

## ORIGINAL ARTICLE

# Caring through things at a distance: Intimacy and presence in teletherapy assemblages

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## Abstract

The COVID-19 crisis in the UK precipitated a sharp rise in the use of remote technologies to provide therapy during the lockdown. With mental health care services migrating to devices and video-conferencing platforms, nearly all forms of therapy had become ‘teletherapy’. Drawing on interviews with UK-based practitioners, this paper explores how existing ideas of intimacy and presence are challenged when care is practiced at a distance. Against the background of concerns that remote technologies erode intimacy and degrade physical presence, the argument is made that presence, distance, intimacy and control are reconfigured within mediated therapy. Analysis of practitioners’ experiences of teletherapy examines the material and expressive components of ‘assemblages’ characterised by their stable and fluid properties. Two assemblages are identified and discussed: emergency care assemblages and assemblages of intimacy, both of which are aligned with specific sectors of mental health care. Evidence that therapeutic encounters are constrained by technologies are considered alongside the material conditions and inequalities of vulnerable groups, while assemblages with relatively stable properties are generative of new ways of relating to clients online. These findings highlight the material and expressive components of human

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and nonhuman assemblages that create new kinds of affective relations in distanced care.

**KEYWORDS**

assemblages, care, distance, intimacy, presence, teletherapy

## INTRODUCTION

Therapy has long considered itself an ‘in-person’ practice that necessarily takes place in a room with two or more people. Since Freud, practitioners have insisted on the purity of physical presence as the inviolable core of therapeutic practice (Russell, 2015). And yet in the months following the first UK lockdown, nearly all forms of therapy had become ‘teletherapy’. In rapid succession, mental health care had migrated to telephones, smartphones, messaging apps, personal computers and video-conferencing platforms. Practitioners with little formal training suddenly found themselves immersed in a mediated landscape of distanced encounters where ideas of intimacy and presence were transformed. What emerged from the COVID-19 pandemic was the speed and agility with which various forms of mental health care were delivered *at a distance*.

This paper explores the unique circumstances in which a global crisis had transformed traditional therapy into teletherapy. Drawing on the experiences of therapists working during the first UK lockdown, I will argue that digitally mediated encounters are not devoid of intimacy and that distance is not the opposite of presence. The incidental rise of teletherapy presents a unique opportunity to explore how presence, distance, intimacy and control are reconfigured by mediated technologies. The most interesting aspects of caring at a distance is not the power of technologies to ‘facilitate’ or ‘extend’ human agency but the immanent capacity of living matter to self-organise (Braidotti, 2019). From a neo-materialist/post-humanist perspective, teletherapy is a complex interplay of human and non-human assemblages (Bennett, 2010), all the components of which interact and intermingle on the same ontological plane. In what follows, I will use Deleuze and Guattari’s (1987) concepts of ‘assemblages’, ‘territorialisation’ and ‘deterritorialisation’ to reinterpret care as the affective remaking of relationships through objects. In the style of thinking of what Puig de la Bellacasa (2011) calls ‘matters of care’, this paper expresses a commitment to neglected things and their intrinsic liveliness within caring relationships.

### Teletherapy as distance care

Teletherapy is a catch-all term that refers to the use of remote technology to conduct synchronous therapy sessions with clients who are not physically co-located. Today, teletherapy is a complex marketplace of mediated devices and digital platforms ranging from data-driven technologies such as chatbots, mood trackers and wearable sensors, to traditional talking therapies offered remotely by trained counsellors and therapists. Much of the ‘therapeutic promise’ (Rubin, 2008) of teletherapy trades on the democratising vision of universal connectivity—care or help is always available and accessible. This has drawn a mixture of criticism and concern from mainly psychoanalytic practitioners who argue that digital forms of mediated therapy degrade physical presence—distance therapy is at best a disembodied simulation of in-person experience (Essig, 2012; Russell, 2015). Indeed, many of the anxieties about engaging with mental health

care at a distance are often framed as the ‘loss of intimacy’ and the erosion of ‘real’ human connection (Turkle, 2011). For these reasons psychoanalysts worry that technology violates the ‘purity’ of its classical method (Scharff, 2013).

