Chapter 9
Going Telemental:
Contact and Intimacy in Digital Mental Health

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ABSTRACT

Telemental health (TMH) is considered by many to be the future of mental healthcare, with some claiming that these methods should replace more traditional approaches. Early teletherapeutic initiatives demonstrate an immediate set of benefits for patients including improved access to care, reduced costs, better schedule flexibility, greater environmental familiarity, and higher rates of patient engagement. Notable limitations to TMH include enhanced privacy concerns, the variable digital literacy of certain populations/persons, and technological instability. However, other limitations regarding therapeutic relationships, experiences, and settings have gone undertheorized and are not sufficiently represented in the current research. This chapter surveys these considerations and argues that digital medical interventions are unable to effectively replicate the same degree of 'contact' and 'intimacy' available in physical care; providers should therefore be cautious in wholly replacing in-person methods or in implementing a standalone paradigm of digital care.

INTRODUCTION

As experts look to make treatment more accessible and efficient, mental health care facilities and services are undergoing an extensive digital revolution. Enduring issues of social precarity and inequality, along with new challenges presented by the COVID-19 pandemic, have forced practitioners to expand their use of digital technology to meet the diverse concerns of patients. Isolation and prolonged social distancing have since incited a "boom" in therapeutic videoconferencing, automated services, phone calls, texting, and social media (Kluger, 2020). These approaches constitute a paradigm of care known as *telemental health* (TMH) which offers unique techniques for persons to interact without needing to be physically present. As the need for these services continue, many experts are consequently considering

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their long-term advantages and questioning their fit alongside of conventional therapeutic methods. In this chapter, the author applies elements from care ethics to explore and critique the sustainability of TMH, arguing that such services can compromise the quality of care even while providing several benefits. Furthermore, the author suggests that critical examinations of 'contact', 'intimacy', and embodied spaces should be crucial features of therapeutic assessment, including evaluations of TMH.

Care ethics is a normative theory that stresses the moral significance of connection, specifically the responsibilities that emerge from interdependent relationships. Of primary interest to this discussion are the ethical elements of care: attentiveness, responsibility, competence, and responsiveness (Tronto, 1993, 127). These features address different points of engagement in the caring/treatment process and expose significant limitations for TMH services. By focusing on connection, the elements allow us to consider the capability of persons to intimately share information, embody spaces together, and empathize with one another, points which are of great interest to many clinicians and counselors. They also help redefine health care ethics by challenging several assumptions of biomedicalization, most notably the depictions of illness and deficiency; the author understands persons in distress instead as functioning on a spectrum of disconnection. Care ethics provides a useful lens for carefully applying innovative services like TMH and for reflecting on the broader goals of mental health care. With respect to this conversation, digital methods must not be wholly dismissed nor provided free rein as their value is determined but should rather be given due caution and consideration.

THE LOGIC OF CARE

Mental health care is largely a product of biomedicalization, also colloquially known as the medical model. It is the "process by which more and more human problems and conditions have come to be defined and treated as medical problems and thus subject to medical study, diagnosis, prevention, treatment, and/or management... (bio)medicalization generally increases the power of biomedicine as an institution of social control." The pathologies and solutions of problems such as distress are also situated in individuals rather than in/from collective institutions (Gupta, 2019, 2; Conrad, 2007, 5-8). Ethical considerations are therefore a matter of patient choice and accountability, with practitioners obliged to avoid or minimize interference. This has been a rather promising direction for many healthcare specialties but difficult for the mental health field. Patients are simultaneously treated as self-governing *and* as incapable of acting in their own best interests due to their 'mental illness'. They are also regularly treated as sole decision-makers in situations where their personal relationships significantly influence their choices. Finally, they are managed according to undertheorized depictions of illness that sometimes foster fatalism; it is difficult to identify legitimate interests and solutions when one's condition is understood as inevitably restrictive.1

The medical model uses a "logic of choice," where the concept of patient choice acts "as a specific mode of organizing action and interaction; of understanding bodies, people and daily lives; of dealing with knowledge and technologies; of distinguishing between good and bad" (Mol, 2008, 7).2 It asserts that choice and equality are fundamental goods, meaning that patients should have fair opportunities to assess options for themselves. However, it offers no guidance for determining which treatments or solutions are preferable, instead leaving this responsibility to patients (74). This approach exposes patients as uninformed consumers and creates obstacles between patients and professionals who often struggle to interpret situations from the other's perspective. It also motivates providers to invest more in

the marketing of biomedical products than in empirical deliberation (Veatch, 2008). Ethical principles like justice, autonomy, and non-maleficence are key contributions that have emerged from discussions of patient choice, but they are at present insufficient.3 As this chapter demonstrates, these deficiencies are only made more apparent by the challenges associated with TMH services. Instead, mental health should look towards a logic of care to motivate daily practice.

