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Distributed and Mediated Ethos in a Mental Health Call Center

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This pilot study of a mental health call center clinician's workplace tools, processes, and organizational structures proposes a preliminary theory of "distributed and mediated ethos." A distributed and mediated ethos refers to how an organization uses various resources—artifacts, technologies, and processes—situated across disparate locations in order to expand and control their identity in the service of extending their reach and capacity to render essential services. An analysis of a participant clinician's rhetorical context flowcharts and network pictures shows how an agency's ethos is mediated through various technologies. Findings suggest that a distributed ethos (1) projects the impression of being "always there"; (2) relies on dexterity across several human and nonhuman actors; and (3) necessitates targeted tasks from branches that extend ethos farther from the organization. This pilot study, thus, provides researchers of rhetoric of health and medicine (RHM) with a new tool for exploring the intricate and complex nature of health at a distance and other complicated 21st century healthcare delivery formats.

KEYWORDS: ethos, Genre Ecology Models, Communicative Event Models, network pictures, mental health call centers

Since the 1990s, mental health agencies, individual counseling practitioners, and crisis centers have all attempted to provide their services remotely. In addition to reaching individuals and communities who may not have the means of regularly accessing physical spaces of mental healthcare, using

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tele-health modalities have allowed agencies, practitioners, and centers to better meet the demand for services that has ballooned in recent decades (Bureau of Labor Statistics, 2018; American Psychological Association, 2018; Schrobsdorff, 2016). As a result, health-at-a-distance and e-health services have expanded in recent decades, ranging from telehealth communication platforms; online medical sites; discussion forums; and mobile health applications. Even with these remote services and platforms, the demand for mental health services continues to grow, creating a very well-documented shortage of quality care around the globe (Willingham, 2018; Raphelson, 2018; Japsen, 2018; Miller, 2018). As organizations grapple with how to best serve their clients, they increasingly rely on third party call centers to manage the flow of potential patients and to filter them to the right care settings and/or providers. For example, Lifeline, a mental health call center, contracts with mental health agencies and crisis lines around the U.S. to provide client coverage when these agencies are unable to answer calls from their client and potential client populations.[1] As opposed to a messaging service that would only let mental health agencies, clinics, and providers know when they have missed clients' calls, Lifeline is staffed with mental health counselors who take over an unreachable agency's clinical work in targeted ways. Hence, when Lifeline clinicians answer the phone, they not only rely on their education and training, but also become savvy rhetoricians when they must adopt the identity of the contracting agency for which they have pre-established procedures pertaining to client interactions.

To showcase Lifeline's important work in providing essential mental health services, I present the following two scenarios that show how Lifeline adapts to callers' localized expectations.[2] Jose, a man in his 40s who resides in Washington, D.C., is going through divorce and finds himself needing counseling help. When he calls the mental health clinic Pathways for assistance with his emotional state, the clinician on the other end answers, "Pathways, my name is Marie, how can I help you?" Jose reports feeling depressed and aimless, but denies any suicidal ideation based on the assessment that Marie conducts. Marie checks her procedures for the Pathways

[1] All names of organizations, individuals, and locations are pseudonyms to protect anonymity.
[2] Caller names and locations that appear are fictitious and are meant to illustrate typical calls my participant might receive. At no point were names of callers or their calling locations shared with me for the purposes of this research, nor were they requested.

agency and sees that she has permission to refer him to a therapist, so she checks Pathways' database of providers and makes an appointment for him with one of them directly. The two hang up.

A few seconds later, after Marie finishes documenting her exchange with Jose, she receives another call. Only this time it is from Deborah, a Spanish-speaking client calling from Texas, also hoping to make a mental health appointment. Marie answers the phone by saying "Texas Support Group; how can I help?" Deborah asks for an interpreter, which prompts Marie to put Deborah on hold while she dials the number of Lifeline's interpreter service. When Marie continues the call, Deborah relays what she has been experiencing recently. The interpreter translates, and Marie takes notes. Marie responds, and the interpreter translates. Finally, Deborah mentions that she is calling for a counseling referral. However, after checking the procedures for Texas Support Group, Marie notices that they would prefer that their clients schedule directly with the agency. Marie, therefore, tells Deborah (via the interpreter) that she should call back the next day when the scheduling specialists are in the office.

In these scenarios, Marie plays multiple roles in a matter of minutes. She has been reached by two individuals—each from different parts of the country—hoping to reach their local clinics. Yet they do not know that Marie does not directly work for the organizations that they are attempting to reach. Instead, Marie is acting as an *intermediary* between caller and organization via numerous technological and rhetorical affordances. She can conduct this vital work through the use of various tools, providing targeted counseling for individuals with various mental health needs. The *mediated* work of these *distributed* tools, combined with Marie's expertise in mental healthcare, are all put in service of extending an ethos of care from a variety of contracting agencies.

This essay presents a pilot case study of a clinician's work at Lifeline to examine how the construction and maintenance of ethos occurs through a distributed network of tools, technologies, and entities. In doing so, I put forth a preliminary concept of "distributed and mediated ethos," which refers to how an organization uses various resources—artifacts, technologies, and processes—situated across disparate locations in order to expand and control their identity in the service of extending their reach and capacity to render essential services. In the context of this pilot study centered on a mental health call center, I show how a distributed and mediated ethos projects the impression of being "always there"; relies on dexterity across several actors;

and necessitates targeted tasks from branches that extend ethos farther from the organization. This pilot study opens up conversations regarding ethos' conceptualization as always in control of and directly belonging only to a single rhetor and provides opportunities for further research on clients' perceptions of an organization's ethos in both clinical and nonclinical settings.

Health at A Distance

Most rhetorically-inflected studies of e-health platforms have focused on how usability, interdisciplinary collaborations, and the crafting of sound verbal and visual arguments can assist in the transmission and reception of health information at a distance (Kim et al. 2008; Willerton, 2008; Tomlin 2008).[3] More recently, there has also been a focused attention in rhetoric scholarship on the ethics of mobile and "always-on" biometric technologies (Teston, 2016; Moore, Jones, Cundiff, & Heilig, 2017; Hutchinson & Novotny 2018). These timely trends in the literature demonstrate how technological affordances have changed individuals' relationships to health and medical information, and, in turn, focus health rhetorician's attention to the discursive and material elements implicated in such relationships. This study's focus on Lifeline, though, is not meant as a critique of the ethics of such services. Instead, I showcase mental health call center work as an example of health organizations that utilize technological affordances to better serve their clients.

