Doing the Work

Therapeutic Labor, Teletherapy, and the Platformization of Mental Health Care

DATA& SOCIETY

by Livia Garofalo

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Executive Summary

The mental healthcare profession is undergoing significant shifts as it increasingly moves online. Especially since the COVID-19 pandemic, more people than ever in the United States are accessing psychotherapy and counseling remotely. Teletherapy has allowed clients and therapists to connect across physical distance, often to the benefit of those seeking mental health support. Therapists themselves have to contend with these changes, not only adjusting their practice to the virtual space, but also adapting to new ways of how their labor is structured.

This report presents findings from speaking to therapists directly about their work in this new landscape. This includes therapists who maintain a private practice, work in community health or behavioral health settings, and those who work for online therapy platforms that market and organize work like other forms of gig labor.

Therapists describe the many collisions between teletherapy and traditional structures — state-based regulations, lack of privacy in domestic spaces, and uneven internet access — but also speak with optimism about the flexibility and forms of access it provides.

Providers' increased adoption of teletherapy coincides with the exponential growth of therapy platform companies, which seek to disrupt mental health care delivery, promising prospective clients immediate matching with a provider, affordable care, and anytime access. However, therapists describe the reality of such platform work — including fractured schedules, constant client turnover, and unpredictable payment structures — as exploitative of their labor. While platforms provide a new way for professionals to find patients, diminish administrative load, and earn additional income, providers have also increasingly been recruited into labor arrangements that mirror those of other gigified sectors like service and delivery work.

Ultimately, this report argues that by restructuring the *labor* of therapy, platforms formalize powerful assumptions about the work of therapy: that therapy can be done anywhere, that therapy can be scheduled anytime, that therapy can be algorithmically mediated, that therapy can be reduced/diluted to forms of emotional support, at times via text, and that therapists are in endless supply. These assumptions have important implications for the present and future of therapy for both providers and clients.

Introduction

Lisa is a licensed clinical professional counselor and sits in her kitchen, which has become her office since the pandemic. She works for a direct-to-consumer (DTC) teletherapy company. She opens the platform portal and sees clients popping up on her docket, identified only by first name and age. She gets notifications for some "new matches" — potential clients that have selected her as their preferred mental healthcare provider. In conventional mental health practice, these used to be called "referrals." She sees about 25 to 30 clients a week. The hourly rate for some of those sessions is as low as $30.

Across the country, Rita, with a PhD in clinical psychology, is also preparing for a session from her home. She maintains a private practice, but has moved to almost exclusively virtual sessions. In fact, she decided not to renew the lease on her office space sometime in the last year. Initially a skeptic of teletherapy, she has grown accustomed to it, and now believes it is more beneficial for some of her patients.

Mary, a licensed social worker, works in a community mental health center that mostly serves people on public assistance. A case manager and therapist, she works long days and has a high caseload. To earn extra income, she has joined a well-known DTC platform where she sees a handful of patients after hours. While not enthusiastic about using the platform, she finds it helpful — "a side hustle" that allows her to see some clients well suited for virtual therapy, unlike the ones in her community health center who need in-person care.

Lisa, Rita, and Mary find themselves in the same Zoom room with me, as we all talk about what it means to provide mental health services. We are meeting in the same format through which they see the majority of their clients, the rectangles of video conferencing that show as much as they conceal. Seeing ourselves and each other from the waist up leads to looking at the background behind us, noticing a plant, a stack of books, a window.

It is in such a setting that Lisa tells me: "A lot of us feel very disrespected by the company, even though the company would like us to think that they really value us. **It's almost like they have no clue how they are being received by those of us who are doing the work.**"

It is interesting that Lisa used the expression "doing the work" to describe her dissatisfaction. "Doing the work" is a turn of phrase often used to describe "the inner work" of healing on the part of the person undergoing psychotherapy or engaged in deep self-examination.[1] The idea of work associated with the therapeutic process conveys consistency and openness to the changes and growth that clients can experience during treatment. To "do the work" has also become a catch-all term for various journeys of self-reflection.[2] But Lisa was employing this expression in a more literal sense: "doing the work," for her, was about the actual labor of counseling as structured by the platform.

The mental health professionals who guide clients through these therapeutic journeys not only witness the "inner work" of their clients, but engage in paid — and at times gigified — labor to set up their practice and make a living while providing mental health care. **The work of therapy** — the process and techniques of psychological healing — and **the labor of therapy** — the economic and professional arrangement that allows such work to be compensated and recognized — have been intimately connected since the formalization of psychotherapy as a profession. However, the relationship between therapeutic *work* and therapeutic *labor* is being changed significantly through the increasing adoption of teletherapy and the entrance and mediation of platform therapy companies.

This report examines the changing ways mental health professionals in the US are "doing the work" as therapeutic labor is being restructured by teletherapy services and digital platforms. By looking at experiences of mental health providers shifting their work to telehealth, this research examines how this reconfiguration affects therapists' practice, professional expectations, structures of compensation, and overall therapy itself.

Mental health care has become more widely available through the rise of online therapy marketed directly to consumers with promises of instant therapist matching, 24/7 availability, affordable care, and easy signup. Teletherapy and platform therapy have been able to connect people to mental health support in ways that have never been available before, and many people who are "first-time users" of therapy have approached or considered reaching out for help. Teletherapy has provided benefits and advantages for both clients and providers.

This increased availability, however, has often been accompanied by increased fragmentation and intensification of work for the mental health workers who provide these services. By focusing on providers who practice teletherapy and work for digital platforms, this research examines the fundamental tensions that emerge when a profession with clinical expertise, licensing, and training standards meets virtual mediation, the dynamics of platformization, machine learning augmentation, productivity incentives, and algorithmic management. This exists alongside shifting cultural attitudes toward the destigmatization of mental illness and the popularization of therapy and "therapy-speak."[3] Despite increased mental health awareness and a seeming pervasiveness of psychotherapeutic discourse, access to mental health services is actually quite limited and unequal in the United States,[4] especially for Medicaid and Medicare patients.[5]

Examining teletherapy in terms of therapeutic labor provided by mental health professionals and its consequences for therapeutic work turns a critical lens at narratives about the seamlessness, flexibility, and liberatory potential of teletherapy for providers. The objective of this report is not to assess or compare the effectiveness of in-person vis-à-vis therapy. It does not posit teletherapy as a "lesser" medium for the therapeutic process or for mental health treatment, nor does it intend to offer a blanket critique of platform therapy. However, as Hannah Zeavin notes, "teletherapies keep their costs down (by using volunteer labor, by offering asynchronic help, by being informal, and through automation) and access patients that in-person therapy cannot."[6]

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The report argues that changing conditions of **therapeutic labor** — the economic, technological, and professional arrangements of online therapy via platforms — are redefining **therapeutic work**: how mental health providers make a living, how they understand and give meaning to their professional identity, and how they relate to their clients. These changes have stakes for the future of therapy itself.

Teletherapy and Platform Therapy

The therapists interviewed for this report discussed a wide range of experiences with both teletherapy and platform therapy. Teletherapy and platform therapy are related, but not synonymous. **Teletherapy** is a way of providing care at a distance, through virtual means, often through a screen or video.[7] It describes the medium of how therapeutic work is done in a virtual space. **Platform therapy** is the delivery of online psychological care through platforms that feature similar dynamics of flexibility, access, and work intensification of other industries and services.[8] Teletherapy is about the modality and medium of care delivery whereas platform therapy describes a new labor arrangement of such work.

Since the start of the COVID-19 pandemic, more than half of people in the United States have used telehealth at least once.[9] According to the American Psychological Association's practitioner survey, 96 percent of mental health professionals said they have been conducting the majority of their sessions virtually.[10] This uptake accelerated due to the risk conditions of the pandemic, which also brought about a rise in psychological distress, depression, and anxiety, pushing people to seek mental healthcare services in higher numbers.[11] Before this period, mental health care was predominantly face-to-face.

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Teletherapy, intended as care provided at a distance, is far from unprecedented, however; it has a long history. Through most of the 20th century, practitioners, activists, peer groups, and scholars have experimented with using various mediums to connect patients and practitioners.[12] Such experiments addressed the viability of tele-therapeutic participation for different types of patients, such as members of rural populations, children

with special needs, adults at risk of psychiatric hospitalization, and veterans with PTSD.[13] Recent studies[14] suggest that teletherapy not only increases access in restricted or limited areas, but that it can be highly effective for a variety of patients, making teletherapy an additional tool in a therapist's toolbox.[15]

As the popularity of teletherapy has soared in the United States, clients are increasingly comfortable with such practices — and in some cases, even prefer them.[16] However, some research points to experiences of teletherapy not being entirely positive. Some therapists, especially earlier in their career, felt unprepared for the transition to remote care as it was not part of their training, feeling it resulted in poorer therapeutic skills, worse outcomes, and a less ideal therapeutic environment when conducting teletherapy compared to in-person therapy.[17]

The Platformization of Therapy

The provision of care for people who have been experiencing mental and psychological distress is centuries old and has varied in form and approach.[18] Today, psychotherapy and mental health counseling are practiced by a variety of professional figures who subscribe to a range of schools of thought and orientations,[19] with a range of licensing and training programs that enable the practice of therapy and counseling (LCSWs, PhD in psychology, etc.). The field is also increasingly feminized — both in terms of its workforce and its devaluation — and thus engaged often in being responsible for other care work, like raising and caring for children and family.[20] The behavioral health profession is also facing significant shortages,[21] with high levels of provider burnout, especially among therapists of color, in which the majority of the workforce is constituted by women.[22]

Today, digital mental health care is a complex, ever-changing field.[23] The mental health tech ecosystem is made of apps, direct-to-consumer (DTC) platforms, provider-directed services, tools for practice management, and other technologies of care and digital therapeutics, with new companies mushrooming each year. The practitioners interviewed for this project described a wide variety of labor arrangements that changed significantly based on which and what type of platform mediated their work. In addition, many described a patchwork practice, supplementing a main employment relationship with part-time work on other platforms, and having their own private practice. Within the variety of this landscape, we can identify three major categories of therapy platforms that are most significant in structuring therapeutic labor: direct-to-consumer (DTC), business-to-business (B2B), and practice management.

