An Approximation of Freedom: On-demand Therapy and the Feminization of Labor

LINDA HUBER, University of Michigan, USA
CASEY PIERCE, University of Michigan, USA
SILVIA LINDTNER, University of Michigan, USA

Platform labor and gig work have become key sites for understanding a nascent "future of work" hallmarked by informalization and digitization. A growing body of research emphasizes how experiences of platform work are mediated not only by algorithms and user interfaces, but also by gender, race, local cultures as well as labor hierarchies. Drawing from ongoing ethnographic research on the digital transformation of healthcare, we show how therapists' experiences of platform labor are centrally shaped by the historical and ongoing feminization of mental health work. Platforms reinscribe feminized labor conditions that are pervasive in the healthcare industry, and yet platform labor appears as 'useful' to some therapists as they navigate a set of precarious career choices fundamentally structured by feminization. We use the analytic of the stopgap to describe platforms' two-fold reproduction of the status quo: first by offering an approximation of freedom to individual workers, helping to forestall a crisis of unsustainable work conditions; and second by reinscribing the same logics of exploitation in order to make labor scalable. This stopgap analytic reorients the focus away from the impact of the platforms technologies as such, towards the conditions that make stopgap solutions necessary for survival. It also points towards the importance of intervening in the conditions of exclusion and exploitation that help to create a market for platform stopgaps.

CCS Concepts: • **Human-centered computing → Empirical studies in collaborative and social computing**; *Ethnographic studies.*

Additional Key Words and Phrases: gig work, platform labor, gender, care work, telehealth

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1 INTRODUCTION

Over the last decade, media discourse in the United States has shifted from seeing digital technologies as enablers of creative work and worker empowerment towards understanding technology as a *precarity engine*, producing and reproducing various conditions of exploitation. Digital work is simultaneously applauded as an enabler of productivity and accessibility - and challenged for accelerating control, surveillance, and exploitation of workers [17, 25, 60, 61]. In this paper, we build on a body of work in CSCW and digital labor studies highlighting how a binary construal of platform labor as "precarity engine" on the one hand and platforms as inevitable technological "progress" on the other distracts from platforms' fundamental reliance on and reproduction of

Authors' addresses: Linda Huber, ludens@umich.edu, University of Michigan, 500 S State St, Ann Arbor, Michigan, USA, 48109; Casey Pierce, University of Michigan, 500 S State St, Ann Arbor, Michigan, USA, 48109; Silvia Lindtner, University of Michigan, 500 S State St, Ann Arbor, Michigan, USA, 48109.

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long-standing forms of gendered and racialized exploitation [42, 52, 58]. This research emphasizes the situated nature of labor exploitation, which takes on different forms depending on industry and occupation, whether workers are dependent on platform labor for their income [45], on the kind of labor being done [21], and the gendered, raced, and classed nature of the work being platformatized [4, 56]. This body of work traces how global labor hierarchies, histories of outsourcing, colonial extraction, gendered devaluation of work, and racialized othering operate as pre-existing precarity engines that platforms build upon, reinscribe, and amplify [3, 5, 30, 36].

Drawing from our ongoing ethnographic research on digital transformation in the healthcare industry, we demonstrate what might at first seem counterintuitive: while telehealth[1] platforms reinscribe past and ongoing processes of devaluing care work, they appear to therapy workers themselves as "useful", providing an approximation of "freedom" through a sense of greater control and choice - despite the ongoing feminization of their work. In this paper, we explore how this seeming contradiction (the appearance of feminized platform work as a useful "tool" to approximate and one day also achieve better and more just conditions of work) is at the heart of the uptake of telehealth platforms.

Like many other forms of care work, therapy is a highly gendered profession - approximately 80% of therapists in the U.S. are women [55]. Although the field has roots in the male-dominated practice of psychoanalysis, the profession has been feminized over the past half-century [8, 14]. Feminization refers to the incorporation of women into a group or profession once dominated by men - and the subsequent devaluation of that work, especially through reliance on invisible forms of gendered labor that are not seen as "real work" (e.g., emotional labor). The feminist technoscience scholar Donna Haraway [18] describes feminization as the intertwined processes of devaluation, precarity, and vulnerability:

> To be feminized means to be made extremely vulnerable; able to be disassembled, reassembled, exploited as a reserve labor force; seen less as workers than as servers; subjected to time arrangements on and off the paid job that make a mockery of a limited workday; leading an existence that always borders on being obscene, out of place, and reducible to sex. (p. 38)

In line with Haraway's work, we aim to show how telehealth platforms, exactly because they *appear* as a workaround for conditions of feminization, reproduce those same logics in new ways. This ironic function of the platform (as something that both replicates and appears as a workaround for precarity) also aligns with sociologist Millan Cottom's description of the "stopgap" function of platforms: "The platform economy is a stopgap to overcome exclusion, and a tool used to target people for predatory inclusion." (para. 13). Platform labor indeed offers greater accessibility to those excluded from other employment opportunities [58], both in terms of hiring practice and in terms of flexible configurations of work that may be more viable for certain kinds of workers. However, McMillan Cottom and others [28, 49] have argued that this promise of accessibility and flexibility of gig work, which functions as a partial and highly precarious workaround for outright exclusion, nonetheless does so on terms that are predatory, reproducing the marginalization and exploitation of these workers. Our findings trace out the conditions of possibility that have led therapy workers to see platforms as an approximation of freedom - conditions which in turn enable the adoption and proliferation of platforms.

[1] Many hospitals and provider networks use internal telehealth tools to deliver remote services, but this paper focuses on specialized telehealth companies that deliver remote mental health services, either alone or as a suite of other telehealth services. We use the term teletherapy here to refer specifically to the delivery of mental health services via either specialized telemental health or generalized telehealth platforms.

The starting point for our analysis is that platform-based gig work is situated within larger systems of marginalization and global hierarchies of labor [4, 42, 58]. By attending to this larger context of exploitation, we can better perceive how platforms can come to appear to workers and users as an escape from conditions of precarity - even while platforms simultaneously re-create those same logics in order to achieve scalable, profitable business models. In this research, we situate teletherapy platforms within the context of long-term processes of feminization, devaluation, and inaccessibility within the industry and profession. We narrate the conditions that therapists are seeking to escape from when they turn to platform work as an approximation of freedom from those conditions. We also unpack therapists' descriptions of how their work is structured and managed by platforms, and find that these platforms nonetheless reproduce the feminization of therapy labor in new ways.

1.1 Feminization and the therapy profession

As we outline in this paper, feminization appears in many different ways within the therapy profession, including: the devaluation of mental health services relative to physical health; tight bureaucratic control of mental health services by insurance companies and managed care regimes; the shift from a male-dominated Freudian paradigm of expert psychoanalysis to a Rogerian paradigm of relational talk-therapy (more closely associated with the gendered work of empathetic listening [38]); insufficient recognition and support for the emotional labor of therapy work; the need to work multiple jobs to achieve financial sustainability in a poorly-paid industry; and in the large numbers of therapists who leave community mental health settings for private practice, to avoid burnout and to achieve flexibility in schedule and location that are essential for many working mothers.

The platformization of therapy work represents an interesting case study of how systemic precarity can make gig work appealing even for credentialed, in-demand professionals. Therapists working for telehealth platforms are licensed professionals, completing at minimum a 2-year Master's degree program and thousands of clinical hours in order to be able to practice independently. Practitioners also benefit from professional associations, annual conferences, and regulatory protections that many other care work occupations do not provide. Nonetheless, despite having many of the important characteristics of a profession [38], therapists do not have the status, wages, or protections of adjacent professions medicine. In her book, "On the Shoulders of Women: The Feminization of Psychotherapy" [38], Philipson explores the profession's shift towards greater numbers of women workers, linking the shift in gender with the deskilling and degradation of the profession. She argues that "the female psychotherapist of the twenty-first century will share more occupationally with a wage worker than with her professional counterpart in the mid-twentieth century." (p.105). Teletherapy platforms build upon and reproduce pre-existing mechanisms of feminization and devaluation that have brought the conditions of professional therapy work closer to other forms of waged care work.

1.2 COVID-19 and the platformization of healthcare

The CoVID-19 pandemic has significantly accelerated the adoption of telehealth services in the United States, both as a way to safely connect patients and providers, and to meet the physical and mental health needs that have exploded in the wake of a global pandemic. Claims for telehealth services seem to have stabilized in the wake of the pandemic at 38 times more than what they were pre-pandemic, in February 2019 [6]. Telehealth platforms businesses have seen a significant boost in adoption, investment, and legitimacy as federal regulators and American insurance companies have loosened restrictions on the provision of telehealth services [11, 22]. Additionally, insurance companies and employers have set up new contracts with telehealth apps and platforms [12, 43],

and millions of new users continue to use these platforms either through direct-to-consumer subscriptions or via their health plans.