This pilot study provides researchers of rhetoric of health and medicine (RHM) with a new tool for exploring the intricate and complex nature of health at a distance and related 21st century healthcare delivery formats. When thinking about each of the various systems involved in healthcare, processes might come to mind that at first seemed divorced from the client-patient relationship, such as staffing, scheduling, or billing. The move from face-to-face to virtual modalities, however, brings processes that may seem to be tangential or veiled aspects of healthcare into the patient-provider relationship, and, as a result, requires RHM scholars to adjust how they

[3] I specifically refer to studies that explore the rhetorical work of connecting clients, patients, and research subjects to a health organization's resources. There is a separate strand of scholarship in rhetoric that has examined the implications of crowdsourced health information online. These pieces have notably brought up how such developments change the relationship between health practitioners and patients as well as the subject positions of each (Kopelson, 2009; Segal, 2009; Holladay, 2017).

approach not only the relationship between provider and client, but also between organization and client. Distributed and mediated ethos is one way to begin to address this complexity.

Distributed (and Mediated) Ethos

In generating a working definition of distributed and mediated ethos, I adapt and expand on Elizabeth Angeli's (2019) work on "distributed cognition" in emergency medical settings. For Angeli, distributed cognition "refers to the ways in which cognition interacts with the external environment, including the interaction with resources and artifacts used to reduce cognitive workload" (p. 121). Specifically, Angeli articulates how the cognitive workload of emergency medical service workers is distributed across three types of memory: individual memory (sensory and physiological), collaborative memory (social exchanges with other professionals), and professional memory (knowledge from sources such as textbooks and training). Similarly, a distributed ethos helps mental health clinicians working in call centers—those who directly respond to mental health situations—to engage with callers who may otherwise be wary of seeking assistance. In other words, a distributed ethos relies on and is mediated by what Hollins, Hutchins, and Kirsh (2000) refer to as "a system that can dynamically configure itself to bring subsystems into coordination to accomplish various functions" (p. 176) with the principle task of putting forth a seamless connection between callers and the agencies that they attempt to reach.

As a rhetorical appeal, of course, ethos involves the credibility that a rhetor brings to a situation. Conversations pertaining to ethos typically center on either initial credibility that stems from reputation and past actions or on derived credibility that is engendered via stylistic choices (Stoddard 1984, p. 234). While ethos is context-dependent, it is understood that ethos belongs to the writer/speaker, adapting it to each situation as necessary. For example, William Keith and Christian Lundberg (2008) state that ethos is demonstrated by *what* the rhetor chooses to disclose—connecting with the audience by communicating their past actions, deeds, experiences, understanding, or expertise (p. 41). Chris Anson (2016), on the other hand, connects ethos to persona, or the "sense of self that you project through your choice of language or more generally your writing style. . . . When you choose who to be in your text, you're projecting a particular persona" (p. 339). Whether ethos is taught as initial or derived, the basic elements of ethical

appeal concern a rhetor's ability to build a relationship predicated on common ground and trust (Lunsford et al., 2012, p. 993).

The concept of ethos necessarily becomes more complex, though, when looking at the various ways that large, sprawling organizations attempt to control and disseminate an identity. In digital contexts, most contemporary consumers are familiar with websites as extensions of an organization's ethos (Coney & Stechouder, 2000; Spoel, 2008). Far from merely delivering information, an organization's website creates "an online presence—an ethos—that conveys the sorts of values they hold in common with the Web navigators they wish to attract to the site" (Hunt, 1996, p. 377). More recently, with the promulgation of social media, organizations have attempted to put forth content online that is entertaining and persuasive, yet also appropriate for different types of audiences (Mizrahi, 2013).

Further, with the launch of Web 2.0 platforms, interactive affordances can also speak for an organization's credibility—intentionally or not. For instance, Google reviews (Chakraborty & Bhat, 2018a & 2018b) and AI chatbot personas (Zdenek, 2007) all speak to a company's values and can influence how that company is perceived. Often, companies ask that if customers had a good experience, they "rate us on Google or Facebook," requesting customers to use their own ethos to extend the company's ethos on their behalf. Similarly, the artificially intelligent virtual assistants that continue to be developed literally give voice to large organizations (as in Siri for Apple, Alexa for Amazon, etc.). More aptly, for the purposes of this study, a company's customer service representatives who respond to questions and feedback from shoppers, clients, and patrons represent the larger company with each interaction and must therefore carefully manage their identities during these exchanges (Berry, 2000; Jasmand, Blazevic, & de Ruyter, 2012; Medler-Liraz & Yagil, 2012). Each of these examples, notably, relies on various tools to help mediate an ethos, whether it be servers, coding languages, telephones, or the documents and individuals who act as resources for maintaining such knowledge work.

Studies in RHM, of course, already implicitly acknowledge how technological and textual affordances mediate the work of mental health practitioners (Popham, 2014; Berkenkotter, 2008). For example, Popham's (2014) study focuses on how social workers at a juvenile mental health facility deploy a scientific ethos in their writing to make indirect diagnoses of their clients. Yet, the technologies that these social workers utilize, such as tape recorders for audio recording sessions, play as large of a role as the clinicians do

in motivating clients to disclose and seek help during these sessions (p. 341). Similarly, Berkenkotter (2008) describes how the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the international classification of diseases (ICD) codes are both necessary for clinicians to bill clients (p. 149)—thus creating a link to a network located beyond the seemingly confined space of the psychotherapist's office. And, as these notes are most frequently input into a secure electronic charting system, clinicians' writing practices are constrained to align with such affordances as well (Popham & Graham, 2008; and Munger 2000).

This pilot case study adds to this vein of RHM work by similarly analyzing mediation within a mental health context, but with the intention of highlighting how tools, people, resources, artifacts and technologies all help to create a distributed and mediated ethos for organizations.[4] Lifeline's structure and technological ecologies, as I will show, are built around the purpose of extending a contracting organization's ethos by allowing clinicians to speak on behalf of a contracting organization as callers dial in.

