"I'm just saying:" Multivocal Organizing in a Community Health Initiative

Annis Grover Golden
University at Albany, State University of New York
agolden@albany.edu

Nicolas Bencherki
Université TÉLUQ
nicolas.bencherki@teluq.ca

A more recent version of this chapter has been published as:

Golden, A. G., & Bencherki, N. (2022). "I'm just saying": Multivocal organizing in a community health initiative. In C. Benoit-Barné & T. Martine (Eds.), *Speaking with one voice: Multivocality and univocality in organizing* (pp. 41–64). Routledge. https://doi.org/10.4324/9780429297830-3

There is a growing acknowledgement that organizations are not unitary entities and that they comprise a plurality of concerns and interests. This symphonic view of organizations has been referred as "plurivocal" or "multivocal" (e.g., Aggerholm et al., 2012). The coexistence of multiple voices has mostly been viewed as a challenge, for instance by multiplying ethical stances or taking strategic planning in divergent directions (Hautz et al., 2017; van Oosterhout et al., 2004). For community-based organizations (CBOs), which serve diverse populations, strive for inclusive decision-making processes, and deal with contradictory expectations from donors and other stakeholders, the challenges of multivocity may be even sharper (James, 2003; McAllum, 2014). In that sense, multiplicity among CBOs has been studied as so many tensions that impede their work and that must be resolved (Ganesh & McAllum, 2012; Sanders, 2012).

However, there is evidence that multiple voices are not anomalies in an otherwise univocal and smooth organizing process. On the contrary, organizations are constituted and are able to act thanks to the way voices combine (Cooren, 2012; Cooren & Sandler, 2014). This reversal of multiplicity's part in organizing highlights that the symphony of voices is something that organizational members, as individuals, actively and reflexively *enact*, rather than simply arising from the sum of juxtaposed bodies with different interests, concerns and opinions.

Building on these insights, our study looks in more detail at how multiple voices are uttered (including by a single person), how they are interactionally managed, and what organizing effects stem from the interactions. To do so, we follow a version of discourse analysis that considers language as a medium for interaction (Alvesson & Kärreman, 2000; Potter & Wetherell, 1987) to look at data from the Women's Health Project (WHP), a community-based participatory research project focused on health promotion in a small, racially and ethnically diverse urban population center in New York State. The project's purpose was to identify effective strategies for encouraging underserved, minority women to obtain recommended reproductive health screenings (focusing on breast and cervical cancer) toward the goal of eliminating documented disparities between African American and European American women's

reproductive health. A key development was the spontaneous emergence of a group of community residents who encouraged their friends and neighbors to connect with the outreach efforts of the WHP's research team and its local partner organizations. This led the WHP to add to its intervention activities a "peer health advocate" initiative. Five local women who had displayed interest in WHP by attending community events and interacting with staff during outreach were hired by the Project and received training on outreach techniques and reproductive health information. The peer team then took the lead on community outreach, with the WHP capitalizing on their ability to shift between clinical and community voices. Thus, multivocity became a constitutive feature of the organization and its mission of increasing awareness of the need for obtaining preventive reproductive healthcare services and the available options for doing so in this community.

Drawing on recordings of team meetings that included the peer health advocates and the first author, who acted both as a researcher and Project Director, we look for the interactional details through which the women performed multivocity, and in so doing instantiated the WHP's liminal situation between fields of activity. First, we revisit scholarship on multivocity in organizational contexts, with special attention to non-profits. We argue that multiple voices are frequently seen as problematic issues to be managed, rather than, as some other research suggests, a driver of organizing and of organizational action. We elaborate a view of multivocity with more complexity than just the expression of conflicting individual preferences. Building on these insights, we describe our analytic approach to a recorded team meeting that typifies multivocal performances and issues. After presenting our analysis, we consider how thinking of multivocity as something people concretely do within their utterances may help extend current literature on voices in organizational settings, and may provide practical insights on the workings of non-profits in marginalized communities.

Multiple Voices in Community-based Organizations

Multiple voices coexisting in an organization have commonly been viewed as a complication when contrasted with simpler, univocal situations, with some authors describing organizations as political

arenas where people wrangle to reconcile their diverging viewpoints (Crozier & Friedberg, 1980; Mintzberg, 1983). More specifically, the strategy literature deems that including more people in the planning process poses "risks and costs" (Hautz et al., 2017, p. 301), while business ethics scholars reluctantly realize that finding a single, unified theory to identify the "right" thing to do is illusory, and that instead multiple ethical voices must be listened to (van Oosterhout et al., 2004).

Community-based organizations are particularly faced with the challenge of giving a voice to diverse individuals, since they often serve populations whose voices have been muted, such as disabled, poor or otherwise marginalized people (Chaney & Fevre, 2001). Organizations have therefore had to encourage participation from those marginalized groups, including by innovative means such as artistic projects (Eynaud et al., 2018; Wang & Burris, 1997). Consistent with these goals, they also aspire to be inclusive organizations that extend decision-making to employees but also to beneficiaries and community members (Jäger & Kreutzer, 2011). Non-profits must therefore articulate multiple voices across organizational boundaries when it comes to their governance, as they are stewards to the combined interests of their beneficiaries, volunteers, donors, formal members and directors (Lewis, 2005), in addition to coordinators of their workers' and beneficiaries' multiple identities (Meisenbach & Kramer, 2014). Moreover, some organizations must deal with multilingual contexts where the issue of brokering between voices becomes quite literal (Bencherki et al., 2016).

An additional manner in which community-based organizations and non-profits must attend to multiple voices has to do with the necessity for them to establish partnerships with other organizations to fulfill their missions as well as their position between several fields of activity. Through working with other organizations, community-based organizations may form a new, collective identity that transcends any single organization (Koschmann et al., 2012). Community-based organizations also have the duty to work for and with diverse people, including in terms of ethnicity (Henry & Pringle, 1996) and sexual identity (Bell et al., 2011).

In the context of health promotion, one strategy preferred by CBOs in dealing with diverse populations, as well by government agencies, is to employ community health workers recruited from and trained among target populations to disseminate information, thus placing these people in a middle position, between the service providers and the community (Arvey & Fernandez, 2012; Balcazar et al., 2011). However, studies on community health workers have, for the moment, mostly been concerned with the *outcomes* of initiatives employing such workers, without much attention to *how* they communicatively manage their middle position.