To give a sense of scale for this market, the largest telehealth platform company in the U.S., Teladoc, traded on the NYSE since going public in 2015, saw revenues jump from $500 million in 2019 to over $1 billion in 2020, in the wake of the CoVID-19 pandemic. As of 2020, Teladoc boasts 51 million people covered via contracts with insurers and employers [19]; by way of comparison, UnitedHealthcare, the largest private insurer in the U.S., has 70 million members [39]. There are two main direct-to-consumer telementalhealth platforms – Betterhelp, which is owned by Teladoc, and Talkspace, which has 46,000 active members and 39 million people covered through employer or healthcare insurance agreements [19]. Many of the platforms touched on in this paper are undergoing mergers and acquisitions by major insurers or other platforms (see Table 2 for more details). As these platforms consolidate their role in the market and continue to become embedded within larger health infrastructures, it is important to unpack the specific logics of value-production and care that undergird them.

1.3 Historicizing/contextualizing platform precarity

A significant amount of research has gone towards identifying the ways that platforms generate precarity and exploitation, including via: algorithmic surveillance and control of labor, devaluation and acceleration of labor processes, and evasion of the rights and responsibilities of formal employment by positioning themselves as a neutral intermediary for matching workers with customers [13, 15, 24, 44, 51]. More recently, scholars in CSCW and digital labor studies have highlighted how the precarity engendered by platform labor is not exclusively a technological phenomenon, and not, strictly speaking, "new." Instead, platform labor builds upon, reproduces, and co-exists alongside previous mechanisms and conditions of precarity - including but not limited to gendered and racialized exploitation [17, 36, 53, 58]. Narratives which emphasize the "newness" of platform precarity do not do justice to the experiences of workers. This is especially relevant in contexts where informal and highly precarious labor is the norm, as in feminized care work contexts [2, 52] or in the postcolonies [4, 41, 42]. Additionally, platform-as-precarity-engine narratives push us towards techno-deterministic accounts which imply that digitization itself is the cause of precarity, rather than naming the true root cause: the interrelated cheapening and scaling of labor enabled by racialization, feminization, and globalized labor arbitrage. To disrupt and intervene in platform-based precarity, we need to look beyond the platform itself, and towards the locally and historically contingent logics of exploitation that are encoded within platforms technologies and which help to create a market for reconfigured forms of precarity.

This paper contributes to this historical/contextualizing mode of analyzing platforms by exploring the relationship between teletherapy platform labor and feminization. Through this mode of analysis we are able to better understand the systems of marginalization that workers are navigating and responding to when they start working for the platform. Ticona and colleagues [53] argue that "technological systems of work don't necessarily create similar experiences of work across different cultural contexts; rather, different professional norms and historical legacies of work can lead workers to divergent experiences of similar technologies" (p.7). Extending this idea, we argue that cultural contexts and histories are key to not only identifying when these same local logics of exploitation are reproduced by platform features and business models, but also shedding light on what makes platform labor appear 'useful' to workers, thus reducing worker resistance and enabling widespread adoption. Long-standing conditions of exploitation are core to understanding both workers' experience of these technologies, as well as the technologies themselves. A key underlying aim of our paper thus is to further amplify recent calls in CSCW research for critical historical analysis [50], by specifically attending to the ways that historical forms of exploitation

live on, are intensified, and further legitimized via contemporary digital technologies. We argue that studying how historical conditions of feminization are shaping contemporary platform labor is at the crux of both understanding - and also finding ways to intervene in - the precarious and exploitative conditions of work they reproduce.

2 RELATED WORK

2.1 Labor hierarchies and promise of future careers as a market

Labor hierarchies, including the racialization and gendering of labor, can be seen not only as modifying the experience of platform labor workers, but as foundational conditions of work that platforms build upon in their work of creating new markets and structuring labor processes in more scalable, profitable ways. We build here on McMillan Cottom's work [35, 36] exploring how the platform economy works through and reproduces racial capitalism. Platform companies, McMillan Cottom argues, generate profit through "predatory inclusion." Platforms provide access to workforce and financial systems to those previously excluded on the basis of race - but do so on predatory and extractive terms. She describes those subject to predatory inclusion as "subprime entrepreneurs," (para. 13); populations framed as "subprime" within racial capitalism are repackaged as a profitable target of predatory inclusion for platform companies. This parallels our own finding that the ongoing feminization of therapy workers is part of what helps to create a market for platform companies who promise therapists access to seemingly more sustainable working conditions - regardless of the cost or terms of that inclusion.

Similarly, communication science scholar Niels van Doorn's [56] exploration of the role of race and gender in on-demand service platforms highlights a similar logic of inclusion-through-exclusion. He shows how platforms market themselves on the promise of a post-racial, entrepreneurial future– a promise that is predicated not on intervening in hierarchies of labor, but on further invisibilizing and devaluing certain forms of work by acting as an intermediary between client and service worker. The exclusionary and exploitative hierarchies that workers attempt to navigate via platform labor is nonetheless part of what "subsequently justifies lower pay in comparison to management and engineering jobs." (p.907).

Building on McMillan Cottom's and van Doorn's work, this paper examines how teletherapy platforms create a market built on the promise of temporarily or partially escaping exploitative hierarchies of labor. We show how this economization of promise [23, 29, 30] –that is, turning the promise of career advancement in a context of systemic precarity into a market – makes people endure exploitation in the present, in turn perpetuating the invisibilization and devaluation of care work.

2.2 Gender and platformization

Recent scholarship has attended to how platformization looks quite different in contexts other than the male-dominated ride hailing industry. Ticona et al. [53] critique the assumptions about platform labor that emerge solely from case studies of Uber, and trace the different experiences of platformization across multiple dimensions, including: legacies of inequality and exploitation that vary from industry to industry; the differential risks that workers experience depending on race and gender; and the type of platform (on-demand platforms that automatically match clients with workers, versus marketplace platforms where clients can choose from a number of different potential workers). From their report, we start to gather a clear picture of how platform labor is not a singular technological phenomenon and does not impact workers - even within the same industry - in a uniform way.

Research by Anwar et. al [4] and Raval and Pal [41], for instance, shows how the conditions of feminization intersecting with class and caste shape how Indian beauty workers experience and use platforms. Raval and Pal show how childcare responsibilities play into the need for flexibility, and how the "professionalism" encouraged by platforms incidentally is useful as a counter-measure against the risky nature of informal, feminized work. Anwar et al. specifically focus on the ways that workers use platform control to navigate other forms of control they experience (e.g., patriarchal control). Paying attention not only to the way that platforms technologically structure the work, but also to the systemic conditions of precarity that workers have to navigate, Raval and Pal [41] highlight the ways that working for an app has the power to reconfigure the perceived acceptability of work, providing a "socio-cultural opening more than an economic one" (p.175).

In this paper, we similarly trace how past and enduring processes of feminization structure workers' experiences of platformization in the mental health industry. We found many adjacencies to other studies of feminized platform labor, such as the value of flexibility for working mothers and the importance of establishing boundaries in intimate and relational work settings. Nonetheless, therapy work has salient differences from other forms of platformized care work, including that this work is done entirely remotely, it entails a more professionalized status than other forms of service work, and it takes place within a tightly regulated and bureaucratically controlled industry.

As Raval and Pal [41] state, platforms are "situated technological artifacts" (p.175:2); the very features of platforms that are criticized in one context (e.g., informalization, invisibility of labor) are either the norm or even valuable affordances to workers in another context (e.g., working mothers; workers in stigmatized industries). This intersectional lens on the differential impacts of platformization corroborates van Doorn's [57] provocation that "there is no such thing as 'the gig economy'" (para. 5). Instead, van Doorn argues for a "more differentiated approach to studying platform-based gig work" (para.5) that accounts for the very different hierarchies and power dynamic at play across different industries and occupations.

3 METHODS

This paper draws from ongoing ethnographic research into the platformization of the healthcare industry. The findings in this paper specifically emerge from engagements over a period of 8 months (February to October 2020) with a group of therapists, all based in the United States, who were working on platforms on a regular basis. The first author, also based in the U.S., conducted semi-structured interviews with 25 working, licensed therapists, including 23 current teletherapy platform workers. Interviews were approximately 60 minutes long and took place over video conference. All interviews were recorded and transcribed. A discourse analysis of platform companies' websites and messaging was also conducted, along with analysis of materials (websites, social media posts, blogs) shared by professionals in the online therapy community.