Platform Types	Description	Examples
Direct-to-consumer platforms	Direct-to-consumer platforms are client centered, where the client usually pays a subscription depending on the level and frequency of services. The provider is predominantly employed via a contractor model (hourly/gig).	Talkspace, BetterHelp, Cerebral[24]
Business-to-business platforms	Business-to-business platforms function usually within a benefits model where the payer is a third party (university, employer, health plan, insurance company). Some providers work on salary and others do contract work.	Lyra, Ginger (now part of Headspace), Ableto
Practice management platforms	Practice management platforms help providers develop their practice by matching with potential clients, aiding with administrative work, and assisting in paneling and reimbursement rate negotiation with insurance companies. These platforms offer the closest arrangement to private practice.	Alma, Headway, Soundermind

Existing research has examined the rise of platforms and the consequences on the quality of care and the work of therapy. For instance, some practitioners have reflected on the possible benefits of specific platforms and their affordances for the experience of a range of clients;[25] this includes possibilities like time-shifted or remote care and texting features. However, such platforms, especially DTC ones, have also changed therapists' autonomy, labor conditions, and practices. A new kind of precarity now pervades work in the profession, as digital platforms create care settings that escape the usual institutional boundaries and forms of oversight by state licensing boards. As Linda Huber, Casey Pierce, and Silvia Lindtner write,[26] platform therapy offers providers flexibility and an ability to earn an income outside of traditional structures of private practice or behavioral health institutions, but this also constitutes an "approximation of freedom," a stopgap arrangement that actually reinscribes dynamics of the feminization of the labor of care.[27] Sociologist Elizabeth Cotton has called this increasing phenomenon the "Uberization of therapy" in the UK context.[28]

These platforms restructure the therapeutic experience for both the patient and practitioner. They often herald tech as a tool for meeting the needs or desires of the actors involved in the therapeutic encounter (providers and patients, but also payers like insurance companies).

In addition to providing a space for immediate therapeutic interaction, several major digital health platforms promise the practitioner an easier time reaching new clients and the convenience of receiving compensation via direct billing or automated insurance claim processing.

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Some mental health practitioners use practice tools such as Simple Practice, or companies like Alma or Headway, to streamline their administrative burden and maximize potential insurance reimbursement by offloading the tasks of insurance eligibility confirmation, timely claim submission, and identification of the appropriate current procedural terminology codes, given it is particularly difficult and time-consuming for practitioners to obtain reimbursement for mental health services.[29]

Platform therapy companies have also gained high visibility through targeted advertising, celebrity sponsorships, and increased involvement in mental health care delivery. DTC therapy companies like BetterHelp and Talkspace also are increasingly partnering with public entities. In November 2023, Talkspace announced a partnership with New York City to create “NYC Teenspace” and “power a teen mental health program” for teens aged 13–17 to offer free mental health support via text.[30] In January 2024, the California Department of Health Care Services was set to begin a partnership with the behavioral telehealth company Brightline to provide free mental health care for California children and families.[31]

The flip side of this visibility for some companies has been scrutiny and concerns around their ethics and data privacy practices. Cerebral, a platform company offering DTC psychotherapy and medication, has come under examination for sharing private health information of more than 3.1 million users in the US with advertisers and social media companies,[32] and for a burdensome cancelation process that led users to keep being charged after attempted cancelations.[33] In 2023, BetterHelp was fined by the Federal Trade Commission for $7.8 million after the service disclosed and sold consumer data, including sensitive health information, to third parties for targeted advertising.[34] The same year, a class-action lawsuit was filed in California against Talkspace, another mental health platform now publicly traded on the stock market, based on claims that it misled users into automatically renewing subscriptions without the sufficient therapist labor force to provide services.[35] Investigative journalism has covered some of the internal workings of telemental health startups’ world booms and busts, layoffs and acquisitions,[36] as they increasingly expand to partnerships with Medicaid and other state-based public care.[37]

Therapeutic Work and Therapeutic Labor

Therapists have always worn several hats. In addition to being clinicians and providing mental health care, administrative tasks like writing clinical notes, managing scheduling, billing, and insurance have always constituted a large part of their workload. With the shift to teletherapy, providers have also had to become versed in managing technology, troubleshooting faulty connections, and receiving notifications and nudges, often outside their working hours.

If working for a platform and engaging in what often is contract-based flex work, they have also become in many ways platform workers, their compensation and labor tied to algorithmic management and their work performance quantified.[38] If doing asynchronous sessions via text, therapists are also typists and content producers, especially in certain compensation schemes that pay per word. The therapist has become a data subject engaged in practices of making themselves readable and scalable in a data-driven world,[39] as platforms also capture and analyze huge quantities of data as part of their business model.

The tradeoffs and promises made to mental health providers are similar to ones made to other gig laborers. Digital workers in a variety of sectors, including Instagram influencers, gig workers, and content moderators, experience the precarity and contingency that are hallmarks of platform-mediated labor.[40] Similarly to how ride-sharing platforms increase workers' precarity and change the way services are delivered, teletherapy platforms make therapists' labor uncertain and change the way therapy is practiced.[41]

Platforms promote the idea that they are making mental health care more accessible for customers. However, unlike driving where the barrier to entry is fairly easy, telehealth platforms cannot really influence the supply of therapists. To expand this pool, they adopt different strategies to make therapy more accessible and available to a larger number of people. They do so by leaning into other modes of therapy like texting and asynchronous therapy, changing the time of therapy to shorter session times and short-term treatments, and even for some platforms relying on pre-licensed professionals.

Teletherapy and platform therapy have shed light on the changing dynamics of professionalization and the increasing automation and intensification of work applied to care professions, and the mental health field in particular.[42] Professions such as doctors, lawyers, and teachers were once omitted from the logics of automation,[43] which was directed, instead, at manual labor and clerical work.[44]

Now, technical interventions that automate certain parts of service delivery are being broadly applied to health care, and especially mental health care. In the presence of technological innovation, the human labor that is necessary for automation often goes unnoticed and undervalued.[45] Offloading administrative demands of workplace labor to the technology does not make administrative work disappear. Rather, workers must strive to integrate it into their work practices.[46] By incorporating algorithmic management, gig

platforms also fragment labor through repeated tradeoffs between humans and machines, breaking down work-life boundaries by encouraging "work-anywhere" attitudes.[47]

There are frictions, however, in the meeting of gig labor arrangements and the mental healthcare profession. Professionalization works against a purely market-driven labor supply by limiting job opportunities and securing higher pay for those who invest in gaining educational credentials. As professionals, therapists are held to ethical standards through licensing bodies that are independent of particular employers. They have to undergo specific training and education, and have a claim to certain job roles and tasks because of specific expertise. In line with Summerson Carr's understanding that "expertise is something people do rather than something people have or hold," therapeutic work is intimately linked to communicative practices that are embedded in institutions, ideologies, and classed, gendered, and racialized political-economic realities.[48] The realities of doing this therapeutic work today are fundamentally embedded in systems that inform and reshape therapeutic expertise, creating new labor relations that conscript therapists in the platform economy, and requiring new forms of technical skills from therapists.

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For many professionals, including the ones interviewed for this research, doing therapy today means engaging in various kinds of tasks: the therapeutic work that is necessary for treatment and the therapeutic relationship with clients, the administrative effort that is inherent to practice/client management, and the technical navigation and decoding of the medium of teletherapy and the features and pressures of platform therapy. The labor of mental healthcare providers is restructured by these digital and economic transformations, with stakes for the present and future of therapy.

The Work of Teletherapy and the Challenges of Virtual Care

"Where do you see your clients?"

"Online."

"On Zoom."

"On the platform."

"In my office."

"I do telehealth."

"At the community health center."

"Sometimes they're in their car."

Until fairly recently, "going to therapy" meant, quite literally, *going*. Clients would travel to visit a physical space dedicated to being present and to seeing and being seen by a professional in their office. And while teletherapy options and platforms predated the COVID-19 pandemic, 2020 forced the redrawing of the spatial boundaries of therapy and changed the way that practitioners and patients engaged in psychotherapeutic and counseling work.

All providers in this research — whether working for a platform company or maintaining their own private practice — have taken up teletherapy since the pandemic. By far the most common means has been the video call, but audio-only conversations and even texting are part of the larger palette of remote therapy methods.

Therapists have rearranged their own domestic space and set up home offices to find some separation from caregiving and other domestic responsibilities. People in small apartments have used their kitchens or dining tables. Laptops and smartphones have become the "where" of therapeutic work. On the other side of the encounter, clients also have found

themselves needing to adapt, finding privacy in closets, bathrooms, or cars.[49] The therapist's couch has become their couch.[50]

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Providers have a range of opinions about this sea change in their profession. Many with whom I spoke highlighted its convenience and accessibility, both for themselves and their clients. However, almost without exception, mental health professionals reflected on the changes made to their ability to "hold space" for their clinical encounters. The notion of holding and creating "space" is one that is at the heart of much of mental health care,[51] as both the physical confines of place and the more metaphorical understandings of the place where treatment, healing, and rapport occurs.