As Mol explains: "The logic of care is not preoccupied with our will, and with what we may opt for, but concentrates on what we do"; "the crucial moral act is not making value judgements, but engaging in practical activities" (7, 75). It alternatively observes "situations of choice" where the circumstances under which decisions are made can be uncertain, malleable, and challenging to overcome. Persons are understood not as self-sufficient consumers, but as interdependent selves situated in complex networks of relationships. Their ability to act and make choices stems from the past and ongoing care of others who have helped form and influence their well-being. Practices are evaluated by their specificity, adaptability, and collaboration, and are understood as open-ended processes without fixed timeframes or limits: "Care is not a transaction in which something is exchanged (a product against a price); but an interaction in which the action goes back and forth (in an ongoing process)" (Mol, 18). Mental health care treats diverse patients whose distress frequently affects and/or is caused by others around them. It can last for extensive periods of time depending on the needs of the patient and involves daily decisions that have lasting implications. The needs of patients are incredibly different and will manifest themselves in unique ways; their ability to make choices and their access to certain choices are also highly unequal. The logic of care is therefore better suited to address these challenges.

This explanation of care is largely descriptive, but the normative implications of care may be readily uncovered by reflecting on care practices. Past analyses by care ethicists have produced four concepts for consideration, what Tronto (1993) describes as the "ethical elements of care": attentiveness, responsibility, competence, and responsiveness. These correspond with different parts of the caring process: "caring about, noticing the need to care in the first place; taking care of, assuming responsibility for care; care-giving, the actual work of care that needs to be done; and care-receiving, the response of that which is cared for to the care" (127; Tronto, 2013, 22). Attentiveness means detailed attention to and acknowledgement of the needs of those dependent on us. Responsibility requires someone to assume accountability for ensuring that those needs are reasonably met. Those who do the work of caring must then do so with competence since, short of resource constraints, one may attempt to meet another's needs but do so ineffectively or inappropriately. Responsiveness appeals to the role of the cared-for in indicating their needs and reacting faithfully to the care they are receiving; their participation and feedback is a crucial part of whether a caregiver actually can be attentive and competent.4 These elements encourage experts to ask different questions and to identify suitable outcomes. They invite patients into discussions of illness (thereby promoting autonomy) and stress closer attention to their unique circumstances and situations. Principles of responsibility ensure that patients are neither ignored nor left behind. Lastly, competence motivates clinicians to emphasize empiricism when developing solutions and to communicate evidence-based treatments with more transparency and accuracy. These elements define the quality of care and thus serve as indispensable tools for assessing the efficacy of TMH.

Mental health care itself is a fluid science that must treat individuals as complex and indeterminate, despite its dependency on stable diagnostic categories that serve more as templates for the identification of symptoms than as necessarily accurate representations of mental distress. Professionals can observe patterns or abnormalities in one's 'expected' behavior and intervene in a myriad of ways; diagnoses and treatment are more so a matter of judgment than they are an exact science.5 Ethical considerations thus

provide proper direction and boundaries, though they need not be purely restrictive. As Puig de la Bellacasa (2017) writes, "Constraints are not negative – enforcing – aspects of a practice; on the contrary, they are 'enabling' the practice, they make it specific, and develop in close relation to ways of being and doing" (152). Caring 'constraints' empower professionals to be more attentive, responsible, and competent, which in turn allow them to engage more fruitfully with highly diverse patients who might not "match well" with predetermined classifications. These constraints can then be used to assess the ability of professionals to develop sound observations, judgments, and solutions via digital technology.