3.1 Participants

We initially contacted therapists who listed employment with teletherapy platforms on their LinkedIn profiles. From there, we used a snowball sampling method to reach additional therapists working on platforms, with initial contacts sharing the study with colleagues and in Facebook groups for therapists. All participants were licensed to practice as therapists; some were licensed in multiple states. Most participants practiced across the United States, with one practicing remotely from Japan. A slight skew towards therapists licensed in Florida likely reflects the population of one of the Facebook groups that was used to share the study. A total of 22 of 25 participants identified as women, with an average age of 40 across all participants. A total of 22 participants held Master's degrees, and 3 held doctoral-level degrees (see Table 1). Most of these participants held Master's degrees and/or licenses with a social work orientation (e.g., Master of Social Work, Licensed Clinical

Table 1. Participant Demographics (n=25)

Participant	Age	Gender Identity	Highest degree and license type
P1	52	Woman	Master of Social Work; Licensed Master Social Worker
P2	52	Woman	Ph.D. Clinical Psychology; Licensed Clinical Psychologist
P3	36	Man	Master of Social Work; Licensed Clinical Social Worker
P4	33	Woman	MA, Counseling Psychology; Licensed Marriage and Family Therapist
P5	28	Woman	Master of Social Work; Licensed Master Social Worker
P6	41	Woman	Master of Social Work; Licensed Clinical Social Worker
P7	50	Woman	Master of Social Work; Licensed Clinical Social Worker
P8	40	Man	MS in Counselor Education, Mental Health Counseling; Licensed Mental Health Counselor
P9	46	Woman	Master of Social Work; Licensed Clinical Social Worker
P10	33	Woman	MA, Psychology; Licensed Marriage and Family Therapist
P11	28	Woman	M.Ed., Licensed Professional Counselor
P12	32	Woman	Master of Social Work; Licensed Clinical Social Worker
P13	31	Woman	MA Marriage and Family Therapy; Licensed Marriage and Family Therapist
P14	40	Woman	Master of Social Work; Licensed Clinical Social Worker
P15	65	Woman	MS, Mental Health Counseling; Licensed Mental Health Counselor
P16	30	Woman	Master of Social Work; Licensed Clinical Social Worker
P17	35	Woman	Master of Social Work; Licensed Master Social Worker
P18	62	Woman	Ph.D. Marriage and Family Therapy/Counseling; Licensed Marriage and Family Therapist
P19	32	Woman	Masters of Counselor Education; Licensed Mental Health Counselor
P20	47	Woman	MA, Mental Health Counseling; Licensed Mental Health Counselor
P21	34	Woman	PsyD; Licensed Professional Counselor
P22	36	Woman	MA, Mental Health Counseling; Licensed Professional Counselor
P23	29	Woman	MA, Counseling Psychology; Licensed Professional Counselor; Licensed Mental Health Counselor
P24	36	Genderqueer	Master of Social Work; Licensed Clinical Social Worker
P25	36	Woman	MA Marriage and Family Therapy; Licensed Marriage and Family Therapist

Social Work). This is notable because social workers - as opposed to those with doctoral-level degrees, such as clinical psychologists - are more likely to work in non-profit agencies or community mental health settings. As we explore in our findings, these settings can pose challenges and risks for therapists that other settings (e.g., working in private practice) do not.

Interviewees worked across 10 different teletherapy platforms, many working across multiple platforms (see Table 2 for counts of the number of therapists interviewed working for each platform). These different platforms can be divided into two major categories: the "direct-to-consumer" (DTC) platforms (specifically, Betterhelp and Talkspace) that sell subscriptions to on-demand therapy services directly to users, and "business-to-business" (B2B) platforms that primarily contract with employers or insurance companies. Several of these B2B platforms (e.g., Teladoc, Amwell, MDLive) are more general telehealth platforms that provide access to therapists alongside other kinds of medical professionals. Based on our interviews, there seems to be clear differences between working for DTC platforms compared to B2B platforms, both in terms of compensation as well as the way the platform structures therapists' work arrangements. For example, Betterhelp and Talkspace typically pay approximately $25 per hour, whereas B2B platforms range from approximately $55–$100 per hour or more. DTC platforms rely on algorithmic management and promote their services as

Table 2. Representation of teletherapy platforms across interviewees

Platform Name	Platform Description	Platform Category	Number of Interviewees Working for Platform
Betterhelp	Therapy only; largely direct-to-consumer; owned by Teladoc	DTC	14
Talkspace	Therapy only; largely direct-to-consumer	DTC	5
Teladoc	General telemedicine platform; contracts with insurers and corporate employers; owns Betterhelp	B2B	10
Amwell	General telemedicine platform; contracts with insurers	B2B	5
MDLive	General telemedicine platform; contracts with insurers; acquired by a Cigna subsidiary in 2021	B2B	4
Ginger	Behavioral health only; contracts with large employers; merger with Headspace announced in 2021	B2B	2
AbleTo	Behavioral health only; contracts with insurers; Optum is a significant stakeholder	B2B;	2
Lyra	Behavioral health only; contracts with large employers; include both telehealth and in-person services	B2B	2
ModernHealth	Behavioral health only; contracts with large employers	B2B	2

on-demand therapy. By comparison, therapists working for B2B platforms described their therapy work comparable to private practice work.

Therapists working for DTC and B2B platforms are independent contractors. Among our 25 participants, there was a mix of therapists working for platforms full-time, working part-time across multiple platforms, or working for platforms as a side-gig in addition to another full-time job. For some of these platforms, participants described them as a "stepping stone" to private practice.

3.2 Data Collection

At the beginning of each interview, the interviewer was careful to note that she had no professional background in healthcare or mental health, emphasizing that the interviewees had significant knowledge and expertise about the field and the work itself that the interviewer did not share.

Interview questions covered 3 main areas: 1) description of the therapists' overall career path and goals, including how and why they got started working for platforms; 2) details of their experiences working on the platforms, including what a typical session looks like, how their work and pay is structured by the platforms, any tips/tricks/hacks for working on platforms, and any training or support they receive; and 3) a detailed comparison of their own experiences in different work settings, platforms and otherwise, and what they liked/disliked about each. The interview protocol was iteratively refined to better reflect the workers' experiences and to include questions around their most salient concerns and issues. For instance, the initial interview protocol included a strong line of questioning about algorithmic management, platform control, and the kind of data/analytics captured by the platforms. The interview protocol was revised as initial data suggested that these technological aspects were not salient in the platform teletherapists' work experience: rating and review systems are not heavily used, if at all; the data or tracking required often is not any more stringent than the requirements expected by any insurance company to complete notes in a timely manner. Some therapists pointed to the components of algorithmic management on DTC platforms (e.g., pay by word, incentivizing on-demand responses) as a reason that they immediately or quickly left those platforms for other platforms that do not have that component. After the 5th or 6th interview, the interview protocol became more fixed, and a point of saturation (e.g., clear emerging trends on each topic, and significant repetition across interviewees) was reached on the revised interview topics around interview 20.

3.3 Data Analysis

The first author was also primarily responsible for coding the data from these interviews. Memos were captured throughout the interviewing and open-coding process. Grounded theory techniques

[16] were used to iteratively analyze the interview data, memos and literature. In the first round of coding, the interviews were coded using an open-coding process, focusing on the high-level and descriptive codes about therapy work and the profession itself (e.g., "career paths", "pros/cons of platforms", "labor practices"). In the second round of coding, these codes were further refined to detail the nuances of how therapists interpreted their work as therapists and carried out their work on teletherapy platforms (e.g., "emotional labor" was further refined into "trauma", "burnout", and "crisis work"). During this second round of coding, new codes, often dealing with concepts related to their experiences specifically as online therapists working on teletherapy platforms (e.g., "teletherapy as a stepping stone"; "on-demandness"), were added. The second and third authors provided additional input on the development and refining of codes at this stage as well. Saturation was achieved when no new codes emerged from the interview data. Finally, using constant comparison [16], the codes were reviewed for commonalities between how therapists described their experiences working in traditional therapy settings and online platforms. This allowed us to identify commonalities in the feminization of therapists' work both in the context of platforms in other settings. These themes are detailed in the findings described below.