Yet the idea that teletherapy is a recent invention ignores the role that media and technology have played in the history of psychoanalysis. Zeavin’s (2021, p. 5) provocative retelling of the ‘history of therapy as teletherapy’ reminds us that Freud used letter writing regularly to communicate dreams, develop theories and analyse cases, all of which are illustrated in the extensive correspondence between Freud and Wilhelm Fliess. The orthographic technology of paper and pen was a *medium*, the envelope a *seal* and the postal service a *network* for establishing closeness in spite of distance. Zeavin argues that psychotherapy has always operated through a variety of different technologies and media including advice columns, radio broadcasts, crisis hotlines, home computers, the Internet and mobile phones. And while these may seem marginal forms of mental health care that lack the physical presence and embodiment of traditional therapy, teletherapy has exploited its material and mediated form to arise contingently in places where traditional therapy cannot go.

## Teletherapy as crisis care

Long before the ‘tele’ prefix inspired visions of improving access to professional therapy, teletherapy was a marginal practice of caring for those in *crisis*. The first ‘crisis hotline’ appeared in 1953 when an Anglican Vicar in South London, Chad Varah, established a telephone counselling service for suicide prevention. A memorable number advertised in the national newspapers attracted not only a deluge of calls across the UK but also a mixture of volunteers, amateurs and helpers offering to answer the telephones (Varah, 1965). The response was ‘wholly unexpected’ (Day, 1974) and grew into a movement that founded the Samaritans as the first 24-h helpline. Several aspects of this origin story are worth highlighting: teletherapy emerged outside the professional domain from the charity sector; telecommunication was an ordinary technology that afforded universal access to emergency care; and, unlike traditional therapy, distance counselling was anonymous and free. These conditions explain to some extent why teletherapy has remained peripheral to in-person therapy and why crisis care is still largely a ‘deprofessionalised’ (Haug, 1975) sector of trained volunteers.

The rise of teletherapy during the COVID-19 pandemic is a well-documented phenomenon (Rains et al., 2021) and consistent with its historical relationship to crisis care. The introduction of strict containment measures to prevent the spread of infection forced many health-care professionals to adopt teletherapy as a matter of necessity. Coupled with rising demand as a direct result of exposure to infection, the effects of control measures and subsequent socioeconomic upheaval, the practice of teletherapy accelerated in many countries (Van Daele et al., 2020). Some even refer to the coronavirus crisis as a ‘black swan’ for mental health care—an unforeseen event that will potentially transform the delivery of mental health services (Wind et al., 2020). Despite the historical aversion to adopt teletherapy, recent studies have reported more favourable attitudes among professionals with growing evidence of their efficacy (see Poletti et al., 2021 for a systematic review), though concerns remain regarding practitioner ‘burnout’ (Zeavin, 2021) and the ‘digital social inequalities’ that arise from poor access to socio-technical networks (Halford & Savage, 2010).

Whatever effects we attribute to the pandemic, this was an event that profoundly disrupted the ordinary structures of mental health care. The subsequent transition from traditional in-person

therapy to teletherapy is illustrative of how a historically marginal form of distance care and crisis intervention became mainstream. Technologies normally used when people cannot meet in person were now front-line tools for mediating care in a global emergency. But to understand teletherapy as ‘things’ in care practices, we need to explore how the medium of digital technologies structure the possibility of intimacy and presence.

## Mediated intimacy and presence

Sociologists of science, technology and medicine are careful to observe that mediated technologies are not merely ‘tools’ that improve care but reshape care practices in unexpected ways. Similar to psychoanalyst’s concerns about teletherapy, several studies have shown that remote technologies of telecare reduce intimacy between patients and health-care providers. In Oudshoorn’s (2009) study of telemonitoring, the shift from physical to ‘digital proximity’ leads to more structured and responsabilising interactions with patients. Mort et al. (2008) consider the ‘making and unmaking’ of telepatients as the deinstitutionalisation of traditional health care that privileges information over intimate care encounters.

Others see remote technologies structuring care in ways that offer new possibilities for intimacy. Pols (2012) argues that telecare challenges the idea that being physically close to patients is the gold standard of good care. In her own study of remote technologies, she shows how monitoring devices coexist with other forms of care, while webcams contribute to intimate communication for ‘care at a distance’. Other authors show that intimacy in virtual clinical encounters is a negotiated and precarious accomplishment that require subtle and significant articulation work (Langstrup et al., 2013). The possibility of ‘digital intimacy’ in care encounters is not an additional or expected trait of mediated interactions but rather an emergent phenomenon shaped by the textures and affordances of digital technologies (Piras & Miele, 2019).

