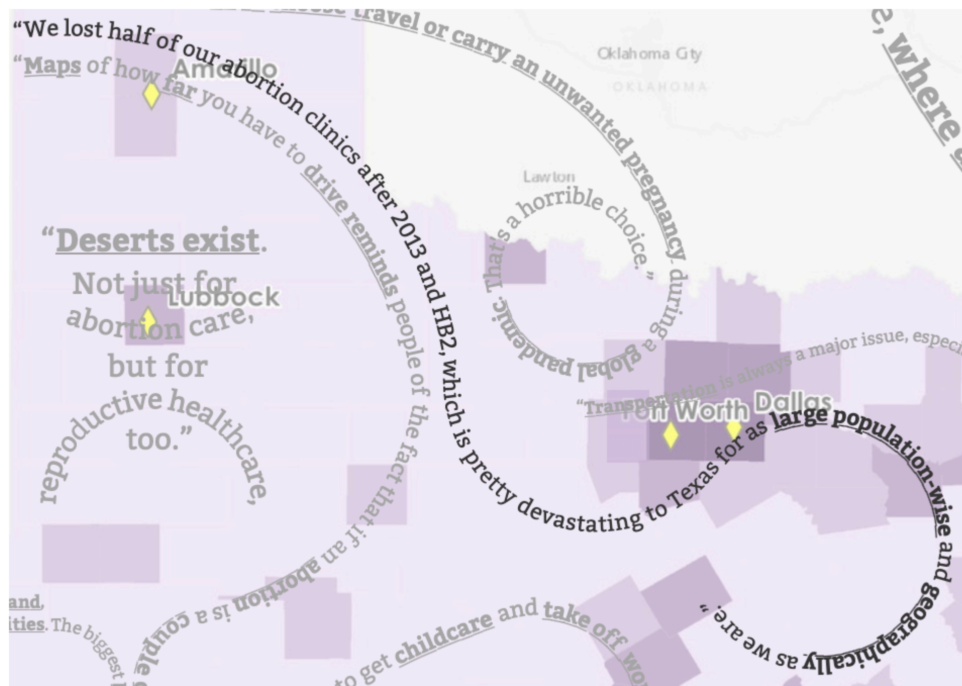

Figure 10. Intimate Flow H

Intimate Flow I (see *Figure 11*) also starts at Texas' Panhandle but bends through Oklahoma, circling back into Texas:

> *People* [are] *being forced to choose travel or carry an unwanted pregnancy during a global pandemic. That's a horrible choice.*

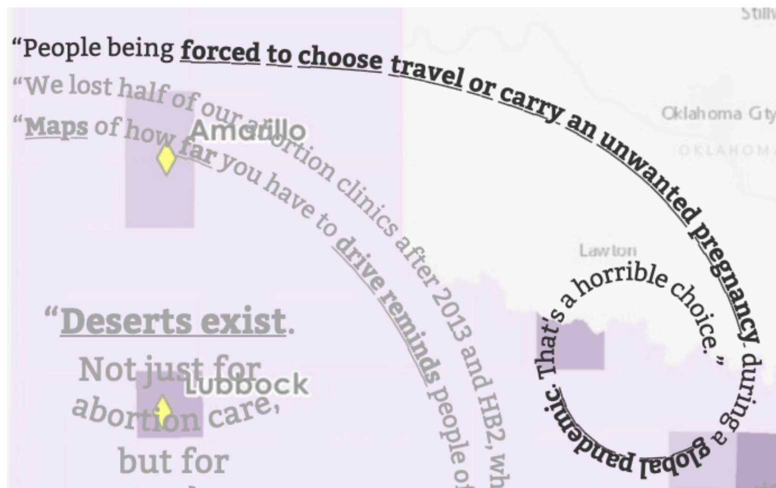

Figure 11. Intimate Flow I

Intimate Flow J (see *Figure 12*) bends around the entire state of Texas, moving through Arizona, New Mexico, Colorado, Kansas, Oklahoma, Missouri, Louisiana:

> *The states around us, often—I think a few of them—have trigger laws, just like Texas, where if* Roe *falls in their state, where are the states that Texans can go?*

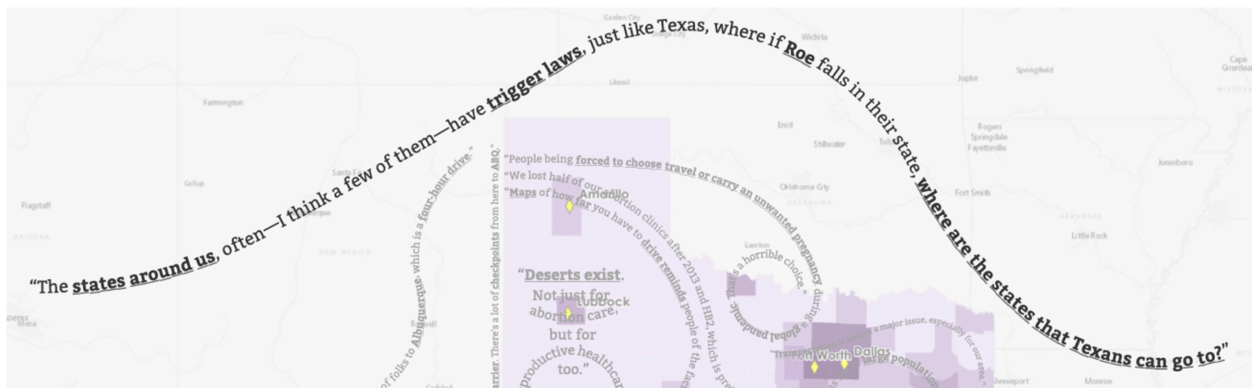

Figure 12. Intimate Flow J

The barriers articulated in the three flows are relational; they simultaneously produce and perform one another. Each intimate flow describes pasts, presents, and futures that have, currently, and will materialize restrictive legislative initiatives that limit reproductive health(care) and abortion access in Texas. Taken together, these three intimate flows provide an overview across time of how Texas' reproductive landscape is constantly being (re)shaped and actualized by unending, repetitive, restrictive legislation.

Intimate Flow H refers to *past* events, specifically to House Bill 2 (HB2), a bill that restricted and saw to the closure of abortion clinics in Texas (Gerdts et al., 2016; Jones & Jerman, 2014). This flow materializes the effects of HB2 and how the introduction of the bill physically (re)shaped Texas' reproductive health(care) landscape in adverse ways, the "devastating" effects of which are still felt throughout the state (i.e., diminished abortion clinic presence). This intimate flow also reveals some of the hidden and unarticulated implications of HB2's impacts on repro workers, whose organizing efforts became intensely more complicated, limited, and physically and emotionally labor-intensive.

As we move through this series of intimate flows, we can trace how the complexities of Intimate Flow I are directly scaffolded on top of Intimate Flow H. This intimate flow articulates the *present*. It specifically refers to the effects of the temporary abortion ban that was implemented by Attorney General Ken Paxton between March and April 2020 at the initial height of COVID-19, which was discussed in Chapter III. "People are being forced to choose to travel or carry an unwanted pregnancy" is a dire claim, one that underscores the restrictiveness of the ban that was instituted to bar abortion care during a global pandemic. Most important, this second intimate flow brings our attention to the present conditions of the reproductive health(care) landscape in Texas. As such, Intimate Flow I largely echoes Intimate Flow H. It

captures, in different ways, how barriers materialized in the forms of restrictive policy and legislation limit access to reproductive health(care) under different circumstances and time periods (i.e., non-pandemic versus pandemic). Although, the effect of the barriers articulated in Intimate Flow H incrementally increased in severity from the effects of Intimate Flow I. Between two flows, we see that, overtime, that limiting reproductive health(care) and abortion clinics evolved into a complete ban—albeit temporary—during a one-month period.

The third and final intimate flow in this series—Intimate Flow J—speaks to the *future* of Texas' reproductive health(care) landscape. This intimate flow does two things. First, by cutting through Texas' surrounding states, the flow considers the larger population beyond Texas. In this way, it visually interrogates the neighboring and bordering states that would, or could, provide reproductive allyship in the event that "*Roe* falls." This means that abortion trigger laws—pre-emptive legislation that will activate and ban abortion—would implemented in the event that *Roe v. Wade* (1973) is ever reversed. By asking, "Where are the states that Texas can go to?" in the event that "Roe falls," the intimate flow shows how restrictive legislation materializes the mobilizing efforts of repro workers' *within* and *outside* of Texas. More specifically, this flow reveals an intimate network of intimate flows that exists beyond Texas' reproductive health(care) landscape. This indicates that the flows constituting Texas' reproductive health(care) landscape also constitute the reproductive health(care) landscapes around it. Texas' reproductive health(care) landscape, then, is a part of the larger reproductive health(care) landscapes of the United States and beyond.

