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Digital Discontents: Freedoms and constraints in platform social work

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1 Introduction

Within the United States, digital technology has altered social work practice in a variety of contexts. Digital tools, in particular, are impacting the practices of social workers who provide services and resources to clients across domains, from mental health care to public benefits to the criminal legal and child welfare systems (Brown et al., 2020; Busch & Henriksen 2018; Eubanks, 2018; Gillingham, 2019). This evolution across the profession is also enforcing change to the practices that licensed professional social workers utilize to deliver tele-mental health services. While psychotherapy has long been conducted through many different technologies, including radio programs, telephones, and the internet, in the twentieth century (Zeavin, 2021), other forms of technology-mediated therapy have emerged in the wake of the Covid-19 pandemic–especially as consumers are searching for accessible services, governments are eager to leverage cost savings, and investors are wishing to make the most of a new business opportunity (Mills & Hilberg, 2018; Pendse et al., 2020; Teghtsoonian, 2009). In response to this demand, social workers practicing in various settings are now offering clients tele-mental health care via video, text, phone, or email. Many social workers within the United States are seeking out new opportunities within the gig economy, contracting with direct-to-consumer (DTC) digital platforms that offer therapy to subscribers.

As a relatively novel actor within the American healthcare system, digital platforms promise consumers and practitioners greater *freedom* to receive and to provide mental health care. Consumers who seek out care on these platforms are promised wellness with minimal effort.“ You deserve to be happy,” some sites assert, “Feeling better starts with a single call,” invites another. Similarly, providers turn to work on tele-mental health platforms as a mechanism to practice privately without the responsibilities of maintaining a business or partnering with a group, contracting to offer services with flexible working hours and working arrangements. workers who choose to contract with platforms are promised the freedom to elect an arrangement that aligns with their individual goals. Therapists seek platform employment to supplement their income, to find resources to sustain their own private practice, or to cultivate clinical skills that they might not otherwise develop in their full-time jobs (Goldkind & Wolf, 2021).

While platforms hold out the promise of offering greater freedom for social workers, working with these actors imposes many *constraints* upon their practices. Providing therapy on platforms requires different kinds of work and increasing volumes of labor in order to maintain a desired caseload. Digital platforms advertise that a skilled therapist will be available to provide twenty-four hour support via video, phone, or text messages. In order to

meet these promises, providers adapt the style of care that they offer to their clients on digital platforms. Practitioners, in particular, undertake targeted efforts to cultivate (digital) intimacy with their clients in synchronous and asynchronous modalities. Much of the labor that providers undertake to cultivate intimacy with their clients remains invisible, and thus uncompensated.

This qualitative study describes how the emergence of digital platforms as a relatively new actor in the delivery of tele-mental health care within the United States has shaped the experience of providing therapy. It reports on a sample of 22 licensed social workers who contracted with digital platforms, describing the ways in which they work creatively to sustain caring relationships with their clients. The resulting analysis emphasizes the different workplace *freedoms* that digital platforms promise to their contracting practitioners and the resulting workplace *constraints* that contracting practitioners experience once they begin offering therapy to platform subscribers. This description of how a subset of social workers are providing mental health care on digital platforms can inform future efforts to provide mental health care within the gig economy. It encourages mental health professionals and researchers to pay thoughtful attention to another domain in which technology promises to change social work practice within the United States.

2 Literature review

For those social workers who are seeking to offer therapy in private practices within the United States (Kazdin & Blase, 2011), new opportunities to provide tele-mental health services have arisen within the gig economy (Huber, Pierce, & Lindtner, 2022). Privately owned, technology driven, direct to consumer tele-mental health platforms have become a new actor in the fragmented American mental health landscape (Goldkind & Wolf, 2021). These platforms facilitate virtual forms of short term work, allowing workers to participate in the gig economy by "using apps [also commonly known as platforms] to sell their labour' (Taylor et al. 2017, 23). Companies–including Breakthrough, BetterHelp, iTherapy and Talkspace–that provide DTC tele-mental health services rely on proprietary software platforms to provide a digital interface (Huang & Bashir, 2017). Platforms serve as a "broker" between consumers and practitioners, as well as the site that manages the logistical and interactive components of therapy.