As Barnes (2012) notes, attentiveness includes "recognition of the social and cultural circumstances and factors that affect the experience and nature of need" (20). Care is not just a "private concern" between individual persons but also a reflection of broader situations. Therefore, it is worth noting that here, distress is understood as a normative response to different forms of *disconnection*, defined by Hari (2018) as "being cut off from something we innately need but seem to have lost along the way" (82-83). Other scholars like Cvetkovich (2012) view conditions like 'depression' as public feelings: expressions of persons who "keep disappearing under the weight of daily life" (159).6 Types of disconnection include detachment from other persons, from meaningful work or activity, from a hopeful and secure future, from status and respect, from the natural world, and from life-enhancing values.7 People need purpose, security, community, activity, and assurance. Threats to these needs, especially within destructive sociocultural institutions, can compromise their psychological welfare. Sustainable treatments in this respect are difficult to facilitate since they require reconciliation with certain disruptive features that can be outside the control of treatment. Clinicians thus usually aim for symptom alleviation and short-term relief.8 Consequently, TMH services must be evaluated according to both immediate assistance and the long-term prevention of distress.

TELEMENTAL TRENDS

TMH is designed to "serve unmet health needs for professional resources, now aided by advancing capabilities of an ever-evolving and ubiquitous technology and the promise to improve access to quality healthcare while containing or restraining the rising cost of care" (Bashshur et al., 2016, 91). Essentially, TMH aims to bridge temporal, cultural, economic, geographical, and psychological gaps that prevent some persons from accessing care. These can include financial constraints, issues of stigma or shame with visiting counseling offices, and scheduling difficulties. Due to recent shutdowns related to COVID-19, they have also become the sole option for some. According to recent surveys, approximately 76% of mental health clinicians claim to only provide remote services at this time (American Psychological Association, 2020). They contend that TMH offers a low-cost, safe, and easy way to connect with existing clients while also allowing them to accept new persons experiencing distress.9 Providers enjoy greater access to clients and are able to meet more regularly than was formerly possible (Newsome, 2020). Born out of innovation and stimulated by necessity, TMH emerges as an attractive option for those seeking alternatives in a time of uncertainty and rampant disconnection.

'Telemental health' is used fairly interchangeably with *teletherapy*, which refers more generally to therapeutic counseling conducted via videoconferencing, phone calls, or texting. Despite the widespread equivalence, it is worth stating that there are some features of TMH that might not appropriately fit within conventional interpretations of therapy. For example, Abilify MyCite is a recently approved antidepressant used primarily for schizophrenia and bipolar disorder in addition to serving as a supplemental drug

for some patients with depression. The drug contains a sensor that indicates whether it has been taken by connecting to a mobile application used by both patients and clinicians (Food and Drug Administration, 2017). Products like these are still appropriately contained within the class of TMH but would more aptly be categorized as medication management. One must also consider the range of popular meditation/mindfulness applications that patients can use to develop therapeutic strategies. These options involve less interpersonal interaction and instead provide users with tools to help heal themselves (Beard 2020).

The intended advantages of TMH services are well-documented and supported by the initial data available. Treatments like teletherapy produce lower service costs, offer greater schedule flexibility for both parties, have better environmental familiarity, report higher rates of patient engagement, reduce wait times and travel, and allow providers to reach more remote populations (Bashshur et al., 2016; Tutty et al., 2010; Langarizadeh et al., 2017; Zhou et al., 2020; Hilty et al., 2013). By eliminating travel and using exclusively digital appointment services, providers expand the range of options for their patients and themselves while eliminating a barrier for clients who may be less willing to schedule new sessions in-person or over the phone. TMH can also make care more affordable and mediate some of the financial constraints that prevent many from seeking assistance. This is surely a benefit to be commended in an era where mental healthcare is incredibly inequitable and difficult to access across the globe (Patel, 2012). In short, TMH has proven to increase convenience and help reach previously inaccessible and/or disadvantaged persons. Early reviews state that TMH appears to demonstrate a similar or equivalent ability to accurately diagnose patients and assess their symptoms and is comparable to in-person care for symptom alleviation. Certain endpoints like rehospitalization rates and the prevention of future symptoms will require more extensive research (Hilty et al., 2013, 451).

Most of the associated limitations of TMH are also apparent and can be anticipated given the digital modalities that make them possible. These services will likely exclude persons who are less proficient with platforms like *Zoom* or *Skype*, or who are prone to become frustrated when using social media or creating online appointments. Many will confront unreliable or inaccessible broadband and technological instability depending on the resources available to the client and clinician. In some studies, digital literacy and reliable internet service were the greatest obstacles to the expansion of telehealth (Langarizadeh, 2017, 244; Aboujaoude et al., 2015; Blandford et al., 2020). There are also plausible risks associated with the ableism and racism potentially embedded into the normative use of the technology: some are sensitive to or inhibited by the light and audio utilized by certain digital media, while others can have their differences in language or dialect distastefully amplified by phones or videoconferences. In an attempt to make care more accessible for some persons, TMH could exclude others who do not fit the primary archetype of these platforms.