Summary: Intimate Flows as Organization and Organizing

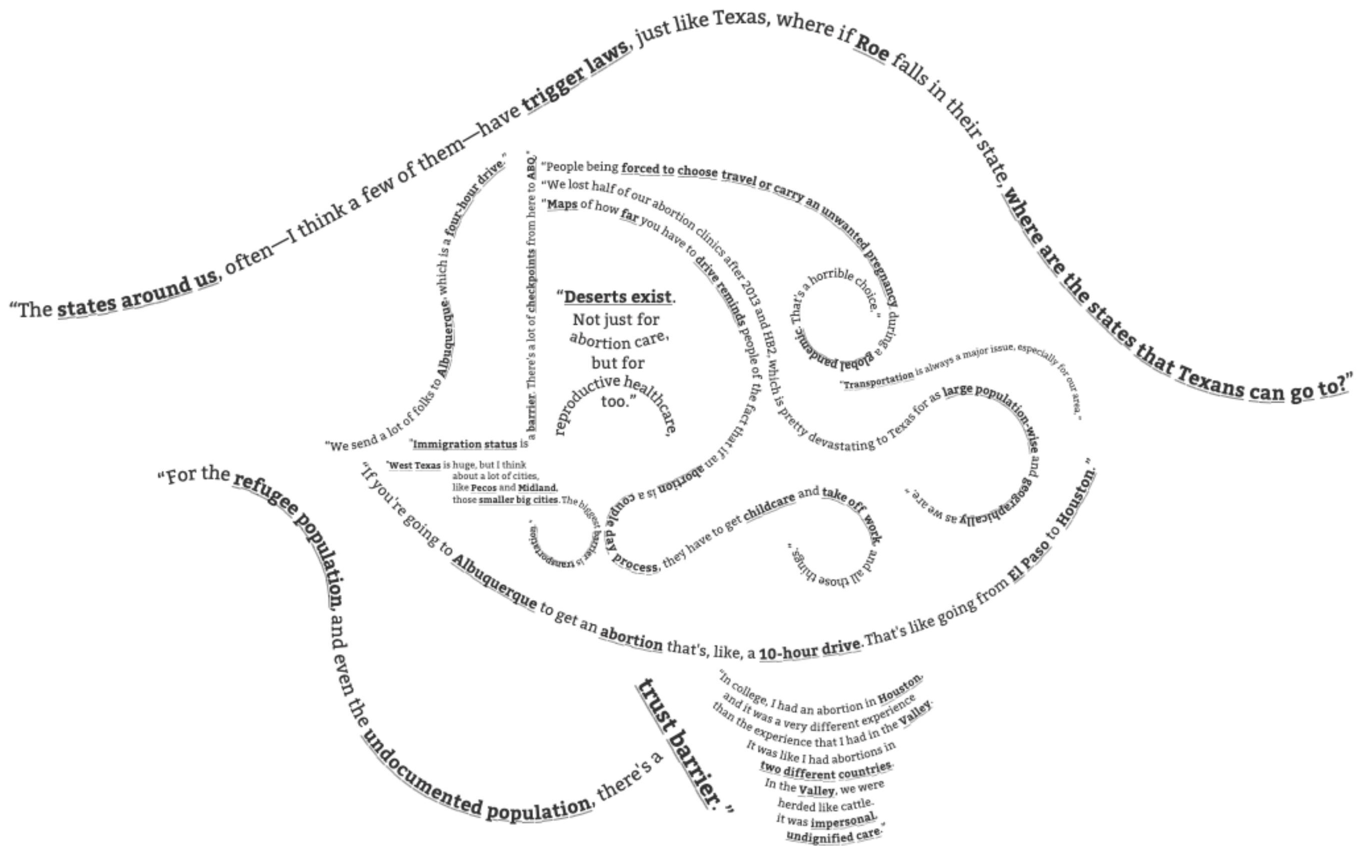

Figure 13. Intimate Flows of Texas' Reproductive Health(care) Landscape without Basemap

This chapter presented an intimate mapping of Texas. The intimate map conveyed a landscape of reproductive health(care) in Texas produced in the interaction between the participants' words, land masses, rivers, borders, walls, the two-dimensional representation of space on the map, and my own manipulation of space and text. The intimate flows that constituted the map were comprised of the participants' spatial stories containing their knowledges, struggles, emotions, and experiences that swirled within the boundaries of South-Central United States. These intimate flows materialized the simultaneous, fluid, and intimate contestations of the sociopolitical barriers, spatial awareness, and first-hand experiences that

constitute Texas' reproductive landscape. As communicative forms, the intimate flows made visible what is often invisible: the active role reproductive health, justice, and rights workers have in (re)shaping the reproductive health(care) across Texas. This intimate mapping is meant to be a chaotic, challenging, hard-to-follow milieu because it ultimately conveys what Whitesell and Faria (2019) call the "messy, fleshy, multidirectional flows of things, ideas, feelings, and people" (p. 1284) that materialize Texas' reproductive health(care) landscape. A good illustration of this messiness is depicted in *Figure 13* where the intimate map appears without its choropleth basemap layer. Without the basemap, we can see how the intimate flows interact with one another in unity, or "constellation" (Putnam, 2019), but also as individual fragments.

As I reflect on this chapter's analysis, ending with *Figure 13* seemed fitting. The intimate map without the basemap layer shows us a different representation of the analysis. It also conveys how the assemblage of intimate flows serves as an organizing force of Texas' reproductive health(care) landscape. By removing the basemap layer, we can roughly follow how the reproductive health(care) landscape is held together and contoured by the intimate flows. Taken together, the intimate flows recreate an approximation of produced and performed experiences through the intimate map. They are 12 of the countless intimate flows—that have been articulated or have yet to be manifested—that continually constitute and organize reproductive health(care) in Texas.

CHAPTER VII

DISCUSSION & CONCLUSION

This dissertation drew from the Communicative Constitution of Organization (CCO) approach to develop a constitutive understanding of reproductive health(care). I demonstrated that reproductive health(care) is not a solid, tangible entity. Rather, it is a vibrating assemblage of tension, conflict, organizations, organizational members, ideologies, language, and values. The existence of reproductive health(care) as an entity depends on this ebb and flow of tension that takes place between the assemblages that produce competing interpretations, understandings, and applications of reproductive health(care). The organizations—such as reproductive rights, justice, and health organizations, and CPCs—and immaterial figures (principles, values, beliefs, missions, conversations, discourse) that contribute to the constitution of reproductive health(care) are a part of a collective, tensional space called the reproductive domain. Even if some of these organizations resist being grouped together or identified as "reproductive-related," they all contribute to the sociomaterial production of reproductive health(care).

Using semi-structured interviews and intimate mapping as my primary methods, I explored three research questions about the constitutive nature of reproductive health(care). The first research question addressed how organizational members in the reproductive domain communicatively constitute reproductive health(care). I showed how members drew upon three discourse clusters to constitute reproductive health(care) as *an aspect of women's health*, *an aspect of human health*, and *a euphemism for abortion*. Through these discourse clusters, organizational members constitute reproductive health(care) differently on behalf of their organizations. In the shared space of the reproductive domain, members are in constant

competition with one another to constitute reproductive health(care) according to the values, principles, ideologies, and beliefs of their organizations.

The second research question asked how member identification in the reproductive domain is animated and constrained by the values, beliefs, ideologies, and positions of members' organizations. I demonstrated that members' identification with their organizations is positioned and ventriloquized by four value figures: *equity*, *care*, *purpose*, *scarcity*. Taken together, tensions arise from the complementary and contradictory overlap caused by the value figures. These tensions inform how the members' identification with their organizations is aligned (or supported) and constrained. The ventriloquial approach revealed an imperfect identification, one that enabled the members to simultaneously speak on behalf of their organizations while maintaining some form of agency over their personal identities.

The final research question addressed how members' reproductive work experiences constitute an affective, embodied landscape of reproductive health(care). The members' reproductive work experiences manifested in the form of intimate flows on an intimate map. Intimate flows are spatial stories that consist of the deep stories of *felt* experiences of members from the reproductive domain. The intimate flows were categorized into two "intimate collections:" *Intimate Flows of Distance and Time* and *Intimate Flows of Barriers*. Taken together, these collections of intimate flows constituted an intimate map, one that conveyed a reproductive health(care) landscape of the intimate flows. The intimate map ultimately conveyed the chaotic, affective nature of Texas' reproductive health(care) landscape, specifically highlighting issues related to distance, barriers, borders, time, and access.

The remaining pages of this chapter consider the theoretical, practical, and methodological implications of the findings. Then, I discuss the limitations and potential future

directions that might extend this dissertation in the continued development of the communicative constitution of reproductive health(care).

Reproductive Health(care) as Relational

One of the most challenging things I grappled with throughout this dissertation was finding a way to collectively refer to the members of the reproductive rights, justice, and health organizations, and CPCs that participated in my study. This is because members of these organizations categorize themselves and their organizations through inflexible binaries, such as pro-life/pro-choice and anti-abortion/abortion-rights advocacy (or pro-abortion). I experienced these binary categories as real at multiple points during this project, even in the ways I initially framed my interview questions and initial recruitment e-mails. I viewed reproductive health(care) as a tangible thing that each organization shared in common. However, I realized that there are various configurations, values, and hierarchies that constitute what reproductive health(care) is.

Positioning reproductive health(care) as a relational accomplishment—a "buzzing hive" of activity—is one of the primary contributions of this dissertation. As a relational accomplishment, reproductive health(care) is produced by the organizations that exist in the shared, contested, conflicting space of the reproductive domain. Within this reproductive domain exists the various, conflicting forces that are in competition to constitute the social realities of reproductive health(care). From the perspective of relationality, Costantini and Wolfe (2021) remind us that

> human and nonhuman, symbolic and material, ideas and things, swirl together in a frenetic dance to produce a vibrating assemblage that appears, from a distance, to have a

> stable form. The centripetal and centrifugal forces produced by the push and pull of various identity-building practices create tensions that bind the constitutive elements together in an electric, bussing, constantly moving *relation* of things and ideas, discourse and material, the social and the physical (pp. 22-23).

In turn, relationality demonstrates how various "matters" of concern, interest, power, principles, and ideologies constitute the basis of our social realities and ways of being (Cooren, 2015). Relationality also shows the messiness of these various "matters" that constitute reproductive health(care), and how these matters obscure the dimensions of social reality that make it difficult to address entrenched conflict across the reproductive domain. It also shows how we take the rigid, binary categories (i.e., pro-life/pro-choice) for granted as "real" and tangible when, in fact, they are not. It is through the messiness in between these perceived binaries where can see the push and pull of conflicting forces, misalignments, alignments, and in-group frustrations around how reproductive health(care) is constituted as one thing over another. This was demonstrated in how the participants simultaneously constituted reproductive health(care) as an aspect of women's health, an aspect of human health, and a euphemism for abortion.

For some participants, reproductive health(care) was viewed as a matter of women's health. For these participants, "women's health" was a discourse cluster that became the broader, overarching category. So, when I discussed reproductive health(care) with these participants, I was missing a larger point because, to them, I was focusing exclusively on reproduction and childbearing. To these participants, reproduction and childbearing are the functional aspects of women's health and *much* smaller components of the overall broader category. By constituting reproductive health(care) as an aspect of women's health, these participants upheld a social reality of reproductive health(care) that excluded those that do not identify with the category

"women." For these organizations, LGBTQIA+ reproductive health(care) is not a matter of concern because it falls outside of the realm of their interests, principles, ideologies, and what they do.

Other participants used discourses of "human health" to constitute reproductive health(care). For these participants, "women's health" excluded a large portion of the population that does not identify with notions of care specifically geared toward cisgender women. The reproductive rights and reproductive justice frameworks, in particular, center the reproductive health(care) needs of *all* people. This discourses around "human health" address the broad nature of gender identity, sexuality, and care. For these participants, reproductive health(care) is *more* than health(care). It is justice, legal rights, abolition, access, and autonomy. But these notions of reproductive health(care) become complicated when reproductive health(care) is used as a euphemism, specifically to refer to abortion. Applying reproductive health(care) as a euphemism strategically enables multiple interpretations to exist of what is meant by reproductive health(care) to avoid conflicting goals and meanings among organizations in the reproductive domain.