Scholars have criticized the introduction of digital platforms into the mental health care sector. Sherry Turkle, a scholar of digital connectivity, for example, has argued that "networked life" is discouraging the formation of close relationships (2012). Turkle along with other critics have asserted that meaningful therapeutic engagement requires "bodies together in the room" (Turkle, Russell, & Essig, 2018). Todd Essig, a clinical psychologist and psychoanalyst, has observed that many "mental health technology entrepreneurs" are seeking to enroll an army of tele-mental health providers to yield an "explosion in the products they're selling" (Zeavin, 2021, p. 231). Despite such criticisms, practitioners are still drawn to practice on platforms by the "approximation of freedom" over their therapeutic labor (Huber, Pierce, & Lindtner, 2022).

The mental health services provided on digital platforms require practitioners to create digitally intimate relationships with their clients. Although it has long been possible to conduct intensive forms of therapy over distances, using phones or video technology (Ehrlich, 2019), mental health professions must identify new ways to use technology to sustain intimate therapeutic relationships that compete with the social connections offered by other social media platforms like Facebook (Thompson, 2008; Reade, 2021). Sociologists of technology

and biomedicine have acknowledged how–in spite of the skeptical view that technology would transform care from a warm, human enterprise to a cool, artificial one–the introduction of digital modalities can facilitate intimate relationships (Oudshoorn, 2011; Pols, 2012; Pols & Moser, 2009). Within the biomedical field, the concept of "digital intimacy" refers to "relationships characterized by a thorough familiarity made possible, sustained or reinforced through electronic devices by means of both data sharing and personal communication" (Piras & Miele, 2019, p. 117). Providers, caregivers, and patients have demonstrated that they actively can adapt to these technological changes and create supportive therapeutic relationships in the process (Langstrup 2013; Roberts et al, 2012).

In the context of mental health care in the United States, digital platforms have (paradoxically) facilitated intimate relationships by promoting the anonymity of clients. In the 1950s, crisis hotlines with Protestant origins relied heavily upon the illusion of anonymity to create a confessional space for callers to speak about sinful subjects, such as suicidal ideations (Zeavin, 2021). By promising anonymity, digital platforms offer clients a means to therapy that they might not otherwise utilize and a space to discuss sensitive topics that they might otherwise suppress. Although practitioners struggle with the ethics of these anonymity requirements, as they deprive them of identifying information that they need to make use of in an emergency, they acknowledge that anonymity helps clients to feel more comfortable discussing issues that make them feel ashamed or uncomfortable (Goldkind & Wolf, 2021).

The cultivation of digital intimacy requires providers to engage in emotional labor. Most studies of professional caregivers who provide mental health services have attended to the related phenomena of 'vicarious trauma' or 'compassion fatigue,' but they have failed to describe the *practices* that providers have developed to provide therapy for individuals in digital environments (Huber, Pierce, & Lindt, 2022; Taylor & Furlonger, 2016). Much like Arlie Hochschild identified the emotional labor, or "feeling management," that flight attendants exhibited when providing genuine care to airline passengers, mental health providers undertake many forms of labor to turn their acts of care into a commodity that digital platforms can market and sell (1983). Many of these social practices are associated with sustaining engagement with their clients. Digital platforms do not compensate providers for these informal acts of care, but such labor is essential to sustaining relationships with the consumers who receive mental health care within the gig economy.

Much of this emotional work falls under the umbrella of what scholars have termed invisible labor. Invisible labor refers to those "activities that occur within the context of paid employment that workers perform in response to requirements (either implicit or explicit) from employers and that are crucial for generating income, to obtain or retain their jobs, and to further their careers, yet are often overlooked, ignored, and/or devalued by employers, consumers, workers, and ultimately the legal system itself" (Crain, Poster, & Cherry, 2016, p. 6). This concept was borne out of the work of feminist sociologists in the 1980s, including Arlene Daniels, who described the unpaid work that women performed in the domestic sphere as invisible. Marjorie DeVault further identified the conceptual biases that accompany the evaluation of such work, noting that most capitalist cultures frame different caregiving duties–such as preparing meals–as "act[s] of love" or an "expression of a natural role" as female caregiver as opposed to uncompensated forms of labor (DeVault, 1994; Star & Strauss, 1999, 10). Within the context of frontline healthcare workers, scholars have begun to observe many forms of "invisible work," or labor that is "unnoticed, unacknowledged, undervalued or unregulated" (Ming et al, 2002, 139).