Towards a View of Multiple Voices as Constitutive of Organizational Action

As an alternative to the "multiplicity as a challenge" perspective, some authors suggest that multiplicity is a constitutive feature of organizations, as well as of individuals, including organizational members (Bencherki, 2017; Cooren, 2006). This suggestion builds on Bakhtin's (1986) conception of polyphony, meaning that each utterance, text or communicative event already comprises multiple voices (Belova et al., 2008; Cooren & Sandler, 2014). A polyphonic lens recognizes that an organization's multiple voices do not fragment its alleged unity, but that they participate in constituting organizational reality. This could mean, for community-based organizations, that a multiplicity of voices might be more productively viewed as an asset for organizing and for people to accomplish their various goals. Indeed, from a communication perspective, apparently contradictory voices may be seen as "productive" or "collaborative tensions," as people interact to handle seemingly opposing imperatives (Lewis et al., 2010). In fact, in some organizations, members may even "cultivate" and reaffirm tensions that help them get on with their work (Matte & Cooren, 2015).

This cultivation is possible because tensions do not merely result from two opposing abstract forces; they are discursive performances, in which various expectations in terms of goals, values or other principles materialize through speech and writing and are thus assessed against each other (Cooren et al., 2013). Whether these contradictory imperatives constitute a tension or not depends on *how* these demands are formulated initially, as well as *how* people invoke them again as relevant when they engage together

in collective action. Thus, a community-based organization's strategy may stem from the way multiple voices are mingled, in order to shape a program of action that cannot be reduced to any single person's preference. Moreover, previous research suggests that organizational reality materializes through the integration of voices from multiple people, but also through the co-existence of voices in a single person's utterance (Cooren et al., 2015) .

However, while the literature that bears upon multivocity in organizational settings has studied the potentially conflicting *suggestions* of different voices – voices can "suggest," "warn," or "guide" people to do something or against doing it (Cooren & Taylor, 1997) – it has offered us less in terms of extended discourse analyses of situated interactions in which not only discreet ideas or interests are expressed, but in which voices coalesce to display different genres of talk and to constitute and invoke discursive communities. Such an analysis, which we offer here, attends both to the suggestions that the voices make as well as the sequential way in which they are organized and the language they use. The same suggestion may be expressed in different ways by different voices, as is the case for the Women's Health Project. Indeed, similar "suggestions" concerning reproductive health – for instance, that women consult with their local health provider – must be expressed in different voices, each with their own vocabulary, tone and other discursive features. For women in underserved communities to be persuaded to obtain recommended health services, then, health information must not be provided in a voice associated with the medical establishment, which African American women may be particularly mistrustful of (Holloway, 2011), but in a community voice. This entails challenges for the peer health advocates, as they work at bridging a communication disjuncture between community residents and local service providers. At the same time, they must also strive to preserve the WHP's credibility as a fledgling CBO , functioning within a community of organizations, and their own credibility as organizational members. To understand how the peers navigated these tensions through their communicative performances, we next provide further background on the case and our data collection, before turning to our analysis of the peers' talk in interaction.

Studying Multivocal Discourse

Case Setting

The Women's Health Project was initiated with funding from the National Institutes of Health as a community-based participatory research project in a smaller, racially and ethnically diverse urban population center north of New York City. The project's immediate goal was to identify effective strategies for bridging a communicative disjuncture that local health and human service organizations had identified to the first author as existing between themselves and underserved, minority community residents. The ultimate goal was to increase the uptake of available reproductive health services, with a particular focus on lower income African American women, toward the end of reducing documented health disparities.

The Project's initial strategy for bringing together residents and CBOs consisted primarily of health education and resource fairs where women could meet with organization representatives in neighborhood locations they were comfortable with. Of interest to us here is that, after approximately 18 months of community events organized by the research team in collaboration with CBOs, the WHP recruited women from the community as "peer health advocates," who took over some of the organization's community outreach activities and relayed information to their peers. The women who were recruited were identified because of their regular attendance at WHP events and their proactiveness in encouraging their fellow community members to interact with the research team and CBOs. While employing community health workers is a common strategy in health information dissemination initiatives, the WHP inverted the typical trajectory. Instead of first training individuals and then sending them off to the community, the project recruited women directly from the community, but focused on individuals who had already displayed a keen interest in reproductive health and proven their leadership among their peers; then it provided them with training on reproductive health information, offered by a well-established women's health organization, referred to here as Women's Health Services.

The first author audio recorded several team meetings in this phase of the project as part of documenting its workings as they developed over time. At the time, these recordings were not made with a specific research question in mind. Over time, however, the first author identified as a recurring issue how the peer health advocates communicatively constructed their roles as members of this organization who were also members of the community, a matter with both practical and theoretical implications. The team meeting we focus on here took place immediately after one of the training sessions.

The recordings were initially transcribed using a reduced transcription scheme. After selecting the segment we focus on in our analysis, additional details were added, adapted from the transcription system suggested by Jefferson (2004), in the interest of providing readers with a clearer sense of the interaction.

Data Analysis Strategy

Given our interest in *how* peer health advocates express multiple voices, the analysis we present below is informed by the version of discourse analysis articulated by Potter and Wetherell (1987), and described by Alvesson and Karreman (2000) as viewing language as "a medium for interaction," and thus analyzing discourse in search of "what people do with language in specific social settings" (p. 1127). Wetherell and Potter (1988) underscore that individuals use discourse "constructively," meaning that "discourse has an action orientation: it has practical consequences" (p. 171). Consistent with a constitutive view of communication, this means that we do not only view discourse as an expression of opinions or cognitive states, but also as action, in the sense that what people say informs, suggests, warns, etc. other participants, thus in turn altering their own action (Cooren, 2010, 2015). Each discursive action's performance and each reaction to it is guided by prior turns of talk that cumulatively form the next turn's context, thus gradually constituting an organized social order that informs people's action (see Bencherki et al., 2016). Our analytical orientation to action is important as it clarifies that we are interested in the performative effect of talk, and that what words mean is witnessable in other participant's reaction to them.

Our approach to analyzing the peer health advocates' discourse is also guided by the insider/outsider team research approach to organizational inquiry described by Bartunek (2008). In this approach insiders are defined as "the individuals for whom the personally relevant social world is under study . . . who hope to understand and act more effectively in the setting" (p. 4). Insiders are typically organizational practitioners, and outsiders are academic researchers, though Bartunek acknowledges the possibility of more complex combinations of statuses. Indeed, in our situation the first author, Annis, has a dual status of "insider" who is also an "outsider" or academic researcher, as is typical in community-based participatory research. She is an insider for the purposes of this analysis by virtue of being the Project Director for the organizational entity we focus on, while at the same time, she is an outsider to the community of local residents and the community of local health and human service organizations by virtue of her status as a university professor. Nicolas, the relative "outsider," accepted an invitation to collaborate on this analysis of field data and theorizing about the results, given the project's congruence with his own methodological commitments and longstanding interest in community-based organizations.

The collaboration entailed a requirement on Annis's part to narrate to Nicolas the history of the Project and create ethnographic context for the communicational event we focus on here. This has provided a means for Annis to surface what might otherwise have remained taken for granted. The insider/outsider status of researchers thus enriches researcher reflexivity for both the insider and the outsider; moreover, given the focus of this particular analysis, the productive tensions between insider and outsider perspectives served as a sensitizing device insofar as the dual hats of the researchers mirror the dual hats of the "research participants" (i.e., the peer health advocates).