Taken together, each discourse cluster exists simultaneously and in competition with one another to mobilize the constitution of reproductive health(care). As such, relationality provides a lens that can destabilize organizations' tunnel vision of reproductive health(care) by demonstrating how conflicting positions and interpretations can exist at one time. In this way, not one interpretation of reproductive health(care) is right or wrong; rather, they each contribute to the constitution of reproductive health(care) in different ways. Therefore, it is critical that organizations within the reproductive domain recognize these clusters of discourses simultaneously exist and contribute to the social realities of reproductive health(care) and the

barriers, support, care, and access, and policies that shape it.

Membership Identification and Reproductive Health(care)

Exploring how the participants' member identifications with their organizations also elucidated the ways that organizations within the reproductive domain situate their values, beliefs, and ideologies. As I discussed in Chapter V, member identification is a process where individuals define and negotiate their purposes within their organizations (Cheney & Tompkins, 1987). Using a ventriloquial approach, I demonstrated how the participants' spoke through and/or on behalf of four value figures that were central to their organizations' existences—equity, care, purpose, scarcity. While these value figures were demonstrated as matters of concern across the participants' organizations, the participants animated each figure in different ways, depending on the organizations they were affiliated with and the roles they held.

From the perspective of the ventriloquial approach, human interactants are animated and constrained by different matters of concern, interests, and values (Cooren, 2012; Cooren et al., 2013). The ventriloquial approach demonstrates how organizations are presentified through "the polyphonic or multivocal character" nature of the voices that are ventriloquized. An organization is materialized through the process of presentification, where it is authorized to speak on behalf of certain issues, problems, and values (Costantini & Wolfe, 2021). Through my interviews, it was made evident that organizational identification was presentified through the participants' animation of the four value figures. As such, this resulted in tensions and contradictions that occurred between the figures.

Cooren et al. (2013) explain that tensions arise when "figures contradict or clash with each other" (p. 256). The four value figures—equity, care, purpose, scarcity—supported and/or

contradicted each other at various times. For instance, equity and care as figures complemented one another, but both figures were ventriloquized differently by the participants, depending on their organizational affiliations. For some participants, equity and care were ventriloquized as social justice, equitability and access, and material care (e.g., providing access to resources, services). However, other members did not locate equity as a figure crucial to their membership identification. Instead, care was centered as the most important matter of concern, particularly in the forms of social/emotional support and religiosity/spirituality. These incongruent relations that materialized between the members and their animation of the value figures revealed an imperfect identification. Imperfect identification is the friction that occurred when members' personal interests contradicted or clashed with their organizations'. Imperfect identification provides several opportunities for employers and organizational members in the reproductive domain.

First, members' imperfect alignment with their organizations can create opportunities for coalition building and interorganizational partnerships that might not have existed before, especially between reproductive rights, justice, and health organizations. The discrepancies that were revealed in these imperfect alignments also demonstrate that occasions exist to reconcile how each value figure is animated across different organizations and reproductive contexts (i.e., rights, justice, health, CPCs). Additionally, the ventriloquization of each value figure shows us how members' organizations position specific matters of concern that are important to their existence but are not necessarily as important to the members' personal interests, which leads to an imperfect alignment.

Intimate Mapping and Reproductive Health(care)

An aspect of this dissertation demonstrated how an intimate mapping of reproductive

health(care) constituted an affective, embodied site of participants' reproductive work experiences. This intimate map is a transdisciplinary achievement that aimed to (a) disrupt traditional understandings of distance, scale, space, and place, (b) communicate the affective stories and experiences of the participants, and (c) show how reproductive health(care) is communicatively constituted as a landscape of tension and conflict. As such, the purpose of the intimate mapping was to join CCO scholarship and critical feminist geographic methods into conversation to create an artifact that simultaneously organizes the relational social activities of the participants' reproductive work and defines a landscape of reproductive health(care).

First, I showed how the intimate map communicates the affective, embodied stories and experiences of the participants. The participants' experiences were categorized into two "intimate collections:" Intimate Flows of Time and Distance and Intimate Flows of Barriers. Through these two intimate collections of flows, I demonstrated how the social activity of the reproductive workers materialized one iteration of a map that visually conveyed the swirling, twisted, and bending text of the participants' stories juxtaposed against the space of their landscape. As such, the intimate flows were arranged in ways that organized understandings of reproductive health(care) space and work in Texas and the South-Central region of the United States. Some organizational communication scholars have taken on the project of conceptualizing organizational space and place (see, e.g., Beyes & Steyaert, 2011; Wilhoit, 2016; Wilhoit & Kisselburgh, 2019). However, much more work needs to be done on this front. An intimate mapping—like the map I presented in this dissertation—is one relational (and visual) approach that we can use to explore organizational space and place from a different lens.

Beyond demonstrating the relational aspects of the intimate map and the various affective stories and experiences that constitute it, intimate mapping can be used as a distinct tool for

research and advocacy practice for organizations across the reproductive domain. First, the intimate map produced for this dissertation serves as a testimonial to the various barriers, borders, and access issues that are experienced by members of the reproductive domain throughout the state of Texas. Texas is the second largest state (by square miles) in the United States. While people may have a general understanding of the distances from El Paso to Houston, for instance, they might have never traveled the extreme distances between both cities and, as such, never considered the time and labor it takes to coordinate reproductive health(care) from one end of the state to the other. Thus, the intimate map is a visual artifact of testimonials that invites community members, policymakers, legislators, and organizational members to live in "unseen places" and experiences. In her short piece "The Wizard of Oz" (2003), artist and writer Roni Horn provides a deeply moving and helpful description of how we are all implicated in unseen places:

> We come to dwell in places we've never been. It's a form of dreaming—these unseen places, only known through rumor, word of mouth, flight of fancy, a map—or no map, just a story told. We need the idea of them…We need these places that we've never traveled to, that we may never go. We need them not for escape, but for measure: of all the places we have been to, and of ourselves as well. We need them as a way of balancing what is with what might be, and as a way of understanding the scope of things, of admitting that the things beyond us are also the things that define us. These rarely experienced places are no less. Valuable than those we occupy daily, no less inhabited by us than our most familiar and intimate ones. In acknowledging them, we understand that we are something more than the body, we inhabit and the things we consume, and that we dwell in places beyond our immediate perception or reach—so that we may see beyond

our sight (p. 243).

By positioning the intimate map as an advocacy tool that enables people to "see beyond their sight," to situate themselves in places that they, perhaps, will never travel to or experience, organizations within the reproductive domain can make an affective, visual case that conveys how various barriers, borders, and access constrain reproductive health(care) and their reproductive work. Ultimately, the intimate map materializes the realities of reproductive health(care) constraints and limitations that may be understood as "rumor, word of mouth, flight of fancy" to those who have dismissed or never experienced these realities firsthand.

Methodological Implications

The methodological contributions of this study are largely in response to Keri Stephens' (2017) call for methodological curiosity in organizational communication research:

> as we continue to transform and build organizational communication, we face some distinct challenges. Those challenges center on how we continue to embrace methodological diversity, while simultaneously developing methodological depth. I challenge our field to openly discuss our pedagogy/andragogy and how we teach our next generation to be methodologically curious (p. 152).

In this dissertation, I introduced intimate mapping as a method to organizational communication research. Specifically, I brought CCO theory and critical feminist geography together to create an intimate mapping of reproductive health(care) in Texas. I drew several connections between CCO theory and critical feminist geography, showing how the intimate map is a communicatively constitutive artifact where organization and organizing are expressed and performed through the various tensions of the figures, interactants, and things that constitute the

map. As such, the intimate map visually communicated how reproductive health(care) is organized as an assemblage of tensions, conflict, and emotions from the participants' embodied, felt work experiences.

While organizational communication researchers draw from humanistic geography to conceptualize organizational space and place (see, e.g., Nash, 2020; Wilhoit, 2016), what is missing from these developments is a visual mapping of these concepts. As such, the intimate map in this dissertation lifted space, place, landscape, organization, and organizing out of abstraction and into visualization. Costantini and Thompson (2021) have also accomplished this by introducing Esri's ArcGIS as a useful methodological tool in organization studies scholarship through their analysis of the spatial relationships between organizations in the reproductive healthcare sector. The intimate mapping this project offers is an additional method of visualization.

As I discussed in Chapter III, my goal in this dissertation was not to claim maps or mapping as "new" or "groundbreaking." My goal was to advocate for the use of maps and mapping in organizational communication research as a productive interdisciplinary methodological and analytical practice and form of communicative visualization. Following Stephens' (2017) call for methodological curiosity, I believe that organizational communication scholars, should experiment with new methods and transdisciplinary partnerships. However, my use of intimate mapping in this dissertation does not mean that I would now call myself a geographer. Rather, I used intimate mapping to problematize organizational communication research questions and issue areas from a different methodological lens.

Limitations

Like any study, this dissertation was constrained by limitations. First, COVID-19 presented several challenges that forced me to quickly alter this study's original design in several key ways. Originally, this dissertation was built around conducting ethnographic research at an abortion clinic and crisis pregnancy center in the same community. Once the effects of COVID-19 started setting in, I had to quickly adapt the project to accommodate virtual semi-structured interviews. Even though I was able to recruit 67 participants in a short period of time, my interview time with many of the participants was often cut short due to limited availabilities and personal obligations related to COVID-19.

Second, the majority of the participants I recruited identified as female (91%). Among the 67 participants I interviewed, only 4 identified as male and 2 identified as nonbinary. While reproductive health(care) was attributed to women's health and human health, both male and nonbinary perspectives on what constitutes reproductive health(care) were missing from this study. These perspectives are important to capture because men and nonbinary folx have a significant stake in reproductive health(care). They, too, are reproductive beings. Men and nonbinary folx also participate in decisions, conversations, and social realities that constitute reproductive health(care). What is lost without these perspectives? What can these perspectives add to the communicative constitution of reproductive health(care)? Why do men and nonbinary folx seem to have a limited and diminished presence in organizations across the reproductive domain? Ultimately, investigating how reproductive health(care) is constituted from the male and nonbinary perspectives could add more complexity to future iterations of this study.

Third, my recruitment efforts were specifically directed toward reproductive rights, justice, and health organizations, and CPCs in Texas. As such, the perspectives and experiences

of my participants are limited by a specific geographic region. Although the participants represented a range of organizations and members from across Texas, their experiences were largely specific to the geography of Texas and, more broadly, the South-Central region of the United States. Given the legislative landscape, sociopolitical tensions, culture, and general attitude toward reproductive health(care) in Texas, it is likely that conducting similar research elsewhere in the United States—even in different countries—might reveal the ways different organizations and their members constitute reproductive health(care).