Invisible forms of work also define tele-mental health care work conducted as part of the gig economy. A vast "human infrastructure" provides emotional support to clients seeking assistance via technologically-mediated mental health services (TMMHS) (Pendse et al, 2020). Many forms of this "virtual work" rely upon humans to perform tasks in the background that easily remain hidden (Cherry, 2011; Scholz, 2013). Professional therapists working on digital platforms undertake many forms of labor that go uncompensated, but remain instrumental to assuring that digital platforms make a profit off of their subscribers. Much of this invisible labor pertains to setting boundaries with clients, as many platforms invite consumers to connect with their provider at any time or to share photos, audio messages, video messages with "unlimited plans" (Zeavin, 2021; Kehrwald, 2008). By making such practices visible, this study joins other scholarship that "pulls back the screens of invisibility" surrounding the use of technology within the helping professions, in general, and tele-mental health care conducted on digital platforms, in particular (Raval, 2021, 27; Ming et al, 2022).

Study Questions:

This research is guided by three primary study questions:

1. How do digital therapy platforms invite new practices among clinical social workers?

2. What attributes of platform work shape the delivery of clinical social work?

3. What new strategies are social workers developing in the platform service delivery context?

3 Method

This qualitative study utilized semi-structured interviews and a grounded theory approach to explore how licensed professional social workers experience working for private direct to consumer tele-mental health platforms. All of the participants were practicing, or had practiced on one or more privately operated tele-mental health platforms. Interviews were conducted by telephone and audio recorded. The electronic audio files were transcribed by a professional transcriptionist. This research was conducted under the auspices of one of the principal investigator's Institutional Review Board.

3.1 Sample

Possible participants were recruited from the websites of two United States-based private for profit third party direct to consumer tele-mental health platforms. Platforms were selected because they are national in scope and each of the selected platforms provided the credentials and names of the providers publicly. A total of 750 licensed social workers were invited to participate in an individual interview. An initial postcard was mailed to the social workers followed by two reminder mailings. For this sample, traditional mail through the US Post Office was appropriate, as practitioners' mailing addresses are public domain and published on the National Provider Identifier website, as opposed to practitioner emails which are not public domain. Fifty individuals responded to the mailing, contacting the principal investigator and leaving a message to indicate interest. Of these, 30 individuals responded to a follow-up call to schedule an interview appointment. Ten individuals canceled or did not attend a scheduled interview. A single practitioner who missed a scheduled interview participated thereafter. The remaining nine who canceled did not respond to researchers' attempts to reschedule. Twenty one individuals completed a one hour telephone interview.

3.2 Data Analysis

Transcripts were imported into Dedoose, a Web-based qualitative tool for data analysis and warehousing. Dedoose was used for the coding of all the transcripts. All three members of the research team were involved in reviewing the transcripts. Open coding was used (Strauss and Corbin, 1998) to help identify concepts and their properties. As in the model outlined by Strauss and Corbin, the goal was to uncover common themes 'grounded' in the data themselves (Beard et al., 2009). By reviewing the codes and memos and constantly comparing the data, themes and categories were initially developed. First, all authors independently coded the data. The authors then met to discuss the coding and themes that emerged.

A member-checking process was implemented using a modified focus group – modeled on the Synthesized Member Checking approach described by Birt, et al. (2016), in which study participants are asked to help co-construct findings by responding to findings that have been synthesized. Tobin and Begley (2004), describe member checks as "the most crucial technique for establishing credibility" (p. 314) in a study. In this way, the participants may add credibility to the qualitative study by having a chance to react to both the data and the final narrative (Creswell & Miller, 2000). Focus groups are a recognized way of exploring the opinions, beliefs, and attitudes of a group of people and of enabling people to interact and respond to one another.