Webcams and videoconferencing platforms are technical devices that do more than facilitate communication—they also create a sense of presence and reality despite their mediated nature. Minsky (1980) calls this *telepresence*: the subjective experience of being present in another location despite geographical distance. Technology recedes into the background as actors ‘look through’ their devices into another world. Pols (2012, p. 21) shows that patients using webcams to access homecare experience intimacy through telepresence by ‘making people stare at each other’s faces on the screen’. Webcams also have unique characteristics of intensifying gaze and concentration to the extent of being intrusive. Variations in power relations or familiarity and trust can make patients feel that their personal space is violated (Pols, 2012). This idea that remote technologies can be ‘too personal’ and ‘too intimate’ is reported elsewhere with several studies confirming that technologies can create unwanted closeness (Piras & Zanutto, 2014; Pols, 2013).

Writing about teletherapy, Zeavin (2021) explains that mediation and distance are essential requirements of what she calls ‘distanced intimacy’. She argues that distanced intimacy is different to telepresence in that perception of presence at another location does not override the perception of being present in the *immediate* location. In other words, intimacy is a distance that must cross the therapeutic encounter but also sustain that distance as a ‘shield enabling safe disclosure’ (2021, p. 20). That distance is a precondition for online intimacy is consistent with the phenomenon known as the ‘online disinhibition effect’ (Suler, 2005), the observation that people appear less inhibited online than in person. Distance intimacies will vary according to the technical affordances of the medium and the specific elements that constitute their heterogenous arrangement. For this reason, we need to think about intimacy and presence in teletherapy through a materialist lens as contingent and emergent properties of therapeutic assemblages.

## Teletherapy assemblages

In recent years, the concept of ‘assemblage’ has been applied in the sociology of health and illness to highlight the active role of technologies in health-care practices (Buse et al., 2018). People, practices and things are conceived as ‘social wholes’ (DeLanda, 2006) that occupy a single plane of consistency affecting their relations to one another. A common theme is to show that health and illness are not states derived by relations of interiority (e.g., an organic body-with-organs) but by relations of exteriority that locate the body within a wider network of material, social and affective relations. Drawing on Deleuze and Guattari’s materialist ontology, Fox (2011) explains that the embodiment of health and illness is the effect of all the relations that ‘territorialise’ the body. From this perspective, practices of care are the coming together of processes and materials to increase the body’s capacities to affect and be affected. Here, affect is taken to mean the intensive forces of the body’s capacity to form specific relations (Buchanan, 1997).

Several works have applied assemblage thinking to examine the dynamic, multi-directional and multi-sited nature of healing and care (Bell et al., 2018; Foley, 2011; Ivanova et al., 2016; Trnka, 2021). Foley (2011) invokes a ‘therapeutic assemblage’ to describe the healing properties of place containing material, metaphoric and inhabited dimensions. In a similar vein, Bell et al. (2018) acknowledge the emergent therapeutic properties of space in the context of material, social, spiritual and symbolic dimensions of healing. Emmerson (2019) combines ideas of assemblage and landscape to consider a wider range of ‘more-than-therapeutic’ activities that occur in nursing care homes. Trnka (2021) conceives the emplacement of young people’s online and offline engagement in mental health support as ‘multi-sited therapeutic assemblages’. Downing et al. (2021) conducted a qualitative survey of Australian psychologists to understand their experiences of using teleconferencing platforms during the COVID-19 crisis. They adopt a ‘more-than-human’ perspective to analyse telepsychology as various spatial, relational, embodied and multisensory dynamics that form part of therapeutic assemblages.

Given teletherapy’s marginal history and its recent ascendancy, there is an opportunity to rethink intimacy and presence as emergent properties of human–non-human assemblages (Bennett, 2010). My aim is to understand how the experiences of therapists working digitally and remotely during the first lockdown in the UK can tell us something about the role that technologies play in holding care relationships together. In what follows, I outline the methods of my study and discuss two related themes in which the possibilities and constraints of ‘caring at a distance’ are examined. I argue that under the exceptional conditions of distance being the only means of accessing mental health care, teletherapy plays a vital role in remaking affective relationships between people and objects.