For the client/user of therapy, the shift to the therapist's office being "anywhere" has allowed people to access services, especially for people in rural areas.[52] Remote therapy has provided several advantages to both parties: practitioners do not need to rent an office space, don't need to factor in time between other responsibilities, and can better balance domestic and professional life.

Four years into telehealth and its spatial adjustment, some therapists expressed their preference for telehealth and even reluctance to have an office or do in-person work again. Some had rented offices that they let go shortly after because clients themselves had started to prefer remote care and sought to continue this modality. Others felt a need to have a hybrid practice, missing the face-to-face, bodies-in-the-same-room component of psychotherapy. Many clients have mostly appreciated the flexibility of doing therapy virtually, often calling their therapists on their lunch break or in their car.

Tara, a counselor living in a southern state, emphasized how the virtual space expanded access for people in rural areas or small communities where going to therapy is still quite stigmatized, "I live in a very rural area and most of the people I see are pretty much from within 60 miles of where I am, but I'd also see people four and six hours south of me."

Susan, who worked in a hospital system that switched to telehealth and lived in a very expensive city, found that the collapsing of the two spaces — domestic and professional — was hard for her:

> This was once my dining room table and now it's my workspace. I felt like in the pandemic, I was working with a pretty high acuity caseload and

> invited so much trauma into this space. And then after work, especially when things were shut down during the pandemic, I would just kind of sit in it and didn't have anywhere to discharge. I believe so much in emotional contagion as much as the viral contagion and it just felt so heavy to me.

Many providers noted that the digital therapeutic space is structured differently. Adapting to this new configuration was a challenge that at times they felt they were not ready nor trained to face. This was true, especially for providers further in their career who had done in-person work for decades.

In video-based teletherapy, all the provider sees is a rectangular frame and their client from the waist up against a background, depending on where the person has positioned themselves for that session. Many providers noted having to make a concerted effort to "reach across the screen," through gestures, facial expressions, and probing. Virtual visual cues can also provide insight into the life of clients, allowing for increased rapport building, which is a pleasant surprise for some providers.

Protection and safety were concerns of many providers in the move to the digital space. Sometimes finding a private location to talk was hard for clients, especially for people first approaching therapy and learning what kind of rules are at play within it. Fear of being overheard by a family member or having to stop conversations because sessions were interrupted by other people was also a factor. For those working with clients in abusive households or relationships, for example, stay-at-home orders also raised safety concerns for therapists. One therapist asked, "How do these people have a safe space to actually talk about what they need to talk about?"

Some providers deeply missed in-person interactions where they could see their patients in an office. The availability of having a therapy session in any space was perceived by some providers as affecting the sense of commitment and presence that some clients displayed. Lisa, a social worker, noted that virtual sessions took away the buffer time that comes with in-person therapy and expressed how this had some implications for how clients approached therapy:

> What we've lost with telemedicine is the transition time. It is very important for people to come to a session and then exit a session both for mental preparation and also for integration of what happens. I find that when I'm just a different tab that they click over a lot of times they're still thinking about work. Therapy feels a little bit more optional and just another meeting in their day. The space doesn't feel as protected.

Technological "glitches" — internet outages, platform infrastructure issues, poor connection — are also part of the virtual therapy environment. As the digital becomes the "where" of therapy, co-presence can be interrupted and therapists have to recreate the space for emotional reconnection. This expansion and compression of space changes the experience of providing therapy, as providers described, but this transformation also has

structural consequences. Care might happen in a virtual environment, but providers need to know where the client is physically located because providers are licensed in specific states. The "anywhere" promise brushes against the realities of a profession that is still very much bound to geography, state lines, and state licensing boards. Many providers virtually see clients and are licensed in states where they themselves do not reside. This practice is also incentivized by some telehealth employers and platform companies, who will help pay for licensing exam fees and continuing education credits to study for credentialing.

This expanded virtual presence of providers has created a paradox of simultaneous presence and distance.[53] On one hand, mental health professionals can potentially see clients virtually in states that they are licensed in but where they do not reside. On the other hand, they need to know where the client physically is calling from in case there is a need to call in a "wellness check" if the provider believes that their client is a danger to themselves or to others. One therapist explained:

> It's practice providing telehealth that you ask your clients where they are, especially if they're not in the same space that we always meet. ... It was trickier when I was using Zoom because Zoom gives you the option of providing the virtual backgrounds. So really you cannot take that visual cue of is this the space familiar with? So getting into the practice of asking "are you in the same place or where are you today?

Another therapist stated, "If you have a client in crisis and you may have to get a wellness check for example. That's the piece that is anxiety-provoking because that client is not physically there, and you can only do so much."

Managing the risk of suicide is something that trained, licensed providers accept as part of their profession. However, managing this risk in telehealth and platform work was perceived as increasingly difficult to handle. Therapy services often have a disclaimer on their website that points people who need immediate support to a crisis line, 911, or the 988 number.

Therapeutic Labor and the Platformization of Telehealth

One of the consequences of the rising feasibility of telehealth — through widespread internet connectivity and more reliable video chat services — is that the profession of therapy is newly accessible to the labor arrangements that come with platformization. Freed from many of the historical physical and geographic constraints, therapy (and therapists) can now be managed and connected using the algorithmic techniques developed in other gigified sectors (like driving, delivery, and increasingly freelance creative work).

Telehealth companies and platforms had long aimed to "disrupt" the in-person clinical encounter as the predominant option for therapy,[54] with emphasis on increased access and flexibility. The pandemic offered the testing bed for providers to engage in this care at a distance, experience the challenges and opportunities of creating a safe therapeutic environment in a virtual setting, and adapt to this digital transformation. DTC platforms and other telehealth companies have founded some of their core mission around the expansion of access to mental health services online and therefore detached from a physical space. "Your therapist anywhere" is a promise that platforms make to potential therapy seekers and "work from anywhere" is the adage to potential therapists.

In many ways, and with notable differences among them, these platforms have harnessed and molded the remoteness of telehealth to greater lengths, promising not only therapy from any location, but at any time, for different rates, and for variable, customizable forms of instant support. The result for therapists is that their labor is not only transformed by the move to remote sessions allowing them to earn income and be more flexible, but the work of therapy itself is also newly shaped by the techniques and business models of platform companies looking to treat mental health care as a fungible service delivered on demand.

Time Management and Flexible Scheduling

The unit of psychotherapy has conventionally been the "session," a protected, dedicated time between 45 and 60 minutes, in which the therapist and client are engaged in treatment. This type of paid attention constitutes the "clinical hour" and is the unit of time in which therapists mainly do — and bill for — their work. In a session, therapists are keenly aware of time — usually having a timer or clock to make sure there is closure within the allotted minutes. In a private practice model, therapists decide how many clients to see per day and per week, and have control over how their time is structured.

For every clinical hour, therapists spend a significant amount of their time doing other tasks that are not direct patient care. Before, between, and after sessions with clients, professionals must do several things: prepare, write, and review therapy notes; schedule and arrange their caseload for the week; communicate with their clients during the week; perform administrative and clerical work that includes billing, insurance management, and payroll; and engage in clinical supervision, whether as a supervisor or supervisee. How much autonomy therapists have over their schedule and how many people they can see per day often depends on where and how they are employed, how their practice is structured, and their personal emotional and mental capacity. Practitioners in private practice usually have much more agency over how they organize their time compared to someone who works in a community health agency or hospital, for example. Having high caseloads — seeing upward of seven or eight people per day — is something many community mental health therapists deal with, with little to no agency on client selection.

The introduction of teletherapy has affected therapists' use of time and the temporal structure of their labor. Video sessions, not confined to a physical space, have allowed for practitioners to schedule more clients, reduce break times between sessions, and/or see people at later hours in the day between other duties and tasks.

But it is especially the professionals providing therapy via DTC platforms that have seen their time restructured in this new labor configuration. Several platforms advertise to potential clients easy scheduling, availability 24/7, and a "message your therapist anytime, as many times as you like" function. To potential practitioners, some of these companies tout several advantages when it comes to time management and scheduling. Akin to promises of platformization and flex work in other industries and DTC services,[55] professionals can choose their own schedule and caseload, pick up as many clients as they like, while much of the scheduling and reminders to clients are handled and automated.

The ability to "pick up" work given the flexibility of these patchwork arrangements allows some professionals to have more freedom and control over their schedules and caseload. Tiffany, a licensed social worker, described how she structures her time in this configuration:

> I work for two platforms and a private practice. ... But the start of my day is always what I call my full-time job. I see seven clients there via their system. ... I take about a two-hour break. And then in the evening I do groups because that's what my second platform is, and I do two or three groups for that platform. I work those two platforms on Monday, Tuesday, and I work the private practice clients in the evenings on Wednesdays and Thursdays. I don't work on Fridays at all. That's my day for me, for my family. Occasionally I'll pick up some groups on Saturday morning, because that's also an option on that second platform.

Another provider had transitioned from on-call mental health work to platform therapy that allowed for a less intense clientele need:

> I was on call and in the emergency room, and two o'clock in the morning for suicide attempts, and drug overdoses, and all kinds of things, so my schedule was awful. And I look at it now and sometimes I feel guilty for having a flexible schedule. ... This seems too good to be true. It's just a weird transition for me, but it's because I was working so much before. But again, as a mom of a small kid, I need the flexibility.