Our joint discussion concerning the Project's history and Annis' experience as its Director helped us construct an ethnographic narrative of in which Annis's perceptions of the challenges were defined: she saw the "problems" of the WHP as twofold and interrelated. First, she identified a challenge with managing multivocity on the part of the peer health advocates that had to do with balancing their community-specific ways of understanding and talking about health information – an asset to them in

interacting with other women in the community – with the need to convey information in a way that was nonetheless accurate.. Second, a longer-range problem concerned the survival of this organizational entity given its liminal position between the community and health-related CBOs and its resource uncertainties. We focus here primarily on the former problem, though the success with which this problem is managed has implications for the latter, since it impacts the way in which the local community of CBOs views the WHP.

Following the definition of the relevant problems, Annis identified the segment of a team meeting we focus on here as being of particular interest in this regard. She chose the segment because it was typical of interactions involving peer health advocates while also capturing a key moment in the WHP's trajectory, as it consists of a debriefing session immediately following a training session the peers received from a healthcare provider partner organization.

As the two collaborators discussed this particular interaction, the notion of multivocity was found to provide a productive lens for viewing the communicative practices of the meeting participants. Working together, the co-authors' analysis of the meeting segment proceeded through a series of sessions characterized by tacking back and forth between the specifics of the performances of the actors in this particular social context, forms of discursive practices identified in the literature on discourse analysis, the broader ethnographic context of the communicational event, and implications for the "problems" identified above. Throughout this process, the second author's sensemaking frequently invited the first author to "open up" her experientially informed interpretations of the data, in an iterative process.

Managing Multivocity

The post-training debriefing session that we analyze here consists of discussion among the team members following a session that focused on contraceptive techniques, and the relationship between pregnancy prevention and the prevention of sexually transmitted infections. The peers were asked by the Project Director to identify information that they were provided during a training session earlier in the day

which they found particularly important and would like to pass along to other community residents. As they select information to discuss, and articulate their understandings of the information provided by the trainers, the peers interactionally work through, with one another and with the Project Director (Annis) and the Field Coordinator, the central "facts" of the topics, and their significance, particularly within the context of their own community. Of relevance is the fact that Annis is a white, middle-aged university professor, and the Field Coordinator is an older African American woman, retired from a position managing a publicly funded reproductive healthcare clinic and currently an assistant pastor in a local church. The five peer health advocates are African American women between 35 and 55 years old who are, as noted earlier, from the local community. The session was audiorecorded with the peers' consent.

The multivocity displayed in this event provides a window into an essential quality of this organizational entity and a fundamental challenge it faces: balancing the requirement for cultural competency in communicating with residents with the need to ensure that accurate health information is transmitted and that an organizational identity consistent with other, more established, community based health and human service organizations' understandings of formal organizational membership is enacted.

Our analysis identified three modes in which the peer health advocates' discourse displayed and managed multivocity: *discursive positioning* in relation to present and absent others (Davies & Harré, 1990), *presentifying* contexts from outside the social context of the meeting (in the sense of Benoit-Barné & Cooren, 2009), and voicing multiple *discursive genres* (see Cornut et al., 2012). We identify instances of multivocity both within and between individual participants in the discussion, as the interaction among the peers unfolds, moderated by the Project Director. Given our space constraints here, we focus primarily on the peer health advocates, but we note that the Project Director also engages in these multivocal performances to balance her relational requirements with the other organizational members with organizational goals; that is, her recognition of the need to interact with community residents in a respectful, culturally competent manner, yet also convey accurate health information.

For each mode, we first describe the performance itself; we then illustrate it with discourse from the debriefing session; we explain how the specific discourse functions as an instance of this type of performance; and we discuss the effects the performance produces vis-à-vis productively managing tensions between multivocity and univocity. We present the modes in the order in which they are displayed in the group interaction.

Discursive Positioning in Relation to Present and Absent Others

One mode in which the peer health advocates' discourse displays and manages multivocity is *discursive positioning*. As defined by Davies and Harré (1990), this is "the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines" (p. 48). They identify two forms of positioning: *interactive positioning,* in which "what one person says positions another," and *reflexive positioning,* in which "one positions oneself" (p. 48). As peer health advocates who are both members of the community that the project seeks to serve, and members of the project staff, they position themselves in relation to others both present and absent from the actual scene of the team meeting.

To provide some additional context for the segment of discourse that exemplifies this mode of multivocity, Annis, in her role as Project Director, had opened the group discussion by asking the peer health advocates what they had heard in that day's training session that they thought would be "most important to pass along to other women." The discussion then turned to the topic of birth control, with Shirley specifically focusing on information that had been provided about the effectiveness of the intrauterine device, but noting that the male partner would still "need the condom on anyhow, cuz to prevent sexual transmitted diseases." Annis takes this opportunity to remind the group of one of the key takeaways from the training, namely that "contraception and disease prevention are not one in the same, you know? That a condom will do both, ideally, um, but, just because you have – an IUD is a really effective form of birth control but it doesn't give you any protection against sexually transmitted

diseases," a point that Shirley immediately aligns herself with by replying "None whatsoever." She then goes on to say:

1 Shirley: You know, some people feel like because they have them contraceptive (.) uh (.) uh (.)
2 uh (.) internally (.) that (.) uh (.) "oh <u>well</u> you know I can't get pregnant" but they're not
3 thinking about the risk.

Both forms of positioning identified by Davies and Harré are evident in this brief segment. With respect to reflexive positioning, Shirley positions herself as knowledgeable, specifically about the relationship between contraception and "risk" (of sexually transmitted infections). She makes a knowledge claim about sexual and reproductive health to the other members of the Project who are present in the field office for this discussion, who constitute the present others. She also reflexively positions herself as having knowledge of the other community residents, inferentially by virtue of being a community resident herself, and able to speak about what these absent others think and say. At the same time, she engages in interactive positioning, even though with absent others, positioning other community residents ("some people") as less knowledgeable than she is herself. Shirley literally speaks in both the voice of a trained peer health advocate and in the voice of the community as she drops into and then out of quoted speech, which is also performed in a different tonal registry.

These performances of discursive positioning produce powerfully significant effects vis-à-vis managing tensions between multivocity and univocity. While Shirley speaks in two voices, her discourse enacts univocity in relation to the organization's mission in the sense that she aligns with the single voice of the Project's overarching mission: to provide information related to reproductive health that community residents may be unaware of. Moreover, her multivocal discourse marks her dual status as a community resident and a Project member, yet this dual status is actually an essential aspect of the peer health advocate role within the Project and thus a performance of a unified organizational member role identity.