As the analysis below will show, three elements of distributed and mediated ethos are most salient in this study. The first is that a distributed ethos allows for an "always there" locality. That is, clients who call their mental health agencies seeking resources can rest assured that they will speak to someone who can help them. Because Lifeline clinicians are trained to consult procedures and supervisory support, they can provide whatever level of care the contracting organization feels is appropriate during these calls. This presents a second characteristic of distributed ethos: dexterity. Multiple tools and organizational structures are in place to support the work of Lifeline clinicians. However, with multiple options and numerous calls that come in from all over the country, clinicians must demonstrate dexterity in navigating through a call. Even the nonhuman artifacts in these assemblages must be able to link up to the appropriate resources as soon as a call comes in. A final element in this exploration of distributed ethos is targeted distribution. That is, nodes such as Lifeline that extend an organization's ethos do so with specific tasks in mind. Rather than providing clients with a full range of services, these extensions of an organization have targeted, in-the-moment roles. By paying attention to the interconnected actors that

[4] A distributed ethos is necessarily a mediated one given that the tools utilized to distribute such an identity have the capacity to shape a communicative activity (Swarts, 2013, p. 149).

undergird Lifeline's work, rhetoricians of health and medicine can learn more about the networked ways that agencies rhetorically connect to their constituents.

Research Design

Participant

Having previously worked as a case manager and as a counselor, I made various connections in the mental health fields. As I became immersed in the study of writing, rhetoric, and technical communication, I became intrigued by the work happening at Lifeline after one of my former colleagues, who refers to herself as Marie in this piece, started working there and discussing her workplace responsibilities. I was interested in the opportunities to study technological mediation within her organization.[5] While single-subject case studies prevent generalizable findings, they do provide solid grounding for expanding and building on preliminary and flexible theoretical structures (Yin, 2003), such as the concept of a distributed and mediated ethos.

Methods

I approached this project as a workplace study on technological mediation within the mental health call center. I was interested in gaining data that focused on clinician perspectives of daily micro-level work and macro-level organizational structures, and analyzing it from a rhetorical perspective. For the micro-level data, therefore, Marie was asked to create "rhetorical context flowcharts," which readers might recognize as an amalgamation of genre ecology models (GEMs) and communicative event models (CEMs) of her activities over the course of a week (described to Marie as "flowcharts"). Afterward, to get at macro-level structures in place that mediate Marie's daily patterns, she was asked to draw a network picture that showcased the relationships among different departments that are most relevant for supporting calls that come through. I explain both of these data collection methods further in the subsections below so that readers will appreciate the rich data they yield.

[5] Marie agreed to participate in this study on mediational activity in her workplace after I had contacted her with IRB approval (protocol # 1343273).

Rhetorical Context Flowcharts

As I mention above, the rhetorical context flowcharts that Marie created are an amalgamation of GEMs and CEMs that stem from research on workplace contexts. GEMs are visual representations of the different genres that writers and designers utilize when performing a task (Spinuzzi, 2002). They most typically resemble a web of different tools and artifacts; they showcase relationships via lines connecting items that work in tandem. In a GEM, "genres" include the tools associated with the writing process. For example, the process for creating a set of instructions could include the program(s) utilized to create the instructions, pictures taken by the writer to help recall certain steps, dictionaries consulted, whiteboards used for drafting, email correspondences, a laptop, and several display monitors that help the writer to organize her process, and so forth. In this way, genres are tools that mediate the work of writers (Spinuzzi, 2013, p. 267) in that they inform the relationships that a writer has with the texts and documents that they write.

Typically, GEMs are useful in revealing what tools and resources guide a particular task in the moment (Spinuzzi & Zachry, 2000; Spinuzzi 2004). As a result, they can only capture the genres that are utilized *in situ* without attention to patterns in workflow. In other words, GEMs can communicate what is used, but not how or when it is used (Gygi & Zachry 2010, p. 370). CEMs, on the other hand, can be utilized as a research tool to gain data regarding the chain of events in which such genres are used. As visual representations of workflow events, CEMs record "events in which actors exchange information by exchanging texts, speech, or other signs" (Spinuzzi, 2013, p. 273). In effect, the exchanges that occur as a writer, designer, or communicator attempts to enact or resolve a process are displayed as chronological interconnections, from side conversations with supervisors to composing processes that help the writer to accomplish a task. If GEMs are a visual web of genres, then CEMs can be thought of as workflow charts that show how writers moved along the steps of a process.

While GEMs and CEMs are separate research methods, I found it useful to merge the two into a hybrid, rhetorically-inflected form: rhetorical context flowcharts.[6] I define "rhetorical context flowcharts" as a hybrid tool through which researchers gain insight into rhetorical relationships and

[6] Indeed, because CEMs and GEMs may be constructed from the same dataset, they have an intertwined relationship (Hart-Davidson, Spinuzzi, and Zachry, 2007).

implications via gathering vital information on *both* the tools and genres used as well as the chain of events that characterizes their uses. When analyzed alongside other visually-rich data (such as network pictures) and other qualitative methods (such as semi-structured interviews) via rhetorical lenses, new theories such as distributed and mediated ethos can become clear. Due to time constraints on the participant's part and since the study was a pilot, the participant was asked to trace a combination of genres and patterns over the course of one week. During this week, Marie was to create flowcharts of as many communication processes as she felt would be appropriate *and* to include specific genres—resources, tools, technologies, or artifacts that she uses in order to accomplish several tasks that involve a caller.[7]

Network Pictures

Additionally, I asked Marie to draw a network picture of her organization. Typically, when researchers utilize network pictures as a research tool, they ask participants to create a perceptual organizational chart and pay close attention to which departments a participant has placed close together, which they have connected with lines, and which they have placed in the periphery. To illustrate, network pictures have been used to compare managers' and employees' understanding of their own organization's functions (Henneberg, Mouzas, & Naudé, 2006; Laari-Salmela, Mainela, & Puhakka, 2015), or how individuals (mis)perceive an organization's relationship with other companies (Leek & Mason, 2009, 2010). I use network pictures not to compare Marie's perceptions with the realities of Lifeline's organizational structure, but to gain a better insight into her perception of the structure itself. Although her flowcharts make the micro-level tools and processes that are at play in Marie's work salient, network pictures depict how Marie's work takes place within a larger ecology and helped me to learn how different macro-level entities commingle in that work.[8]

[7] Because Marie works in a location with sensitive information regarding clients' mental well-being, all protected under HIPPA, I relied on Marie to log her own hybrid CEM/GEM flowcharts.