Methodologically, there were two major limitations. First, the virtual interviews presented technological challenges for participants who were unfamiliar with Zoom. There were also several forms of distractions and internet connectivity issues that impeded on the interview sessions. If time and situation permitted, it would have been meaningful to conduct longer in-person interviews with the participants. Second, the intimate map I created for this study represents one of *many* potential interpretations of Texas' reproductive health(care) landscape using one specific set of interview data. This project could have benefited from additional maps and mapping techniques that could have enriched the current intimate mapping.

Theoretically, this study considered how reproductive health(care) is constituted through discourse, membership identification, and the embodied, affective site of reproductive members' work experiences. While each of these components contributes to the constitution of reproductive health(care), they are not the *only* things and beings that do so. I have not fully explored the possibilities of the other objects, beings, and things that contribute to the constitution of reproductive health(care), as this was beyond the goals of this project's agenda. However, this does present opportunities to consider constitutive forces that contribute to the constitution of reproductive health(care) in future iterations of this project, beyond what is

presented here.

Future Directions

When I initially began this dissertation, I intended to conduct an ethnographic analysis of an abortion clinic and CPC located in the same community. The purpose of the initial dissertation design was to gain an understanding of how different organizations' values, principles, and practices constitute reproductive health(care) from organizational and community perspectives. Due to COVID-19, I was unable to continue with this study design due to restrictions around in-person contact and traveling. Pursuing this project is still valuable for several reasons. First, the original study design can provide a nuanced understanding of specific organizational practices, perspectives, principles, and values from two organizations that constitute reproductive health(care) in different ways. Second, it would be meaningful to observe organizational members' interactions with other organizational members to determine how reproductive health(care) is constituted in their conversations, the ways they craft organizational materials, and how they fulfill their roles and responsibilities on a daily basis. Third, it would be beneficial to observe how members' interactions and understandings of reproductive health(care) influence their larger community's knowledge about reproductive health(care).

Another area for future research involves delving deeper into how the reproductive domain is constituted by its members. As demonstrated in this dissertation, members from reproductive rights and reproductive justice organizations do justice-oriented, rights-related work, advocating on behalf of people's reproductive autonomy and freedom. Yet, their working conditions are not met with the same standards. There are many social media accounts, such as @ReproJobs, dedicated to documenting and sharing reproductive workers' anonymous

experiences about poor working conditions and pay, restrictive policies, subpar health insurance, and unpaid labor. Drawing from Sara Ahmed's complaint framework, additional research around the specifics of reproductive members' work would investigate how reproductive health(care) is constituted in a contested space of complaint. For Ahmed (2021), a complaint can consist of:

> an expression of grief, pains, or dissatisfaction, something that is a cause of protest or outcry, a bodily ailment, or a formal allegation. To tell the story of a complaint, then, can be to tell a life story. And to tell the story of a complaint made within an institution can be to tell another story about an institution, and that story or complaint.

Ahmed's (2021) idea of complaint offers a framework to center how reproductive members' complaints *about* or *toward* their organizations contribute to the constitution of their member identification (or lack thereof). Qualitative interview studies around reproductive members' complaints could reveal levels of institutional abuses (i.e., organizational, reproductive domain) that affect these members, whose work revolves around reproductive equity and justice.

Building from the limitations of this project, future research should also explore the perspectives that were missing from this study, namely male and nonbinary perspectives. As I discussed in the limitations, men are reproductive beings that have a stake in reproductive health(care). Capturing how men communicatively constitute reproductive health(care)—specifically men within who work within the reproductive domain—can add complexity to future iterations of this study in ways that would highlight an underrepresented perspective.

Conclusion

The overarching goal of this dissertation was to demonstrate how reproductive health(care) is communicatively constituted. As such, I conducted semi-structured interviews

with organizational members from reproductive rights, justice, and health organizations, and CPCs, and developed an intimate mapping of these members' reproductive work experiences to theorize how reproductive health(care) is communicatively constituted. The main contribution of this dissertation demonstrated that reproductive health(care) is not a solid, tangible entity; rather, it is a vibrating assemblage of actors, organizations, and things that contribute to its sociomaterial production. Organizational communication research—specifically CCO scholarship—has yet to consider reproductive health(care) as a constitutive entity. As such, this research contributes to CCO theory by demonstrating how reproductive health(care) is a contested site comprised of multiple, tensional, and competing interactants and figures that forward different social realities of reproductive health(care) based on their values, principles, ideologies, and beliefs. This dissertation also joined CCO theory into conversation with critical geographic feminist methods to produce an intimate mapping of reproductive health(care). While organizational communication scholars borrow from humanistic geography more frequently to conceptualize understandings of organizational space and place, this study takes one step further by producing a map of affective, embodied experiences. The intimate map was meant to attune our understandings to the affective aspects of organization and organizing. Ultimately, it is through the intimate map where we see how the flows of felt experience constitute an artifact that visualizes the struggles, emotions, and embodied testimonials of reproductive work. This project encountered several limitations, including limitations imposed by COVID-19 and lack of additional perspectives that contribute to the constitution of reproductive health(care). This dissertation offers several practical implications for members of the reproductive domain, who are vested in reproductive-related work, but also for people who have a stake in crafting policy and legislation that affects and constrains reproductive health(care). This dissertation also offers

several future directions to investigate other interactants and figures that play a role in the constitution of reproductive health(care).

REFERENCES

ACLU. (2021). *Reproductive freedom*. https://www.acludc.org/en/issues/reproductive-freedom

Adams, P. C., Hoelscher, S. D., & Till, K. E. (2001). *Textures of place: Exploring humanist geographies*. University of Minnesota Press.

Ahmed, S. (2021, March 16). *Knocking on the door: Complaints and other stories about institutions*. Lecture presented at the Humanities Institute at Stony Brook University, Stony Brook, NY. [Virtual].

Allan, K., & Burridge, K. (1991). *Euphemism and dysphemism: Language used as a shield and weapon*. Oxford University Press.

Alvesson, M., Ashcraft, K. L., & Thomas, R. (2008). Identity matters: Reflections on the construction of identity in scholarship in organization studies. *Organization*, *15*, 5-28. https://doi.org/10.1177/1350508407084426

Alvesson, M., & Willmott, H. (2002). Identity regulation as organizational control: Producing the appropriate individual. *Journal of Management Studies*, *39*(5), 619-644. https://doi.org/10.1111/1467-6486.00305

Archibald, M. M., Ambagtsheer, R. C., Casey, M. G., & Lawless, M. (2019). Using Zoom videoconferencing for qualitative data collection: Perceptions and experiences of researchers and participants. *International Journal of Qualitative Methods*, *18*. https://doi.org/10.1177/1609406919874596

Arcury, T. A., Gesler, W. M., Preisser, J. S., Sherman, J., Spencer, J., & Perin, J. (2005). The effects of geography and spatial behavior on health care utilization among the residents of a rural region. *Health Services Research*, *40*(1), 135-156. https://doi.org/10.1111/j.1475-6773.2005.00346.x

Ashcraft, K. L., Kuhn, T. R., & Cooren, F. (2009). 1 Constitutional amendments: "Materializing" organizational communication. *Academy of Management Annals*, *3*(1), 1-64. https://doi.org/10.5465/19416520903047186

Aspers, P., & Corte, U. (2019). What is qualitative in qualitative research. *Qualitative Sociology*, *42*(2), 139-160. https://doi.org/10.1007/s11133-019-9413-7

Avow. (2021). *Access to abortion*. https://avowtexas.org/access-to-abortion/

Bagheri, N. (2014). What qualitative GIS maps tell and don't tell: Insights from mapping women in Tehran's public spaces. *Journal of Cultural Geography*, *31*(2), 166-178. https://doi.org/ 10.1080/08873631.2014.906848

Bencherki, N. (2016). How things make things do things with words, or how to pay attention to what things have to say. *Communication Research and Practice*, *2*(3), 272-289. https://doi.org/10.1080/22041451.2016.1214888

Bennett, J. (2010). *Vibrant matter: A political ecology of things*. Duke University Press.

Best, K., & Hindmarsh, J. (2019). Embodied spatial practices and everyday organization: The work of tour guides and their audiences. *Human Relations*, *72*(2), 248-271. https://doi.org/10.1177/0018726718769712

Beyes, T., & Steyaert, C. (2011). Spacing organization: Non-representational theory and performing organizational space. *Organization*, *19*(1), 45-61. https://doi.org/10.1177/1350508411401946

Bisel, R. S. (2010). A communicative ontology of organization? A description, history, and critique of CCO theories for organization science. *Management Communication Quarterly*, *24*(1), 124-131. https://doi.org/10.1177/0893318909351582

Blithe, S. J., & Wolfe, A. W. (2017). Expanding organizational research methods: Analyzing ruptures in qualitative research. In P. J. Salem & E. Timmerman (Eds.), *Transformative practice and research in organizational communication* (pp. 168-183). IGI Global.

Boivin, G., Brummans, B. H., & Barker, J. R. (2017). The institutionalization of CCO scholarship: Trends from 2000 to 2015. *Management Communication Quarterly*, *31*(3), 331-355. https://doi.org/10.1177/0893318916687396

Broadfoot, K. J., & Munshi, D. (2007). Diverse voices and alternative rationalities: Imagining forms of postcolonial organizational communication. *Management Communication Quarterly*, *21*(2), 249-267. https://doi.org/10.1177/0893318907306037

Brummans, B. H. J. M., Cooren, F., & Chaput, M. (2009). Discourse, communication, and organisational ontology. In F. Bargiela-Chiappini (Ed.), *The handbook of business discourse* (pp. 53-65). Edinburgh University Press.