Other limitations include fiscal responsibility and online privacy. While there are active efforts to implement and incentivize parity measures between TMH and in-person care, insurance companies control the terms by which they do or do not cover certain treatments and expenditures. The majority of insurers in the US (as well as in some other countries) apply location restrictions that can severely limit those who may access TMH services (Adams et al., 2018, 300). For those patients who are uninsured or underinsured, these treatments are actually *less* accessible. Issues of privacy plague TMH as well, particularly whether certain platforms are vulnerable to external interference. The security of social media, videoconferencing sites, and mobile networks owned by private companies is a frequent concern, one that will only be enhanced by the clinician's privileged access to a patient's personal information. Without an effective and independent set of regulations to protect health data, threats to privacy will likely be much higher among TMH services. It is worth mentioning that such privacy concerns are not

limited to cyber-security. While many might enjoy a therapy session from the comfort of their own home, there are others who live in precarious environments that do not offer the same degree of ease. Clients who experience problems with persons they live with will have difficulty discussing those complications free from the inquisitive or accidental participation of those in their household. Furthermore, addressing these concerns could expose patients to additional and undue discomfort or harm. The author will elaborate on this problem later in the chapter.

The developing market of TMH will demand scrutiny as providers and clients surveil their options. Most will inevitably default to the options available or referred to them in accordance with their physical, economic, and cultural positions. Though the immediate effects of TMH appear mixed, this chapter appeals to the broader preferences of those receiving care: "Approximately 78% of rural patients and 72% of urban patients were 'moderately' or 'extremely' satisfied using TMH at the clinic. However, 44% of rural patients and just over 51% of urban patients strongly preferred face-to-face visits. Only 15.8% of rural respondents and 13.4% of urban respondents strongly preferred TMH visits" (Bashshur et al., 2016, 94). This conclusion is even more noteworthy: "participation rates also reflect that many adult participants (approximately one third) preferred face-to-face counseling. This finding may reflect the perceived value of in-person treatment features, such as eye contact, body posture, and touch" (Tutty et al., 2010, 234). It is thus crucial to examine the extent (if any) these conditions have on mental health treatment, including whether they may be sensibly accommodated by TMH.

CONTACT AND CONNECTION

Each element of care requires an appropriate amount of *contact* and connection between persons. According to Haraway (2013), the subjectivity of creatures is constituted within embodied relationships to others where their copresence, interactions, diverging associations of power, and intersecting customs or understandings meet. In her words, "meetings make us who and what we are in the avid contact zones that are the world. Once 'we' have met, we can never be 'the same' again" (287). Persons form and modify their complex personalities as well as meet many needs through these meetings, and there is some concern as to whether digital environments function as ideal 'zones' in this respect:

Most of us aren't getting a fraction of the person-to-person interaction we're accustomed to, and most of us are pretty well fed up with it. Virtual birthday parties are no party at all. Virtual happy hours have everything but the happy. Call it Zoom fatigue, cabin fever, flat-out loneliness—many today are suffering from isolation to one degree or another and long for the moment that the virtual lives we've been forced to live can be tossed aside. (Kluger, 2020)

Technology might help persons imitate or mitigate contact to some extent or in temporary bursts, but these benefits can occasionally fizzle out through extended exposure. Not only could the disconnection of clients be further exacerbated by digital media, but the platforms could stifle the engagement of both (or multiple) parties over time and prevent them from being sufficiently attentive and responsive to one another.

Through contact, Haraway claims that various knowledges are produced or amplified. These spaces of assemblage produce modes of "touch," though this analysis is careful to avoid necessarily conflating the term with direct physical contact in therapeutic settings. There are obvious and controversial problems

with those who may abuse their position to facilitate inappropriate touching. Rather, touch refers to the embodied ability to inhabit a setting and physically interact with other creatures or things who also exist in that space. This ability initiates exchanges that are extremely informative and, for many, ward of disconnection. Touch creates informed affects: it in many ways accompanies and enables our capacity for empathy and sympathy: "In touch and regard, partners willingly are in the miscegenous mud that infuses our bodies with all that brought that contact into being... Caring means becoming subject to the unsettling obligation of curiosity; which requires knowing more at the end of the day than at the beginning" (Haraway, 36). Touch drastically influences the quality of caring exchanges by enabling persons to gather more information and engage more deeply with one another.