4 FINDINGS

Our initial questions going into this research were centered on how and why therapists transitioned into platform work, and how working for these platforms changed how they do therapy. Consistently, interviewees pointed to the need to escape poor working conditions in community mental health and non-profit settings, the difficulty of starting a private practice, and the constraints of needing to care for their families as the main reasons for starting platform work. Situating our findings historically, we show how these reasons are fundamentally a by-product of the past and ongoing feminization of mental health work. In what follows, we analyze how therapists use platforms as a tool as they try to navigate a set of career options structured by devalued labor and the demands of both paid and unpaid care work. We also examine how awareness of these enduring processes of feminization of their work, combined with their professional status, enables some workers to push back against the devaluation of their work - while those with less personal or professional resources are less able to do so.

4.1 Feminization in community mental health

Many of our interviewees described platform labor as a lesser-evil in relation to their experiences in community mental health (CMH) and non-profit agency work settings. When asked why they started working for teletherapy platforms, many described it as a way out of the unsustainable and traumatizing working conditions they experienced in CMH or non-profit agency settings.

4.1.1 Emotional labor, trauma, and burnout. After therapists complete their master's degree, they are typically placed into low-paying[2] CMH/non-profit settings, working with high-needs clients including: prison-reentry programs, abused/battered women, and unhoused or uninsured populations. Interviewees described this work as inherently challenging given that clients are facing a complex set of problems that cannot be addressed by therapy alone:

> *"How do you start doing something like inner child work with a guy who doesn't know where he's gonna sleep tonight? You're doing case management at that point. You're trying to get him a bed. You can't get into like the - the stuff that probably caused all these problems in the first place." (P12)*

[2]The median salary mental health workers holding a Master's degree is around $50,000, below the median wage of $68,000for all Master's-level occupations [54].

Some described this work as difficult not only because of the magnitude of the problems their clients were facing, but also because it exposed them to the "secondary trauma" from exposure to their clients' experiences. This was often in addition to the more direct trauma of losing patients to suicide or needing to make calls to child protection services (CPS) as mandated reporters.

Although emotionally intensive work is an expected part of therapists' occupation, many described working conditions that tended to exacerbate, rather than alleviate, the emotional difficulty of the work. They described seeing patients back-to-back, with few opportunities for breaks or vacation during which to process and reset, often leading to "empathy fatigue." Many explained that they received insufficient support from their clinical supervisors, who in theory could help provide advice or support to early-career therapists but themselves had limited time or focused their mentoring instead on administrative aspects like how to properly bill insurance companies. Many interviewees described experiencing "burnout" resulting from intensive emotional labor combined with unsupportive working conditions:

> *"I got really burned out there...at the end of that job I had 75 clients, all homeless families with trauma. So it was just very intense. And I just wasn't really receiving the supervision or the support to maintain it, it was completely unsustainable." (P4)*

Although intensive working conditions are common in other service and medical professions, the burnout that therapists experience can be specifically tied to insufficient recognition of and support for the heavy emotional labor involved in the job. This is a common characteristic of many feminized occupations: because emotional labor is not recognized as labor, it is typically taken for granted by employers, even when that work is crucial to the product or service being delivered [14, 47]. Additionally, emotional labor tends to exceed the bounds of what is easily visible or "trackable" as part of the labor process. One therapist described how the emotional work of treating high-risk, high-needs clients extends beyond the actual office walls, and contrasted this with the relatively lighter burden of treating clients in other settings:

> *"Anxiety, depression, self esteem are like the main things that come up. So it doesn't feel as heavy... I don't feel like there's something to take home with me...[As opposed to] you know, I'm going to court with my teenage client who got raped tomorrow. Those are very different end of the day thoughts for me." (P13)*

In effect, therapists working in these settings often are taking home with them the emotional burdens and secondary trauma of this work, which contributes to the seeming "weight" of the work that often isn't recognized or supported by the organization. This labor is highly individualized and invisibilized, rather than seen as a core part of the work that therapists do and that they need to be supported in and compensated for. In contrast, in private practice settings where therapists have more control over their own work, they often try to space out their appointments to give themselves time for the emotional labor of processing, debriefing, and preparing for the next client. In CMH/non-profit settings, where managers are primarily concerned with maximizing billable time and shortages of workers relative to the demand for services are common, this much-needed time for emotional labor is stripped away.

4.1.2 Bureaucratic control & cost-cutting. As mentioned above, therapists in CMH/non-profit settings often experience quite restrictive controls on their time that can contribute to burning out. Restrictive controls over therapists' time and labor processes in these settings can be directly tied to the ongoing privatization of mental health services.

In her book, "On the Shoulders of Women: The feminization of psychotherapy" [38], sociologist and practicing therapist Ilene Philipson describes the shift towards managed care – wherein Medicaid oversight and reimbursement was contracted out to private insurance companies – as a

core part of the deskilling and loss of autonomy for therapy workers. Philipson notes that managed care regimes, by circumscribing "who can be seen, for how long, using what form of treatment" (p.83), diminish the therapist's control and autonomy.

One interviewee nearing the end of an almost 30-year career in public health agencies of the impact she had seen of the shift to managed care:

> *"I think that most people who work with Medicaid clients have consistently cursed the advent of managed care because it's basically just meant more difficulty with less money or the same money." (P15)*

Even beyond the direct impacts of managed care policies, workers' experiences in these settings are fundamentally structured by conditions of austerity, including insufficient funding, overwhelming demand for services, and bureaucratic control by insurance companies attempting to minimize costs. One therapist we interviewed described being treated like a "billing machine", seeing more and more clients to help maximize the number of clients that their non-profit agency would be able to bill for. P12 described feeling like there were no limits on the amount of work they could be given:

> *"It's agency work. It's like, you are working non stop...there's no such thing as like a maximum caseload. It's like, "Oh, you have a free spot, we'll just - you'll see seven clients a day, and you'll have an hour for lunch. And we don't know when you're going to do your notes, but you got to get them done within 48 hours." (P12)*

As this interviewee alludes to, each additional client doesn't just represent an added hour-long appointment time, but also a responsibility for the administrative work of filing notes and paperwork associated with each patient. Because this paperwork is key to agencies and therapists being reimbursed for their work, it can sometimes feel like the paperwork overshadows the actual work of care in these settings. Echoing the sentiment of the therapist who described feeling like a "billing machine", another therapist described how the paperwork had been part of the reason for him leaving non-profit work:

> *"I love nonprofits, because you really get to work with the people..I felt like it was like an honor to really provide services, because these were people that had limited access to really good services and mental health care. But at the same time working for nonprofits, it was always about the bottom line. It was always about all this paperwork that you had to do." (P3)*

Of course, managed care does not only impact the mental health industry: medical service providers of all kinds have had to grapple with the cost-cutting and tighter bureaucratic controls that have come with the introduction of private insurance companies into the provision of public health services [27, 47]. However, therapy and social work are feminized forms of relational care that are typically seen as less valuable or less essential services relative to medical interventions. As a result, the cost-cutting and bureaucratic control of these workers can be particularly extreme [26, 31]. Mental health parity laws, designed to require insurance companies to provide equivalent coverage for mental and physical health, have attempted to address this gap in the valuation of and investment in these services. Nonetheless, the hierarchy of feminized mental health services relative to other kinds of health services exacerbates the difficult working conditions that therapists experience.

4.1.3 Balancing the "second shift". Given that the profession is largely made up of women, career choices for therapists also tend to be highly structured by the demands of being the primary caregivers for children and elderly family members, or what Arlie Hochschild has described as "the second shift". As Hochschild explores, women face compounded pressures of entering the

workforce, continued cultural practices that place women as being primarily responsible for unpaid childcare and housework, and insufficient workplace and governmental support for care work through flexible work arrangements, paid leave, etc. [7]. In the therapy profession, the "second shift" has contributed to the appeal, if not necessity, of leaving community mental health settings in favor of private practice settings that allow for greater flexibility in scheduling, and even offers the potential to see clients out of one's own home [38]. Nonetheless, as we explore further in the next section, starting a private practice has many barriers to entry, especially for working mothers or those with relatively limited access to capital. As a result, many interviewees described choosing to work for teletherapy platforms to achieve the flexibility in time and location they need for care work, without needing to overcome the significant barriers to starting their own business. The therapists' descriptions of these "flexible" working conditions nevertheless reveal the stopgap nature of this solution, in that care work responsibilities are not alleviated or better-supported by platform work, but instead have redefined boundaries in a remote work context:

> *"My little one was just below the counseling screen for the first year of his life. I'd be counseling my client and nursing a baby." (P22)*

> *"It's ironic because now I'm seeing clients only at night, because my can't have my kids like, bursting into the room. So I am able to see clients from like, 8 to 11 every night. That's what I'm trying to do." (P10)*

Our interviews also took place in the height of the COVID-19 pandemic, at a time of remote schooling and closed daycare centers. Although many therapists had started to explore platform work options pre-pandemic, just as the pandemic has accelerated the adoption of telehealth, several interviewees described turning towards platform work to help them deal with additional demands of reproductive labor during the pandemic. In this regard, platform work - despite having many downsides in terms of work control, support, and pay - operates as a stopgap workaround to help therapists navigate systemic conditions of disproportionate care work responsibilities and lack of institutional support for the invisible, unpaid work of care. Platforms make systemic conditions of feminization appear more tenable, putting a "band-aid" on an unsustainable and precarious set of conditions, potentially forestalling a more serious reckoning with these fundamentally inequitable conditions.