While significant differences exist between these arrangements, the reality of providing care via these systems can lead to very high caseloads, working after hours, and complex to opaque algorithmic mechanisms of "flexible scheduling" that allow therapists to "fill their slots." In most configurations, therapists mark their availability on a calendar within the interface/system, their schedules signaling how many "slots" are open or available to be potentially booked by a client. As many professionals mentioned, algorithms mediate, intervene, and affect how they build their schedules and caseloads, restructuring how therapists spend and invest their time.

B2B arrangements, which allow clients and providers to connect via a service that processes insurance, have more agency over this aspect. In salaried positions, part-time or full-time, there usually is a minimum number of clients that providers are required to see, with incentivized, tiered structures for increased availability and "slow booking" features. One therapist who worked for an employee assistance program (EAP) company that followed this model appreciated the opening of these slots in limited quantities:

> We just basically open it up for how many clients we want, and they just roll in or they don't. There is something kind of nice if they don't roll in, there's something called slow booking where you have more than two open slots on your calendar. They'll actually change the algorithm a little bit to be in your favor and it won't count against you.

Several therapists mentioned "the algorithm" as the mediating agent or as something they had more or less control over in how their schedules were structured. In some DTC platform models, this algorithmic scheduling was described as "good" or "bad," perceived as working either in favor or against the therapist and allowing them to see more or fewer clients. In some models, therapists were rewarded for keeping their availability open and penalized for restricting it. These rewards and penalties often undercut the promises of self-directed work, and resulted in feelings of decreased autonomy and control over their schedule:

> The team would see if you were available, how many slots. ... If all your slots were taken up, then they'll see this as a red alarm and message you telling you need to open up more slots. But they didn't present it that way when you first started. They made it seem like you were more in control of how many sessions that you wanted to be available for.

One provider noted that keeping her availability limited to protect her time and energy resulted in unpredictability regarding how many people filled her schedule. She describes how this system contributed to feeling she had little control over her time:

> I understand they're doing predictive modeling and all that stuff like that. But for me it's frustrating because if you take on more clients at a time, then it won't let me. I want a slow progression. I don't want a fast progression. I don't want five people at a time. To me, I wish there was a way to say I can take on two more clients, or I can take one more client. **Because if I were working in my own practice, I would be making those decisions, not the algorithm.**

These narratives highlight "the algorithm" as in control of providers' time, and a feeling of limited agency that echoes those of gigified workers in other industries.[56] Like other sectors marked by algorithmic management and flexible scheduling, the attempt to reduce work to highly discrete, on-demand units always overlooks the forms of transitional and supplemental labor necessary for good working conditions. The result is new sources of pressure for workers, who often contort their schedules to the perceived patterns of algorithmic systems.

A licensed clinical professional counselor described feeling that she was "at the mercy of the platform as far as maintaining the calendar and maintaining client load" while working for a well-known DTC platform. The platform would then keep notifying the therapist to "keep another 10 slots open" for the week, even though she often had up to 30 clients on her calendar at that time, leading to a feeling of burnout and overwhelm.

Messaging, Notifications, and Text Therapy

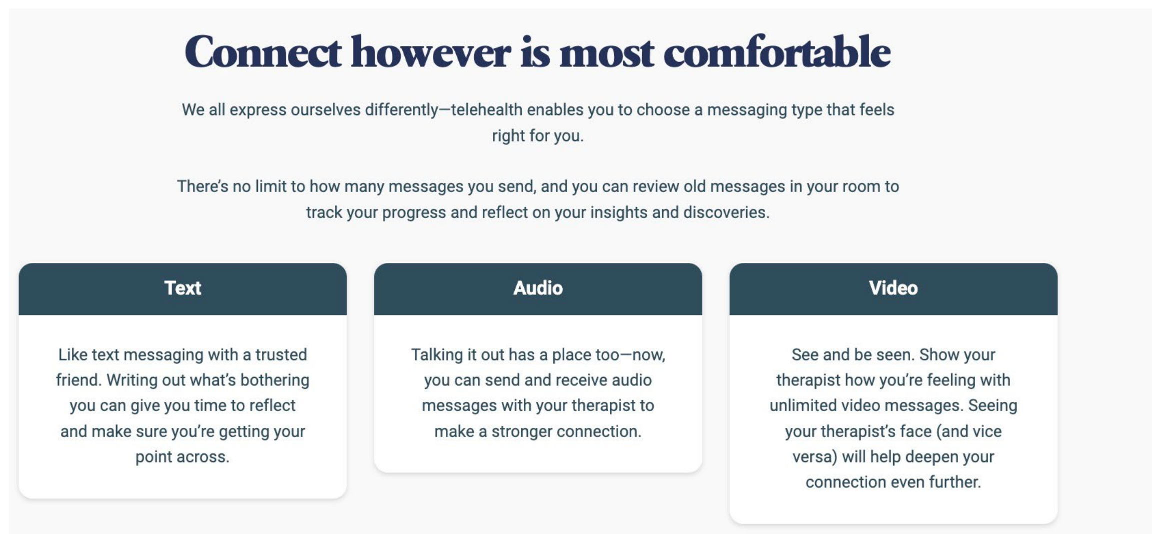

Image 1: Talkspace page featuring "unlimited text messaging" ™ February 2024

Along with the algorithmic scheduling of video-based telehealth care, some platforms have also proactively marketed the availability of messaging your therapist anytime or providing therapy via text. In short, therapists provide care to a user through a text-only chat interface, thus further removing the boundaries of time and place required for video calls. Text therapy can be understood as a form of "written speech," "a primary form of tele-presencing the self for the other over distance."[57] This is true not only for the client trying to express themselves via text, but also for the therapist, who has to adapt the fostering of a therapeutic relationship via a written, word-counted, instant medium.

Several therapists mentioned "the algorithm" as the mediating agent or as something they had more or less control over in how their schedules were structured.

However, the incorporation of texting into telehealth platforms — making therapy more accessible via a professional who is available 24/7 and can receive messages "anytime" — has meant that the providers at the other end of these promises feel at times like "instant therapists" who are perennially accessible, perennially on demand, ready to provide mental health support. One therapist expressed concern about the "the high level of accessibility and the invisible labor that goes into it."

Given the platform therapy model's expectations of constant availability, therapists have found themselves doing virtual therapy sessions, while also performing a lot of asynchronous

labor, whether communicating with clients, responding to constant notifications, or doing actual therapy sessions via text. The platforms' automated nudging and notifications and the ability for clients to reach out "anytime" to their therapist have made it more difficult for clinicians to be fully "off," blurring the separation between working and non-working time.

While boundaries are an important component of therapeutic work and something that professionals are trained to do and strive for in their practice, this is challenged by working in an environment of constant notifications and "24/7" access to a therapist. As one provider mentioned: "I'd rather have that really strict boundary as much as possible. And I know with a lot of telehealth stuff, that's difficult. And even more so the platforms that encourage that 24-hour connection, I don't think anybody should be on for 24 hours on anything." Another professional remarked that, even though her own employer encouraged her not to check messages during non-working time, the 24/7 model "creates no boundaries or safety for the clinician, no separation from work."

Therapists had different strategies to protect their time (like not having the app on their phone or explicitly reinforcing communication boundaries with their clients), but this was harder for those who worked on platforms that encouraged them to be available at all times:

> Part of what makes it hard is that you're going to answer the message ... The moment you've seen it, it's taken you out of whatever mode you are in and into work mode. And I think we advocate for our own patients to make separation and have downtime and especially because of tech and how it is in your phone, and it does ping you and it tries to get your attention, we try to teach mindfulnesss. ... I think it makes it impossible to practice that as a provider if your phone is pinging.

The fine print of "24/7" availability differs across platforms. Even though the client might be able to contact the therapist anytime, the provider is not required to answer immediately (some companies say within 24 hours or 1 business day). Despite this, platform automated messaging sends notifications that remind the provider of these expectations of asynchronous contact with the client:

> [The platform] expects that you respond to them within 24 hours, and even though they say it's okay to take a day off, they actually send you an email if you didn't respond to somebody within 24 hours. So all weekend long, you're getting notifications saying you didn't respond to so and so. Their expectation is that you're basically online 24/7.

Some platforms offer the ability to text your therapist without limits. In some models, the client just pays for text therapy, which can be asynchronous (therapist and client responding at different times) or synchronous (client and therapist log on at the same time for a timed texting session). In these arrangements, it is also made very clear that text therapy is not crisis care and, in case of an emergency, clients should call 988, 911, or, in some cases, the crisis phone line offered by the platform.

Depending on the platform and the user's preference, some of the providers who engage in text therapy might never see the client in a video session but only have a name. The client can leave messages with the therapist in a variety of ways (audio, text, or video), although most people choose text messaging. For the mental health providers who engaged in this particular kind of therapeutic labor, text therapy presented unique temporal, ethical, and professional tradeoffs and challenges.

Nora, a licensed professional counselor who works for several DTC platforms, describes the challenges of engaging in text therapy:

> You don't have a face to a name, you never see their face, you don't know what they look like. It's a person on the other end of the text like the keyboard. And if they say anything about suicidal ideation, then you remind them that this is not an emergency platform and you give them 988 [the emergency number] or tell them to go to the emergency room. So it's not a perfect platform by any means, but I do have some clients that feel like it's very beneficial to them for their schedule with texting when they can as opposed to having to sit for an hour each week. I do think that there's a piece of that that makes it less intentional to get help. It's more of a convenient thing as opposed to an intentional working-on-themselves kind of thing, purposely taking the time out of their day to dedicate to their well-being.