Presentifying the Community

A second mode in which the peer health advocates' discourse displayed and managed multivocity was through the discursive practice of presentification. Brummans and colleagues define this as "the ongoing process of making something or someone present in time and space … communication between agents allows 'us' or 'it' to be embodied or 'incarnated' in a certain way. […] The incarnation that enables presentification occurs through the interplay between spoken and written language (conversations, speeches, document, memos, posters), nonverbal language (gestures, symbols), context (circumstances, previous interactions) and materialities (costumes, buildings, desks, computers)" (Brummans et al., 2009, p. 57). In the segment below, which immediately follows the segment discussed above in the group discussion, we see Shirley collaborating with another peer health advocate, Mary, to presentify, in the setting of the team meeting, institutions, roles, and modes of social interaction from outside of this setting, which are connected to their community life. This excerpt is lengthier, since the effect produced depends in part on Mary's repeated contributions. In this excerpt from the team meeting, we focus on Mary's contributions to the discussion and notice how she functions as a sort of chorus, affirming Shirley's contributions (we have highlighted Mary's contributions to make the pattern easier to see in this textual representation of their discursive interaction).

1 Shirley: You know, some people feel like because they have them contraceptive (.) uh (.) uh (.) uh
2 (.) internally (.) that (.) uh (.) oh <u>well</u> you know I can't get pregnant but they're not
3 thinking about the risk.

4 Annis: Right. [Right.

5 Mary: [Yeah and] they need to think about the risk.

6 Shirley: =Yeah because it's <u>really</u> something else these days.

7 Mary: =Um-hum.

8 Annis: Yeah. So if people were only gonna do one thing

9 Shirley: That's not gonna work=

10 Mary: It sure ain't.

11 Shirley: You have to take both uh steps=

12 Mary: Um-hum-hmm?

13 Shirley: To protect yourself.

14 Annis: Ri:ght. But if people were only gonna u::se one thing=

15 Shirley: Just a condom, put on [a condom.

16 Annis: [=Yeah.

17 Shirley: Yes. And practice it.

18 Mary: Yeah.

19 Annis: It's like (.) it's so basic. And=

20 Mary: =Mm hmm=

21 Shirley: It is↑

22 Annis: You know.

23 Shirley: It's so simple to check it? ↑You put it on ↓your partner. You don't need him to put it on.

24 >↑You know how ↓to do that? <

25 Mary: =Yeah. Yes.

26 Shirley: ↑Put it on ↓there. Make sure it's (.) not (.) broken?

27 Mary: =Um-hum.

28 Shirley: And then uh whatever (.) and if he wantsomemore then take that one off and put another
29 one on and check it ↑too

30 Mary: Yeah. hhh

31 Shirley: [I'm just ↑saying]

In effect, we see in this performance evidence that the peer health advocates, who are all members of the local community, support one another in their performance of the organizational member role (as part of the staff of the Women's Health Project) through communicative practices that are imported into this Project meeting setting from the community. More specifically, they deploy a "call-and-response" practice recognizable from African American churches, presentifying institutions and oral traditions from outside the immediate context of the team meeting. Shirley plays the role of the "leader," and Mary performs as an affirming audience member. It is notable that Annis's contributions, while a part of the discussion, are not a part of this flow, even when she is affirming Shirley's statements, thus marking her as a member of a different speech community. In addition, she performs another, "pedagogical" role in this exchange, different from the other participants.

Pattillo-McCoy's (1998) analysis of African American church culture in a Chicago neighborhood argues that the church provides a "cultural blueprint for civic life in the neighborhood," with "call-and-response interaction" identified as one part of a "cultural 'tool kit'" (p. 767) for social action (along with prayer and Christian imagery). Thus, this tool kit, or set of cultural practices, she maintains, informs social interactions outside of the physical boundaries of the church and church services, extending into secular contexts.

Functionally, Pattillo-McCoy explains, call-and-response "invoke[s] the collective orientation of Black Christianity" (p. 768). As such, she points out, it has organizing properties, constituting part of "*how* social action is constructed" (p. 768). Similarly, a study in another social context found that the use of call-and-response by teachers with their elementary school students was employed to encourage

spontaneous and active participation in the collectivity, in contrast to the practice of requiring students to raise their hands and be called upon before they were permitted to speak (Haight, 1998). Within the context of the peer health advocates' interactions in this team meeting, , we can see that through the call and response practice, multiple voices are joined, and univocity is affirmed, as one peer performs the role of supportive chorus to another peer's declarations. At the same time, individuals' voices and their right to be heard are affirmed through this discursive practice, as the leader role (the individual making a declaration) is shared among different group members, and other group members spontaneously jump in with affirmations (rather than requesting to be recognized). Thus, the very use of the practice, imported from a community context outside of the team meeting, but shared by the peers as members of that community, contributes to unity within the organization, and to the unity provided by their shared identities as peer health advocates, even as the practice itself requires the participation of multiple voices.

Voicing Multiple Discursive Genres

The label "genre" has mostly been applied to written organizational texts; for example, strategic plans, annual reports (Cornut et al., 2012). However, we can usefully borrow from this the notion of discourse that draws on extra-organizational, institutional conventions and is deployed in specific organizational social situations to orient interactants to specific organizational activities and aims. The notion of genre can then be usefully combined with that of "voice" in the context of discourse on health-related matters. In particular, we can borrow from Mishler's (1985) "voice of the lifeworld" as performed by patients in medical encounters (when it is not suppressed), and "voice of medicine" as performed by healthcare providers, which are in turn derived from Habermas' (1984) Theory of Communicative Action. In the communicational event we focus on here, we associate the voice of the lifeworld with the everyday life of the members of this community rather than patients per se; the voice of medicine is associated with expert knowledge of reproductive health. Thus, we hear two discursive genres: the voice of the community (the language of everyday life in the neighborhood), and the voice of the clinic (the language of the expert trainers).

Returning to the excerpt above, we can hear Shirley slipping seamlessly from a more generically clinical description of effective condom use (in lines 15-26) to one that is contextualized within a more specific sexual behavior (in lines 28-29), which, it might be inferred, is drawn directly from her own experience or/and indirectly from conversations with other women and men in the community. Thus, we hear her transitioning from one voice or discursive genre to another. At the same time, as she concludes with "I'm just saying" we hear her acknowledging the shift and perhaps the questionable appropriateness of deploying this lifeworld voice in the organizational context of the team meeting. In their analysis of "I'm just saying" as a metadiscursive expression in group discussions around controversial issues, Craig and Sanusi (2000) point out that "just" can function as a hedge against an anticipated critique, as in *this is "just" my view*, and others might take issue with it. Similarly, in this instance Shirley's "I'm just saying" might be heard as indicating that others – for example, those who speak in the voice of the clinic – might deem the genre she voices this description in to be not fitted to the context (debriefing on a training session), but she is insisting on its accuracy: this is *just* the way it is. As Craig and Sunusi point out, "just" can also be used in other ways than hedging; for example, to provide emphasis (as in "just incredible"). This may be an equally convincing interpretation of Shirley's intent in deploying this meta discursive marker, particularly in this final position in her conversational turn. Finally, "just saying" can be used to specify that the speaker's point of view is located somewhere in the acceptable range on "an implied continuum of acceptable to unacceptable standpoints" (p. 438), perhaps "just" at the boundary – in this case, a boundary between discursive genres.