## METHOD

The following analysis is based on semi-structured interviews with 25 therapists, all of whom were interviewed between August and October 2020. The term ‘therapist’ designates a wide range of practitioners working across counselling, psychotherapy and other specialised therapeutic modalities. Opportunistic sampling targeted relevant gatekeepers of professional bodies and networks such as the British Association for Counselling and Psychotherapy (BACP), the United Kingdom Council for Psychotherapy (UKCP), the Psychotherapy and Counselling Union (PCU) and the Psychotherapists and Counsellors for Social Responsibility (PCSR). Snow balling techniques widened the search to include practitioners working across sectors, including the

NHS, private practice and various non-profit organisations. In total, 18 women and 7 men were interviewed ranging from mid-30s to 70 years of age. All the participants were white, Caucasian and broadly 'middleclass' in terms of occupation, education and social status. In many cases they worked across multiple sectors: 16 worked in private practice, 11 for non-profit organisations and 8 for public bodies, such as universities and the NHS. All interviews were conducted on Zoom and varied in length from 1 to 2 h. Interviews elicited biographical accounts of events surrounding participants' formative training, career progression and detailed descriptions of expertise and caseload. Adopting a narrative approach (Mishler, 1986) to account-building carefully traced practices and events before and during the COVID-19 pandemic.

The following analysis applies assemblage theory (DeLanda, 2006, 2016) to characterise the 'identity' of assemblages in practitioner's accounts of teletherapy. Assemblages have a historically contingent identity defined by two dimensions: the heterogeneity of its components and the internal homogeneity of its variable processes. Assemblages with a relatively 'homogeneous repertoire' of components are characterised by their *degree of territorialisation*, while the *degree of deterritorialisation* refers to processes that destabilise or decode an assemblage (DeLanda, 2016). Analysis of interview data attends to an assemblage's *degree of coding and decoding*. Coding refers to the role played by the expressive components of an assemblage in fixing the identity of the whole, for example, through the expression level of signs emitted by language, voice, gaze or gesture. Decoding refers to less formal and rigid rules of expression that produce a more fluid and changeable identity. Analysis of teletherapy assemblages also attends to the role played by material components such as telephones and webcams that not only mediate expression but change the requirements of co-presence. Different components determine the *coding parameters* of each teletherapy assemblage (DeLanda, 2016). For instance, the telephone and the voice have a different territorialising function to that of webcams where *the face* plays an active role. Indeed, Deleuze and Guattari (1987) treat the human face—via the concept of 'faciality'—as a key component in the 'functioning of language and sign systems, the formation of subjectivity and the deployment of power relations' (Bogue, 2003, p. 79).

Iterative reading of interview transcripts identified two distinct assemblage identities. Mediated encounters characterised by degrees of decoding and deterritorialisation were more unstable and difficult to control therapeutically, whereas those characterised by relatively stable relations of coding and territorialisation were generative of therapeutically novel processes and affects. The thematic organisation of the following analysis examines two kinds of assemblages in which therapeutic practices are constrained to that of 'emergency care' and those which establish new forms of relational 'intimacy'. In both cases, the notion of 'presence' in mediated therapy is territorialised as a thoroughly relational and embodied phenomenon, the shape and direction of which have important implications for exercising control in therapeutic encounters.

Ethical approval for the research was obtained from Cardiff University Research Ethics Committee (SREC/3764).

## Emergency care assemblages

This section focuses on how teletherapy assemblages emerged as rapid but highly deterritorialised forms of emergency care during the lockdown.

In the UK, therapy services are distributed according to 'sectors' of care that vary in scale, density, authority structure, sources of revenue and physical location. Each of these sectors—public, private and non-profit organisations—are networks of assemblages that differ in terms

of access, cost and modality of care. In the public sector, for instance, ‘psychological therapies’ delivered through the NHS are free at the point of access, though the choice of modality is often restricted to evidence-based treatments such as Cognitive Behavioural Therapy (CBT). The vast ecology that makes up the non-profit sector is a more diversified field of therapeutic modalities often free or low cost but less centralised in terms of regulation and jurisdiction.