Describing the tradeoffs of this modality of therapy with one DTC service, Nora found herself establishing a therapeutic alliance often with people she never saw, but who preferred this mode of engagement and found it more suited than a traditional/video synchronous session. Another provider commented on the misunderstandings around the temporal bounds of client-therapist contact:

> Some people do well with the texting piece of therapy, but some people just don't. They expect immediate responses and that's not what [this platform] is. It's very asynchronous. I'll check the room twice a day, and when you respond, then I'll give you a response and then if you talk back to me, then I'll check it again tomorrow. The platform says it equals out to a session a week roughly. So a 50-minute, 10 minutes a day, five days a week kind of thing is how much you're supposed to spend on a client.

Setting up the expectations of immediacy while fragmenting a session was something that several providers experienced. Adam, a counselor who worked for another DTC service for a long time before leaving for a more hybrid arrangement, used to do "synchronous texting sessions" that were timed, leaving him feeling uneasy and under pressure:

> The texting piece, I have very sort of mixed feelings about that. It is a little bit of a timed session, and you're sort of doing the work, being thoughtful. But writing back and forth to me just didn't come very organically. You got a timer up on your screen and you're trying to make the most of a session.

"Sort of doing the work" appears in Adam's narrative as an approximation of what therapeutic work is meant to be, both his job as a mental health provider and the inner workings of the therapeutic process that he is supposed to facilitate.

Because some of the compensation model for this kind of therapy is per typed word, some therapists found themselves spending many hours typing up messages to various clients.

Paula remarked that, while this way of establishing rapport with clients asynchronously via text allowed for expanded access, this also promotes being perennially on demand, which blurs the boundaries of a professional relationship and calls into question what the figure of a therapist is supposed to be:

> The downside is that [clients] act as if I'm this instant therapist. ... It's like the tradition of what we went to school for, how we were taught how to initiate therapy, is having to change without us actually cosigning on that aspect. It's like [clients] they instantly want you now. They don't realize that you have other clients. And it's the system ... "I get that you need me, but we have to follow protocol to make sure that we're not friends, I'm your therapist."

One provider admitted that the multiple media of communication with clients actually suited her schedule because she liked the flexibility. She liked that clients had the choice to communicate when and how they desired: "I could work when I wanted too. If I was awake at 3 a.m. and I wanted to respond to client messages then, I could do that."

Ultimately, most providers said texting and notifications felt like an intensification of the culture of immediacy, shaping how clients perceived therapists' temporal, professional, and emotional availability and the work of therapy in itself.

Therapy "Matchmaking"

> I probably have like 30 people just sitting there that still are a match. And, to me that doesn't feel okay. Am I supposed to be providing them care? I'm like technically matched with them as a therapist, but they don't want to engage.
>
> — Sarah, DTC therapist

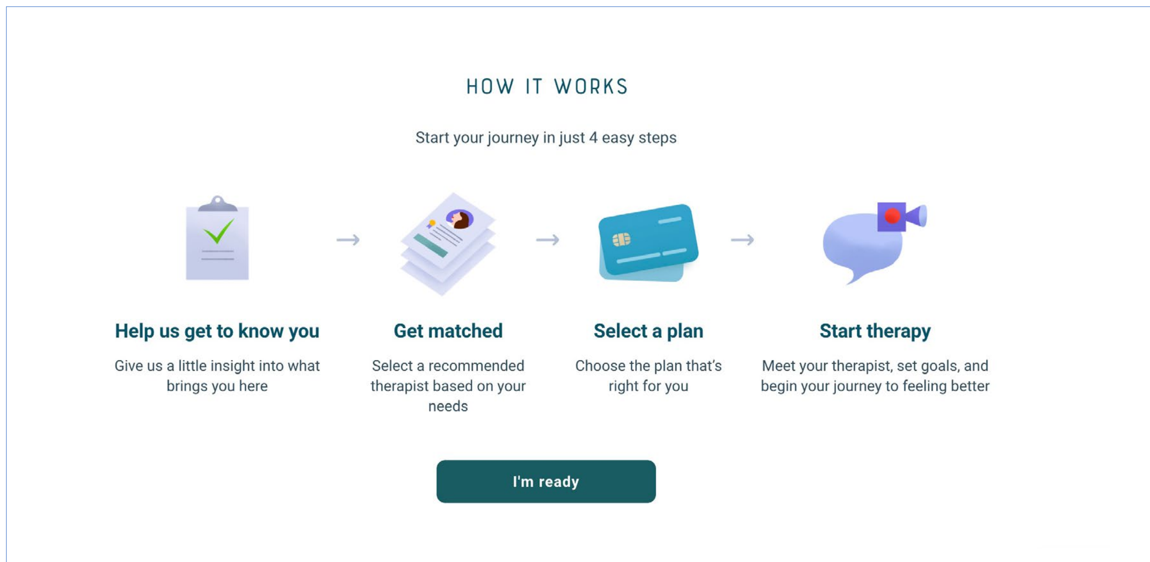

Image 2: Talkspace process. "Get matched"

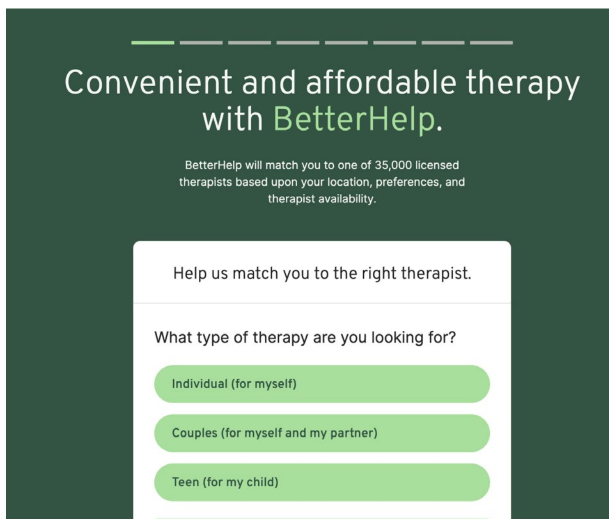

Image 3: BetterHelp page featuring "matching" process February 2024

Working with a mental health professional is a lot about "fit."[58] Therapists have different specializations, approaches, and credentials in addition to their own lived experiences and positionalities. Many providers on directory sites like psychologytoday.com provide a description of their approach and have a profile that clients can read to understand if they might be a good fit. In platform therapy, a new element is introduced to ensure this fit: the matching algorithm.

In all the different typologies of platforms, therapists answer questions so that they can be listed with a profile. Clients, who also answer questions on their side of the fitting equation, are presented with profiles of providers who are in line with their search criteria. Similarly to dating profile matches or other platform care services,[59] the algorithm mediates and brokers the first encounter and the relation between patient and therapist.[60] Like

with some aspects of algorithmic scheduling, the advantages of the matching process are that therapists don't have to actively recruit or find their clientele. One therapist mentioned she was ok with relinquishing some control to the matching process: "I don't feel I'm recruiting anybody, they just come, and I have clients, if that makes sense. ... I'm okay with that."

Some of the language used to advertise this matching process parallels dating apps explicitly,[61] such as "find the perfect match/fit" via the platform, a "symbolic 'third' that influences the client-psychologist relationship, producing fantasies, meanings, and representations based on a 'couple match.'"[62] For the algorithmic therapy matchmaking to function, it requires intense data collection from both therapist and client, but also renders both parties "scalable subjects" that are legible to algorithmic psychometrics.[63] Despite the high level of personalization promised by platform therapy, the matching process sometimes appears to heavily rely just on the demographic characteristics such as age, religiosity, and sexual orientation and gender identity provided by prospective clients,[64] which is not a guarantee of therapeutic fit.

Therapists working for different platforms described the process of "client matching" as more or less effective, with varying ability to explain or understand the algorithmic component of this matchmaking. Mariana, a licensed psychologist working for a B2B platform, described how knowing the extent of the matching algorithm's mediation made her put effort into writing her bio and answering questions that would facilitate a good match:

> I appreciated that [the company] was very transparent about the algorithm in our orientation. They said "we have an algorithm, and that algorithm helps you to get matched to the right client based on what's in your bio." If I put in there that I do trauma-focused therapy, clients that are looking for "trauma" are going to immediately be matched to my area. ... Had I not known that the algorithm was so strongly connected to client matching, I don't know if I would've spent as much time doing that.

Tori, a social worker, noticed that on their particular platform the algorithm expanded to include race, gender, and more general positionality of the therapist, saying that the company "bragged about their matcher a lot":

> It's a rather detailed thing that you fill out about different identity pieces, race, I don't think they disclose your age. Recently they expanded it to include if you're part of the LGBTQ+ community in any capacity. If you identify with any specific cultures, religions, kind of things that clients can use to help choose someone.

A therapist's digital representation is key for which clients are directed toward them, even though it is far from perfect given that availability is another variable that gets crossed in the matching (and the "keeping the slots open" factor mentioned earlier). The algorithmic

"matcher" becomes one of the mediators between the patient-therapist dyad. While many therapists reported they were quite satisfied with their "client matches," for Kristin, a licensed social worker working for two different DTC platforms, this mediation not only was not always effective or of quality, but also affected how much she felt she could accept or decline potential patients:

> I think the algorithm to match people is not great. One of the reasons why I don't like platforms is because I also don't get a say. So on the lower paying one, I could decline a client if I wanted to. On the other platform, clients would be assigned to me based on the state that I'm licensed in and the availability that I have. I wouldn't get to pick my clients and I couldn't decline them.

In some models of smaller startups or companies, the algorithmic matching is also mediated by some care coordinators who do an initial consultation, which often resulted in therapists being more appropriate fits for their patients.