We also notice that Shirley's description of using a condom is voiced in the second person "you," and while it is delivered in the voice of the expert, that is, the discursive genre of the clinic, in terms of its tone, it is also very plain language, thus fitting it to the neighborhood world of the community. Thus, it can be heard as a rehearsal of her organizational role as peer health advocate in interacting with a member of the community.

Immediately after Shirley marks the conclusion of her turn with "I'm just saying," there is a definitive shift to the discursive genre of the clinic, with Patricia explicitly referencing the discourse of the trainers, Tina and Nancy, who are from a reproductive healthcare clinic (see below for a continuation of the transcript). Patricia reflexively positions herself as an expert in being able to not only reproduce the facts that were presented by the formally recognized experts, but also to extrapolate from those facts a possible additional fact not explicitly addressed. This is a kind of scientific reasoning clearly in the discursive genre of the clinic, even though the clinical vocabulary is not entirely accurate. Shirley initially follows Patricia's lead in invoking the clinic with a version of a medical term for a part of the female reproductive anatomy. However, she quickly shifts back to the discursive genre of the community as she likens the nylon filament attached to the intrauterine device (IUD) to fishing line.

32 Patricia: [(I have a question on) Shirley's um Shirley's thing. I wanted to ask Tina when um (.)
33 was it Tina or Nancy. I wanted to ask Nancy (.) even though (.) like she was saying using
34 the (.) um (.) the IUD string irritatin the man (.) but also if it's irritatin the ↑man it must
35 be irritatin the woman by rubbing up against the wall of the cervix. (.) Don't you think?

36 Lynette: =I would think. The string?

37 Shirley: [Well not not scratchin' her. I mean I would say

38 Patricia: [If it's scratching her (.) I mean

39 Shirley: [I mean (.) I'm just sayin' (.) your lebbia

40 Patricia: [Yeah

41 Shirley: [cuz the string's] too long and uh

42 Patricia: =It could irritate [her too (.) yeah.

43 Shirley: [and and uh it's like fish wire (.) I mean fish line. And yeah (.) yeah (.)
44 that's scratchin' [you ↑too.

45 Patricia: [It could like (.) it could like cut her and cut him also.

46 Shirley: That's right.

The effects produced by these discursive practices vis-à-vis producing and managing multivocity are threefold. First, speaking in the voice of the clinic helps to instantiate the organization's character as a health-related organization, and thus orients to the Project's overall aims and organizational identity. Second, speaking in the voice of the clinic also helps to set the speaker apart from other members of the community whom they are there to help and share helpful information with (thus, overlapping with the practice of discursive positioning). Conversely, speaking in the voice of the community establishes for the peer health advocates the cultural and linguistic competency that makes them credible messengers from the Project to the community residents, as well as to the community-based health and human service organizations the Project acts as a liaison to, and who value the Project and the peers precisely because of their ability to connect their organizations with community residents. Thus, as we pointed to earlier, in the context of the practice of discursive positioning, multivocity is a constitutive feature of both the unified mission and identity organization as a whole (as it strives to speak both with and for the members of the community and the local CBOs); and the unified definition and performance of the peer health advocate member role. We discuss this dynamic further below.

At the same time, this preoccupation with an outlier circumstance (i.e., the intrauterine device needing adjustment after being inserted because of being improperly measured and creating discomfort during sexual intercourse) creates concern on the part of the Project Director about the fidelity with which the information about IUD's will be transmitted, which we see in her attempt to recontextualize and restate the "take-away" from the training session in lines 47-48 and 50. However there is some resistance to her move, and persistence in the "problem narrative" as demonstrated lines 51-56.

45 Patricia: [It could like (.) it could like cut her and cut him also.

46 Shirley: That's right.

47 Annis: But they <u>can</u> adjust it. I mean when it's (.) I think the message was (.) if it's in

48 [properly=

49 Mary: [yeah]

50 Annis: =it's adjusted properly and the string is cut to the right length then it [works

51 Lynette: [They need to]

52 think of something else to make that string out of.

53 Annis: Yeah.

54 Shirley: Yeah. That's (.) that's <u>fish</u> line.

55 Lynette: Fish line will cut you?

56 Shirley: ↑<u>Shoot</u> ↓yeah.

57 Louise: Well (.) have Women's Health Services had plenty (.) ah (.) a lot of complaints about it?

58 Carrie: Well we don't know.

At the same time, it is also notable that in the final two turns here, two other peers bring a more "scientific" form of reasoning into the discussion, with Louise asking whether this problem is a common occurrence, and Carrie pointing out that the group was not provided with that information. These contributions implicitly ask the group to consider how much attention and concern the problem warrants, and presumably how they should convey information about this form of contraception to other women in the community. While unresolved in the context of this team meeting, the exchange is indicative of the group's tolerance for multiple voices and viewpoints in the working through of how to make sense of the information provided in the training.

Discussion

In framing this chapter, we argued that multivocity is most often seen as a problem to be managed so that an organization can speak with a single voice. However, the fact is that, for many organizations, multivocity is actually an asset, and even constitutive of organizational action. This is particularly the case for community-based organizations, which often work at the interface of several fields of activity and aspire to participatory decision-making, among other commitments. While this argument is not entirely novel, and how multivocity materializes in actual talk and contributes to organizing has been pointed to in prior research, we maintain that this research has provided less in terms of extended discourse analyses of situated and consequential interactions that demonstrate multivocity at the level of discursive communities and genres . In this sense, our discursive analysis advances contributions of two kinds. First, it extends current literature on multivocality in organizations by clarifying *how* multivocal organizing takes place within interactions. Second, keeping in mind Bartunek's (2008, p. 11) invitation to provide "a practical solution to identified problems," we discuss our findings' implications for the management of a community-based organization employing workers drawn from the focus community.

The Situated Performance of Multivocal Organizing

Our findings confirm that multivocity does not challenge otherwise unitary organizations; it is rather a feature of the way people talk and interact as they carry out their daily activities. The impression that multivocity is disruptive derives from the assumption that voices correspond to individuals expressing their preferences, interests, experiences or trajectories, thus leading to the organization's "fragmentation" (Sullivan & McCarthy, 2008). However, our findings show multivocity also takes place through people's joint production of talk sequences. Through each of their utterances and how they arrange them, people also materialize different voices that are not only their own, but also those of the collectives they belong to, and make them available in the interaction for their joint scrutiny. This also means that whether those voices converge harmoniously or cause fragmentation depends on how they are materialized, picked up by others and incorporated in the unfolding of the interaction.