Reading across the interviews, it was clear that the deterritorialisation of therapy during the lockdown affected each of these sectors differently. Therapists working for non-profit organisations experienced the most disruption with many reporting a chaotic return to services while managing a high case load of vulnerable clients. One therapist, an addiction counsellor, working for a small charity in South Wales described support from management as ‘exceedingly weak’; counsellors had to rely on their own initiative to contact clients using WhatsApp. Given that clients with addiction and dependency ‘live quite chaotic lives’, the territorialising function of WhatsApp encodes regular meetings ‘every morning for 6 weeks’. In the following extract, the therapist is explaining how the move to the telephone imposed severe limits on his ability to care for clients:

**Addiction counsellor:** The rhythm of [in-person therapy] has been totally bugged up by having to do things remotely [...] So most of my counselling will be over the phone because, there were more clients who just have a phone and don’t have access to a computer, the groups will be via zoom. But the numbers of clients who have relapsed have gone up. Because you put someone under house arrest for 6 months, and they have an addiction problem. So there’s more firefighting, and losing face to face is losing 60% of your tools as a counsellor because you can’t say, oh hey, Peter or John, you seem quite anxious today, you seem like you’ve got the weight of the world on your shoulders. Well I wonder what’s happening with you there? Because, you know, you can’t see them. And also you’ve got these quite literally vulnerable clients at home... I have one guy who’s got serious mental health issues, and alcohol problems, but because he’s at home all the time, he’s realised he’s got a very anti-social neighbour. Normally, you’d never see this person. But you’ve got this incredibly aggressive man downstairs...

The physical setting of the therapy room plays an important territorialising role in addiction counselling. The habit of attending sessions at a physical location provides a therapeutic ‘frame’ for building client motivation and self-discipline. But when the lockdown deterritorialised *all* therapy, it exposed the digital social inequalities of a sector with no access to computers or the Internet (Halford & Savage, 2010). The swift move to teletherapy was an effort to recontact clients and to reterritorialise care using ordinary technologies and devices. For those without a computer or the Internet, the telephone was the most agile point of connection. The therapist above expresses frustration that by ‘losing face to face’ therapy is reduced to ‘firefighting’. People with ‘serious mental health issues, and alcohol problems’ living in isolation are acutely affected by their living conditions. The acoustic properties of the telephone territorialise encounters of signification and affect, but emergency assemblages are defined by the openness of forces that erupt and flow from the client’s environment. Rather than inducing a therapeutic ‘rhythm’ of motivation and self-discipline, teletherapy attends to all the intensive forces of isolation, anxiety, addiction and aggressive neighbours ‘downstairs’ that potentially decode the client’s world.

Therapists working with refugees and asylum seekers also recognised the limitations of teletherapy. A family therapist working in Northern England discussed the complex work of talking to families via an interpreter. Trained in the modality of systemic therapy, she explained that

relational work involves taking a wholistic view of the family as an assemblage of heterogeneous 'voices'. Therapy implies an ethical responsibility to address power imbalances and give voice to marginal members of the family. However, many of these therapeutic ideals were 'scrapped' during the lockdown. Recontacting families with mobile devices revealed stark inequalities of living conditions and poor digital connectivity. In the following, she explains how the imbalances that normally occur with families in face-to-face encounters are accentuated when using a mobile phone:

**Family Therapist:** So what happens in the first meeting with these families face to face is that you realise very quickly that there's a spokesperson [...] someone usually takes the role, whether because they feel like they have more rights to or because they feel they're more confident than the rest [...] so they reverted back to that [during the lockdown] in a way and that wasn't... well technology wasn't helping me to change that

**Researcher:** So the technology was not helping to enable these voices to be heard within the family?

**Family Therapist:** No, in fact in some ways it did the opposite because I guess, when you have a smartphone in the family [...] you have one microphone, you have one camera, which means that in many cases people had to squeeze very close to each other to face me. That meant that I'm not going to ask them to talk about things that will make them feel uncomfortable with each other, while physically squeezed next to each other. Imagine I asked them to talk about oh, so why are you so angry with so and so? And then being so physically close. It makes no sense. But it also meant that the person who was holding the camera or the person who was closer to the microphone had some sort of power. So a lot of things that I rely very heavily on I was suddenly not able to do. Yeah I guess I feel responsible for these conversations. And when that responsibility lies with me, and I have no way of altering these conversations, then I'm sort of maintaining something that isn't very equal.

The therapist's image of the family of asylum seekers huddled around a single smartphone on the sofa, talking via an interpreter, is illustrative of the jarring inequalities that appeared on her screen. The limited affordances of the smartphone accentuated the constriction of space, making families 'squeeze very close to each other' to enter the field of signification. To be seen and heard through the medium, the family is compressed into a space that makes affective work impractical. As the therapist explains, 'it makes no sense' to discuss or raise issues that will make family members 'feel uncomfortable with each other'. Furthermore, remote access to the family is controlled by whoever is holding the device—the therapist is literally an 'object' of diminished power and presence. While mobile phones have the territorialising function of establishing parameters for mediated interaction, the directionality of forces are skewed by the user's control of devices. That clients have 'some sort of power' in how they handle and use technologies in their own environment is a counter-interpretation of therapeutic relations. Like the previous extract, teletherapy can offer highly flexible and rapid responses to people in crisis but they are also territorialisations of competing forces that subvert therapeutic processes of making things 'equal' or intimate.