4.2 Platforms as an "approximation of freedom"

Unlike many other service and care workers, the archetypal career ladder for a therapist offers the promise of a potential escape route from unsustainable, devalued work conditions. After "being in the trenches" in an agency or community mental health setting, as one therapist (P22) described it, therapists can try to go out on their own to start or join a private practice. They can also often find better pay and working conditions by teaching, or by working for insurance companies - though these do not offer the same opportunity to practice therapy, which they are trained for and presumably enjoy. Private practice, in contrast, offers an opportunity to continue working with clients, but with better working conditions including greater autonomy, higher wages, scheduling flexibility, and the ability to choose to work with lower-risk, lower-needs clients. As a result, many therapists describe private practice as the obvious and natural top of the career ladder for their profession:

> *"I only went into this profession knowing that I could eventually do private practice and make decent money. I feel like I'm going to hell for saying this, but...it really is only where the money is. Unless you do like a professorship, maybe you know, something in that vicinity, but it's just unfortunately not a lucrative profession. So, to go into this profession,*

> *I did research on what the most successful route could look like, that would allow me to do what I wanted to do, and that's gonna sustain me." (P23)*
>
> *"Building my own practice seemed like...I always wanted to do that, like right from the get go going to school, that was one of the reasons why I wanted to be a therapist. Because I wanted to have something, like work for myself and do my own thing." (P17)*

Although the pay and working conditions for private practitioners can be quite reasonable, many interviewees described struggling with the significant barriers, risks, and costs of actually going into private practice work. In this context, platform work is experienced as a more accessible *approximation* of the freedom from feminized working conditions promised by private practice work.

4.2.1 The promise of private practice: "Freedom, flexibility, flow". Several of our interviewees mentioned Amber Lyda, a therapist who offers coaching on how to break into private practice work. Her marketing materials, which we analyzed as part of the discourse analysis component of this research, describe the promise of private practice work through the phrase "freedom, flexibility, and flow". This notion of "freedom, flexibility and flow" refers to the more sustainable conditions of private practice work that some therapists seek an approximation of via platform work. Below, we examine what these ideas refer to in terms of the actual labor processes and material conditions of private practice work.

Freedom: In a private practice setting, therapists have significantly more freedom to choose their clientele. Many therapists turn away those that are high-risk or high-needs, in part because these clients may be better supported by a larger practice, and in part because the demand for mental health services is so great that therapists can often fill their schedule just by serving lower-needs clients. Overall, a two-tier system has evolved between CMH and agency settings which treat higher-risk, higher-needs clients, while private practitioners primarily treat a population described in the industry as "the working well" - those with jobs and therefore insurance coverage who may share a similar set of mental health struggles but at least have the resources to deal with them more readily (as opposed to the client who is "sleeping behind the Publix", e.g.). This different clientele is a big dimension of the "freedom" promised by private practice work.

Additionally, if a therapist can pull in clients who are willing and able to pay out of pocket, they can avoid the time-consuming processes of paneling[3] and reimbursement by insurance companies. Circumnavigating the bureaucratic control of insurance companies contributes as well to the "freedom" promised by private practice work.

Flexibility: As we previously explored, flexibility in scheduling and work location is particularly vital for those therapists who are working mothers. Although Amber Lyda's marketing materials convey this "flexibility" as the flexibility to do your work from a hammock with drink in hand (see: Figure 1) [32], most of our therapists described this flexibility of private practice or platform work as more of a logistical necessity than a luxury. Several interviewees described needing to accommodate both their children and their partner's own career demands. This was particularly true for the military wives we interviewed, for whom their family's frequent moves across state and international lines lines meant that they needed to take their work online if they wanted to continue seeing their clients at all.

Flow: One of the biggest challenges as a private practitioner is to achieve a steady income stream via a consistent clientele. For both private practitioners and platform workers, cancelled sessions or lost clients can have a non-trivial impact on the stability of their income. Flow, in this

[3]Therapists can be directly reimbursed by insurance companies if they are part of the insurer's panel. The process of getting on an insurance panel requires a fairly intensive application process, and approval can take several months.

Fig. 1. Podcast banner image for Amber Lyda's podcast, "Online Income For Therapists: Freedom, Flexibility and Flow." Image ©Amber Lyda.

context, refers to Amber Lyda's promise to help therapists address these financial risks, both by using market strategies build up both a consistent "flow" of clientele and ideally, a larger flow of income by moving away from capped insurance reimbursement figures and towards more sizeable out-of-pocket hourly rates (e.g., $150+/hour).

While therapy is a difficult profession, fundamentally structured by feminized working conditions, Amber Lyda's materials market the promise of escaping conditions of bureaucratic control, inflexible scheduling, and devaluation to a world of "freedom, flexibility and flow" via private practice. Of course, Amber Lyda's promise itself glosses over two underlying limitations: 1) The path to successful private practice is by no means an easy one, which is precisely why coaches like Amber Lyda exist, and why so many of the therapists we interviewed were familiar with her; and 2) private practice represents a highly *individualized* escape from systemic conditions of feminization. Those with the time and resources to go into private practice may be able to find an approximation of freedom from systemic precarity, but many others who aren't able to pursue private practice work are left struggling in the "trenches."

4.2.2 Platforms as a stopgap for feminized labor. The small cottage industry of coaches and consultants dedicated to helping therapists start their own private practice - of which Amber Lyda is a part - reflect the many barriers to access for this promised "escape" from feminized working conditions. Starting a small business is challenging for anyone, in any context, and the gendered and feminized nature of therapy work only compounds that difficulty. Capital is of course one major requirement; however, given the underpaid nature of the work and the costs associated with obtaining a degree

and license, many therapists struggle to find the money to start their own business. Starting a business also requires a significant time investment, especially in a highly regulated industry like therapy, and the requirements of the "second shift" again limits many therapists' ability to invest the time to explore private practice:

> *"I'd always thought about opening a private practice, but I have a young child and it just felt like too much - figuring out all the details…" (P24)*

Many therapists start a private practice on the side, while maintaining another job, in order to maintain a stable income while kicking off a new business - but this option too is much less accessible for working mothers:

> *"I knew people who worked for agencies and then had private practice on the outside, you know, maybe a few evenings a week or whatever. They were making a lot more per hour. But as I said, I was a single mom. And I was raising kids. So for me, it was more important to have more balance in my life rather than working extra hours." (P15)*

In the face of these barriers, interviewees described working for platforms as either a stepping stone towards, or a more accessible, low-risk approximation of working in private practice:

> *"Eventually I want to do private practice. I think that's the end goal. But it's not something I want to jump into without a lot of experience or knowledge how to do it. I think a lot of therapists do. And they do it without a business plan, and then they end up not making any money or being in debt, or being a huge mistake and really stressful. And I don't want that to happen. I'd rather take a slow approach to that point." (P12)*

> *"It showed me that Betterhelp and Talkspace can be my cushion while I built my private practice. It gave me the insight that I can leave the agency, do telehealth from home and build my private practice slowly." (P19)*

> *"I did not have the time or space to go into private practice full force. Nor is that my personal inclination, I am not a huge risk taker. So that's how I wound up on the Teladoc platform." (P11)*

Pervasive conditions of feminized labor in the mental health industry are part of what makes private practice so appealing, as it offers the promise of increased "freedom, flexibility and flow". But these same feminized conditions make it very difficult for many therapists to break into private practice. As a result, platforms start to look like an appealing option to achieve at least an approximation of freedom, or as a stopgap workaround for extremely unsustainable working conditions in CMH/agency settings. As we highlighted, private practice is itself a kind of "stopgap", in that it offers an escape for some workers with the time and resources to invest in their own business, while leaving the fundamental conditions of feminized labor in mental health unaddressed. But platform work represents an even more problematic kind of stopgap, in that although it is more accessible than private practice while still offering some modicum of "freedom, flexibility and flow", the conditions of platform work are often quite predatory, reproducing the devaluation and feminization of therapy labor. In this way, platform telehealth work adds yet another "tier" to the layered cake of feminized labor, presenting an extremely limited workaround for some, while the basic conditions of feminization in the industry remain unaddressed. In the next sections, we explain how we see the same logics of feminization playing out in the way that platforms structure and remunerate therapy work.