Bryant, A. G., & Levi, E. E. (2012). Abortion misinformation from crisis pregnancy centers in North Carolina. *Contraception*, *86*, 752-756. https://doi.org/10.1016/j.contraception.2012.06.001

Bryant, A. G., & Swartz, J. J. (2018). Why crisis pregnancy centers are legal but unethical. *American Medical Association Journal of Ethics*, *20*(3), 269-277. https://doi.org/10.1001/journalofethics.2018.20.3.pfor1-1803

Butler, J. (1988). Performative acts and gender constitution: An essay in phenomenology and feminist theory. *Theatre Journal*, *40*(4), 519-531. https://doi.org/10.2307/3207893

Buzzanell, P. M. (1994). Gaining a voice: Feminist organizational communication theorizing. *Management Communication Quarterly*, *7*(4), 339-383. https://doi.org/10.1177/0893318994007004001

Buzzanell, P. M. (2021). Reflections on feminist organizational communication. *Management Communication Quarterly*, *35*(1), 127-141. https://doi.org/10.1177/0893318920975211

Callaghan, W. M. (2014). Geographic variation of reproductive health indicators and outcomes in the United States: Place matters. *American Journal of Obstetrics and Gynecology*, *211*(3), 278-284. https://doi.org/10.1016/j.ajog.2014.06.043

Casti, E. (2015). *Reflexive cartography: A new perspective in mapping*. Elsevier.

Center for Reproductive Rights. (2017, January 23). *Trump orders Global Gag Rule, cuts off vital, safe abortion services for women* [Press release]. https://reproductiverights.org/press-room/trump-orders-global-gag-rule-cuts-off-vital-safe-abortion-services-for-women

Chalker, R., & Downer, C. (1996). *A woman's book of choices: Abortion, menstrual extraction, RU-486*. Seven Stories Press.

Chaput, M., Brummans, B. H. J. M., & Cooren, F. (2011). The role of organizational identification in the communicative constitution of an organization: A study of consubstantialization in a young political party. *Management Communication Quarterly*, *25*(2), 252-282. https://doi.org/10.1177/0893318910386719

Cheney, G., & Tompkins, P. K. (1987). Coming to terms with organizational identification and commitment. *Communication Studies*, *38*, 1-15. https://doi.org/10.1080/10510978709368225

Chrisler, J. C. (2012). Introduction: What is reproductive justice?. In J. C. Chrisler (Ed.), *Reproductive justice: A global concern* (pp. 1-10). ABC-CLIO.

Clifton, J., Fachin, F., & Cooren, F. (2021). How artefacts do leadership: A ventriloquial analysis. *Management Communication Quarterly*, *35*(2), 256-280.

https://doi.org/10.1177/0893318921998078

Cnossen, B., & Bencherki, N. (2019). The role of space in the emergence and endurance of organizing: How independent workers and material assemblages constitute organizations. *Human Relations*, *72*(6), 1057-1080. https://doi.org/10.1177/0018726718794265

Colman, S., & Joyce, T. (2011). Regulating abortion: Impact on patients and providers in Texas. *Journal of Policy Analysis and Management*, *30*(4), 775-797. https://doi.org/10.1002/pam.20603

Condit, C. M. (1994). *Decoding abortion rhetoric: Communicating social change*. University of Illinois Press.

Cooren, F. (2020). Beyond entanglement: (Socio-) materiality and organization studies. *Organization Theory*, *1*(3), 1-24. https://doi.org/10.1177/2631787720954444

Cooren, F. (2012). Communication theory at the center: Ventriloquism and the communicative constitution of reality. *Journal of Communication*, *62*(1), 1-20. https://doi.org/10.1111/j.1460-2466.2011.01622.x

Cooren, F. (2015). In media res: Communication, existence, and materiality. *Communication Research and Practice*, *1*(4), 307-321. https://doi.org/10.1080/22041451.2015.1110075

Cooren, F. (2018). Materializing communication: Making the case for a relational ontology. *Journal of Communication*, *68*(2), 278-288. https://doi.org/10.1093/joc/jqx014

Cooren, F. (2004). Textual agency: How texts do things in organizational settings. *Organization*, *11*(3), 373-393. https://doi.org/ 10.1177/1350508404041998

Cooren, F. (2006). The organizational world as a plenum of agencies. In F. Cooren, J. R. Taylor, & E. J. Van Every (Eds.), *Communication as organizing: Empirical and theoretical*

explorations in the dynamic of text and conversation (pp. 81-100). Lawrence Erlbaum.

Cooren, F., & Caïdor, P. (2019). Communication as dis/organization: How to analyze tensions from a relational perspective. In C. Vásquez & T. Kuhn (Eds.), *Dis/organization as communication: Exploring the disordering, disruptive and chaotic properties of communication* (pp. 36-59). Routledge.

Cooren, F., Fairhurst, G., & Huët, R. (2012). Why matter always matters in (organizational) communication. In P. M. Leonardi, B. A. Nardi, & J. Kallinikos (Eds.), *Materiality and organizing: Social interaction in a technological world* (pp. 296-314). Oxford University Press.

Cooren, F., Kuhn, T., Cornelissen, J. P., & Clark, T. (2011). Communication, organizing and organization: An overview and introduction to the special issue. *Organization Studies*, *32*(9), 1149-1170. https://doi.org/10.1177/0170840611410836

Cooren, F., & Martine, T. (2016). Communicative constitution of organizations. In K. B. Jensen & R. T. Craig (Eds.), *The international encyclopedia of communication theory and philosophy* (pp. 1-9). John Wiley & Sons.

Cooren, F., Matte, F., Benoit-Barné, C., & Brummans, B. H. (2013). Communication as ventriloquism: A grounded-in-action approach to the study of organizational tensions. *Communication Monographs*, *80*(3), 255-277. https://doi.org/10.1080/03637751.2013.788255

Cooren, F., Taylor, J. R., & Van Every, E. J. (Eds.). (2006). *Communication as organizing: Empirical and theoretical explorations in the dynamic of text and conversation.* Lawrence Erlbaum.

Costantini, R. A., & Thompson, C. M. (2021). *Leveraging geographic information in organization studies: Beginning the conversation*. 37th European Group for Organizational Studies Colloquium, Amsterdam, Netherlands. [Virtual].

Costantini, R. A., & Wolfe, A. (2021, May 27-31). *Authorial incongruity and organizational presence(s): A ventriloquial analysis of shadowed organization*. 71st International Communication Association annual conference, Denver, CO, United States. [Virtual].

Cresswell, J. W., & Ploth, C. N. (2016). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Sage Publications.

Cruz, J. (2015). Dirty work at the intersections of gender, class, and nation: Liberian market women in post-conflict times. *Women's Studies in Communication*, *38*(4), 421-439. https://doi.org/10.1080/07491409.2015.1087439

Cruz, J. M. (2017). Invisibility and visibility in alternative organizing: A communicative and cultural model. *Management Communication Quarterly*, *31*(4), 614-639. https://doi.org/10.1177/0893318917725202

Cruz, J. M., Gist-Mackey, A. N., Hanchey, J. N., Lockwood Harris, K., Jensen, P. R., Kenney, S. C., & Leslie, K. J. (2020). #ToneUpOrgComm. *Departures in Critical Qualitative Research*, *9*(2), 152-154. https://doi.org/10.1525/dcqr.2020.9.2.152

D'Ignazio, C., & Klein, L. F. (2020). *Data feminism*. MIT Press.

Davis, W. [@wendydavis]. (2021, April 22). *Friends, next week one of the most dangerous anti-abortion bills in the country will be voted on in the TX House. HB 1515 bans abortion at 6 wks (before most women even know they're pregnant) and creates a private cause of action against ANYONE who helps someone get an abortion.* [Tweet thread]. Twitter. https://twitter.com/wendydavis/status/1385329584514551808

de Onís, K. M. (2015). Lost in translation: Challenging (White, monolingual feminism's) <Choice> with justicia reproductiva. *Women's Studies in Communication*, *38*, 1-19. https://doi.org/10.1080/07491409.2014.989462

De Souza, R. T. (2019). *Feeding the other: Whiteness, privilege, and neoliberal stigma in food pantries*. MIT Press.

Deakin, H., & Wakefield, K. (2014). Skype interviewing: Reflections of two PhD researchers. *Qualitative Research*, *14*(5), 603-616. https://doi.org/10.1177/1468794113488126

Deetz, S. (1982). Critical interpretive research in organizational communication. *Western Journal of Communication*, *46*(2), 131-149. https://doi.org/10.1080/10570318209374073

Eisenberg, E. M. (1984). Ambiguity as strategy in organizational communication. *Communication Monographs*, *51*(3), 227-242. https://doi.org/10.1080/03637758409390197

Eisikovits, Z., & Koren, C. (2010). Approaches to and outcomes of dyadic interview analysis. *Qualitative Health Research*, *20*(12), 1642-1655. https://doi.org/10.1177/1049732310376520

Ellingson, L. L., & Sotirin, P. (2020). *Making data in qualitative research: Engagements, ethics, and entanglements*. Routledge.

Falconer, K., Kawabata, A. H., & Kawabata, H. (2002). Toward a more fully reflexive feminist geography. In P. Moss (Ed.), *Feminist geography in practice: Research and methods* (pp. 103-115). Wiley-Blackwell.

Forbat, L., & Henderson, J. (2003). "Stuck in the middle with you": The ethics and process of qualitative research with two people in an intimate relationship. *Qualitative Health*

Research, *13*(1), 1453-1462. https://doi.org/10.1177/1049732303255836

Fourie, C. (2021). *Choropleth maps*. https://storymaps.arcgis.com/stories/087f57e344244d2a9f85b39fd65d9309

Frost, J. J. (2013). *U.S. women's use of sexual and reproductive health services: Trends, sources of care and factors associated with use, 1995–2010*. Guttmacher Institute. https://www.guttmacher.org/report/us-womens-use-sexual-and-reproductive-health-services-trends-sources-care-and-factors

Gerdts, C., Fuentes, L., Grossman, D., White, K., Keefe-Oates, B., Baum, S. E., Hopkins, K., Stolp, C. W., & Potter, J. E. (2016). Impact of clinic closures on women obtaining abortion services after implementation of a restrictive law in Texas. *American Journal of Public Health*, *106*(5), 857-864. https://doi.org/10.2105/AJPH.2016.303134

Gist-Mackey, A. N., & Kingsford, A. N. (2020). Linguistic inclusion: Challenging implicit classed communication bias in interview methods. *Management Communication Quarterly*, *34*(3), 402-425. https://doi.org/10.1177/0893318920934128

Golden, A. G., & Pomerantz, A. (2015). Interpretative repertoires that shape low-income African American women's reproductive health care seeking: "Don't want to know" and "taking charge of your health." *Health Communication*, *30*(8), 746-757. https://doi.org/10.1080/10410236.2014.898363

Goldenstein, T. (2021, January 4). *Second-trimester abortions increased 61% after Texas lifted temporary ban, study shows*. *Houston Chronicle*. https://www.houstonchronicle.com/politics/texas/article/Second-trimester-abortions-increased-61-after-15845695.php

Gómez, M. C. (2009). Towards a new approach to the linguistic definition of euphemism. *Language Sciences*, *31*(6), 725-739

Görkariksel, B., Hawkins, M., Neubert, C., & Smith, S. (2021). *Feminist geography unbound: Discomfort, bodies, and prefigured futures*. West Virginia University Press.