The perspective on voices that emerges from our analysis aligns with Bakhtin's (1986) dialogical theory. The Russian scholar viewed each utterance as already comprising multiple voices (Cooren & Sandler, 2014). In this sense, we extend recent work on organizational ventriloquism that has suggested that phenomena such as authority (Benoit-Barné & Cooren, 2009; Bourgoin et al., 2019) or ethics (Cooren, 2016; Matte & Bencherki, 2019) are interactionally accomplished as principles, duties, values or rules express themselves through people's talk and action. Our contribution is original in the sense that we show that what is expressed is not only discreet ideas – a particular rule or interest, for instance – but also ways of talking that bring into the interaction the discursive communities they correspond to.

Our findings suggest that bringing into the interaction different voices and managing their relationship – or the productive tension between multivocity and univocity – is accomplished through at least three interactional processes, which map to the discursive practices identified in our analysis above. The first is *deploying alternative identities*. Empirically speaking, this was particularly visible when we looked at the way the peer health advocates performed *discursive positioning* and made different identity claims with respect to the way the interaction unfolded. We saw, for instance, that Shirley positioned herself as being knowledgeable both with respect to reproductive health issues and about community members, while also depicting others as being less knowledgeable than herself, for instance through an imagined quoted speech episode. In doing so, Shirley is also claiming to embody the WHP's mission of articulating both identities, and thus shows that she contributes to carrying out the organization's work. The understanding that some community members would benefit from additional reproductive health information is grounded in both Shirley's status as a member of that community and her status as a peer health advocate with knowledge and training different from other community members.

The second process we refer to as *transposing practices*, a particular form of presentification, the exemplar being the way the peers adapt the call-and-response interactional format, which they may use at church, but also in other community interactions, to the debriefing session. Consistent with Pattillo-McCoy's (1998) study of Church culture in African American communities, the use of the call-and-

response format in the team meeting brings into the interaction an acknowledgement of prior organization – namely the structured relationships that these women already have. This organization allows them to jointly examine the new information they are faced with, for instance by validating the main speaker's claims regarding how their community members would react to reproductive health information. It also separates community insiders from outsiders, in this case positioning Annis in the latter category, although at the same time she provides an essential contribution to the unified voice with which the project speaks to the community. Arguably, other forms of practices could be transposed and such transpositions have been described as sources of innovation (Boxenbaum & Battilana, 2005).

Finally, the third process consists in *melding voices*, in this case by merging community and clinical voices, which can be viewed as a practice of creating new discursive genres. In the same way as metals are melded to create a new, stronger alloy, the work of peer health advocates is not only to switch *between* codes or discourses, or to translate terminology, but also to find ways of making different voices *co-present* within a single utterance. This is particularly apparent in the third part of our findings where Patricia initiates a conversation regarding whether an IUD's monofilament string may cause injury during intercourse. The conversation can be seen as an attempt to speak at once using clinical terminology and format (for instance by extrapolating from known facts) while also using community terminology and comparisons (by describing the string as a fish line).

Together, these three processes show that multivocal organizing proceeds through people's discursive performance of *who they are*, *what they do*, and *how they talk.* These three components are not abstract realities but must be observed in how people concretely engage in interaction.

Addressing the Practical Problem: Letting Voices Speak

The Women's Health Project itself, and later the peer health advocate initiative, were conceived as a practical solution to a problem voiced by local CBOs to the first author when she first began working in this community: connecting CBOs with underserved community residents (Matsaganis et al., 2014).

However, the above analysis shows how multivocity in the context of the peer health advocate initiative can be both solution (to the problem of connecting CBOs and residents) and another problem – at once an asset and a potential liability for the organization.

From the Project Director's standpoint, the first problem was a localized interactional challenge of managing multivocity on the part of the peer health advocates to effectively share health information in the community's voice maintaining fidelity to the original sources. Said otherwise, the Project had to balance cultural competency with fidelity in the peers' interactions with the community residents. The second problem concerned the longer range survival of this liminal organizational enterprise (assuming that the community continued to find it valuable), and credibility with the local CBO stakeholder group (Golden, 2017). Our preceding analysis speaks most directly to the first problem, through its focus on a specific communicational event; however, the success with which the first problem is managed has implications for the latter one, since it impacts the way in which the local community of CBOs relates with the WHP and the peer health advocates.

The analysis shows how the peers discursively bridge between the world of the clinic and their neighborhood world, enacting a delicate balance. They are most successful in the discursive performances that are at the margin, with elements of both the community and the clinic held in productive tension (e.g., Shirley's description of how to use a condom effectively; Mary's call-and-response affirmations). They are somewhat less successful in deploying the clinical discursive genre exclusively, not surprisingly given their comparatively limited experience with it. Conversely, we note – from the first author's additional field observations of team interactions – that the peers themselves recognize that employing a discursive genre that's too "street" (to use the language of the peers and their fellow residents) may run the risk of undermining their credibility with fellow residents as they enact the role of a community member who also has expert knowledge. From the Project Director's perspective, this can also undermine their credibility with the CBOs that the WHP is trying to connect with underserved residents. This is something

that Shirley may be aware of when she qualifies a discursive performance that might be construed as shading over into "street" talk with "I'm just saying."

As noted in our findings, we can understand the dialog that follows Shirley's metadiscourse marker "I'm just saying," in which the peers discuss the potential problems of IUDs that have not been properly fitted, as a possible rehearsal of speaking in the voice of the clinic as fitted to their community. However, their rendition of the information they received and the sense they make of it does not, for the Project Director map well onto the intentions of the expert trainers– as demonstrated by her attempt to steer the discussion away from the "problem narrative" and back toward the main takeaways as she understands them:. the effectiveness of the IUD as a contraception method, though it provides no protection against sexually transmitted infections. Yet the transcript also shows that the peers are not uniform in their response. As our analysis earlier notes, two peers in the group attempt to temper the "problem narrative" with a more "scientific" assessment of the "evidence." The tensions between the multiple voices in this instance are not resolved within the context of this interaction, though it supports the view of the organization and the peers themselves as multivocal, with characteristics of the CBOs and community members they attempt to mediate between, and univocal in their commitment to this mediating role. We would further argue that univocity is not synonymous with harmony; there are disagreements, but the evidence suggests that they are managed. It is through this interactional management of multivocity that the polyphonic voice of the organization emerges.

Being able to reproduce health related information with fidelity can be a significant issue for the WHP's credibility with its CBO partners, who are likely to take the conventional position that it is better to convey no information at all than inaccurate information. Thus, the "problem narrative" could be emblematic of a problem for the WHP. Alternatively, such a performance can be viewed by WHP members who speak fluently in the voice of the clinic (i.e., the Project Director and the Field Coordinator), as an opportunity to gain insight into the difficulties of community residents in translating health information delivered in the voice of the clinic – as well as presenting an opportunity for

correction. If an organization member like the Project Director, who is *not* a community resident, and does not speak in that voice, does not allow for these in-between performances in which translation attempts may be imperfect, it will not be possible to see the *process* of translation. Conversely, if these community members are given a space in which to rehearse and check their understandings, an invaluable opportunity for refinement of multivocal organizing and mutual understanding can be opened up.