4.3 How platforms reproduce and sustain the feminization of therapy work

Platforms appear useful to therapists as a way to navigate the systemic conditions of feminization we have described thus far. Nonetheless, in what follows we show how platforms technologically

reinscribe the feminization of therapy via the invisibilization of para-care, and by shifting therapy to the even more piecemeal, devalued forms of on-demand text messaging. We also highlight the strategies that therapists described using to resist or work around these new technologically inscribed techniques for feminizing and devaluing therapy work.

4.3.1 Screening for scalability, and responsibilization for para-care. Much like private practice therapy, teletherapy platforms are largely intended to serve "the working well." At the bottom of nearly every teletherapy website or app, there is a warning that teletherapy platforms are not appropriate for anyone in crisis or experiencing suicidal ideation. Standardized screening questionnaires and assessments help platforms to categorize people as "the working well", versus those who need more comprehensive services. High-risk/high-needs clients often need a higher degree of coordination between the therapist and the patient's other healthcare providers, family members, and case workers. These clients need more of what anthropologist and STS scholar Beth Semel [48] describes as "para-care": "practices that are care-like, care-ful, but cannot be medically or legally ratified as care" (p.55). This work of coordination and communication is often less structured, and less "visible" under insurance regimes that tend to only reimburse for actual time spent in a therapy session, not for additional administrative or coordination work. And so, by focusing on the "working well" platforms are able to create a simplified, scalable business model - they only need to pay therapists to show up once a week and provide therapy, and do not have to worry about the messier, less reimbursable work of para-care.

This automated screening out of patients who show signs of being high-risk or high-needs, and thus to focus on the reimbursable forms of clinical care rather than para-care, is an important part of what makes platform business models scalable and profitable. Our interviewees' experiences, however, contradicted the apparent clarity of this division of labor between the "working well" who only need to show up for weekly appointments, and high-risk clients needing ongoing para-care. Symptoms can come and go, worsen and improve. Some patients straddle the boundary between being high-risk and "working well," and need assistance navigating different jurisdictional boundaries [1]. And so, in platform business models (as in many other settings), there is still a need for para-care, but this work gets ignored, is left unsupported, and individual therapists must choose whether to go "above and beyond" to provide unpaid para-care for their clients when they are in need:

> *"I've had clients on Betterhelp or at American Well that have issues with DHS, right, or issues with substance abuse. You can't just not do that work, you have to try and help get this person hooked up with resources. You have to write letters to send to court, you have to do those things. You can't bill for it. But you still have to do it. I still try to do the best kind of work that I can, even though it kind of hurts my soul because like you literally aren't getting paid. You know, that's hard. That's always hard…" (P21)*

Recent research has highlighted how on-demand platform work often requires significant invisible labor from workers to actually make standardized, simplified platform services into seamless experiences for the end customer [40, 53]. The attempt to create scalable, standardized services can be particularly problematic in care work contexts, given the unbounded nature of the work. Caring for other people requires deep levels of individual attention, personalization, and quick response times that are difficult to account for via automated, standardized systems. Of course, this is not just a platform problem, but is yet another manifestation of the feminized conditions of therapy work. In Selberg's [47] study of the ways that nursing labor is divided up and reconfigured for greater efficiency, she highlights how quality care for clients hinges on feminized workers choosing to self-exploit, to engage in unpaid and unrecognized labor. In all kinds of care work settings, feminized workers are expected to go "above and beyond" to help and support and care

for people, even if this work isn't officially recognized or remunerated. Following a similar logic of invisibilized labor, in order to make therapy scalable and profitable teletherapy platforms trim away at the margins of para-care and leave individual feminized workers to take up this unpaid work purely out of a sense of moral or ethical obligation.

4.3.2 On-demand therapy. Interviewees in this study work across ten different teletherapy platforms, which can be roughly divided into two major categories: "direct to consumer" (DTC) subscription-based platforms, and "business to business" (B2B) platforms that make money primarily via large contracts with employers and insurance companies. DTC platforms tend to pay substantially less, and rely much more heavily on algorithmic control and on-demand services in order to ensure that consumers continue to pay for their subscription. In contrast, B2B platforms structure work in largely the same way and at similar rates as insurance companies. As a result, we saw a significant divide in therapists' work experience across DTC and B2B platforms, stemming from their fundamentally different models for making therapy scalable and profitable. DTC platforms follow an "Uberization" model of market "disruption", in which they capture market share by creating a more accessible, on-demand version of existing services. This requires a fairly substantial reorganization of basic work practices and employment relations, and thus these companies also largely try to sidestep existing regulations and infrastructures. In contrast, B2B teletherapy platforms do not fundamentally "disrupt" the current market, but instead operate as digital intermediaries, promising increased efficiencies and reduced transactional costs. B2B platforms create centralized markets of contract-based therapists and other healthcare providers, and sell access to this network of online providers to insurance companies and corporate employers.

In keeping with their different relationships to already-existing healthcare markets, B2B platforms tend to largely follow the standard formats for therapy services (e.g., staying within the standard reimbursable unit of weekly 50-minute sessions), and DTC platforms that operate outside of insurance infrastructures and directly target consumers rather than employers or insurers tend to reconfigure therapy work in ways that optimize for consumer subscription renewals. Therapists described two major interventions in their labor practices by DTC platforms specifically: 1) offering asynchronous text messaging therapy instead of, or alongside, synchronous video sessions and 2) incentivizing on-demand services. These two interventions are overlapping, in that the platforms encourage on-demand text messaging therapy service, wherein the client can message their therapist anytime, and can expect a quick, if not immediate, response. Furthermore, one of the DTC platforms pays the therapists partially based on the number of words exchanged between the therapist and the client. This shift away from the standard weekly therapy session seems to be designed to encourage a kind of "always on" behavior from clients, more similar to how we interact with social media apps and platforms.

Several therapists were critical of the on-demand therapy promoted by DTC platforms, not only because it is burdensome for the therapist to be constantly available to a client, but also because it runs counter to the profession's ideas about what therapy is, or what quality care looks like:

> *"The ads that I see, it's like - you're texting your therapist, and you can text them whenever...That kind of rubs me the wrong way because...not that my clients can't reach me if they really need to, but like that's not, in my eyes, that's not really what therapy is. That's you texting your friend." (P5)*

> *"I know like for a while part of their like...graphic kind of logo was like a 24/7 and it was like a texting box, and kind of like ripping on therapy that like well, "how's it going to help you if you only talk to them one hour a week?" - and it's like, well, that's what therapy is. Maybe I'm too old school already, but like...I don't think that therapy should be*

something where, whenever you're feeling dysregulated you can just like text, somebody. Like, you need to learn how to text the people in your life." (P17)

A few interviewees seemed comfortable with the idea that when working for these platforms, they may not always be providing "real therapy," but they are still providing an important form of care and support:

"Some people are just lonely and need someone to talk to - which can be helpful in itself. But - what is real therapy, and what are we doing? And I could probably argue both. Because somebody that is truly that lonely and doesn't have anyone to talk to really needs somewhere to go with this stuff, and it might end up getting worse if they don't." (P6)

Setting aside the contested issue of whether and how on-demand text messaging therapy is therapeutically useful, it seems clear that this reconfiguration of the therapeutic interaction towards on-demand and text-based forms of care is primarily a mechanism for DTC platforms both to reduce the costs of therapy labor, and to increase the rate of usage and subscriptions from clients. In short, these platforms are attempting to make therapy more commodifiable, and more in line with the consumer expectations cultivated by platforms like Uber, Grubhub, or Amazon.

Ticona & Mateescu [52] describe platforms as "cultural entrepreneurs", generating a market by redefining the ways that we conceptualize workers. For instance, Uber drivers become a type of "user" of the Uber platform to reach customers, rather than employees, so that Uber can avoid the responsibilities associated with being employers. They also describe how platforms for nannies attempt to create a perception of platform-based care workers as more trustworthy than non-platform care workers, so that more people will use their platform to research and hire nannies. DTC teletherapy platforms, similarly, seem to be reconstructing therapists to be more like a friend – someone you can text anytime and say anything, rather than a somewhat-distant professional figure – to encourage a much tighter dependence on and utilization of their service.