The convenience of "being matched" with a therapist almost immediately via algorithmic mediation is what makes platform therapy attractive to many clients, especially to those who had never approached therapy and within a healthcare system that makes psychological services difficult to access. In the experience of many providers, however, this convenience came with tradeoffs. One therapist, explicitly invoking the dating app language, noted that "because of the way it works, it's so easy, people could essentially swipe left and right, just like they do on Tinder if they want and find a therapist."

One therapist, explicitly invoking the dating app language, noted that "because of the way it works, it's so easy, people could essentially swipe left and right, just like they do on Tinder if they want and find a therapist."

Some therapists also reported that they got matched with clients who had signed up but never responded to initial messages or would not continue after the initial consultation or intake. This swiping model makes switching therapists very easy on the client side, which often left providers having many clients on their docket who never initiated therapy or who would rotate out of their caseload. One metaphor to describe this feeling mentioned by several providers was how it was like a "revolving door, in and out."

Many of the professionals employed in the DTC model seemed to feel this rotation more acutely, although it was also a common dynamic with short-term therapy offered by EAP. The revolving door not only makes it harder for providers to understand how to allocate their time and schedule, it also has consequences for the therapeutic relationship. Joan, a professional counselor who works for a DTC and an EAP company, explained:

> The other thing that I disliked about the DTC platform was [clients] switched you like that. I don't wear my feelings on my sleeve, but it's not the purpose of therapy to just flip around because they're not getting their therapeutic needs met. They're just going from person to therapist, to therapist, to therapist and I didn't see the benefit in that.

The "flipping around" that Joan experienced as a provider has an effect on the therapeutic alliance. The ability for clients to switch therapists in the platform model very conveniently because they don't see their "therapeutic needs" met has consequences on the depth of the work ("that's not what therapy is"). Paralleling again some of language of dating and intimate relationships, Shayla used the word "ghosting" to describe these dynamics and its contribution to the devolution of the profession:

> You should be able to have closure conversations with your therapist and you'll be able to have those in your real life, that's part of that process. And so when you think about the devaluation of therapists, [clients can] just leave and ghost you. What happens in private practices when a client ghosts me? I still charge them and they get really upset about that because that's what's in my contract. Not in the same way as the platforms.

Closure is an important moment for both client and therapist, a time to learn and model how to practice difficult conversations outside of therapy. Ryan, a midcareer counselor, noted that there are other downsides to the revolving door approach:

> I get that you want to give clients a sense of agency. If you don't like your therapist, switch to anyone, just click and you can work with anyone, wherever you want. But there's a downside. If you're just shopping for a therapist, you have to process why this person might not be a good fit with you. It's a disservice to the client and to the clinician to just make it so incredibly easy just to switch at the drop of a hat for any reason. It's too convenient, I'll say. There's a lot of accountability and respect and due diligence as part of a therapeutic process.

In the new platform reconfiguration of therapeutic labor that assumes an endless reservoir of potential therapists, the nature of the client-provider relationship changes, influencing the accountability that engaging in therapeutic work requires. As Ryan added, "the more you make it convenient for someone, the more it's going to be inconvenient and difficult for whoever is on the receiving end. It's a zero-sum game."

Unpredictable Compensation

> "At 30 plus years in the profession, I want to be paid for my experience and my knowledge. I don't take insurance, which means that I only get a kind of particular subset of the world who can afford me, and I'm very aware of that. The platform allows me to see a very different subset of the world, but I have to be really mindful that I don't want to be resentful that I'm only making X amount of money from my work. **We say that mental health is an important priority in our country. But the message does not reflect how we actually compensate professionals who are doing the work."**
>
> — Laura, psychologist

The experience of Laura, a provider with a PhD in psychology and years of experience, combining work in private practice and a DTC platform encapsulates the tension between compensation, clinical work, and access. Only accepting private pay patients in order to make an income leads to seeing clients who can afford it. Working with a wider population, whether through a platform or in community health or other behavioral health structures, means lower pay. This is a very familiar reality for those engaged in therapeutic labor as mental health professionals and a dynamic that is intensified in the new landscape of teletherapy service and DTC therapy.

Money is a fundamental mediator in the relationship between client and therapist, and paid clinical attention is at the core and origins of psychotherapy.[65] While compensation structures vary according to credentials, expertise, and geographical location, "billable time" is how therapists make an income.[66] An average 50- to 60-minute therapy session rate can range from $70-$200.[67] Some providers in pure private practice do not accept insurance and charge a fee per session that the client pays in full, at times working on a sliding scale. Many providers accept insurance, which requires them to negotiate reimbursement rates with large insurance groups.

A lot of mental health workers, especially social workers and counselors, start their career in community mental health centers that focus on more accessible care and lower starting salaries, but provide supervision and the necessary hours toward credentialing and licensing.[68] The average social worker pay is around $55,350 per year and around $88,000 for a psychologist.[69] According to ZipRecruiter, the average mental health therapist's salary is $76,241/year.[70] Many providers have a large amount of student debt and also must pay for their own supervision.[71]

The platform economy entering the mental health field has changed how therapists earn money. Some providers are fully salaried, W2 employees; others are independent contractors who get paid per time worked. Many patch together income with various

arrangements. For those who had transitioned out of community health or other behavioral health workplaces during the height of the pandemic because of burnout, childcare needs, or illness, platforms, especially DTC arrangements, provided a way to keep earning an income with a flexible schedule, while figuring out new steps in their career. "Doing it on the side" is how one professional worded it. Working for a mental health company (usually a B2B) that provided a salary was a good compromise between autonomy, clinical standards, and having a stable income.

On the client side, in the DTC company model, the user often pays a subscription fee for their chosen level of services/bundles, which is a new dynamic in how people pay for services: the "hour" is not the unit of payment anymore in these arrangements.

In line with other gigified sectors, the advertising by some platform therapy companies that hire contract workers emphasizes the "work as much as you want, earn as much as you need" model and recruit very strongly along that message. Because this model avoids insurance reimbursement altogether, which requires time and energy for the provider to arrange, the administrative work is also pitched as very little.

The reality of this labor for many providers, however, was different. When it came to being paid by the minute, some providers reported that they often went over time in sessions but those extra minutes were not compensated. This mismatch between pay and time was remarked upon by several workers, who also noted that:

> The other hard part was learning about these platforms is that they timed you, and so if you went over the pay actually went down. If you actually did good clinical work, and it was over the 45-minute mark, you didn't get paid for a minute over that. And so not only was I getting paid subpar, but in order to do good clinical work I had to give my own time.

For those who just relied on the DTC model to make a living, the promise of making money was matched by the need to intensify the labor while also experiencing high rates of client turnaround or cancelation. In some cases, the pay per hour was as low as $30 per hour; one provider referred to it as "a manicure fund." Because of the revolving door model where clients can easily cancel or not show up, in one DTC therapists were paid as low as $10 for cancelled sessions ("$10, that's two gallons of gas or like two Starbucks.").

This opacity of the compensation structure and ever-changing business model made understanding and tallying up expected income extremely difficult. Joan, a licensed counselor with decades of experience, explained to me in detail how the DTC she works for continuously restructures the pay scheme. She went from initially making a good income to now working on what she called a "ladder basis":

> When I first started, I remembered thinking "I have never made this much money ever." I was amazed. It was different than it is now. What we've got now is ridiculous ... The way they pay is on a kind of a step, almost like

> a ladder kind of basis. So you start out the week on Monday morning, making 30 bucks an hour. And after you have logged five hours, then you bump up to $35 and then another five hours and you go up to $40 and another five hours and you go up to $45 and so on and so on. The carrot that they hang in front of you is that you can get all the way up to $70 an hour, which sounds pretty good, right? In order to get to $70 an hour, you would have already put in 45 hours of work before you ever reach them.

This ladder system is in place to incentivize the professional to keep seeing clients and keeping the slots open, even when the scheduling was not entirely in Joan's control. Joan also does text therapy with some clients on the same platform. She explained that for texting she was paid "X amount of dollars per 1,000 words and then with the video, 30-minute video equals X amount of words. So it worked out to $40 for the 30-minute session and then whatever the dollar amount was at the end of the month, they totaled up all of your time, and all of your words, and then there were dollar amounts there."

Because Joan did not trust the platform to necessarily tally up the numbers right, she kept a count of her own texted words in her logbook:

> Those are all the messages that I've sent out. I finally realized that I had to keep track in order to make sure that I'm getting paid according to what they say they're going to pay me. So I send out messages. You know, I have my live sessions. And that's about the only way we're able to make money.

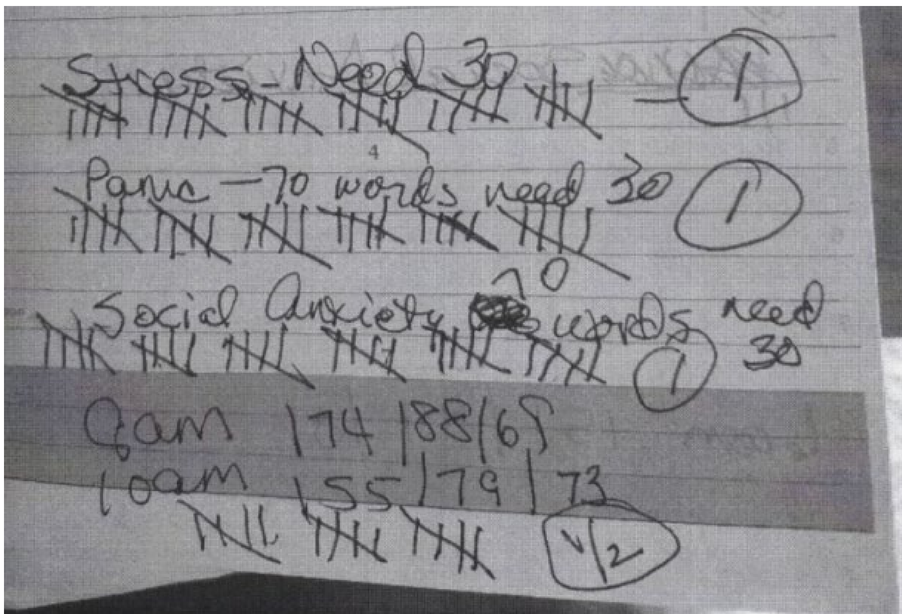

Image 4: Joan's compensation logbook (with permission)

In an already undervalued and underpaid field like mental health,[72] therapists, especially those working for platforms, reported feeling a sense of exploitation and devaluation of

their work. These labor dynamics very much echo how other workers in the gig economy experience (and resist) forms of algorithmic management.[73] In group sessions, during the research, providers in different labor and professional arrangements were surprised to hear the extent of the labor conditions of their colleagues.