According to Puig de la Bellacasa (2017): "Involved knowledge is about being *touched* rather than observing from a distance... Touch therefore opens further meanings of knowledge that cares" (93). Touch is a "reaching out" that activates certain abilities and acquires information in ways that visual, audible, or other sensations cannot necessarily match. This is a prevalent concern given the known limitations of TMH methods, including an absence of visual cues with respect to telephones and audio services, a lack of audible cues in texting and social media, and notable time lapses over email and similar exchanges (Langarizadeh, 2017, 243). Individuals cannot quite "go back and forth" in the same manner as they could under physical settings, despite the technological advances and norms used to streamline communication. For many, digital interactions do not feel as authentic as embodied exchanges:

Virtual meetings lack many of the nuances that make in-person interactions feel connected and organic, while also presenting challenges such as internet connectivity issues, background noises, and awkward pauses or moments of cross-talk. As a result, those with many Zoom obligations may emotionally withdraw, becoming less participative in work meetings and choosing not to join video calls with friends despite already feeling socially isolated. (Sanderson et al., 2020, 260)

If patients cannot participate, stop participating, or participate with less responsiveness in these interactions, then carers will be unable to adequately fulfill the demands of attentiveness, responsibility, and competence. Though physical meetings cannot guarantee that patients will experience ideal conditions for participation, they normally encompass more meaningful sensations than can their teletherapeutic alternatives.

Caring relationships are generally *intimate*: "let us think of relations as intimate to the extent that interactions within them depend on particularized knowledge received, and attention provided by, at least one person – knowledge and attention that are not widely available to third parties" (Zelizer, 2009, 14). Good care involves a privileged and informed familiarity with those who receive care; in fact, patients need and normally expect special attention. Yet, imitating intimacy proves to be somewhat difficult from a virtual distance and can eliminate certain skillsets. These limitations can be harmful to intimate relationships where simple gestures, embodied contact, and empathic attentiveness make all the difference:

Just take the communication skills on which consultations depend: they are extensive. Pick the right words. Accept silences. Look at each other. Patients sit up straight or hunch their shoulders, a frightened or relieved look on their faces. Professionals smile, frown or search for something on their computer. Doctor and patient may lean together over the notebook with the results of blood sugar measurements. A nurse puts her hand on a patient's shoulder before she injects insulin. And then there are ever so many handshakes: consultations begin and end with one body touching another. Good communication

is a crucial precondition for good care. It also is care in and of itself. It improves people's daily lives. (Mol, 2008, 76)

Without access to these skills, professionals are forced into precarious positions where their communication is diminished and where decisions are made without great confidence. TMH might allow clinicians to meet with previously inaccessible clients in remote locations and to meet with higher quantities of patients, but it appears to negatively influence their ability to maintain a certain quality of intimate connection with those clients. These issues are embedded in the technology and will require proper consideration before extensive use and recommendation of TMH.

SECURING SPACES

Most of TMH's restrictions are not necessarily indicative of poor execution by medical providers but are instead built into the digital infrastructures that define and discipline skills of engagement. Consider technological devices like touchscreens and trackpads or computer mice. Each "train us" to construct and relate to environments in distinct ways by placing constraints on what one may do and how they may do it. Similarly, platforms used in TMH orient users towards behaviors and knowledges reflective of the space's design and general preferences. Patients inhabit both physical and digital settings in a manner fitting to the media that facilitate interactions and do so differently as the modes of contact shift. Inhabiting a physical office will thus utilize different skillsets compared to those required by digital media. Elements of care must similarly acclimate to spaces as persons implement alternative skills and play by distinct rules of conduct; dispositions and actions are mediated by the limits placed on relationships. Consequently, TMH apparatuses may expedite the process of connection, but in doing so they also redefine its boundaries and expectations.