[8] While a prolonged study might offer more insight into the perceptions and patterns of work that clinicians engage in, this pilot study allows me to conceptualize how human and nonhuman resources are implicated in extending organizations' identity, thus bringing our discussions of ethos in RHM into growing scholarship on networks, assemblages, and ecologies in health and medicine (Angeli, 2018; Ehrenfeld, 2018).

Data Collection and Analysis

Marie was asked to immediately create as many flowcharts as reasonably possible after closing out calls. Given her workload and the frenetic pace of her role, I left the total number of flowcharts that she would produce up to her. Moreover, she could opt to rename any sensitive or confidential information as she wished (for instance proprietary technology). She was also asked to write a reflection on the process and the charts she created to help provide more context. Afterwards, she created a network picture of her perceptions of her organization's structure. After a week of tracking her calls, Marie produced four flowcharts and one network picture for this pilot study.

I also conducted three short, semi-structured phone interviews with Marie: once after she submitted her flowchart, again after she submitted her network picture, and a third time as I was drafting the initial version of this piece to help fill any gaps in my thinking. It was through the analysis of these drawings and interview transcripts that the concept of a distributed and mediated ethos became salient.[9] In what follows, I offer a look at Marie's rhetorical context flowcharts as well as her network picture before discussing the constitutive elements of distributed ethos that stem from her work.

Results

Marie's Rhetorical Context Flowcharts

All of Marie's exchanges begin with the same four actions: once a caller rings through on the phone, 1) a code appears on the phone that matches a code that pops up on the computer screen; 2) a tab on Marie's screen displays an answer script, which Marie delivers, and then; 3) she clicks a button on her screen to open a form; 4) as she talks to her caller, she types their information into the form.

Some elaboration is warranted here to explain what each of these steps involves. The program that Lifeline specialists use is web-based, so it is accessed by opening an internet browser and going to a specific password-protected web platform. Once Marie is on this platform, any calls that come in cause a new tab to open in that same program. Within the program, she

[9] Given the nature of this study, and the type of information that Marie works with regarding individuals' mental health, Marie controlled what was disclosed at all times. Further, Marie also read through different iterations of this manuscript to ensure that she, Lifeline, the contracting agencies, and the callers were being represented fairly and ethically.

documents calls, keeps a log of calls that come in (for the whole company and for each individual call-taker), and has a homepage that lists important information for the day, such as which supervisor is in charge. She also has access to specific procedures for which each agency has contracted. For example, there is a procedure for what to do if a caller is seeking a counseling referral. In some cases, clinicians can provide this themselves; at other times, they simply document the request and the agency they're representing follows up with the caller.

Each agency contracting through Lifeline has its own code, which appears on the phone and in the program where call specialists document their calls (step one). This code system allows call specialists to know which agency the call is coming for and matches the script that specialists read (step two). Each call is associated with its own document, referred to as a "call report." While there is a standard format to all documents, the content of each may vary depending on the organization or agency that has contracted with Lifeline (steps three and four). As Marie notes:

> In all documents for calls that come in for an Employee Assistance Program, there is a field that asks for the caller's employer as this is needed to confirm their eligibility for services. Conversely, in most documents for calls that come in for a university counseling center, there is no field for their employer, but usually one for their Student ID number. Generally, we are gathering contact and demographic information as well as clinical information [assessment], using a variety of methods: checking boxes, clicking radio buttons, choosing from drop-down menus, and filling out text boxes with narratives.

Additionally, the documentation platform is split in two. Clinicians type their notes on the left side, while the right contains separate boxes with information about that specific agency, including information on procedures and directions for how to manage various requests. Procedures are compiled by individuals at Lifeline who manage agency accounts. Whenever an agency contracts with Lifeline, they must answer a series of questions on their preferences for how call specialists should handle a wide array of issues that range from crisis intervention to contacting the agency's on-call person. Importantly, for all of these agencies, there is always a number designated for an on-call contact should Lifeline call specialists need to reach out.

Clinicians can access this information while they are simultaneously typing in their documentation. Already, even before Marie has provided any intervention, a plethora of tools and resources all are commingling together to assist her in her work. Even though Marie completed four flowcharts, due to page constraints, I will only include and discuss two of them in this article. For increased legibility, Figure 1 and 2 are my renditions of each individual step in the two calls that help illustrate a a distributed, mediated ethos below.

Figure 1 depicts Marie's exchange with a college student who is seeking support for concerns they have about their friend. Marie consults her procedures from the university counseling agency and loops her supervisor in for support before contacting the caller's friend. Figure 2 showcases Marie's call with an individual who is calling after they have overdosed in an attempted suicide. They state that they are willing to be connected to emergency services; so, Marie consults the procedures, contacts her supervisor for support, and coordinates the call between the caller and their local police department.

In regard to Figure 2, Marie explains:

> During my assessment of this caller, they disclose that right before calling, they overdosed on their psychiatric medications in an attempt to end their life. They are willing to be connected to emergency services so an ambulance can take them to their nearest hospital.

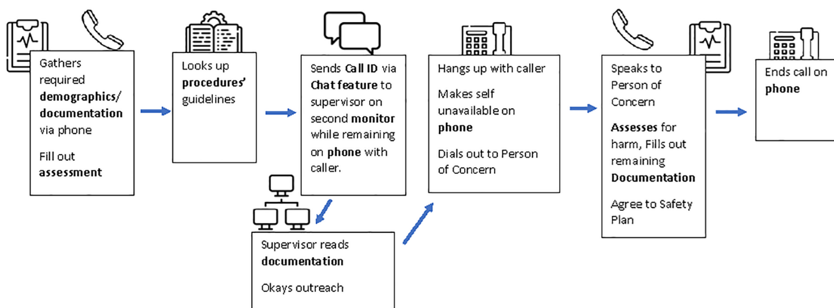

Figure 1. Marie's calling-for-a-friend call rendered as a flowchart.