Whereas working with resettled refugee families on smartphones was too limiting to do 'therapy', platforms such as Zoom afforded more opportunities to 'negotiate privacy' with individual clients. A counselling manager of a refugee charity in Northern England described the rapid development of policy that facilitated a swift transition to working on Zoom during the early days of the lockdown. Aside from realising that Zoom sessions were 'way more tiring', she



became aware of having to be more 'proactive on the screen'. In the account below, the therapist is describing the difficulties of 'working with really traumatised people' on Zoom:

**Trauma therapist:** I think one of the issues for me is I'm being much more risk averse in my practice [...] I think it's because when you're working with really traumatised people, what makes people feel safe is your very solid containing presence and you notice tiny things, that mean your clients are struggling to stay in the present. So you pull away, reassure them that they're safe, and that you're here and not there [...] And so what stops me sometimes, from going into some quite difficult places is he's in his bedroom, do I want this in his bedroom, he says this is where he wants to do the work. But he's going to have this left in his bedroom. And if I asked that question, if I lose him, am I going to be able to ground him when he's on the bed and the kids and his wife are downstairs, let's pull back to something much more safer to talk about so that he's not as aroused as he is now. So I'm really careful in terms of some of the conversations about traumatic and difficult histories. Always negotiating with people whether they want to talk about this here.

Psychoanalysts are often critical of 'presence' in mediated therapy because it lacks the sensory richness and 'authenticity' of embodied communication (Russell, 2015). Essig (2012) describes all mediated relations as 'simulations' of experience maintained by the illusion of 'telepresence', the experience of being physically present at a remote location. The problem with telepresence is that maintaining the illusion of 'being there' is intensely cognitive (Russell, 2015) and draws away from the experience of being present in the immediate location (Zeavin, 2021). The therapist above is drawing a similar comparison to explain why she is 'more risk averse' with clients on Zoom. Telepresence can do the work of going to 'difficult places' together, but it lacks the 'very solid containing presence' that makes people feel safe in the therapy room. She can read signs ('tiny things') that a client is slipping into the past and reliving their trauma, but 'if I lose him, am I going to be able to ground him?' An assemblage perspective reads these mediated encounters as intensive forces of bodies intermingling with things through flows of desire and power. The therapist is not concerned about simulations of presence but that the client will have this feeling 'left in his bedroom'. She is reading his potential to decode into flows of affective intensity (afforded by the images on her screen) and assessing how this will affect him *here* with 'the kids and his wife downstairs'. The therapist's cautious retreat reflects her understanding of how trauma can suddenly and unpredictably decode the therapeutic assemblage. Her decision to 'pull back' to a safer footing suggests that telepresence is not devoid of reality but that it lacks the power to control the forces erupting from the client's environment.

Unlike the relatively homogenous relations of the therapy room, emergency care assemblages are agile but highly deterritorialised responses to absence and contingency. Telephones, mobile phones and webcams establish affective relations while eliminating the need for co-presence, but they also encounter the urgency of novel forces that decode and disrupt therapeutic processes. This is sharply illustrated by assemblages formed around emergent 'sectors' of acute distress, isolation and digital social inequalities. At least half the participants interviewed in this study and nearly all those that worked for charities and voluntary organisations described what they were doing during the lockdown as 'less than' therapy. Caring from a distance was reduced to 'support work' and 'firefighting', consigned to the management of contingencies that destabilise clients and their worlds. If therapists were constrained by the affordances of technologies, it was not because telephones and screens provided poor access to reality, but they provided *less control* over the forces affecting their clients.

## Assemblages of intimacy

In this section, we examine another kind of teletherapy assemblage formed within the relatively stable parameters of public and private sectors of mental health care.

Many practitioners, even those who preferred in-person counselling, indicated that working on video conferencing platforms like Zoom was 'better than they expected'. Finding new ways of working with clients online were experiments in 'material doing' (Puig de la Bellacasa, 2011) that seem to enhance processes of subjectification. To illustrate this point, we turn to a transactional therapist who identifies and role-plays different 'ego states' within the client. She described the experience of working on Zoom as 'immediate'.