Environments not only facilitate care but require care themselves. The majority of counselors are all too aware of how essential it can be to create a relaxing, safe, and welcoming therapeutic space for their clients. Comfortable furniture, soft lighting, clean air, and general sanitation can mean quite a bit to patients. However, "there are many ways in which environmental design can include and exclude, and many ways in which lack of care for physical environments can contribute to a sense that these are risky spaces from which people may wish to exclude themselves" (Barnes, 2012, 135). Prime examples of 'risky' or exclusive spaces include those with physical obstacles that inhibit persons with disabilities from safely traversing and louder locations that trigger certain individuals with autism, post-traumatic stress disorder, or hyperacusis. In fact, these environments can be forceful stimulants for distress in their own right. Suitable spaces of care therefore must provide some alleviation. Given the constant concern that mental health professionals have for maintaining these spaces, TMH appears to provide a unique advantage in that digital platforms eliminate many precarious locations and relocate caring parties to spaces that they are likely to find more comfortable.

However, such a claim would readily dismiss digital platforms, applications, and media as concrete environments in and of themselves. As this chapter shows, this is surely not the case. In training individuals to be effective 'users' of a space, they also construct standards for preserving that space. Medical providers simply prefer digital apparatuses because they offload the responsibilities of preservation onto clients and/or private companies. This approach corresponds well with recent "self-care" initiatives where individuals are given a greater amount of responsibility for their well-being, all while

public institutions and resources are steadily depleted (Ward, 2015).10 Digital platforms thus permit caregivers to disassociate from or eliminate a variety of embedded duties that are associated with their responsibility to patients. This is not an explicit goal of TMH, but rather a feature of the technological infrastructure which makes its methods possible. The constraints of digital zones are largely determined by private companies while the caregiving and cared-for parties essentially rent the space. "Caring for" in this sense is a more difficult endeavor since one has less control over the spatial conditions of care that could affect their patient.

Digital contact zones contain additional intermediaries that are more amenable to some populations while restrictive to others. Regardless, individuals shoulder the responsibility for managing their own digital literacy and accessing remote care. Those who are more vulnerable to technological instability, less familiar with the systems, or dissimilar from prototypical users are frequently "pushed out" of these zones and are discouraged from using them in the future. Issues of accessible broadband, cyber-security, and affordability are salient in these conversations. Deficiencies in embodied contact also mean that caregivers can miss cues from clients that could be of real significance. It may not be immediately obvious that a patient is not well-adjusted to the space and their frustration could cause tensions in the relationship or cause them to terminate treatment altogether. Therapeutic communication also suffers from common technical issues. For instance, "lag" can restrict one's ability to convey distress or impede the counselor from properly understanding their expressions. Videoconferencing and other methods still lack shared peripheral cues; in an embodied space, objects or events that captures one's attention are more easily noticed by others. These details might seem trivial, but they all can affect the competence and attention of users. Since the quality of care fundamentally depends on intimate knowledge, limitations to a clinician's ability to observe physical cues, navigate shared environments, or respond in an appropriate manner can be especially restrictive.

TMH further redefines existing spaces like the home. For example, Oudshoorn (2012) argues that biomedicalization alters the behavior of others who coinhabit that home space: partners, siblings, children, and friends regularly take part in the daily examination and regulation of a patient's body and mind. They might also feel encouraged to listen in on and participate in therapy. In some cases, this is a chance to invite new perspectives into the problem space. In other cases, cohabitants can threaten the emotional security of patients who are now unable to be as vulnerable around these abusive, negligent, or unsupportive others. It therefore is not ideal to encourage clients to divulge distress when precarious stimulants are nearby. The "privacy" of their intimate thoughts and emotions cannot be safely contained within the therapeutic relation and hence expose the patient to possible harm. Though practitioners can stay vigilant for these issues, digital spaces obscure them from understanding whether a foreign distraction is initiating discomfort, danger, or simply disinterest. This compromises the practitioner's attentiveness and competence, fracturing their bond with patients. The absence of a mutually shared embodied space exposes limitations in TMH that are also particularly harmful in certain contexts. Though cyber-security is surely a risk worth critical attention, the emotional security of those involved in therapeutic relations must also be considered.

Without security, digital platforms and the physical settings we engage them from fail to adequately foster trust and solidarity whereas more conventional meetings might offer needed stability and relief. As Baier (1986) notes: "We inhabit a climate of trust as we inhabit an atmosphere and notice it as we notice air, only when it becomes scarce or polluted" (234). The fatigue, inauthenticity, and apathy that one may feel while using TMH could in part involve a disconnection from feelings of trust, stability, and hope, all of which are critical components of the therapeutic alliance. Finding a mental health profes-

sional who "fits" a client's needs and personality is difficult enough.11 Insecure spaces and sustained physical separation will stimulate these challenges and create new frustrations. They can deteriorate or annihilate whatever trust the participants might have had and thus lead to a dissolution of the therapeutic relation. It may be possible for practitioners to simply transmute the therapeutic space, but they must accept that certain cognitive, physical, and emotional benefits could be lost in the process. In terms of disconnection, digital spaces also perpetuate harm by reinforcing sentiments of isolation, frustration, embarrassment, and stress already plaguing those seeking treatment.