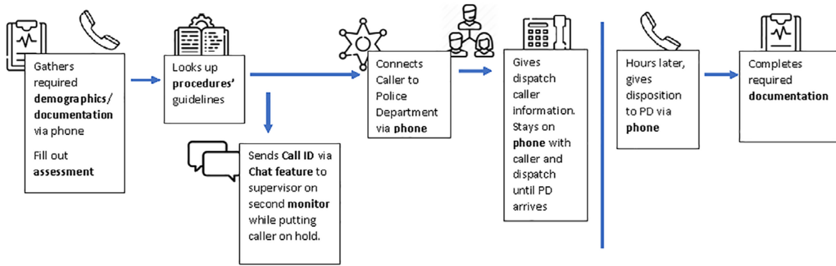

Figure 2. Marie's overdose call rendered as a flowchart.

In most cases, the call-taking process concludes with the same two steps: 1) Marie ends the call by hanging up the phone and clicking the "end call" button in her document, which stops a timer that keeps tracks of how long the call has taken; 2) she then uses as much time as each call warrants to finish filling out the document before clicking a button that electronically sends this document to the linked agency so that they can get information on her intervention and so that they can follow up with the caller in most cases.

Marie's Network Picture

In examining Marie's network picture, Figure 3, a few things become evident.[10] Her placement of call specialists in the center portrays them as the entities that connect together various other entities located both inside of the organization and beyond. Indeed, the hierarchy here is intriguing given that, typically, one would expect internal supervisory and administrative teams to come above one's own role. However, Marie places each of these actors in the order that most typically impacts her work. For example, the other call takers and supervisors are closest to her because she would most likely seek out a supervisor on shift when needing immediate assistance with a call. If they have questions, or an issue comes up, they will go to their

[10] For this analysis, I am relying on Henneberg, Mouzas, and Naude's (2006) systematic framework for the study of network pictures. While there is not sufficient space here to describe all of these elements, I will note that they encourage researchers to locate what a participant prioritizes on his or her map in terms of: centre/periphery; actors/resources; focus; directionality; time/tasks; power boundaries; and concerns that are part of the ecological context but missing from the visual (pp. 418–419).

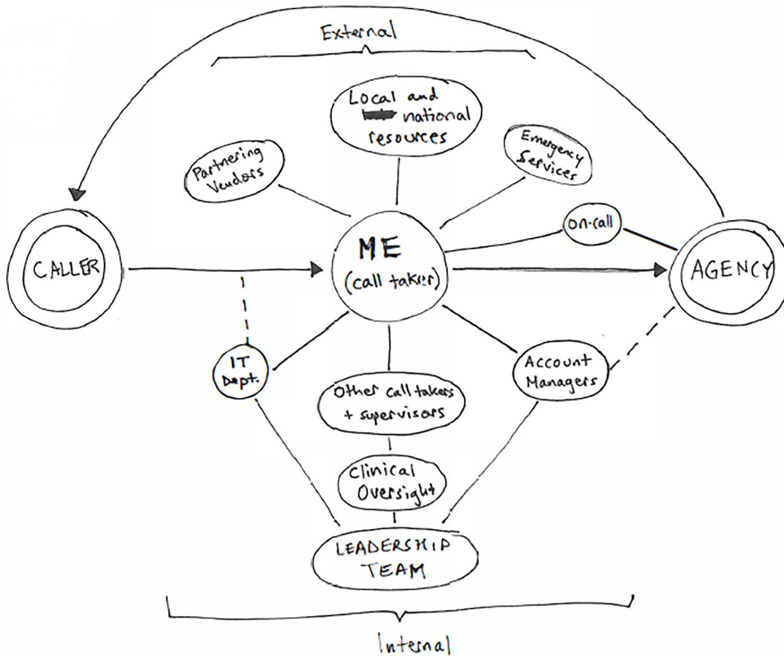

Figure 3. Marie's Network Picture. This handwritten map shows Marie's sense of how various stakeholders and entities participate in her work with Lifeline.

clinical oversight team, and so forth. Yet Marie places them beneath her, not above because, as she states, "These are the things that are supporting me, and these are the foundations that make it possible for me to do my work." Moreover, Marie also wondered if perhaps she doesn't see these entities as hierarchically above her as she has a great deal of autonomy and agency in her work.

Examining the focus and direction here, there is movement that takes place in a couple of ways but involving only a few entities. The most important is how the caller is depicted as moving toward the call taker in order to reach the agency. Indeed, such a diagram supports looking at the work that is performed by these mental health practitioners as intermediary and an extension of the contracting agency. Yet, what's also important here is to note that Marie is focused on the exchanges that take place, not necessarily on the intention of the caller. That makes a big difference because as

Marie describes it, "there's an arrow pointing from the caller to me because the caller contacts me" and, referring back to Marie's documentation from her rhetorical context flowcharts, "then there's an arrow from me to the agency because whatever I talk about with the caller, whatever I do with the caller, that gets documented and sent back to the agency" within minutes of finalizing those documents. Additionally, there is movement that goes from the agency to the caller "because in a lot of cases, it will be up to the agency to follow up with that person" after reviewing the documentation that is inputted into the web platform. Were Marie to be more interested in the intentions of the caller, her role might be visually subsumed by the contracting agency in the picture.

With regard to power and interconnectivity, in addition to arrows, Marie represents connections to various entities by using two other line segment types. One is a straight, solid line, which is used most frequently to denote the direct relationships between various entities. The other is a dotted line that depicts indirect relationships, which are still crucial to Marie's work. For example, Marie's network picture showcases the caller as entering this wide web. Both the caller and the agency are drawn just outside of the web of internal and external resources and stakeholders, but the agency lies closer to it, and it is also connected via two other nodes: directly to the on-call specialist and indirectly to the account managers. The caller, on the other hand, is depicted as moving into this array of people and teams from the outside, meaning that the contracting agency is seen as being more a part of Lifeline than the otherwise symmetrically-placed caller. This inclusion of the contracting agency as being not a part, yet not wholly separate from the network as the caller is, makes sense given the resources (and funding) that it provides to ensure that Lifeline integrates itself well into its processes and practices.