Conclusion

We conclude, reflexively, with a caution to both ourselves and to other community-engaged researchers. As the Women's Health Project's peer health advocate initiative progresses from a spontaneously emergent enterprise, originating as much from the community as from the academic research team that initiated this health promotion project, toward a more conventionally institutionalized mode (in the interests of its long-term survival), the initiative may find itself pushing up against the limits of multivocity. Our caution regards the need to keep sight of multivocity's value, lest in managing its potential problems, we manage it out of existence and sacrifice its benefits. We concede that multivocity can be challenging, but at the same time we note that the communicational event we've focused on here demonstrates that the peers themselves are already handling it with considerable skill, and there is value for "outsiders" in listening to people who speak in different voices to see how they are already dealing with it themselves. In the WHP, the first author's field experiences affirm that considerable allowance was made for the expression of non-professional talk within the context of closed team meetings, though a blending of genres was encouraged in interactions with community residents, and more "professional" talk was encouraged in interactions with CBOs. As the Project continues to evolve toward meeting the requirements of institutionalization, it will be important for the Project Director to encourage reflexivity on and tolerance for multivocity on the part of the peer health advocates and other organizational members they interact with. Organizing must leave room for multivocal expression; therefore, multivocity must be "managed" (i.e., intervened in) with caution so as to respect and value the multiple voices that CBOs ostensibly value.

As a final word, we note a push for medicalization and certification of the "community health worker" role (this being the role that the peer health advocates most closely correspond to) within the American healthcare system that is part of this study's setting. From a healthcare system standpoint, the issue of how the "bridging" services provided by community health workers can be paid for leads to the medicalization of the role so that it can be covered by health insurance plans. The peer health advocates' "outreach" activities cannot be billed for within the current system; it is not a bounded, commodifiable service like a clinical interaction. Nonetheless, we argue that it is a profoundly valuable service which embodies the value of multivocity and authentic connection to a *specific* community, rather than the more limited notion of valuing of the *idea* of a community, as represented in the more medicalized model of the community health worker. This leaves unresolved, however, the issue of resources to support such activities and the management of tensions in the long-term commitments to advocacy on the part of academics who aspire to help effect change in underserved communities.

Support for this research was provided by the National Institute on Minority Health and Health Disparities, National Institutes of Health to the first author (grant number P20MD003373). The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Center on Minority Health and Health Disparities or the National Institutes of Health.

References

Aggerholm, H. K., Asmuß, B., & Thomsen, C. (2012). The role of recontextualization in the multivocal, ambiguous process of strategizing. *Journal of Management Inquiry*, *21*(4), 413–428. https://doi.org/10.1177/1056492611430852

Alvesson, M., & Kärreman, D. (2000). Varieties of discourse: On the study of organizations through discourse analysis. *Human Relations*, *53*(9), 1125–1149. https://doi.org/10.1177/0018726700539002

Arvey, S. R., & Fernandez, M. E. (2012). Identifying the core elements of effective community health worker programs: A research agenda. *American Journal of Public Health*, *102*(9), 1633–1637. https://doi.org/10.2105/AJPH.2012.300649

Bakhtin, M. M. (1986). *Speech Genres and Other Late Essays*. University of Texas Press.

Balcazar, H., Lee Rosenthal, E., Nell Brownstein, J., Rush, C. H., Matos, S., & Hernandez, L. (2011). Community health workers can be a public health force for change in the United States: Three actions for a new paradigm. *American Journal of Public Health*, *101*(12), 2199–2203. https://doi.org/10.2105/AJPH.2011.300386

Bartunek, J. M. (2008). Insider/outsider team research: The development of the approach and its meanings. In A. B. Bashni, N. Adler, S. A. Mohrman, W. A. Pasmore, & B. Stymne (Eds.), *Handbook of Collaborative Management Research* (pp. 73–92). SAGE Publications. https://doi.org/10.4135/9781412976671.n4

Bell, M. P., Özbilgin, M. F., Beauregard, T. A., & Sürgevil, O. (2011). Voice, silence, and diversity in 21st century organizations: Strategies for inclusion of gay, lesbian, bisexual, and transgender employees. *Human Resource Management*, *50*(1), 131–146. https://doi.org/10.1002/hrm.20401

Belova, O., King, I., & Sliwa, M. (2008). Introduction: Polyphony and Organization Studies: Mikhail Bakhtin and Beyond. *Organization Studies*, *29*(4), 493–500. https://doi.org/10.1177/0170840608088696

Bencherki, N. (2017). A pre-individual perspective to organizational action. *Ephemera. Theory and Politics in Organization*, *17*(4), 777–799.

Bencherki, N., Matte, F., & Pelletier, É. (2016). Rebuilding Babel: A constitutive approach to tongues-in-use. *Journal of Communication*, *66*(5), 766–788. https://doi.org/10.1111/jcom.12250

Benoit-Barné, C., & Cooren, F. (2009). The accomplishment of authority through presentification: How authority Is distributed among and negotiated by organizational members. *Management Communication Quarterly*, *23*(1), 5–31. https://doi.org/10.1177/0893318909335414

Bourgoin, A., Bencherki, N., & Faraj, S. (2019). "And who are you?": A performative perspective on authority in organizations. *Academy of Management Journal*. https://doi.org/10.5465/amj.2017.1335

Boxenbaum, E., & Battilana, J. (2005). Importation as innovation: Transposing managerial practices across fields. *Strategic Organization*, *3*(4), 355–383. https://doi.org/10.1177/1476127005058996

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

Chaney, P., & Fevre, R. (2001). Inclusive governance and "minority" groups: The role of the third sector in Wales. *Voluntas: International Journal of Voluntary and Nonprofit Organizations*, *12*(2), 131–156. https://doi.org/10.1023/A:1011286602556

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: Practical approaches to research into the dynamic of text and conversation* (pp. 81–100). Lawrence Erlbaum.

Cooren, F. (2010). *Action and agency in dialogue: Passion, ventriloquism and incarnation*. John Benjamins.

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). *Organizational discourse: Communication and constitution*. Polity.

Cooren, F. (2016). Ethics for Dummies: Ventriloquism and responsibility. *Atlantic Journal of Communication*, *24*(1), 17–30. https://doi.org/10.1080/15456870.2016.1113963

Cooren, F., Bencherki, N., Chaput, M., & Vásquez, C. (2015). The communicative constitution of strategy-making: Exploring fleeting moments of strategy. In D. Golsorkhi, L. Rouleau, D. Seidl, & E. Vaara (Eds.), *The Cambridge handbook of strategy as practice* (pp. 370–393). Cambridge University Press.