Crucially, this redefinition of therapy as an on-demand text messaging service reproduces a logic of feminized labor that has been in place for decades. Philipson [38] describes the historical shift away from the interpretive, psychoanalytic model represented by Freudian practice, towards a more "relational model" of talk therapy, and links this to the historical shift towards having more women therapists. The relational model of therapy involves skills like empathetic listening that have been typically construed as women's work and are seen as being more low-skill and less valuable than psychoanalytic interpretation or prescribing pharmaceuticals, for instance. Selling subscriptions to an on-demand text messaging service feels more like "texting a friend" than seeing a professional in their office. This follows this same logic of moving therapy towards a more "feminine", and therefore lesser-value form of work. This is reflected in the *extremely* low pay that many DTC platforms offer, relative to B2B platforms and even most CMH/agency rate, and the opaque, piecemeal way in which therapists are paid for this work, relative to the standard hourly rates offered by B2B platforms and insurance companies.

Although platform labor can operate as a kind of "stopgap solution" for therapists navigating systemic conditions of feminized labor, DTC platforms simultaneously reproduce the feminization of therapy labor by reconfiguring the delivery of therapy as on-demand text messaging. Although on-demand text messaging is "new" in one sense, the logics of feminization that underlie this work arrangement are nonetheless intimately familiar to therapy workers. As we explore in the next section, this means that many therapists already have a repertoire of skills designed to resist this familiar form of exploitation.

4.3.3 Boundary-setting to negotiate feminized labor. As professional care workers, therapists are trained in the importance of setting boundaries and expectations with clients. Educating clients

on the nature of the therapeutic relationship, demarcating appropriate and inappropriate topics and behaviors, and modelling a professional relationship with clear boundaries are key skills for therapists in any setting. Within the mental health profession, boundaries are understood as key both to providing quality care for the client, and to making intensely personal and emotionally taxing work more sustainable over the long term. Interviewees described repurposing this skill set in a platform labor context, and particularly on DTC platforms that encourage on-demand service:

> *"My introduction would say, like, when you message me, "these are the days I work, this is the time I check my messages. And it may take me up to 24 hours to get back to you." It's not constant" (P19)*

One therapist described teaching his clients specifically about how to use Betterhelp's "urgent" button and Talkspace's "reply by" button, in order to work around the UI affordances that encourage on-demand availability:

> *"If it's something that is more urgent there is a button they can click that says, "this is an urgent message." So you let them know from the get go - "Okay, use the button for THIS", for this time only...But this is tricky, like for Talkspace...They've done it in a way that's convenient... for the client. You educate the client and say, "Look, I will still get the message even if you don't click on the reply-by button." So you let them know that you will get back to them. You tell them not to click on that reply-by button, because if they click and you do not answer within those timeframes, you get deducted pay. Betterhelp, you know, they have their urgent button but they don't deduct you." (P8)*

Some therapists described telling clients that they don't use messaging at all, instead setting an expectation that they will have standard weekly video sessions. In these boundary-setting interactions, we can see the strategies that therapy workers use to navigate conditions of feminized labor that demand more and more of their time and emotional labor. We also see the influence of therapists' professional status, which allows them to set the terms of a relationship in ways that not all care workers are able to. These are skills developed and perpetuated by the profession as an institution, to help resist, as Haraway describes, the tendency for feminized workers to be "seen less as workers than as servers; subjected to time arrangements on and off the paid job that make a mockery of a limited workday; leading an existence that always borders on being obscene, out of place, and reducible to sex" (p. 38). Therapy platform work thus represents a kind of viral mutation of feminized working conditions, reconfigured but still recognizable to the defense systems developed by the therapy profession and individual therapy workers.

5 DISCUSSION

A central aim of this paper has been to highlight that the precarity experienced by platform workers is not just a technological phenomenon, but a newly digitized outgrowth of historical, systemic structures of precarity and exploitation. Specifically, we show how the historical and ongoing feminization of therapy work serves as both a driver for the adoption of platform work and is reproduced by platforms as a technique of scaled exploitation.

Although we came into this research interested in the ways that digital platforms restructure therapy labor, the stories of therapy workers forced us to attend to the way that feminized, precarious working conditions structured people's daily work and career choices – including, but not limited to, platform work experiences. They spoke of the need to find flexible work arrangements to account for the "second shift"; of the stress and burnout of CMH/agency settings where emotional labor is unsupported, the work is underfunded, and bureaucratic controls abound; of the high barriers to entry to the individualized "freedom, flexibility and flow" promised by private practice work. These experiences reflect the pervasive devaluation, invisibilization, and precarity of care work,

and make it clear what might at first appear counterintuitive; that even relatively high-status, in-demand credentialed professionals would take on platform-based gig work in an attempt to navigate conditions of widespread precarious work.

Despite highlighting how platforms operate as a stopgap for feminized work conditions, participants' experiences revealed how feminization is nonetheless reproduced by the platforms themselves. Telehealth platforms rely on divisions of labor that prioritize therapeutic/clinical care, trimming the less-billable work of para-care out of the business model. As a result, platform-based therapists become responsible for taking on unpaid para-care out of a sense of ethical and professional duty. This is similar to CMH/agency settings, where emotional and administrative labor is made invisible, unpaid and under-supported, and is often done "for free" by the (largely women) workers. Additionally, DTC platforms' use of on-demand, messaging-based therapy contributes to the ongoing redefinition of "what therapy is" in ways that are more aligned with feminized, devalued skillsets. By reconfiguring therapy work in ways that make it feel more like friendship or motherhood, on-demand teletherapy platforms maximize the scalability and profitability of care.

We found that platform labor operates as an approximation of freedom for precarious workers who have a limited set of options. Teletherapy work offers features and affordances that seem useful to make precarious work somewhat "sustainable": flexible work schedules, the ability to manage one's own emotional labor and patient load, and slightly lessened bureaucratic controls. Given that these platforms *also* entail features and affordances which reproduce the precarity of this work, we argue that platforms can only be understood or experienced as an "approximation of freedom" against a backdrop of systemic exploitation. As we have shown throughout this paper, it is the past and ongoing feminization of care labor and the therapy profession that makes the reconfigured forms of exploitation experienced via platforms appear acceptable, normal, and useful.

Below, we unpack the significance of the stopgap as a lens for interpreting not only telehealth platforms, but labor platforms and even platform business models more broadly. We also explore some of the implications of the stopgap analytic in terms of the necessity of non-technical approaches to interrupting the reproduction of precarity by platforms. Finally, we discuss some of the limitations of this study and directions for future research.

5.1 Stopgap solutions and the two-fold reproduction of the status quo

The story of the stopgap is a story about the two-fold reproduction of the status quo. First, platform labor provides a partial, individualized workaround to precarious working conditions - enabling some workers to achieve an approximation of freedom, while systemic conditions of precarity and exploitation remain unaddressed. For example, many therapists in our study found platforms useful to escape the unsustainable conditions in community mental health or agency settings. However, this option is not available to all; to even be able to work on platforms still requires most therapists to go through the multi-year gauntlet of becoming licensed within "the trenches" of CMH/agency settings. In this regard, platform labor provides a type of 'workaround' for some, while not addressing the more systemic issues at hand.

Second, despite appearing as a kind of workaround, platforms rely on the same exploitative logics to make care scalable and profitable. In the case of telehealth platforms, feminization appears in both the features of the product (e.g., on-demand text messaging), and in the business model itself (e.g., in the taken-for-granted nature of para-care work). The very thing that looks like a useful tool for navigating feminization is itself a reconfigured manifestation of feminization. Platforms become a new addition to a menu of options all fundamentally structured by precarity, each with slightly different configurations of control and exploitation. In the process, responsibility is placed onto individuals, framed as empowered agents with choices, and future career options that they can seemingly choose from as simple menu options.

Thus, naming platforms as a "stopgap" is debunking platforms' claims to provide a "solution", or something new - instead identifying it as something which doubly enables the reproduction of the status quo: both by forestalling crisis by giving workers another menu-option to try to make things work; and by reproducing the same logics of hierarchy and exploitation within the platforms' mechanisms of scalability.