**Therapist:** [I love working on Zoom] because it's so immediate. Although there are sometimes connection problems and that can be really distracting but, no... we're closer now than we would be if we were in a room. And if we wanted to do some really close work, I'd move in [*moves closer to the camera*] and you would know, we would be really close. And you can't do that face to face, you wouldn't want to do that face to face [...] so some of my clients who might avoid eye contact when we're face to face may still do that now. But I think I feel bolder actually to say to them, Simon, look at me. And he will, it might only be fleeting, but he will whereas face to face that felt far more intrusive. Um it's interesting seeing them in their own environment. Yeah. So I've got one client who's talked to me about hoarding. Well now I've seen it. He couldn't ever have described to me what it was like, what his issues were. Now I've seen it. And that works both ways. I'm able to say to him, wow, that really is a bit of a problem, isn't it? But also, you know, how are you living with it? How do you literally cross from one side of the room to the other?

In this account, immediacy is the intimacy that occurs when people 'stare at each other's faces on the screen' (Pols, 2012, p. 21). The therapist describes how the projection of the face achieves a sense of closeness that breaches norms of interpersonal distance: if faces appeared as close as they did in a physical setting, they would feel *too close*. Doing 'really close work' exploits the coding parameters of the webcam so that the face appears larger on the screen. Faces are expressive components that stabilise and intensify therapeutic assemblages; their function is not so much to communicate than to impose order (Bogue, 2003). Deleuze and Guattari (1987) use the concept of 'faciality' to explain how human faces are components of expression that belong to a 'regime of signs'. The codifying properties of the face function within power structures that form individual subjects. In the socially patterned relations of psychotherapy, the face belongs to a 'postsignifying passional regime', where signs are organised around a 'point of subjectification' (Deleuze & Guattari, 1987, p. 587). The therapist gives a demonstration by leaning into the camera and lowering her voice, an action that visually magnifies the face as the locus of subjectivity. Faciality is generative of new affects where the therapist describes herself as feeling 'bolder' to experiment with a more directive stance. The command 'Simon, look at me' demonstrates the signifying power of the face and voice to intensify processes of subjectification.

Teletherapy assemblages not only intensify the coding properties of faces and voices, but they also reveal intimate and mundane spatialities of clients' worlds. Therapists working across all sectors of mental health care noted that clients appeared in strange and unusual spaces to seek refuge and privacy—some appeared in cupboards, garages or in the private 'bubble' of their cars—while others appeared on beds or in kitchens wearing pajamas. These intimate 'territories of the body' (Fox, 2011) are vectors of forces that sometimes countered the territorialising civility

and formality of the therapeutic frame. On other occasions, the forces exerted by these material settings were therapeutically productive. In the example above, the therapist's description of one client's 'hoarding' is no longer an object of therapeutic discourse—something that might have been discussed in the therapy room—the client's world is a component that actively participates in the therapeutic encounter ('well now I've seen it').

For some therapists, the use of remote technologies during the lockdown was generative of new forms of intimacy. In the account below, a sex therapist explains how 'intimacy over a screen' was somehow enhanced by physical distance.

**Sex therapist:** The thing that surprised me most is about intimacy. Because, um... I didn't think you would be able to create the same feeling of intimacy over a screen as with people in the room. And... I'm not sure I can really explain how this happens. But part of me has guessed that it's because actually, I need that distance away from me. And if you were in the room, you'd be over there (chuckles). So it might be something to do—you know my face is quite close to yours [...] and the other thing is that [...] people are divulging very personal information about their experiences with more ease. It's like it feels safer for them maybe, maybe they're in what they consider to be, a very safe place in their room on the other end [...] it makes the work go, kind of deeper, faster (chuckles) [...] it's somehow better. And now, I think the work is going really well. One or two people have said, come on, can't you go back face to face? But actually, what I'm picking up is that the people who are doing it, have built an acceptance of this as much as I have. And the work is going really well. I almost don't want to have them back face to face... you know, I feel really on it [...] carefully following the process, noticing the changes, seeing the patterns, working with what's going on between you.