But more than just moving into the depicted system, the call is what "activates" this network. It is clear that the IT department is indirectly connected not to the caller, but to the call that the caller makes. Marie notes that this connection, though indirect because the IT department and the caller never communicate, is still essential given that "without the technology of the caller being able to call and contact, we wouldn't be able to do [our work]." Moreover, this dotted line should stretch farther, Marie realized during her interview. She adds, "There should have been a dotted line between the IT department and that arrow between me and the agency

because similarly all of our documents are kept on a computer, they're shared electronically, so if that fails, we can't get that information to that agency." This is particularly important given that it is within this arrow from specialist to agency that the vast majority of Marie's digital documentation that I encountered in her flowcharts takes place.

Constituents of Distributed Ethos

Various actors mediate the work that Marie encounters over the course of one week, as depicted in her flowcharts. Besides the phone, the browser with tabs and script, the procedures overview, the documentation platform, the chat windows, her supervisor, and hardware (such as the computer and dual monitors) are also vital to the work that she does. Importantly, too, all of these engagements are supported by a larger macrostructure that she details in her network picture. This commingling is not surprising given that in workplace environments, technologies, organizational departments, and entities all "hybridize and become something more than the designers or documenters can anticipate. Technologies stop being standalone products and become parts of technological systems" (Swarts, 2018, p. 5). With this in mind, I focus on how such human and nonhuman resources come together for the deliberate purpose of extending and maintaining an organizational ethos. As such, I point to three constitutive elements that are present in this example of distributed ethos. Primarily, my findings suggest that a distributed ethos (1) projects the impression of being "always there"; (2) relies on dexterity across several human and nonhuman actors; and (3) necessitates targeted tasks from branches that extend ethos farther from the organization. I will elaborate on each in the following subsections.

"Always There" Locality

Reynolds (1993) finds value in connecting ethos to its spatial roots in Greek—that is, a gathering place or an abode (pp. 328, 333). Indeed, I find it apt that there is a denotation of familiarity associated with the term, as in "an accustomed place" (p. 327; see also Miller, 1974, pp. 309–310; and Melonçon & Scott, 2018). This is essentially what Lifeline's structures permit contracting agencies to provide to their respective populations even when these agencies are not available. Though it may be a brief utterance, the moment a call specialist answers the phone invoking a familiar agency name or locale,

they are opening a hospitable location for callers—implying a familiarity when the agency itself cannot be reached. Ironically, Lifeline does this by existing as a no-place, hidden from callers' perceptions.[11]

A distributed ethos, that is, most notably provides contracting agencies with a presence that is always reachable, even when the agency itself is not. Lifeline has clinicians who work 24 hours a day, 7 days a week to meet the demands that come not only at off-hours, but also from various time zones across the country. More importantly, however, this presence is attuned to each caller's specific place via technological tools. Marie is able to provide callers with targeted help without asking for their information. For instance, in Call 1, the caller does not tell Marie anything about what university they attend; rather, Marie answers with the name of the university's counseling center because this information propagates onto her phone and monitor. Similarly, in Call 2, she does not ask the caller what city they are calling from. Instead, local services and emergency numbers are obtained from the procedures document that the contracting agency provided to Lifeline. These features allow Marie to maintain the impression that she is close to the caller geographically, which helps to build trust. Not only is this aspect of Lifeline's work important for developing rapport between clinician and caller, but it also boosts the ethos of the contracting agency given that the caller does not have to provide a lengthy explanation of who they are calling.

What callers perceive, then, is the ethos of the contracting agency that they are attempting to reach. The micro-level engagements that Marie encounters as well as the macro-level organizational structures that support her work all are put in place to engender trust between caller and agency via the image of an agency that is "always there." Indeed, the clinician does not have to work hard to establish such trust because the initial ethos is already granted by the distributed assemblage of tools and resources to persuade the caller that this clinician is part of the organization that they are trying to reach.

In some ways, the non-corporeal element of therapy at a distance already allows for callers to construct the clinician in whatever ways they need to.

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[11] Although beyond the scope of this article, it is worth raising the ethical questions regarding Lifeline's model. Answering as a clinician for the contracting agency and not for Lifeline may help to build rapport but when individuals in a mental health crisis or under stress do call crisis lines or seek help, they are particularly susceptible to the guidance given by those they reach out to (Caplan, 1961). That said, Marie does not hide who she is or change her name in her work. If a caller asks her, she will be open about the relationship that Lifeline has to the contracting agency.

Rosenbaum and Calhoun (1977) long observed that because callers do not see a therapist providing care at a distance, the caller "can project onto him/her whatever qualities needed in a therapist, without fear of having the illusion shattered by the therapist's actual appearance or personality" (p. 329). They suggest a type of neutral ethos—one that is more like a Rorschach and can be whatever the caller desires it to be. While I'm not entirely sure that such a blank-slate ethos is desirable or even possible, Rosenbaum and Calhoun's statement does speak to the importance of the caller's perception of Lifeline mental health clinicians' identity. To adapt their hypothesis to more contemporary technology, a distributed and mediated ethos projects for callers an assumed and stable closeness between them and their clinicians precisely because of the incorporeality of care.

Dexterity

The infrastructure in place at Lifeline is particularly well-integrated, to the degree that Marie noted that she does not feel any change in her own persona when taking different calls. "The only piece that is switching," she stated, "is the piece about who I'm working for in the moment and which company I'm representing." This may seem insignificant for clinicians given that their role remains the same. However, as I've discussed above, that small change enforces an agency's ethos immediately and allows the caller to trust who is on the other line.