5.1.1 Digital labor and the importance of historically situated analysis. The stopgap is not *only* a platform phenomenon. The stopgap is a reflection of the ways that both workers and institutions continually invent new ways to work around, to individualize, and to forestall crisis in the context of widespread inequality and infrastructural breakdown. Indeed, therapy itself can arguably be seen as an individualized, stopgap fix for systemic social failures - a way of enabling people to continue being productive citizens in the wake of a world war, or in the midst of a global pandemic. The burnout that therapists experience is partially the result of the Sisyphean nature of trying to create individualized, stopgap solutions to help those impacted by systemic violence and injustice. While stopgaps can help individuals to make-do [9], to find a way to keep moving forward under impossible conditions, they do not address systemic, underlying causal factors that create precarity and inequity, and in fact help to reproduce and perpetuate them. We argue that platforms should be understood within this much larger lineage of stopgap devices.

We argue that the stopgap is nonetheless a valuable lens for analyzing platforms specifically, because it allows us to contest narrative framings of platformization as something fundamentally *new*, regardless of whether that newness is a step towards progress or a step towards precarity. Understanding platforms as stopgaps pushes us towards understanding the much larger historical contexts of precarity that workers are attempting to navigate, and which allows platforms to appear as an approximation of freedom. Attending to this context shifts us away from narrative frames about the "future of work" which focus narrowly on immediate technological impacts, and shear away the historical continuities that are essential to a deep understanding of platforms and their impacts on society. This narrative frame also allows for a political analysis of platforms not as a black-boxed precarity engine [10], but as yet another workaround or form of maintenance [34] for systems of exploitation.

5.1.2 Contextualizing the "usefulness" of stopgaps. Naming platforms as a stopgap is a gesture which points away from the platforms' interventions per se, and towards the context against which a platform can appear as "useful". That is, to say that these platforms are useful without considering the context that they are useful within, is to miss the point entirely. As our findings show, feminized labor is the context against which teletherapy platforms seem "useful". Therapists who turn to platform work are largely navigating extreme trauma and unsustainable work conditions of CMH/agency settings, and unequal and unsupported childcare responsibilities. To call something a stopgap is to identify it as a partial, insufficient workaround for something larger that remains unaddressed - in this case, the feminization of therapy work. A number of recent studies help to bring attention to the specific contexts in which platforms are situated, and against which they appear useful. Anwar et. al [4], for instance, show how feminized Indian beauty workers operating in contexts of significant patriarchal and caste-ist control use platform labor to achieve an approximation of freedom. This local context of control and exploitation is what makes platforms appear useful, even though they "facilitate and reinforce gendered patterns of labor" (250:16). Similarly, van Doorn [58] highlights that "domestic labor platforms like Handy and Helpling can offer an important economic lifeline to vulnerable labor market "outsiders" such as minorities and migrants" (p. 21), but due to platforms' continual innovation in pursuit of ever-greater exploitation, can quickly stop looking like something "useful" and instead become a kind of dead-end. Finally, in her dissertation research on platform workers, Raval [42] notes that "based on the contexts of

unfolding, platforms can have a variety of effects on social and economic life, they are not only "dark media" or emancipatory tools." (p. 180).

We build upon this research situating platform labor within its "context of unfolding" by suggesting the analytic of the stopgap. This framing requires us to name both sides of the platform labor coin: 1) the local contexts of systemic precarity against which platforms appear useful, and 2) the ways that platforms continue to perpetuate and reinforce precarity in pursuit of profit. This analytic also points towards the necessity of more nuanced understandings of the interactions between pre-existing forms of precarity and the forms of precarity perpetuated by platforms. How closely can a platform reproduce local conditions of exploitation while still appearing "useful"? Which platforms, in which contexts, largely reproduce the local conditions of exploitation, and where are platforms introducing unfamiliar paradigms of exploitation to a particular context? In this study we saw that therapists find great familiarity in the invisibilization and devaluation of their work on platforms, and thus have skillsets that help them to resist these forms of exploitation. Further research is needed to understand the implications of platformization for workers who find themselves navigating paradigms of exploitation that depart more radically from the norm for their occupation, industry, or social identity.

5.2 From "implications for design" towards systemic change

A core contribution of this research is to reframe our narratives of platforms and platform labor to account not only for their technological impacts, but to the larger contexts of systemic precarity that they operate within. As such, it also requires us to reframe our thinking about how we might *intervene* in the precarity that platforms reproduce.

The findings from this research can be read to suggest some technological interventions that could help to address feminized working conditions on telehealth and teletherapy platforms. For instance, telehealth platforms could better integrate and support para-care work, develop features that respect patient-therapist boundaries and cease penalizing workers for slower response-times, or remove pay-by-word features that devalue and distort therapeutic care. However, these design interventions themselves could be construed as a kind of "stopgap" - a partial fix that leaves the underlying systemic conditions of exploitation unaddressed.

A truly human-centered design response to the experiences therapists shared with us would require advocating for affordable childcare, for better pay for therapists and social workers, and for investment in public mental health. There are any number of possible interventions that would more directly address the marginalization of mental healthcare and exploitation of therapists which serve as the foundation of telehealth platform markets.

While these suggestions are specific to this industry and occupation, we would argue that most platform business models build upon local forms of precarity and exploitation, and similarly warrant more-than-technological solutions to address the underlying conditions that make platforms appear as an approximation of freedom. As researchers, designers, and technologists, it may feel beyond our wheelhouse to do more than *describe* how systemic and historical injustices appear in the technologies we study - but this is exactly the political necessity that the stopgap analytic points us towards. Echoing Lindtner and Avle [29], we argue that seeing non-technological change as outside of our control is an abdication of our own implication and responsibility for the impacts of technological systems. Concretely, Whitney and colleagues [59] provide valuable suggestions for putting HCI ways of knowing to use for political projects that go beyond "implications for design."

5.3 Limitations and further research: situating digital care work within locally-specific hierarchies, intersectional identities

The logic of feminization traced in this paper is just one dimension of the "matrix of domination" [20] that therapists operate within. Most of our interviewees were white women, reflecting the dominant identity of therapists in the U.S.; this research does not do justice to the specific experiences of men and women of color in the mental health industry and on mental health platforms. As we explored earlier, the apparent "usefulness" of platforms is highly context-dependent, and thus our understanding of the stopgap function of telehealth platforms could be deepened by bringing in more intersectional perspectives and experiences [37].

Throughout this research, we found ourselves wishing that we had a more comprehensive understanding of who decides to take up telehealth platform work, who does not, and why [17, 33, 46]. For instance, several of our interviewees are military wives; it would be interesting to further investigate the role of platform-based labor for this population, and similarly geographically displaced people. Our research was targeted towards therapists working for platforms, but of course many therapists choose *not* to work for platforms; it would be valuable to examine whether there are particular identities or contexts that make platform work seem not-useful. And although we touched on the requirements of the "second shift" as a dimension that made platform work particularly appealing, there's much more to be understood about the role of platform labor as a stopgap for women and others who disproportionately shoulder care work responsibilities.

There is also much more to unpack at the intersection of digital healthcare platforms and global systems of exploitation and inequity. Our research focused specifically on telehealth platforms in the U.S., but there are many digital healthcare platforms being explicitly designed to offer "accessible" mental healthcare to a global audience. How do local forms of exclusion and precarity make these platforms appealing to care workers and patients? How do these logics get reproduced by the platform-as-stopgap?

Additionally, this paper did not touch upon the increasingly pervasive use of automated mental health interventions. It seems apparent that the automation of this work reproduces the devaluation of therapy – but how specifically are decisions made about when and where therapy can be automated? What aspects of therapeutic care are not accounted for in an automatic system, and thus displaced onto family members, and onto the patient themselves? The stopgap lens may be a useful tool to evaluate how digitized forms of care, including automated care systems, can be seen as "useful," despite reproducing inaccessibility - depending on the local contexts in which they are deployed.

6 CONCLUSION

In order to understand how *platforms* impact therapists, we found that we needed to understand how *feminization*, first and foremost, impacts these workers. By digging into the history of the industry and occupation, into the ways that therapists' experiences and career choices are fundamentally mediated by feminization, we came to understand how feminization is itself the "platform" upon which telehealth platforms rely. As stopgaps, telehealth platforms both provide a partial, individualized workaround to feminization, and draw upon logics of feminization to make therapy labor scalable and profitable. In this regard, the stopgap doubly reproduces the status quo, both by forestalling crisis around unsustainable working conditions, and by reproducing exploitation.

By emphasizing the stopgap's doubled reproduction of the status quo, we are not just adding to the chorus of voices showing how emerging technologies reproduce bias, inaccessibility and precarity, but tracing the conditions that make it possible for a platform to be successful and appealing nonetheless. The analytic of the stopgap requires that we have a greater understanding

of the localized context of precarity against which platforms appear useful. It also requires that our political and design interventions address not only the technological reinscription of precarity, but the systemic precarity that makes stopgaps useful in the first place.

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