More generally, many mental health providers felt underpaid and overstretched, and this at times affected the quality of the care they were able to provide. Because of changing pay structures and intensification of labor, the revolving door between platforms also applied to professionals themselves, as they rotated out of some companies to others, trying to find more sustainable financial arrangements. One provider said she had to leave one platform because she started feeling she was "being nickeled and dimed to death." Issues of pay equity and fair compensation commensurate with experience and expertise already existing as an issue in the mental health field seemed to be intensified — not lessened — by the platform economy entering the field:

> I joined forums on Facebook specifically for clinicians of color, and I was looking to see what they thought about platforms. And at the end, I was kind of feeling like they exploited therapists that might be in my position that were looking for the next thing. I feel like it takes advantage of that need for clinicians: "Okay we'll do this for you, but we're also not going to compensate you equitably in a way that you deserve or that is in alignment with your degree, your education, and your expertise."

One provider explicitly compared her work to an Uber driver, echoing exactly what Elizabeth Cotton[74] has described as the "Uberization of therapy":

> I also think it feels like therapists are now part of the gig economy. Sometimes I feel like I'm an Uber driver. Not that there's anything wrong with being an Uber driver, but it just feels like what I'm doing is not the same as driving a car.

In this tendency toward Uberization, other compromises — around ethics, quality of care, and what "therapy" is — are forced and made.

Providing Good, Ethical Care in the Therapy Platform Economy

Teletherapy and platform therapy have presented professionals with new questions about what constitutes ethical, quality care. Providing therapy at a distance, virtually, in some cases in time-shifted modalities or via text, for some on platforms that encourage high caseloads, has intensified issues of ethics, supervision, metrics and productivity, and privacy/confidentiality. It is always individual practitioners who take on the responsibility of making these decisions. In the DTC model, the subscription tiers system that bundle services was seen as raising concerns by David, a counselor who was pushed to move on from platform therapy given this business model:

> That's where there's a lot of these ethical conflicts in my own mind in terms of how I approached the work. It just didn't feel like the way they tiered their product to various people: It's like, if you want to pay a lower amount, you can get therapy, but it's only like a 30-minute session versus an hour-long session. ... It kind of felt like once you're getting into the good stuff, it's like, well, see you tomorrow, sorry, your 30 minutes is up, like I've got to move on to the next person. I was like, I don't think I'm delivering the quality of care.

Intensive restructuring of timed sessions to the minute and its tie to therapist compensation made a provider ask questions about whether the services she was providing were appropriate, describing this as a constant "internal ethical battle" and how this way of working was almost more conducive to losing sight of the client. This tension highlights again the relationship between how the labor is structured and the consequences for the therapeutic work that providers felt was possible. For Matthew, the availability of platform therapy presented dilemmas about the perennial tradeoff between providing quality care and access:

> Because of the quality of the therapy, if you're really good at it, you can do a really good job, but there's some hoops you have to jump through. It's much harder to do very good quality [on some platforms] because you're not going to be able to see people that do the frequency and duration that they might really need in order to get the best service. You're going to be limited by how much you can actually get from the company. ... So it's like, do you want more reach or do you want quality and how much you're willing to compensate for those two?

In short-term therapy models where quality was assessed with clinical questionnaires and clinical scores that were tied to bonus structures, the tension between quality assessment, compensation, and metrics pressure was also experienced as an ethical dilemma.

Supervision and consultation groups are the places where professionals often discuss "sticky situations," ethical questions, and difficult cases. In the experiences of mental health workers, some telehealth employers had solid structures in place for supervision, consultation, and assessment. Others, however, did not have any supervision and quality of care was assessed via client ratings and reviews. This was experienced as especially stressful by early-career professionals who were trying to understand how to build their practice. Robin explained:

> I think the danger of some teletherapy is when there's no direct supervision, when there's no direct connection between a therapist and somebody in a supervisory position. At least in an agency or a clinic, you have those supervisors, those clinical managers. In teletherapy, unless you set that up yourself,

> you don't really have that on some of those platforms. Like I said, the company I work for is doing it right. Otherwise, it's still the "wild Wild West."

Providers all carry their own liability insurance and each provider is responsible and accountable to their respective ethical board of their credential in their state. While providers believed they were providing mental health care that was within the bounds of their own personal and professional ethics at doing the best they could, many sensed that the setup of some companies did not encourage or value transparency and valued profit more than appropriate care. Much of this was attributed to the fact that many companies did not have clinical leadership at the top or did not entirely listen to clinical staff to inform their business decisions and therefore were out of touch with the clinicians doing work on the ground:

> I don't think they particularly care about anybody other than their bottom line. If they just came out and said, "We're here to make money, you will work your butt off, if you're willing to do that, great." They're also not transparent with clients. So that's my real beef with them. It's not how they operate the company, it's their lack of honesty. But I don't think that's a reflection of me, so I still conduct myself in an ethical manner. I hope I'm not taking on any of the company's liability if there is any. We all have liability insurance, and never once in all these years have I had to use it, so I'm hoping that doesn't change.

Liability, for all mental health professionals, is individual. As one provider put it, "The lawyers are only looking at the liability for this company. The lawyers don't know what I'm bound to ethically because of my license." Another provider explained:

> We assume all of the liability. So the companies can have whatever policies they want. But at the end of the day, it's my license. I have strongly advocated within the capacity of the platform that I'm working for, that the care coordinators have a clinical background. Most of the time ... they don't understand diagnoses, they don't understand the acuity of clients, they don't understand who might be a good fit.

The people who are running [these companies] are not necessarily mental health providers, they don't necessarily have a license, they don't know what your requirements are for your state, what you can and cannot do.

Data privacy, confidentiality, and identity verification on some company platforms were described by some therapists as being concerning and made them worry about their own liability.

One quandary was the verification of identity, which some therapists believed put not only the platform but the practitioners themselves at risk. Since in many DTC models, all that

therapists have is a first name; to circumvent this, many providers had their own informed consent or asked for some identity verification to protect themselves:

> In messaging, I don't have any awareness of confidentiality. In private practice, I make it very clear I'm not in control of your privacy on your side of the screen or on your side of your mobile device. But on a platform, I have absolutely no control of privacy, confidentiality, or security. And I don't know who's in those messages on the other side.

Some of the issues around privacy and confidentiality are absolute core pillars of the therapeutic profession and the ability for ethical provision of care and alignment with HIPAA guidelines. Especially given recent scandals and ongoing lawsuits surrounding the reselling of some consumer data including protected health information and misleading advertisements, involving companies like BetterHelp,[75] Talkspace,[76] Headway,[77] and Cerebral[78] among others, this potential created apprehension among professionals.

The Changing Work of Therapy

Throughout the many conversations with therapists, it became clear that there was something deeper occurring in their experiences of therapeutic labor that was affecting the kind of therapeutic work that was possible. Many providers who had long been skeptical of teletherapy had found the virtual medium to not be a problem in itself. On the contrary, some noted how it had some important therapeutic advantages that challenged older paradigms of therapeutic work that needed to be questioned. Kay, a counselor working with trans youth and LGBTQIA+ clients, noted that some of the changes that teletherapy had brought on were long overdue:

> One of the main things about teletherapy that's positive is that I have reflected on my practice. It has made me think about traditional therapy and acknowledging that this model is really based in white supremacists, patriarchal models. We may have these preconceptions of what we've been told in formal education of what therapy is supposed to look like. But what is that based on? Who is that for? Teletherapy encouraged me to expand how I think about valuable care, how we increase access for people who need support, what that can look like, and to try not to be forced into thinking about it in one way. There's a great possibility for [teletherapy] to be a source of growth for our profession.

Most providers saw teletherapy as allowing for possibilities for new ways to practice. Platform therapy, however, and the dynamics of platformization applied to mental health delivery was perceived in general by most people as changing fundamental aspects of "doing the work." Another therapist explained:

> If you are doing traditional therapy, but through a screen, I think that it doesn't necessarily change the work as much as the platform piece does. The platform piece changes it to be a combination of therapy… or check-ins, or support, coaching, a friend who doesn't have skin in the game kind of thing. ... teletherapy is still therapy, but the existence of platforms changes the expectations of therapists.

At the core of shifts around tele-presence, platformization, and digital mental health care are fundamental questions about the essence of the mental health profession. While platforms might expand access to mental health services in a way that reduces friction for the client, the price of this convenience is offloaded on the therapist-worker.