4 Findings

This study found that mental health providers adapted their caregiving labors to suit the demands of digital platforms. They leaned into the promised freedoms, seeking to use their platform work to achieve greater flexibility in their working conditions, and they responded to the ensuing constraints that the platforms laid upon their private practices. In order to facilitate therapeutic engagement on these platforms, providers identified novel ways to build rapport with their clients. Their efforts to create digital intimacy often entailed crafting thoughtful emails, creating introductory videos, offering a free service to facilitate engagement, or responding with emotionally-sensitive language in texts. All of these caring labors, while necessary for providing high-quality therapy in a digital space, remain invisible–and thus uncompensated–by digital platforms.

4.1 Freedoms

Digital platforms promise many freedoms to their contracting practitioners. Many providers turned to work on digital platforms in an effort to build up their own private practices or to supplement their income. "...I needed more money," one social worker shared about joining the platform. Participants often turned to digital platforms because they offered a space for them to provide therapy "on-line, you know after hours, on the weekends." Some providers used platforms to develop their clinical skills while they worked in other capacities, sharing that "it really built my own confidence as I was learning how I practice, and educating myself in other ways too, while I was in my training program." After building up their confidence with providing therapy on platforms, then providers felt more comfortable establishing their own private practices. "I was working at a large state mental health system, and I was looking at my options to be able to leave that job and set up my own business," one participant shared. These opportunities allowed providers to transition out of seeing their clients face-to-face in their private practices: "the clients I even see in the office will need to see me on one of the platforms that I work on."

As part of offering material freedoms to contracting providers, digital platforms also promised them flexible work arrangements. As one provider summarized,“... I think there's advantages for the provider, in terms of flexibility, you know added income if they do have a full-time job, added opportunity for growth, reaching out to people in different places that are more remote…” Some participants celebrated the control that they had over their hours. “I think, yes, you get to set your schedule and you get to work on your own time, and dedicate you know forty hours a week, or four hours a week, or you know one hour a week….” Others appreciated the “mobility of it….I can work from where I am, so as long as my clients are in Michigan I can work from home, I can work from my office, I can work from a motel room, I can work while I'm traveling, and so that is a huge advantage….” The flexibility gave some people the opportunity to “work from home” so that they could cover their childcare duties (“it was all because of childcare”). The allure of flexibility promised providers an ability to deliver therapy to their clients without the obligations and frictions of face-to-face or full-time employment.

Even with these promised freedoms, providers still acknowledged some material downsides to contracting with platforms. Some providers described the policies that limited their compensation for providing therapy. “I mean if I could've added hours to my psych-therapy practice, like if that was a realistic option that would've been my preference, because frankly it pays much better to see someone in person for 45 minutes…” In fact, platforms “would receive a portion of the client's monthly fee or a portion of the clients' fee for their video session or something like that. And I would have a maximum number of clients ….that I was allowed to accept on each platform.” The platform compensation schemes frustrated certain providers. “Again, my husband is my business manager, so it's a little closer to home, literally, and he'll ask me, like, 'Oh, how much did you get…he'll say, 'but you spent so much time on that and that's all you're getting?'” Moreover, the introduction of word count-based remuneration frustrated some practitioners (others felt that they “came out better with the word count” than they did with past compensation schemes).

Similar to these noted setbacks, providers acknowledged that the freedoms promised to subscribers often conflicted with their own interests. Consumers got to choose how often, and by what medium, they wanted to engage with their provider on the platform for therapy. Providers on these platforms noticed that “in a virtual environment…it's client centered, so the client wants a ten minute interaction that's what they get and that's what you get paid for. And if the client wants a ninety minute intervention that's what they get and that's what you get paid for.” Moreover, it rendered the service far more accessible to the client: “....there are times where you know the weather may not be permitting for us to come to the office, so we can do a tele-session. Also, if the client is traveling, it can provide for more consistent income because you know if you're on vacation, if they're on vacation and they still would like to meet, we could have the client do that, so video actually…comes in handy.” Other providers indicated that they believed that “in terms of pricing for some of the apps, it allows access to mental health services to some people who normally might not be able to afford it.” The freedoms promised to the subscriber thereby gave them far more control over the pay that providers received from the platforms.