The same infrastructure that makes Marie's work seem effortless also highlights the contextual nature of ethos. Scholarship in rhetoric has theorized ethos not as a stable identity, but as one that is constructed as a social act via the context and co-created by rhetor and audience (Reynolds 1993; Mara 2008; Schmertz 1999). This negotiation among speaker, listener, and audience is evident in Lifeline. Indeed, since it is mediated by a range of tools, a distributed ethos requires dexterity to maneuver through each call. A lot of this dexterity happens the moment the clinicians answers a call. For example, in situations like Call 1, where she takes information about the caller and the caller's friend, Marie stated,

> When I'm talking with my caller and I've gotten the essential information I need and they are giving me additional background information that is important, but not essential, I keep listening with one ear, but [am] able to divide my attention to chat my supervisor.

> It's a pretty brief chat: 'This is the account I'm dealing with; this is the situation.'

Because the supervisor has the ability to pull up the documentation that Marie is working on, Marie only has to provide a little bit of top-level context for her supervisor to help consult. Importantly, part of Marie's dexterity is due to her level of experience. Newly hired call specialists, Marie reported, have trouble being present with a caller while at the same time shifting between procedures and resources. That is, there is a conflict for new hires in balancing the ethos of being present with a caller and the ethos of a professional who is knowledgeable and credible. It should also be noted that Lifeline has numerous offices across the country, so the supervisor on duty that day may be in a different state. Even when the supervisor in charge is located in the same building, however, the chat function is still preferred as it helps to keep a record of the exchange.

Marie's dexterity is on display during Call 1, as she multitasks and switches between resources to provide a caller with the precise help that they need (and that she is authorized to give). Even though the individual calling a university account indicated that the person they were calling about would be okay with the university's counseling and support services reaching out to him, Marie also had to consult with her supervisor, who gives her the approval, and check the procedures document for that specific agency account. From Marie's experience,

> Sometimes the procedures will say, 'do not make an outreach call,' in which case we don't. Sometimes they will say 'if this seems like it may be warranted, consult with supervisor and decide,' and sometimes they will say that it might be best to check with the on-call person . . . [and] they may decide that we can reach out or they may take the situation on and decide to follow up themselves.

In Call 1, all of the safeguards in place seemed to suggest to Marie that she could reach out and assess the person's mental health, so Marie initiated contact and was able to get them to agree to a safety plan. In this scenario, like in most of these types, Marie calls the person of concern and when they answer, she greets them by saying "Hello, this is Marie calling from × University," before explaining that someone was concerned about them.

What is evident here is that the negotiation of ethos is happening not only between caller and clinician (Does the person on the other line understand why I'm calling the agency? What I need from them? Can I trust this person to deliver the proper resources?) but between technologies that speak to each other to identify the context of the situation and with supervisors who provide assistance when necessary. After all, even before the clinician responds to the call, the system must link the number to the appropriate account to not only facilitate the conversation between clinician and caller, but also to manage the seamlessness of reaching the agency—both the derived and initial ethos. As Marie's network picture shows, these decisions don't simply end within the confines of the assemblage of technologies that Marie uses or even with the outreach to her supervisor. Supervisors themselves receive clinical oversight to help Marie; as she states, she "feels supported" in the decisions she makes. Externally, she can reach out to the agency's on-call contact to aid in her decision-making process when a situation becomes difficult to manage. Furthermore, the notes that Marie takes are linked back to the agency in a process that continually integrates Marie and the work at the agency. In processing through all of this communication, human and non-human agents must showcase dexterity as they calibrate resources to project the appropriate experience for callers.

Ethos, then, is co-constructed not only within the confines of the visible discourse between rhetor and audience but also by the technologies and various other people and artifacts that support Marie's work. As mentioned above, in addition to listening to the caller and consulting with her supervisor, Marie must also read through the procedures to determine how best to proceed according to the wishes of the agency the caller is reaching, making decisions holistically.[12] The implications of these decisions can greatly impact how an organization's actions will be read, and thus require careful interconnectivity and dexterity by all agents.

Targeted Distribution

Not all nodes in a network of distributed ethos are equal. As organizations grow their networks and extend their ethos, the distributed nodes across

[12] Decisions to contact individuals whom callers are concerned about are made holistically, first by asking the caller how they think that the person they are calling about would respond. If there is any indication that it would upset them, Lifeline specialists do not call. However, if there is some indication that the person in question would benefit from a call, call specialists do attempt to reach that person.

these webs do not simply replicate all of the processes of the organization. Rather, the nodes that extend farther out have a targeted purposed—an outcropping derived from a particular aspect of the organization's function.

In the case of Lifeline, although each contracting agency uses Lifeline to extend its reach to their clients, Lifeline clinicians are bound by contracted procedures that let them know what services they are and are not authorized to provide callers. In almost all situations, as intermediaries between callers and their agencies, call specialists provide targeted mental health assistance, not prolonged mental health therapy. Although they may represent an organization, their interactions with an organizations' clients differs from the exchanges that clients might have with clinicians who are directly employed by the organization; the focus is more on immediate needs rather than on long-term care objectives.

As such, Lifeline does not step in and assume the entirety of the processes and responsibilities that a contracting mental health clinic or agency provides to its clients. Instead, it has a particular role to play with regard to each agency that contracts with them. For instance, in the opening scenario with Deborah, Marie was limited in the services she could provide to the degree that she could not schedule an appointment herself and instead had to ask Deborah to call back because the procedures prevented her from doing more. Or, in Call 2, neither Marie nor Lifeline is responsible for any follow-up care. Their targeted role is bound and defined by procedures set in place.

In every call, however, Lifeline clinicians must perform an assessment of the caller and provide targeted help. The assessment protocol is particularly important in these scenarios as it helps to guide what the conversation will focus on. This assessment is the same for every call—regardless of what agency the report is going to—and addresses four basic areas of risk (harm to self, harm to others, substance use, and interpersonal violence) as well as whether a caller is taking any prescribed psychiatric medications and whether they present with any cognitive concerns (such as hallucinations, paranoia, etc.). While this information is not used to make a diagnosis, it does determine how to assist the caller and to mitigate any risk that is present. As Marie points out, "We often have to refrain from engaging in a therapy session with the caller and refocus them—what are they going through *tonight*; what can we help them with *tonight*?" (emphasis in original).