Gossett, L. M. (2002). Kept at arm's length: Questioning the organizational desirability of member identification. *Communication Monographs*, *69*(4), 385-404. https://doi.org/10.1080/03637750216548

Gray, L. M., Wong-Wylie, G., Rempel, G. R., & Cook, K. (2020). Expanding qualitative research interviewing strategies: Zoom video communications. *The Qualitative Report*, *25*(5), 1292-1301.

Guenther, K. M. (2009). The politics of names: rethinking the methodological and ethical significance of naming people, organizations, and places. *Qualitative Research*, *9*(4), 411-421. https://doi.org/10.1177/1468794109337872

Haider, S., Stoffel, C., Donenberg, G., & Geller, S. (2013). Reproductive health disparities: A focus on family planning and prevention among minority women and adolescents. *Global Advances in Health and Medicine*, *2*(5), 94-99. https://doi.org/10.7453/gahmj.2013.056

Hanchey, J. N. (2020). Beyond race scholarship as groundbreaking/irrelevant. *Departures in Critical Qualitative Research*, *9*(2), 122-125.

Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research*, *12*(2), 239-242. https://doi.org/10.1177/1468794111426607

Harvard Health Publishing. (2019, January). *Abortion (termination of pregnancy)*. https://www.health.harvard.edu/medical-tests-and-procedures/abortion-termination-of-pregnancy-a-to-z

Hasstedt, K., & Sonfield, A. (2017). *At it again: Texas continues to undercut access to reproductive health care*. Health Affairs. https://www.healthaffairs.org/do/10.1377/hblog20170718.061085/full/

Hayden, S. (2009). Revitalizing the debate between <Life> and <Choice>: The 2004 March for Women's Lives. *Communication & Critical/Cultural Studies*, *6*(2), 111-131. https://doi.org/10.1080/14791420902833189

Hayden, S. (2018). Toward a collective rhetoric rooted in choice: Consciousness raising in the Boston Women's Health Book Collective's Ourselves and Our Children. *Quarterly Journal of Speech*, *104*(3), 235-256. https://doi.org/10.1080/00335630.2018.1486034

Hochschild, A. R. (2017). *Strangers in their own land: Anger and mourning on the American right.* The New Press.

Holstein, J., & Gubrium, J. F. (2003). *Inside interviewing: New lenses, new concerns*. Sage Publications.

Hoonton, A. (2005). A broader vision of the reproductive rights movement: Fusing mainstream and Latina feminism. *American University Journal of Gender, Social Policy & the Law*, *13*, 59-86.

Horn, R. (2020). *Island zombie: Iceland writings*. Princeton University Press.

Howard, D. (2021, May 4). *Tomorrow, the Texas House will hear SB 8 and HB 1280—bills that effectively ban abortion in Texas. #SB8 & #HB1280 are forced pregnancy bills, and they must be stopped. 1/ #txlege*. [Tweet thread]. Twitter. https://twitter.com/DonnaHowardTX/status/1389765457079582722

Howard, J. (2019, September 23). *Trump administration pushed UN to drop mentions of reproductive health from official documents*. CNN.

https://www.cnn.com/2019/09/23/health/alex-azar-united-nations-universal-health-coverage-bn/index.html

Howlett, M. (2020). Looking at the ‘field’ through a Zoom lens: Methodological reflections on conducting online research during a global pandemic. *Qualitative Research*, *19*, https://doi.org/ 10.1177/1609406920937875

Jensen, P. R., Cruz, J., Eger, E. K., Hanchey, J. N., Gist-Mackey, A. N., Ruiz-Mesa, K., & Villamil, A. (2020). Pushing beyond positionalities and through “failures” in qualitative organizational communication: Experiences and lessons on identities in ethnographic praxis. *Management Communication Quarterly*, *34*(1), 121-151. https://doi.org/ 10.1177/0893318919885654

Jerman, J., Frohwirth, L. F., Kavanaugh, M. L., & Blades, N. (2017). Barriers to abortion care and their consequences for patients traveling for service: Qualitative findings from two states. *Perspectives on Sexual and Reproductive Health*, *49*(2), 95-102. https://doi.org/10.1363/psrh.12024

Jervis, R. (2014, May 17). *Texas abortion law creates obstacles for Valley women*. *USA Today*. https://www.usatoday.com/story/news/nation/2014/05/17/texas-abortion-law-women-valley/8804871/

Jones, R. K., & Jerman, J. (2014). Abortion incidence and service availability in the United States, 2014. *Perspectives on Sexual and Reproductive Health*, *49*, 17-27. https://doi.org/10.1363/psrh.12015

Jones, R. K., & Jerman, J. (2013). How far did U.S. women travel for abortion services in 2008? *Journal of Women’s Health*, *22*(8), 706-713. https://doi.org/10.1089/jwh.2013.4283

Justin, R. (2020a, March 25). *Abortion providers sue Texas over coronavirus-related order*. *The Texas Tribune*. https://www.texastribune.org/2020/03/25/texas-abortions-coronavirus-outbreak-lawsuit/

Justin, R. (2020b, March 23). No abortions in Texas unless the mother's life is in danger, Texas attorney general says as coronavirus spreads. *The Texas Tribune*. https://www.texastribune.org/2020/03/23/texas-stops-most-abortions-during-coronavirus-outbreak/

Kavanagh, Á., & Aiken, A. R. (2018). The language of abortion: time to terminate TOP: FOR: Mandating TOP reduces research visibility and engenders stigma. *BJOG: An International Journal of Obstetrics & Gynecology*, *125*(9), 1065-1065. https://doi.org/10.1111/1471-0528.15137

Kavanaugh, M. L., Jerman, J., & Frohwirth, L. (2019). "It's not something you talk about really:" Information barriers encountered by women who travel long distances for abortion care. *Contraception*. https://doi.org/10.1016/j.contraception.2019.03.048

Kelly, K. (2014). Evangelical underdogs: Intrinsic success, organizational solidarity, and marginalized identities as religious movement resources. *Journal of Contemporary Ethnography*, *43*(4), 419-455. https://doi.org/10.1177/0891241613516627

Kuhn, T. (2006). A 'demented work ethic' and a 'lifestyle firm:' Discourse, identity, and workplace time commitments. *Organization Studies*, *27*(9), 1339-1358. https://doi.org/10.1177/0170840606067249

Larson, G. (2017). Identification, organizational. In C. R. Scott & L. Lewis (Eds.), *The International Encyclopedia of Organizational Communication* (Vol. 1-4). John Wiley & Sons.

Leonard, T. M. B. (2017). Laying the foundations for a reproductive justice movement. In L. J. Ross, E. Derkas, W. Peoples, L. Roberts, & P. B. Toure (Eds.), *Radical reproductive justice: Foundation, theory, practice, critique* (pp. 39-49). Feminist Press at CUNY.

Lilith Fund. (2020, April 23). *What the #$%! just happened?* [Webinar].

Littlefield, A. (2021, February 23). *As the pandemic raged, abortion access nearly flickered out*. The Nation. https://www.thenation.com/article/society/abortion-access-covid-pandemic/

Massey, D. (2005). *For space*. Sage Publications.

Matsaganis, M. D., & Golden, A. G. (2015). Interventions to address reproductive health disparities among African-American women in a small urban community: The communicative construction of a "field of health action." *Journal of Applied Communication Research*, *43*(2), 163-184. https://doi.org/10.1080/00909882.2015.1019546

McGlone, M. S., & Batchelor, J. A. (2003). Looking out for number one: Euphemism and face. *Journal of Communication*, *53*(2), 251-264. https://doi.org/10.1111/j.1460-2466.2003.tb02589.x

McNamee, L. G. (2011). Faith-based organizational communication and its implications for member identity. *Journal of Applied Communication Research*, *39*(4), 422-440. https://doi.org/10.1080/00909882.2011.608697

McVeigh, R., Crubaugh, B., & Estep, K. (2017). Plausibility structures, status threats, and the establishment of anti-abortion pregnancy centers. *American Journal of Sociology*, *122*(5), 1533-1571.

Merelli, A. (2019, October 3). *How the Trump administration is changing the language of reproductive health*. Quartz. https://qz.com/1718372/the-language-of-reproductive-

health-is-changing-under-trump/

Molloy, K. A., & Foust, C. R. (2016). Work calling: Exploring the communicative intersections of meaningful work and organizational spirituality. *Communication Studies*, *67*(3), 339-358. https://doi.org/ 10.1080/10510974.2016.1148751

Morgan, D. L., Ataie, J., Carder, P., & Hoffman, K. (2013). Introducing dyadic interviews as a method for collecting qualitative data. *Qualitative Health Research*, *23*(9), 1276-1284. https://doi.org/10.1177/1049732313501889

Mountz, A., & Hyndman, J. (2006). Feminist approaches to the global intimate. *Women's Studies Quarterly*, *34*(1/2), 446-463.

Mumby, D. K. (2000). Common ground from the critical perspective: Overcoming binary oppositions. In S. R. Corman & M. S. Poole (Eds.), *Perspectives on organizational communication: Finding common ground*. The Guilford Press.

Murphy, M. (2012). *Seizing the means of reproduction: Entanglements of feminism, health, and technoscience*. Duke University Press.

Murphy, S. (2021, April 26). *Oklahoma governor signs 3 anti-abortion bills into law*. ABC News. https://abcnews.go.com/Health/wireStory/oklahoma-governor-signs-anti-abortion-bills-law-77324728

Najmabadi, S. (2021, February 1). *Republican lawmakers push to make Texas' anti-abortion laws among the most restrictive in the nation*. *The Texas Tribune*. https://www.texastribune.org/2021/02/01/texas-abortion-laws-legislature/

Nash, E., & Cross, L. (2021, April). *2021 is on track to become the most devastating antiabortion state legislative session in decades*. Guttmacher Institute. https://www.guttmacher.org/article/2021/04/2021-track-become-most-devastating-

antiabortion-state-legislative-session-decades

Nash, L. (2020). Performing place: A rhythmanalysis of the city of London. *Organization Studies*, *41*(3), 301-321. https://doi.org/10.1177/0170840618789161

Nathues, E., van Vuuren, M., & Cooren, F. (2004). Speaking about vision, talking in the name of so much more: A methodological framework for ventriloquial analyses in organization studies. *Organization Studies*. https://doi.org/10.1177/0170840620934063.