Finally, many patients report feeling restricted by the medicalization of their home and feel uneasy about their ability to "escape" their disorder/issue (Oudshoorn, 2012). TMH patients under these conditions may similarly feel trapped, thereby restricting their responsiveness and autonomy. A phenomenon known as biosociality, individuals tend to form particularly strong identities around their medical conditions and will relate to themselves accordingly (Rabinow, 2008). One is more likely to identify *as* a "schizophrenic," "depressed," or "bipolar" person rather than believe themselves to "suffer from" depression, schizophrenia, or bipolar tendencies. Their perceptions and actions tend to be more fatalistic, and they repeatedly refer to themselves as bystanders or victims to their neurological (or physical) activities. These are not inherently dangerous or wrong tendencies for one to have depending on the circumstances, but they can be detrimental to those who want more power over their distress or those who need sustainable relief. Biomedical spaces including the home can condition persons to interact with others, themselves, and their settings in ways that stimulate these tendencies. They could then foster more tentative patients who are less willing or able to be necessarily responsive. TMH approaches should consider not only who they might reach with digital spaces but also the types of persons they might create.

LESSONS AND REFLECTIONS

TMH offers flexible and innovative service options for both patients and providers to choose from but restricts the quality of care pertaining to embodied interpersonal benefits. They should be recommended as supplemental options in times of necessity or support but are likely not desirable as standalone forms of care for a wide range of patients. These methods have grown more favorable in response to recent concerns of cost-effectiveness, temporal efficiency, geographical accessibility, and consumer appeal, but prioritize these factors at the expense of crucial elements of care. The ability of a clinician to reasonably assess one's state, to take responsibility for their care, and to respond competently and with confidence is reduced, as is the ability of patients to be responsive and vulnerable. The biomedicalization of mental health care requires negotiations of this kind and TMH as a paradigm simply embraces its economic limitations more directly. However, as care it must be evaluated according to some minimal standard of use and efficiency. The author thus recommends elements of care as assessment tools and further suggests that emphasizing these elements exposes the significance of core features like contact, intimacy, and embodied spaces. TMH can be valuable for the future of mental health care if it is implemented with caution, purpose, and precision. To conclude then, this chapter will briefly discuss what discussions of TMH mean for mental health ethics and practice.

Early indications demonstrate that TMH is effective at reaching more remote populations and could accommodate those who are suddenly displaced or unable to participate in conventional meetings (such as those isolated during a pandemic). These are exceptional benefits that should prevent experts from merely disqualifying digital methods. Yet, in bridging these gaps the rollout of TMH services must pre-

vent creating new exclusions based on technological literacy or environmental security. Committing to a comprehensive digital paradigm is not necessarily more inclusive, but rather entails an active choice in *who* is deserving of accessible or effective care. For these discussions, experts decide at a broader level who responsiveness and responsibility apply to by transitioning to a new subset of contact zones. Those who are not accustomed to or ready for these spaces will be (intentionally or unintentionally) left behind. In the meantime, there might be hybrid combinations of conventional and digital methods worth considering. Regardless, experts should critically evaluate the capability of digital techniques to *create* distance or omissions even as they rightfully meet the needs of those previously marginalized and/or excluded.

Second, conventional methods have much to gain from TMH when they are compared using these terms. For instance, one of the luxuries of TMH for many providers and clients has been participating from the comfortability of their own homes. Instead of simply moving care to the home, it is feasible to consider how they might bring 'home' to the therapeutic space. Gosselin (2020) makes a similar claim with respect to psychiatric hospitals: by developing "practices of home-making," hospitals reduce distress and increase compliance by treating these spaces as long-term comfortable environments where one may patiently heal. The use of "home-like" objects inspires positive cognitive associations, fosters familiarity, and reinforces trust. The home is also a special place where people can build meaning, ground themselves, and develop important networks of relations.12 Building on this idea, maybe professionals can use their interactions with remote clients to reimagine medical offices to be less awkward and more inviting. This is not a criticism of the many wonderful facilities who already diligently care for their spaces but rather an invitation to use TMH for additional reference points. Conventional offices could also reevaluate treatment affordability and schedule flexibility, as many barriers common to traditional methods may not only be inconvenient but also expensive and wasteful.