Lifeline, then, as an extension of an organization's ethos, is trusted with providing immediate, specific, and targeted assistance without engaging in

longer therapeutic exchanges. These calls, in essence, are meant to be much shorter, although there are exceptions, such as in Call 2, which requires Marie to follow the situation over the course of over an hour. The robust tools that are available for Marie and the complex internal and external structures that support her work are all in place to provide agencies' constituents with only a slight extension of the agency's presence—one that deals specifically with in-the-moment needs and crises. That is not to say that they are not vital. As is evident from the examples above, sometimes callers dial in with matters of life and death.

Implications and Future Work

Angeli's (2019) main takeaway regarding distributed cognition in the emergency medical services (EMS) field stresses the importance of paying attention to how numerous actors are implicated in carrying much of worker's cognitive workload in these unpredictable situations. Making the case for future work exploring distributed cognition in workplace settings, she writes,

> If a workplace document is incomplete or inaccurate, we often turn to the writer and ask, "Did you forget something?" We are quick to ask the writer to see what he [*sic*] forgot, but, as the EMS workplace shows, the writer is not the only one involved in the documentation and recall process. External forces that make up professional and collaborative memory play a role in recall (p. 145).

Here, too, with distributed ethos, it must be acknowledged that a speaker's identity is not entirely controlled solely by the rhetor. Rather, complex systems and people are all implicated to various degrees in maintaining an ethos across digital, analogue, print, and face-to-face situations.

Because of the service they provide, Lifeline presents a clear example of distributed ethos. However, other settings might open up further work into researching distributed ethos both inside and outside of health settings. For example, the professionals who interact with patients at a clinic or a hospital all represent a unit of care. In what ways does the distributed ethos of that clinic merge to successfully build trust with patients? At the same time, where might all of the tools that support building credibility create inconsistencies that skew patients' perceptions of an ethos of care? An incongruent ethos of care can exist across numerous medical contexts. For instance,

there may be an inconsistency in how a patient is treated or referred to by doctors, nurses, and in written materials at a clinic; such inconsistencies can have consequences for how a client perceives the professional care that they are receiving from this provider. Hence, it would be important to not only examine differing medical messaging that make up part of the distributed ethos of the clinic, but also the tools that mediate such interactions with patients as well as the organizational structures and processes that lead to inconsistent or problematic messaging. The question to keep in mind is, "Where might there be incongruence in the assemblage that spreads an organization's ethos for clients and patients?"

I offer three elements that define a distributed and mediated ethos in this case study: an "always there" presence, dexterity, and targeted distribution. Future work should explore these constituents further with engagement from more participants. For example, it would be fascinating to collect network pictures from various clinicians and staff at contracting agencies to see where Lifeline is visually depicted in these cognitive maps. Is it a prominent branch, co-equal with other areas of support that an agency provides, or would it be omitted altogether given that Lifeline is not a physical or structural part of the organization and provides a very specific service to the therapeutic work that takes place at these agencies? Such studies could paint a more in-depth picture of the blind-spots and differing perceptions that those embedded within these networks have regarding people and systems that are implicated in maintaining and extending an organization's ethos.

Moreover, future studies should examine what these three constituents look like in other settings as well. Of particular importance is to determine if these constituents remain true for all cases of distributed ethos or if they vary based on context. For instance, there may be cases where an organization distributes its ethos to a node that is disconnected from its organizational structure, but not for the purpose of being "always there." In these scenarios, it would be important to determine what time-based and localized affordances this extension of ethos provides.

There are also opportunities to study breakdowns in the projection of a distributed ethos. While Lifeline's structure and processes attempt to create a seamless connection between patient and agency, there are times when breakdowns in messaging occur periodically. For example, when technology crashes, call specialists must take notes with pen and paper. While this solves the issue of documentation, in Marie's words, call specialists are still

"flying blind [because] we don't have access to caller's particular agencies' procedures." In these instances, clinicians do not know how exactly to move forward with a call and must use their best judgement in proceeding, which may lead to contradictory messaging when the caller eventually does reach the contracting agency or when s/he reaches Lifeline again once clinicians have access to their documentation. Similarly, by examining what happens during the breakdown of one tool or miscommunication between departments, researchers can gain a better understanding of what role they play in disseminating ethos via their absence.

Of course, ethical questions arise as well when studying sites that utilize a distributed ethos—particularly when clients may not be informed that they have not, in actuality, reached whom they are calling. As I have mentioned above, clinicians are free to reveal that they work for Lifeline when callers ask. Because disclosing such information immediately would cause confusion during potentially sensitive or urgent situations, it is not standard practice for clinicians to do so without being asked. Opportunities exist to investigate the role of ethics within such networks, particularly within the backdrop of human-machine interactions, given that a distributed and mediated ethos is inherently supported by a variety of technological artifacts and processes.

For clinicians—particularly graduate students and recent graduates from social work, counseling, and clinical psychology programs—focusing on a distributed ethos might help them better acclimate to the different roles that mental health call centers such as Lifeline require of them. Marie pointed out that new hires tend to struggle with adjusting to providing care at Lifeline; often, this is because graduate programs typically only cover traditional career paths for their students (Richards & Viganó, 2013; Anthony, 2015). Since they have only been trained to provide care as the focal care provider during a face-to-face therapeutic session, new graduates might have a hard time adjusting to expectations in employment contexts such as call centers. Thinking about distributed ethos may help them to gain a broader perspective of their role within an organization—especially in terms of where they must adjust their actions and their identity to conform to the desires of a contracting agency.

While this pilot study offers a small glimpse into how Marie utilizes technologies to implement appeals to ethos, the main concern of this study has been to examine how the different human and nonhuman actors at Lifeline help to distribute and mediate a mental health agency's ethos when

callers attempt to contact that agency. As mentioned, single-subject case studies cannot necessarily be generalized to larger populations. However, opportunities exist in small-scale research to focus more closely on the specific role of mental health call workers as they navigate these mediated identities via distributed resources. As part of a larger, more prolonged study at Lifeline or a similar mental health setting, it may be worth studying how judgement calls are made by clinicians in the moment (kairos) and how the ethos of the clinician is itself co-constructed by supervisor's guidance and other mediational tools. Such a study might measure not just the spread of the initial ethos of contracting agencies, but also the derived ethos of clinical mental health workers as they switch during calls between tasks and identities for each of the agencies that they represent.

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