National Resource Center on Domestic Violence. (2021). *Reproductive justice, reproductive health and reproductive rights: A framework*. https://vawnet.org/sc/reproductive-justice-frameworks

NCJW. (2021). *Understanding reproductive health, rights, and justice: An NCJW primer.* National Council of Jewish Women. https://www.ncjw.org/wp-content/uploads/2017/12/RJ-RH-RR-Chart.pdf

Nelson, J. (2003). *Women of color and the reproductive rights movement.* New York University Press.

Olwig, K. R. (2001). Landscape as a contested topos of place, community, and self. In P. C. Adams, S. D. Hoelscher, & K. E. Till (Eds.), *Textures of place: Exploring humanist Geographies* (pp. 93-120). University of Minnesota Press.

Ostrach, B., & Cheyney, M. (2014). Navigating social and institutional obstacles: Low-income women seeking abortion. *Qualitative Health Research*, *24*(7), 1006-1017. https://doi.org/10.1177/1049732314540218

Papa, M. J., Daniels, T. D., & Spiker, B. K. (2008). *Organizational communication: Perspectives and trends*. Sage Publications.

Phillips, J. W. P. (2006) Agencement/assemblage. *Theory, Culture & Society*, *23*(2-3), 108-109. https://doi.org/10.1177/026327640602300219

Planned Parenthood. (2021). *Abortion*. https://www.plannedparenthood.org/learn/abortion

Pratt, G., & Rosner, V. (2006). Introduction: The global & the intimate. *Women's Studies Quarterly*, *34*(1-2), 13-24.

Putnam, L. L., & Mumby, D. K. (Eds.). (2013). *The SAGE handbook of organizational communication: Advances in theory, research, and methods* (3rd ed). Sage Publications.

Putnam, L. L., & Nicotera, A. M. (Eds.). (2009). *Building theories of organization: The constitutive role of communication*. Routledge.

Putnam, L. L. (2019). Constituting order and disorder: Embracing tensions and contradictions. In C. Vásquez & T. Kuhn (Eds.), *Dis/organization as communication: Exploring the disordering, disruptive and chaotic properties of communication* (pp. 17-35). Routledge.

Railsback, C. C. (1984). The contemporary American abortion controversy: Stages in the argument. *Quarterly Journal of Speech*, *70*(4), 410-424. https://doi.org/10.1080/00335638409383707

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (Eds.). (2013). *Qualitative research practice: A guide for social science students and researchers*. Sage Publications.

Rose, G. (1993). *Feminism & geography: The limits of geographical knowledge*. University of Minnesota Press.

Ross, L. J., & Solinger, R. (2017). *Reproductive justice: An introduction* (Vol. 1). University of California Press.

Ross, L. J. (2017). Trust Black women: Reproductive justice and eugenics. In L. Ross, E. Derkas, W. Peoples, L. Roberts, & P. B. Toure (Eds.), *Radical reproductive justice:*

Foundation, theory, practice, critique (pp. 58-85). Feminist Press at CUNY.

Russo, N. F., & Steinberg, J. R. (2012). Contraception and abortion: Critical tools for achieving reproductive justice. In J. C. Chrisler (Ed.), *Reproductive justice: A global concern* (pp. 145-172). ABC-CLIO.

Schoeneborn, D., & Blaschke, S. (2014). The three schools of CCO thinking: Interactive dialogue and systematic comparison. *Management Communication Quarterly, 28*(2), 285-316. https://doi.org/10.1177/0893318914527000

Schoeneborn, D., Kuhn, T. R., & Kärreman, D. (2019). The communicative constitution of organization, organizing, and organizationality. *Organization Studies*, *40*(4), 475-496. https://doi.org/10.1177/0170840618782284

Schoeneborn, D., & Vásquez, C. (2017). Communicative constitution of organization. In C. R. Scott & L. Lewis (Eds.), *The International Encyclopedia of Organizational Communication* (Vol. 1-4). John Wiley & Sons.

Scott, J. A. (2007). Our callings, our selves: Repositioning religious and entrepreneurial discourses in career theory and practice. *Communication Studies*, *58*(3), 261-279. https://doi.org/10.1080/10510970701518363

Sethna, C., & Doull, M. (2013). Spatial disparities and travel to freestanding abortion clinics in Canada. *Women's Studies International Forum*, *38*, 52-62. https://doi.org/10.1016/j.wsif.2013.02.001

Shalev, C. (1998, March 18). *Rights to sexual and reproductive health – the ICPD and the Convention on the Elimination of All Forms of Discrimination Against Women.* United Nations. https://www.un.org/womenwatch/daw/csw/shalev.htm

SisterSong. (2021). *Reproductive justice.* https://www.sistersong.net/reproductive-justice

Smith, A. (2005). Beyond pro-choice versus pro-life: Women of color and reproductive justice. *NWSA Journal*, *17*, 119-140.

Solinger, R. (2007). *Pregnancy and power: A short history of reproductive politics in America*. NYU Press.

Stephens, K. K. (2017). Adapting and advancing organizational communication research methods: Balancing methodological diversity and depth, while creating methodological curiosity. In P. J. Salem & E. Timmerman (Eds.), *Transformative practice and research in organizational communication* (pp. 151-167). IGI Global.

Swartzendruber, A., & Lambert, D. (2018). *Crisis pregnancy center map*. http://www.crisispregnancycentermap.com

Mohanty, C. T. (2003). *Feminism without borders*. Duke University Press.

Tan, T., & Leal, R. (2012, August 24). *Photo essay: Women's health issues along the border*. *The Texas Tribune*. https://www.texastribune.org/2012/08/24/documenting-womens-health-along-the-border-/

Taylor, B. C., & Trujillo, N. (2001). Qualitative research methods. In F. M. Jablin & L. L. Putnam (Eds.), *The new handbook of organizational communication: Advances in theory, research, and methods* (pp. 161-194). Sage Publications.

Taylor, J. R., & Van Every, E. J. (2000). Communication as coorientation. In J. R. Taylor, & E. J. Van Every (Eds.), *The emergent organization: Communication as its site and surface* (pp. 33-68). Lawrence Erlbaum.

Thomsen, C. (2013). From refusing stigmatization toward celebration: New directions for reproductive justice activism. *Feminist Studies*, *39*, 149-158.

Thomsen, C. (2015). The politics of narrative, narrative as politic: Rethinking reproductive justice frameworks through the South Dakota abortion story. *Feminist Formations*, *27*(2) 1-26. https://doi.org/10.1353/ff/2015.0023

Tonn, M. B. (1996). Donning sackcloth and ashes: *Webster v. Reproductive Health Services* and moral agony in abortion. *Communication Quarterly*, *44*(3), 265-279. https://doi.org/10.1080/01463379609370017

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837-851. https://doi.org/10.1177/1077800410383121

Tracy, S. J., & Trethewey, A. (2005). Fracturing the real-self↔ fake-self dichotomy: Moving toward "crystallized" organizational discourses and identities. *Communication Theory*, *15*(2), 168-195. https://doi.org/10.1111/j.1468-2885.2005.tb00331.x

Tracy, S. J. (2019). *Qualitative research methods: Collecting evidence, crafting analysis, communicating impact*. John Wiley & Sons.

Tracy, S. J. (2021, January 8). *Intermediate coding and interpretation methods in qualitative research*. [Webinar].

Trethewey, G. E. A., & Ashcraft, K. L. (2004). Special issue introduction: Practicing disorganization: The development of applied perspectives on living with tension. *Journal of Applied Communication Research*, *32*(2), 81-88. https://doi.org/10.1080/0090988042000210007

Tuan, Y. F. (1977). *Space and place: The perspective of experience*. University of Minnesota Press.

Tuma, M. (2021, April 30). *Local legal leaders come out swinging against anti-abortion bills*. *The Austin Chronicle*. https://www.austinchronicle.com/daily/news/2021-04-30/local-

legal-leaders-come-out-swinging-against-anti-abortion-bills/

Tuma, M. (2015, April 17). *Millions for propaganda … nothing for women's health*. *The Austin Chronicle*. https://www.austinchronicle.com/news/2015-04-17/millions-for-propaganda-nothing-for-womens-health/

United Nations Population Fund. (2009). *Comprehensive reproductive health care*. https://www.publichealth.columbia.edu/sites/default/files/pdf/fs_crhc.pdf

Vasilyeva, A. L., Robles, J. S., Saludadez, J. A., Schwagerl, C., & Castor, T. (2020). The varieties of (more or less) formal authority. In N. Bencherki, F. Matte, & F. Cooren (Eds.), *Authority and power in social interaction: Methods and analysis* (pp. 37-55). Routledge.

Vásquez, C. (2016). A spatial grammar of organising: Studying the communicative constitution of organisational spaces. *Communication Research and Practice*, *2*(3), 351-377. https://doi.org/ 10.1080/22041451.2016.1221686

Vásquez, C., Bencherki, N., Cooren, F., & Sergi, V. (2018). From 'matters of concern' to 'matters of authority': Studying the performativity of strategy from a communicative constitution of organization (CCO) approach. *Long Range Planning*, *51*(3), 417-435. https://doi.org/10.1016/j.lrp.2017.01.001

Vásquez, C., & Cooren, F. (2013). Spacing practices: The communicative configuration of organizing through space-times. *Communication Theory*, *23*(1), 25-47. https://doi.org/10.1111/comt.12003

Vásquez, C., Schoeneborn, D., & Sergi, V. (2016). Summoning the spirits: Organizational texts and the (dis)ordering properties of communication. *Human Relations*, *69*(3), 629-659. https://doi.org/10.1177/0018726715589422

Vasudevan, P. (2021). Brown scholar, Black studies: On suffering, witness, and materialist relationality. In B. Görkariksel, M. Hawkins, C. Neubert, & S. Smith (Eds.), *Feminist geography unbound: Discomfort, bodies, and prefigured futures* (pp. 27-47). West Virginia University Press.

Vickers, M. H. (2002). "People first—always": Euphemism and rhetoric as troublesome influences on organizational sense-making—A downsizing case study. *Employee Responsibilities and Rights Journal*, *14*(2), 105-118.