4.2 Digital Demands

As platforms have become more ubiquitous within the sphere of tele-mental health care delivery in the United States, they have created new digital demands for providers. In particular, they have influenced the practices that providers use to build intimate, therapeutic

relationships with their clients. The platforms structure in protocols to encourage rapport building. “Yeah, so I mean they want you to initially like send out an intro, like, 'this is who I am,' and this is about” the platform. “I find it hard because I think you know there isn't much time for patients to really say, like, 'I like to practice yoga,' or, 'I like to garden,' or whatever.” Clients are able to choose the modality in which they would like to communicate with their therapist; and many practitioners described the additional kinds of communication that they had to use when they were not able to engage strictly with video. Providers shared that they had to think carefully about their language and phrasing “by phone where they don't have a visual of you, and then even more so in writing when they don't have any cues except for what you write.” Providers had to creatively adapt their clinical practices to engage clients and to cultivate a sense of intimacy that would retain their clients on the platforms.

Many providers preferred using visual modalities to cultivate intimacy with their clients. “I just feel like there's more of a connection, and you can build a rapport more.” When “you're not face-to-face, you really don't get to see the body language, you're not really building a rapport,” someone continued. Providers found the lack of visual clues to be especially challenging when building relationships with clients: “And then, I don't know, it's harder to build rapport via texting when you don't have some initial contact, you know.” For this reason, some providers offered “everybody a free video session just because I think it really helps with the engagement and also getting more clinical assessment data.” Some providers noted that “even via like the video sessions, like there's ways in which an engagement suffers just from the lack of like face-to-face interaction,” stating that “all the ways in which people can mis-perceive one another's intent, obviously it becomes amplified.” These challenges did not, however, deter many providers from identifying strategies for effective communication and engagement within the digital modalities that working on the platforms entailed.

In an effort to adapt their practices to fit the demands of digital platforms, practitioners explained their adaptations to provide therapy over text. This deliberative process involved trial and error: “I've also had people that mis-interpreted what I'm saying to them on the platform.” Many participants detailed the effort that they put into thinking through their written dialogue with clients in order to secure effective communication: “... I just wanted to make sure they sound right, and you know how it’s coming across…” The asynchronous nature of text or email gave providers an opportunity to carefully craft their responses to their clients.

Although it often took greater effort to convey meaning precisely in text, providers described attending to their own textual specifics and to a client’s relationship to language as critical to cultivating close relationships in writing. Therapists also worked to extract meaning from every aspect of a client’s digital communication: some providers described how they could analyze how frequently their clients wanted to reach out to them for support, observing how their clients would either send or delete emails. Such escalated forms of attention afforded providers with a supplementary conduit to understanding their client’s thought process. These various hermeneutic and psychological strategies reveal some of the ways that providers adapted their practices to cultivate intimate, digital relationships–and to meet the material demands of the platforms in the process.

4.3 Invisible Labor

In order to build these intimate relationships, practitioners actively engaged in invisible labor for which they did not receive compensation. Although platforms suggested that their practitioners engage in “an interaction once a week,” practitioners still had to make judgments

about the kind of care that they provided via text or email exchanges. Some participants had to explain to their clients that they were “not on call, it's not like texting your best friend.” Other participants engaged in more frequent text exchanges if they felt that it was clinically indicated for their clients: “if somebody's motivated I don't mind them texting several times a week even if I'm just getting paid for one interaction a week or something.” Platforms did not, however, remunerate providers for making these decisions. “So if I respond to three people during the week then I'll get paid for that week no matter how many times I ended up responding to them,” one provided explained. When providers frequently engaged with clients via text, they made a therapeutic–as opposed to financial–investment.