This restructuring of labor has a direct impact on the "work" of therapy. No matter the therapeutic orientation, credential, or specialization, all providers agreed: the practice of therapy itself is changing as technology and "big tech" enters more and more in the delivery of mental health. For some professionals, these dynamics created worries about the quality of care and potential dilution of therapy itself. As one therapist noted, "The collision that happens is that clients are coming in, and they're getting subpar therapy because therapists are getting paid like $20 a session."

…teletherapy is still therapy, but the existence of platforms changes the expectations of therapists.

In addition, because of big platforms' advertising and recruiting, perceptions of therapy have also changed on the part of prospective clients, moving away from the traditional hour-long, weekly sessions of Freudian fame. This emerged, for example, in providers having to remind clients about the boundaries, rules, or expectations for a session, and how it differs from checking in with a friend: "This is actually therapy, it isn't just informal like FaceTime check-in." These understandings have also been affected by increased exposure and popularization of therapeutic language and resources via social media.[79] One therapist noted:

> I wonder if it impacts the culture of what people think therapy is as well. Because if we're not able to do our best therapy, that's what people think therapy is, like you're doing some coaching and whatnot. Because you're not able to do anything more substantial, people are going to get the wrong idea as to what we're actually doing.

There is a difference, as professionals noted, between something being "therapeutic" and "actual therapy." As a mental health worker put it, "that's what happens when we start using the therapeutic versus therapy. We're not getting to the root of the problem." Coaching, peer-support and other forms of care might be beneficial, but also are not provided by trained providers. Some of the platform features that encouraged instant availability or the introduction of an asynchronous "message anytime" option seemed to push therapists to both question and redraw the confines of what is — and is not — therapy. This boundary work was especially felt toward "coaching" or other instances that were perceived as a dilution or deprofessionalization of their expertise.

Ultimately, many therapists desired to be in a private practice model where they could be in control of their schedules, time, and compensation. Big tech and mental health tech companies, some of these being publicly traded, have sought to increase access and "disrupt" a field where large entities like insurance companies mediate the relation between clients and providers. But this has also contributed to feelings of devaluation and exploitation, making therapy increasingly more "convenient." Renee, a professional counselor, asked a question about such convenience in the new ways of doing therapy:

> It's convenient, but is it appropriate? This feels like a more general question about the society we live in and technology in general. But if that were the question — is it appropriate versus is it convenient — a lot of interventions would change.

"Appropriate versus convenient" encapsulates well some of the tensions and changes brought about by online therapy, opening questions about what doing therapeutic work means for providers, now and in the future.

Conclusion: The Future of Therapeutic Labor

This report has examined the realities of therapeutic labor and its consequences on therapeutic work for mental health providers, from intensified yet flexible schedules, pressures around constant availability, shifts in compensation, and questions about the delivery of good care through virtual means. These shifts have important implications for the present and future of therapy for both providers and clients.

And as providers adapt to these new challenges, practitioners are still facing past and present challenges of providing mental health care in an already difficult system: lowered insurance reimbursements, student loans, licensure, paid supervision, and high levels of burnout.

When asked about the future of the profession, therapists expressed a mix of worry, fatalism, and also enthusiasm for some of the shifts that teletherapy could offer.

As part of this future, providers named the increasing presence of chatbots catered for emotional and psychological support. With the mission of "solving the mental health crisis" and the perennial shortage of professionals, companies like Woebot among others have sought to provide "a mental healthy ally," a perennially available conversational agent that can give mental health advice and support. The attempts of automated psychotherapy and the replaceability discourse and imaginary — "will AI replace therapists?" — are as new as they are old. Through these imaginaries that replace talk therapy with chat therapy, the chasm between therapeutic labor and therapeutic work has one simple solution: removing the human therapist labor altogether. Therapists viewed automated therapy and the entrance of AI agents for emotional and psychological support with attitudes that ranged from mild optimism, fear of further devaluation of the profession to concern for potential harm and ethical breaches and firm conviction that "true" therapy can never be automated or provided by artificial intelligence agents. As one provider noted, "you need emotion to help people with their emotions."

Currently, therapists across credentials, orientation, and employment want their work valued and recognized and their labor compensated and respected. From reimbursement rates, insurance parity to ensure fair compensation, to the facilitation of teletherapy practice across state lines, to better structures of supervision, and more oversight of large mental health companies, there are ways forward that can make how therapists do their work and the labor arrangements they are engaged in fairer, more meaningful, and more equitable.

Ultimately, professionals all agreed that teletherapy, platform therapy, and virtual care are here to stay. They want to shape how they do.

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Authorship

Author Livia Garofalo worked on recruitment, logistics, conducted research interviews, did data analysis, conceptual framing, and wrote the report.

Suisui Wang worked as a research analyst on the project, helping with recruitment, logistics, interview coordination and facilitation, data analysis, and conceptual work.

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Appendix: Methods

This research was an unusual digital, patchwork ethnography project,[80] where I interviewed and spoke to mental healthcare professionals via Zoom either in one-on-one interviews or in small group sessions. The format of these interviews was the same format of the therapist's labor — the video call. This mirroring provided a reversal of the therapist role as the person on the receiving end of questions and opportunity for providers to be listened to in their concerns. In another strange additional game of mirrors, during the course of this project, I became increasingly algorithmically targeted by mental health platforms, both as a potential user of these services and as a potential provider seeking work.

A total of 51 mental health professionals participated in the study, ranging in numbers of years practicing, credentials, location, and professional orientation. All providers had experience with teletherapy and providing services virtually. Some worked entirely with/for direct-to-consumer (DTC) platform companies, while others were employed and provided care/reached clients through a combination of direct-to-consumer platforms, business-to-business platforms (B2B), private/group practice, and community health agencies. Some practitioners worked entirely in private practice but shifted their entire practice online. Out of the 51 professionals, 28 had worked for or were working for one or more platforms.

The research consisted of 14 group sessions and nine individual interviews. Focus groups sessions ranged from two to five participants each. Participants were recruited through professional networks, associations of mental health providers, professional associations, and recruitment postings on relevant social media and listservs. Respondents were first asked to fill out an intake survey to verify license and credentials, gather relevant demographic data, and understand more regarding their mental health practice. The research was reviewed and approved by institutional review board Pearl IRB. All participant names are pseudonyms and none are associated with the specific company that they work or worked with.

The focus groups and interviews lasted 90 minutes, and each participant was compensated with a $100 gift card. The sessions were audio recorded and transcribed, and then coded and analyzed in AtlasTI. [81]

The opportunity for responses, follow up, and flexibility in semi-structured, small-group interviews allowed me to compare provider experiences across different platform types and employment structures.[82] The small-group format also was key to convene professionals together who are often in repeated one-on-one interactions and might not have exposure to professional comradery or the opportunity to hear from their colleagues across location, orientation, and credential. The individual interviews complemented the small group sessions and were geared toward understanding the intricacies and specificity of platform and non-platform work and allowed for more in-depth conversations.

To better understand how different telemental health platforms affect providers' time, a subset of these providers were asked to keep a "time diary" to track how they spend their time over the course of three working days.[83] The goal of this was to document how professionals' time is distributed and fragmented between clinical tasks, administrative labor, and breaks or personal time off. This was compensated an additional $30.

Data from websites, job postings, discussion boards, popular writing and other publicly available materials was also collected to provide a context for the mental health field.

Several months after the group sessions and interviews, mental health professionals who participated in the study were invited to listening sessions where initial findings and themes were presented. More than half of the participants joined and provided feedback and thoughts on the content, format, and reach of this research. This time was also compensated with a $50 gift card.

The mental health workers that were interviewed reflect the heterogeneous existing patterns of labor and diverse backgrounds of the profession. The age of participants ranged from 30 to 60 and over, and slightly over half of participants were between 30 and 40 years of age. Slightly below half of participants had less than five years of practicing experience and the majority had less than 10. The high composition of early-career practitioners may arise from the recruitment strategies of teletherapy platform companies as some platforms offer free or subsidized supervision and employ practitioners still undergoing licensure as associate therapists. Consistent with patterns of feminization in the profession, out of 51 providers, 45 identified as women, five as men, and one as nonbinary. They practiced in 21 different states and are racially diverse: 68 percent identified as white, 18 percent as Black/African American, 5 percent as Latinx, and 9 percent as Asian. They also reflected heterogeneous traditions of degrees, training, and licensure in the therapeutic profession including social work (e.g., LCSW, LSW), counseling (e.g., LMHC, LPC), and psychology (e.g., PsyD, PhD).

While all 51 participants practiced teletherapy, 36 had experiences of providing teletherapy through platform companies. Represented are 23 different platforms, for which our participants work or used to work for. To protect the confidentiality of professionals, no individual therapist is identified with the platform or company they work for. Within the larger ecosystem and market of digital mental health, all providers worked for companies that employ licensed therapists as providers of mental health care. This means

that platforms whose services exclusively focus on coaching, wellness, or chatbots were excluded. Among the 23 platforms represented, these can be classified into three broad categories: 1) client-centered platforms including BetterHelp, Talkspace, Cerebral, WellNite, and Brightsite, 2) provider-centered platforms including Alma, Headway, and Soundermind, and 3) third-party-centered platforms, which include insurance-contracted telemedicine platforms that also offer teletherapy (i.g., AmWell, MDLive, Included Health, Foresight), employer or university contracted platforms providing teletherapy to employees and students (Lyra, Ableto, Headspace, Spring Health, Timely Care), and platforms providing specialized teletherapy services for addiction, kids and family, intensive outpatient programming, and group therapy (Lionrock, Manatee, Charlie Health, and Sesh). This typology is informed by analysis of empirical data, platforms' public materials, third-party market research, and pre-existing research. A more detailed explanation of their business model, labor arrangements, is in the background section.

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