Lastly, TMH offers a unique opportunity to understand and navigate the fundamental features of spaces, media, and relationships in everyday mental health practices. These are underappreciated and vital conditions of care that radically affect its quality and meaning to persons. They may also be used to unpack the peculiar forms of disconnection that threaten the health, safety, and ambitions of patients seeking care, including those stimulated by certain treatment methods. Complacency and/or ambition can blind providers to the significance of concepts like contact and intimacy: specifically, how they are always present in care and how they might inform more effective, genuine, and equitable models of treatment. Care exists only in relationships where intimate information, opposing or collaborative values, and diverse needs are circulated in ongoing exchanges. Mental health care, including the innovations of TMH, is best served by embracing these facts even if it must accommodate several economic and social challenges. Whether digital technology will be an enabling or restrictive force moving forward is at present unclear, but it is certainly an intriguing source of controversy and exploration.

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ENDNOTES

1. Holm (2019) unpacks these challenges in greater detail, suggesting that the field of bioethics has much to learn from complications in mental health practice. These revelations are salient given the vast numbers of people who suffer from chronic mental disorders. As Barker (2011) further notes: "ethics is only meaningful where people – or groups of people – are self-governing and have the opportunity to make choices free from any coercion. Rarely is this the case in the mental health field. The limits imposed on a person's exercise of freedom – however explicit – continue to haunt contemporary practice" (3).
2. Mol (2008) uses the term "logic" rather loosely. The approach is not categorically coherent or fixed but essentially states that: "Events somehow tend to fit together, there are affinities between them"; logic is understood by her as the rationale behind "modes of ordering" (8).
3. Healthcare ethics are largely informed by Beauchamp and Childress's (2001) principles of medical ethics: autonomy, non-maleficence, beneficence, and justice. These are supported by four rules: veracity, privacy, confidentiality, and fidelity.
4. Engster (2007) notes that attentiveness means asking, "Do you need something?" while responsiveness then directs us to ask, "What do you need?" (30-31).
5. Classifications of mental disorders cannot be reliably attributed to biomedically discerned attributes but are rather the product of expert consensus in how symptoms and 'diseases' should be understood (Whooley, 2017, 47).
6. Cvetkovich (2012) continues to assert that we are at an impasse with what clinical research can reasonably show us: "We don't need scientific research to explain what's going on; we need better ways of talking about ordinary life, including the dull feelings of just getting by" (159).
7. Not included in this description are genetic predispositions that cannot *cause* distress but may make certain synapse assemblages more likely. One's neurological changes are more accurately understood as synaptic conditioning that responds to exterior stimuli. Prolonged exposure to discomfort or pain may train the brain into proactively activating those synapses which correspond with emotions such as fear or anxiety (Hari, 2018, 146-148).
8. Despite the conflict between sustainable healing and immediate relief, both goals are extremely important. Gupta (2019) identifies this problem within mainstream medical interventions that simultaneously alleviate some individual suffering while enhancing social inequality. In her analysis, she claims that relief and survival frequently come from paradigms of normalization, including those induced by treatment.

[9] Zhou et al. (2020) specifically argue that TMH services are "perfectly suited to this pandemic situation – giving people in remote locations access to important services without increasing risk of infection" (378). They, along with Sanderson et al. (2020), report a surge in persons seeking mental health treatment as a direct result of pandemic-related distress and disruption.

[10] Ward (2015) argues that 'self-care' is an initiative that neoliberal policy makers use to reduce support for public welfare and increase responsibility for individual citizens. Rather than subsidize or enhance public modes of healthcare, for instance, individual citizens are forced to "stay healthy" and avoid harm.

[11] Within therapy, a patient's fit with their therapist or their "cognitive match" is a crucial part of the therapeutic alliance. This can include not only ethnic and cultural similarities, but also alignment in beliefs, perspectives, and experiences (Woo et al., 2017, 503-505).

[12] Gosselin (2020) covers these home-making practices and objects in greater detail. Since one effectively "moves into" a psychiatric hospital for a temporary or extended period of time, some of these suggestions will reasonably not apply to other therapeutic spaces.