In response to their clients having constant access to their services via the platforms, practitioners engaged in different kinds of emotional labor. Many providers believed that clients abused platforms to try to receive real-time feedback on their issues. While clients could easily text their therapists the minute an issue arose, many providers believed that “…people need to cope on their own a little bit.” Certain clients did not, however, share this sentiment: “in the past I have had some people that messaged like all day long, and, 'I haven't heard back from you. I haven't heard back from you. I want to make sure you're getting my message…” When they faced clients who did not sensitively utilize their communications with them, participants managed their strong emotions. Providers found it “pretty frustrating” when their clients tried to engage in a “text conversation” because it set up a mismatch between their therapeutic expectations. “I think it's frustrating,” one provider reflected, for the clients “too because they don't feel like they're getting anything out of it but they're not really putting a lot into it either.” These diverging expectations set up many occasions where practitioners had to manage their emotions in order to offer their therapeutic service on the platforms.

In addition to managing their own feelings, practitioners had to engage in additional forms of care that went uncompensated. Some of these extra labors pertained to the close reading practices that text or email exchanges engendered. Certain clients might “send these multiple pages' that required providers to take a “long time” for developing an adequate response. “I look at the kinds of words the person's using to describe what they're going through, you know the grammar, and not so much from an intelligence standpoint, but from a, 'I'm in so much emotional turmoil, I'm just spewing right now'” The digital platforms did not, however, pay providers for the time that they spent preparing these responses. Other additional labor pertained to safety planning for clients who were in crisis. The anonymity requirements of platforms made it harder for providers to assist clients experiencing suicidal ideations. “I believe you know they say there's disclaimers all over the place about you know suicidal behavior or suicidal thoughts, but people do get through who are suicidal…” The work that they took to secure the safety of such clients was just one of many forms of invisible labor that practitioners engage in to offer appropriate care to their clients.

5 Limitations

This study intentionally sought reflections, thoughts, and ideas about platform based tele-mental health from licensed professional social workers in order to gain a more nuanced understanding of the practice of therapy in digital spaces. The primary limitations of this study are the generalizability of the findings, the small, self-selected sample and a qualitative coding scheme. While the modalities may overlap, contract work on a platform may not be generalizable to all virtual therapy. Our aim here is not to represent an entire population, but rather to call attention–and to initiate future discourse about how social workers experience freedoms and constraints while working on direct to consumer tele-mental health platforms.

While the number of participants is small, we do not regard the sample size, per se, as a study limitation due to our desire to learn in detail and depth about the experience of practitioners. The authors believe that the perspectives offered from this pool of subjects raises useful insights about conducting social work on a digital platform that would otherwise go unnoticed by scholars of the gig economy.

6 Discussion

This paper has described the freedoms that commercial mental health platforms promise to providers delivering therapy via platforms and the digital demands that this virtual contract work makes of providers. In particular, it has identified some of the strategies that clinical social workers undertook to successfully cultivate digital intimacy with their clients and noted the invisible labor that creating such intimacy required. These direct observations can inform how mental health professionals and researchers engage with future discussions of tele-mental health care work. In particular, this description of social workers' experience working on platforms offers one example of the "technologization of service delivery" in social work (James, et al., 2023). It suggests how this technologization could alter professional potentials and may redefine the skills necessary to provide services.

Based on the findings, this research suggests that social workers may not understand the implications of taking on digital forms of work and of partnering with commercial actors to provide services. The findings enumerated here suggest that participants were individually responsible for discovering the constraints that accompany contracting with platforms in addition to noting the attractive freedoms. Study participants felt responsible for building new skills to deliver quality interaction, and to labor in uncompensated ways to establish and sustain digital intimacy. Congruent with research on behavioral health providers more generally, licensed clinical social workers in this sample cultivated these skills through self-study, via trial and error, or by initiating conversation with peers, in the absence of required supervision or relevant academic training (Goldkind & Wolf, 2021; Perry, Gold, & Shearer, 2020). From efficacy concerns to the under-articulated labor arrangements imposed by commercial platforms, more research and professional dialogue is needed to help social workers to become aware of the material and clinical expectations that working on platforms may entail in the future.