Wainwright, J., & Bryan, J. (2009). Cartography, territory, property: Postcolonial reflections on indigenous counter-mapping in Nicaragua and Belize. *Cultural Geographies*, *16*(2), 153-178. https://doi/org/ 10.1177/1474474008101515

Weitz, T. A., & Kimport, K. (2015). The discursive production of abortion stigma in the Texas ultrasound viewing law. *Berkeley Journal of Gender, Law & Justice*, *30*, 6-21.

West, R. (2008). From choice to reproductive justice: de-constitutionalizing abortion rights. *Yale Law Journal*, *118*, 1394-1432.

White, K., Potter, J. E., Stevenson, A. J., Fuentes, L., Hopkins, K., & Grossman, D. (2016). Women's knowledge of and support for abortion restrictions in Texas: Findings from a statewide representative survey. *Perspectives on Sexual and Reproductive Health*, *48*(4), 189-197. https://doi.org/10.1363/48e8716

Whitesell, D. K., & Faria, C. V. (2020). Gowns, globalization, and "global intimate mapping": Geovisualizing Uganda's wedding industry. *Environment and Planning C: Politics and Space*, *38*(7-8), 1275-1290. https://doi.org/10.1177/2399654418821133

Wieland, S. M. B. (2010). Ideal selves as resources for the situated practice of identity. *Management Communication Quarterly*, *24*(4), 503-528.

https://doi.org/10.1177/0893318910374938

Wilhoit, E. D. (2016). Organizational space and place beyond container or construction: Exploring workspace in the communicative constitution of organizations. *Annals of the International Communication Association*, *40*(1), 247-275. https://doi.org/10.1080/23808985.2015.11735262

Wilhoit, E. D., & Kisselburgh, L. G. (2019). The relational ontology of resistance: Hybridity, ventriloquism, and materiality in the production of bike commuting as resistance. *Organization*, *26*(6), 873-893. https://doi.org/10.1177/1350508417723719

Wilson, M. W. (2017). *New lines: Critical GIS and the trouble of the map*. University of Minnesota Press.

World Health Organization. (2021). *Reproductive health*. https://www.who.int/westernpacific/health-topics/reproductive-health

Zoom Video Communications Inc. (2021). *Closed captioning and live transcription*. https://support.zoom.us/hc/en-us/articles/207279736-Getting-started-with-closed-captioning

APPENDIX A

INTERVIEW PROTOCOL

1. Warm-Up Questions (*Questions related to organizational identification and identity*)
   - What is the official name of your position?
   - Tell me about your position. What are your responsibilities?
   - When did you start working at [insert organization here]?
   - Why did you choose to work at [insert organization here]?
   - What are three words you would use to describe [insert organization here]?
   - What do you like about [insert organization here]? What do you dislike?
   - How do you describe the goals of [insert organization here]?
   - What services and/or resources does [insert organization here] offer?

2. General Questions (*Questions about reproductive healthcare disparity and access*)
   - Some people use reproductive health(care) and women's health(care) interchangeably. Do you identify differences between the two? If so, what differences?
   - How does [insert organization here] define reproductive health(care)?
   - What are some issues related to reproductive health(care) in your community?
     - What are some issues related to reproductive health(care) in your community that are priorities of [insert organization here]?
   - Sometimes people feel like they cannot get the care they need because they are disadvantaged in some way. Can you tell me about the types of barriers you notice that keep some folks from using the services [insert organization here] provides?
   - What is being done or needs to be done to help with access to reproductive health(care) in your area/community?
   - How does [insert organization here] talk about issues or initiatives related to reproductive health(care) access?

   - *COVID-19*
     - How has COVID-19 altered the ways in which you deliver care to your community?
     - How has COVID-19 changed the way you communicate about care to your community?
     - How have your organizational practices changed at [insert organization here] since COVID-19?
     - How has your position as [insert position here] changed—or evolved—since COVID-19?
     - What, if anything, has COVID-19 brought to your attention about reproductive health(care) (1) in your community and (2) in general?

3. Debriefing Questions (*Summative questions*)
   - How do your views on issues of disparity and access compare to what you understand [insert organization here]'s position to be?

- How is [insert organization here] involved in the larger community?
- We talked about how you understand reproductive health(care) and how [insert organization here] defines reproductive health(care). How do your understandings and the [insert organization here]'s understandings relate and differ?

4. Closing Questions
   - Is there anything that we have not discussed that you think would be important to add to our conversation?
   - Before we end this interview, is there anything you would like to ask me?

APPENDIX B

RECRUITMENT E-MAILS

1. Recruitment e-mail to reproductive rights, justice, health organizations

My name is Rebecca Costantini, and I am currently writing my dissertation at Texas A&M University on the ways that reproductive healthcare organizations contribute to reproductive healthcare awareness within their local communities (and beyond). I am also interested in how volunteers and employees talk about their work. Ultimately, the research presented in my dissertation underscores several urgent issues related to reproductive healthcare.

I would very much like to speak with someone at your organization about my dissertation project and the possibility of interviewing volunteers and workers about their understandings of reproductive healthcare. If a representative has availability then or during these next few weeks, I would be happy to delve deeper into the goals and practical implications of my dissertation, as well as my credentials and any other background information.

2. Revised recruitment e-mail to CPCs

My name is Rebecca Costantini, and I am currently writing my dissertation at Texas A&M University on organizations that provide a spectrum of care for pregnant women within their local communities. I am interested in how volunteers and employees talk about their work.

I would very much like to speak with a representative about my dissertation project and the possibility of (virtually) interviewing volunteers and employees from your organization. I would be happy to delve deeper into the goals and practical implications of my dissertation, as well as my credentials and any other background information.

3. Original recruitment e-mail to CPCs

My name is Rebecca Costantini, and I am currently writing my dissertation at Texas A&M University on the ways that reproductive healthcare organizations and nonprofit pregnancy clinics contribute to reproductive healthcare awareness within their local communities (and beyond).

I would very much like to speak with you about my dissertation project and the possibility of interviewing volunteers and employees from your organization about their understandings of reproductive healthcare.

If you have some availability during these next few weeks, I would be happy to delve deeper into the goals of my dissertation, as well as my credentials and any other background information, via a virtual meeting or phone call.

APPENDIX C

IRB INFORMATION SHEET

Title of Research Study: The Constitution of Reproductive Health(care): Understanding the Communicative Tensions of Organization, Identity, and Geography

Investigator: Rebecca Costantini, Doctoral Candidate; Dr. Anna Wolfe, Assistant Professor

Funded/Supported By: This research is supported by Texas A&M University. This project has not received internal funding from Texas A&M University of any other external sources.

Why are you being invited to take part in a research study?
You are being asked to participate because you are a current or former full- or part- time worker or volunteer at an organization that supports reproductive healthcare aged 18+.

What should you know about a research study?

- Someone will explain this research study to you.
- Whether or not you take part is up to you.
- You can choose not to take part.
- You can agree to take part and later change your mind.
- Your decision will not be held against you.
- You can ask all the questions you want before you decide.

Who can I talk to?
If you have questions, concerns, or complaints, or think that the research has hurt you, you may contact Principal Investigator Anna Wolfe if you have a concern or complaint about this research at annawolfe@tamu.edu. You may also contact Rebecca Costantini at costantinir@tamu.edu.

This research has been reviewed and approved by the Texas A&M Institutional Review Board (IRB). You may talk to them at 1-979-458-4067, toll free at 1-855-795-8636, or by email at irb@tamu.edu, if

- You cannot reach the research team.
- Your questions, concerns, or complaints are not being answered by the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

Why is this research being done?
Reproductive health(care) is a contentious issue, one that is barred, limited, and regulated across the United States. There is empirical evidence that reproductive health(are) access is impacted by stigma, socioeconomic disparity, and one's geographic location. However, Communication scholarship—specifically organizational communication—has yet to draw from these issue areas

to understand the spatial and communicative implications of organizations that support reproductive health(care), their identities, and whether placeness is intentional.

For these reasons, this dissertation seeks to understand how space and place matter in the context of understanding how organizations and organizational affects are situated in particular ways. This project also focuses on problems of organizing and identity-building in the context of reproductive health(care) by utilizing spatial analysis and critical-qualitative methodologies. It also analyzes problems related to reproductive health(care) by considering how spatial and organizational practices converge. Additionally, this dissertation project explores geographic questions of where organizations that support reproductive health(care) are located, why they are there, and the implications of accessing care.

How long will the research last?
We expect that you will be in this research study for approximately 30-60 minutes. The length of the interview may vary, as it is self-paced, but should take no longer than an hour.

How many people will be studied?
We expect to enroll about 30 people in total in this research study.

What happens if I say "Yes, I want to be in this research"?
If you say "yes" to participating in this study, you are agreeing to participate in a 30-60-minute interview session that will involve discussing your organization, your role at your organization, and how you understand reproductive health(care).

- Participants will be contacted by Rebecca Costantini to schedule an interview.
- All interview will be conducted virtually via collaborative chat platform, such as Skype or Zoom, during April-July 2020.
- The interview will be audio/video recorded and transcribed to ensure all participants will be quoted accurately.
- The interviews will be divided into the following sections: (1) warm-up questions (e.g., "Tell me about yourself"); (2) general questions related to reproductive health(care) and your understandings of reproductive health(care); (3) debriefing questions; (4) closing questions.

Participants will have the ability to assign themselves pseudonyms to protect their identities. No identifiable information will make it possible to connect you with the interview recordings. Your identity will be kept confidential.

What happens if I do not want to be in this research?
You can leave the research at any time and it will not be held against you.

What happens if I say "Yes", but I change my mind later?
You can leave the research at any time and it will not be held against you.

Is there any way being in this study could be bad for me?
Although the researchers have tried to avoid risks, you may feel that some interview questions

may be too personal. You do not have to answer anything you do not want to. Responses will remain confidential.

Will being in this study help me in any way?
We cannot promise any benefits to you or other from your taking part in this research. However, this study may offer opportunities to think introspectively about how you conceptualize reproductive health(care) access, disparity, and what it means to you (a) as an individual and (b) employee/volunteer of your organization. The study may also prompt you to reevaluate current understandings of reproductive health(care) and uptake new perspectives of how reproductive health(care) is considered within your organization and its larger community.

What happens to the information collected for the research?
Efforts will be made to limit the use and disclosure of your personal information, including research study and other records, to people who have a need to review this information. We cannot promise complete privacy. Organizations that may inspect and copy your information include the TAMU HRPP/IRB and other representatives of this institution.

All records of this study will be kept private. No identifiers linking you to this study will be included in any report that might be published. Research records will be stored securely, and only Rebecca Costantini will have access to the records.