Cooren, F., Matte, F., Benoit-Barné, C., & Brummans, B. H. J. M. (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., & Sandler, S. (2014). Polyphony, ventriloquism, and constitution: In dialogue with Bakhtin. *Communication Theory*, *24*(3), 225–244. https://doi.org/10.1111/comt.12041

Cooren, F., & Taylor, J. R. (1997). Organization as an effect of mediation: Redefining the link between organization and communication. *Communication Theory*, *7*(3), 219–260. https://doi.org/10.1111/j.1468-2885.1997.tb00151.x

Cornut, F., Giroux, H., & Langley, A. (2012). The strategic plan as a genre. *Discourse & Communication*, *6*(1), 21–54. https://doi.org/10.1177/1750481311432521

Craig, R. T., & Sanusi, A. L. (2000). "I'm just saying . . .": Discourse markers of standpoint continuity. *Argumentation*, *14*(4), 425–445. https://doi.org/10.1023/A:1007880826834

Crozier, M., & Friedberg, E. (1980). *Actors and Systems: The Politics of Collective Action*. University of Chicago Press.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, *20*(1), 43–63. https://doi.org/10.1111/j.1468-5914.1990.tb00174.x

Eynaud, P., Juan, M., & Mourey, D. (2018). Participatory art as a social practice of commoning to reinvent the right to the city. *VOLUNTAS: International Journal of Voluntary and Nonprofit Organizations*, *29*(4), 621–636. https://doi.org/10.1007/s11266-018-0006-y

Ganesh, S., & McAllum, K. (2012). Volunteering and Professionalization: Trends in Tension? *Management Communication Quarterly*, *26*(1), 152–158. https://doi.org/10.1177/0893318911423762

Golden, A. G. (2017, July 5). The Women's Health Project: A case study of the problematics of a liminal organization. *Communication Constitutes Organization: The Practical and Social Relevance of CCO Thinking*. European Group for Organizational Studies Pre-Conference Development Workshop, Copenhagen, Denmark.

Habermas, J. (1984). *The Theory of Communicative Action*. Beacon Press.

Haight, W. L. (1998). "Gathering the Spirit" at First Baptist Church: Spirituality as a protective factor in the lives of African American children. *Social Work, 43*(3), 213–221. https://doi.org/10.1093/sw/43.3.213

Hautz, J., Seidl, D., & Whittington, R. (2017). Open Strategy: Dimensions, dilemmas, dynamics. *Long Range Planning*, *50*(3), 298–309. https://doi.org/10.1016/j.lrp.2016.12.001

Henry, E., & Pringle, J. (1996). Making voices, being heard in Aotearoa/New Zealand. *Organization*, *3*(4), 534–540. https://doi.org/10.1177/135050849634010

Holloway, K. F. C. (2011). *Private bodies, public texts: Race, gender, and a cultural bioethics*. Duke University Press.

Jäger, U. P., & Kreutzer, K. (2011). Strategy's negotiability, reasonability, and comprehensibility: A case study of how central strategists legitimize and realize strategies without formal authority. *Nonprofit and Voluntary Sector Quarterly*, *40*(6), 1020–1047. https://doi.org/10.1177/0899764010378703

James, E. (2003). Commercialism and the mission of nonprofits. *Society*, *40*(4), 29–35. https://doi.org/10.1007/s12115-003-1015-y

Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G. H. Lerner (Ed.), *Conversation Analysis: Studies from the first generation* (pp. 13–31). John Benjamins.

Koschmann, M. A., Kuhn, T., & Pfarrer, M. D. (2012). A communicative framework of value in cross-sector partnerships. *Academy of Management Review*, *37*(3), 332–354. https://doi.org/10.5465/amr.2010.0314

Lewis, L. (2005). The civil society sector: A review of critical issues and research agenda for organizational communication scholars. *Management Communication Quarterly*, *19*(2), 238–267. https://doi.org/10.1177/0893318905279190

Lewis, L., Isbell, M. G., & Koschmann, M. (2010). Collaborative tensions: Practitioners' experiences of interorganizational relationships. *Communication Monographs*, *77*(4), 460–479. https://doi.org/10.1080/03637751.2010.523605

Matsaganis, M. D., Golden, A. G., & Scott, M. E. (2014). Communication Infrastructure Theory and reproductive health disparities: Enhancing storytelling network integration by developing interstitial actors. *International Journal of Communication*, *8*(0), 21.

Matte, F., & Bencherki, N. (2019). Materializing ethical matters of concern: Practicing ethics in a refugee camp. *International Journal of Communication*, *13*, 5870–5889.

Matte, F., & Cooren, F. (2015). Learning as dialogue: An "on-the-go" approach to dealing with organizational tensions. In L. Filliettaz & S. Billett (Eds.), *Francophone Perspectives of Learning Through Work: Conceptions, Traditions and Practices* (pp. 169–187). Springer.

McAllum, K. (2014). Meanings of organizational volunteering diverse volunteer pathways. *Management Communication Quarterly*, *28*(1), 84–110. https://doi.org/10.1177/0893318913517237

Meisenbach, R. J., & Kramer, M. W. (2014). Exploring nested identities: Voluntary membership, social category identity, and identification in a community choir. *Management Communication Quarterly*, *28*(2), 187–213. https://doi.org/10.1177/0893318914524059

Mintzberg, H. (1983). *Power in and Around Organizations*. Prentice-Hall.

Mishler, E. G. (1985). *The Discourse of Medicine: Dialectics of Medical Interviews*. Praeger.

Pattillo-McCoy, M. (1998). Church culture as a strategy of action in the Black community. *American Sociological Review*, *63*(6), 767–784. https://doi.org/10.2307/2657500

Potter, J., & Wetherell, M. (1987). *Discourse and Social Psychology: Beyond Attitudes and Behaviour*. Sage Publications.

Sanders, M. (2012). Theorizing nonprofit organizations as contradictory enterprises: Understanding the inherent tensions of nonprofit marketization. *Management Communication Quarterly*, *26*(1), 179– 185.

Sullivan, P., & McCarthy, J. (2008). Managing the polyphonic sounds of organizational truths. *Organization Studies*, *29*(4), 525–541. https://doi.org/10.1177/0170840608088702

van Oosterhout, J. (Hans), Wempe, B., & Willigenburg, T. van. (2004). Rethinking organizational ethics: A plea for pluralism. *Journal of Business Ethics*, *55*(4), 385–393. https://doi.org/10.1007/s10551-004-1347-6

Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, *24*(3), 369–387. https://doi.org/10.1177/109019819702400309

Wetherell, M., & Potter, J. (1988). Discourse analysis and the identification of interpretative repertoires. In *Analysing everyday explanation: A casebook of methods* (pp. 168–183). Sage.