These findings suggest that a key focus of these discussions must be the cultivation of digital intimacy. While psychotherapy has long been conducted across distances, introducing asynchronous and synchronous modalities–email, video calls, phone calls, and texting–into the caring relationship requires the practitioner to develop a host of new social skills. Providing care through emails and texts requires a combination of close reading skills and writing skills that licensed mental health professionals would have developed outside of their formal training. Conveying empathy through video or phone calls requires a familiarity with communicating emotional responses with limited body language or exaggerated replies that licensed mental professionals would have had to develop on their own time. All of these skills, nevertheless, are essential to creating caring relationships through the technology that digital platforms entail. In the future, educational curricula should account for the skills that providers use to build digital intimacies.

Most of the practices that providers employ to show care in digital modalities are currently hidden from the view of platforms or consumers. The human infrastructure that currently sustains digital platforms perform a variety of uncompensated tasks that build rapport, sustain engagement, and monitor risk of harm with clients. Digital platforms do not presently

compensate providers for the intensive work that they do to ensure that their clients receive engaging care that meets their professional standards. Many practitioners dedicate significant conceptual resources toward determining when to respond to asynchronous communications via text or email or devise innovative strategies (such as offering free video consultations) to build a therapeutic relationship with their clients. The compensation policies that digital platforms have developed, then, should not serve as the precedent for future iterations of digital psychotherapy. Rather, future compensation policies need to account for the formerly invisible forms of labor that providers put into producing caring, digital relationships with their clients. Future approaches that digitize mental health care–and the policy or regulation that attends digital forms of care–must attend to the freedoms offered to and demands made of mental health professionals that are laid out in these findings.

7 Towards a Future of Care

This work is in dialogue with research that documents and interrogates how digital platforms are changing the nature of labor within the virtual service economy. Cole (2017) explains that platforms "maintain a proprietary architecture that mediates interaction possibilities" (np); and mental health platforms generate income by brokering and mediating the relationship between therapists and their clients. As virtual intermediaries, platforms obfuscate many practices that providers utilize to sustain digital relationships with their clients. In other sectors of the gig economy, the labor that goes on "behind the website" has been termed *Ghost Work*. Coined by anthropologist Mary Gray and computer scientist Siddharth Suri, "ghost work" describes the conditions in which humans must step in to compensate for the work that computers can or cannot perform (2019). When it comes to delivering tele-mental health services, practitioners are devising new practices to adapt to the demands of the platforms, including the subscribers who are using them. Much like the ghost work required to sustain the constant availability of sites and interactions across the internet, these practices often remain invisible to users.

In addition to generating a demand for novel forms of unseen labor, the platform model has transformed the purchase of services. Highly visible transformations have reconfigured access to transportation, food delivery, and low-skilled tasks over the past decade, while more recent "platforming" has offered alternate conduits to the purchase of professional services from lawyers, architects, accountants and licensed therapists. Substantial research describes this development, conceptualizing its economic implications in broad terms and well as iterating the specificity of its impact in the lives of individual workers. Study of the worker experience of contracting with platforms describes accelerating alienation, loss of autonomy, and precarity, while evoking ever-evolving practices of resistance (Moore & Joyce, 2017). Researchers note that the proffered freedoms of platform work–flexibility across time and space and anonymity–sever workers from the economic and social benefits of traditional employment configurations; moreover, they explain how the attendant siloing of individuals imposes novel relational demands, impacting the capacity to derive meaning from labor (Grant, 2007).

The entry of commercial platforms' into the provision of therapy has inserted a new actor into the fragmented landscape of mental health care in the United States. A variety of "commercial entities" now influence the health of the American population, and a lack of conceptual study has so far obscured their effects on the quality of care (Lacy-Nichols et al, 2023). Digital platforms are just one set of commercial actors that are altering the provision of mental health care in an overburdened healthcare system (Pierce et al., 2021). While research on tele-mental health is expanding, documenting uptake by clients and growing acceptance by professionals,

little research describes how commercial platforms are shaping the virtual delivery of therapy. While advocacy for health justice, efficacy, and the ethical provision of care traditionally center on client-consumers, findings from this study and others urge that, in order for the delivery of tele-mental health care on digital platforms to be truly just, those who labor to provide it must be valued in their working conditions and by the policies that govern their work.

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