Zeavin (2021, p. 18) argues that in teletherapeutic communication 'distance is not the opposite of presence' but constitutive of what she calls 'distanced intimacy'. The therapist is alluding to the same phenomenon when she explains that physical distance is necessary for intimacy to occur 'over the screen'. In the therapy room, the experience of faces engaged in the same relations of proximity would be too intrusive (Pols, 2012). Yet webcams create the immediacy of relational closeness by transmitting a semiotic system of faciality: screens become surfaces displaying the signifying traits of faces that 'absorb signs in a system of subjective identities' (Bogue, 2003, p. 89). On the one hand, remote technologies deterritorialise face-to-face interaction, allowing therapeutic relationships to 'break away from the limitations of spatial location' (DeLanda, 2016, p. 32). On the other hand, teletherapy assemblages are territorialisations that seem to enhance processes of subjectification. The therapist's experience of mediated intimacy coincides with the so-called 'disinhibition effect' (Suler, 2005), where 'people are divulging very personal information about their experiences with more ease'. As such, physical distance combined with digital presence increases the productivity of therapy ('it makes the work go, kind of deeper, faster'). One reading is that therapeutic assemblages are multi-sited and multi-directional forces that alter the material and expressive intensities of the therapeutic encounter. The authority normally encoded in the physical setting of the therapy room is replaced by a mediated system of faciality in which faces, signs and things intermingle with bodies to create emergent spaces of affective intensity.

For practical reasons, webcams are often used in teletherapy to simulate the closeness of face-to-face interaction, but this static arrangement of 'staring at faces' is inappropriate when working with children. One child therapist who worked for several schools in London explained that relating to children requires working in non-discursive ways with a range of materials—puppets, figurines, pencils, paper etc.—as proxies for exploring feelings and relationships through

play. During the lockdown, schools were initially reluctant to work with children due to anxieties and 'stirred up fantasies' of online exploitation and pornography, but eventually it was the willingness of parents to give consent that initiated remote contact with children. This required a level of practical support from parents to ensure children had access to a computer or a mobile phone. In the account below, the therapist describes how teletherapy exceeded his expectations of merely 'keeping in touch' with children:

**Child therapist:** That was one of the interesting things with some of the children, I was expecting that it would mainly be just keeping in touch and sort of maintaining a relationship, and not necessarily developing very much, it would be just a holding process, but with some children quite a lot of new ideas or new ways of relating emerged. There was a girl I was working with who... she would appear in lots of different settings, she'd be like in her garden, with her mom in the background but, she'd be in her garden and sort of do magic shows and performances and things like that, and then we'd move indoors and be in a room. So there is this freedom of movement that the child had but, I don't know it seem to open up a space for different kinds of spontaneity [...] rather than them being in my room, I was a guest in their home and with some children they'd be showing me their toys or the view from their bedroom window.

In psychoanalysis, the concept of 'holding' (Downing et al., 2021) refers to the therapist's capacity to create a supportive emotional and physical space for building empathy and trust. Russell (2015) argues that in digitally mediated therapy, the process of holding is impoverished because 'screen relations' lack authentic embodied connection. In the account above, the therapist had similar expectations that teletherapy would be 'just a holding process' of maintaining superficial contact with children. However, he describes a dynamic encounter with a girl whose access to her mother's mobile phone allowed her to 'appear in lots of different settings'. From a more-than-human perspective (Bennett, 2010), we can read this encounter as a complex interplay of affective forces in which different spaces, objects and connections are distributed among human and non-human assemblages. The fact that the therapist is not (from the child's perspective) a fully embodied persona, but a *thing* comprising human and non-human traits reinterprets the process of therapeutic holding: it is the child who is 'holding' the therapist and controlling the interaction. Rather than containing affects within the therapist's space, the therapist is guest to all the intimate things and relations that *matter to the child* in her world. In this sense, therapeutic assemblages produce diffuse and emergent spaces for children to express a range of affective intimacies through 'freedom of movement' and 'different kinds of spontaneity' that reveal novel aspects of subjectivity.

In these accounts, practitioners working mainly within public and private sectors of mental health care reported using mobile phones and teleconferencing platforms in ways that enhanced relational intimacy. These are assemblages with relatively stable parameters and codifying properties that permit new ways of relating to and working with clients. Following Deleuze and Guattari's (1987) assertion that faces are components of expression that operate within structures of power, assemblages formed around the dynamics of 'faciality' have the territorialising effect of intensifying processes of subjectification. Rather than denying or degrading embodiment, teletherapy assemblages are territorialisations of digital devices, webcams, bodies, faces and physical distance that constitute emergent spaces of presence and intimacy.

## DISCUSSION AND CONCLUSION

One of the aims of this paper has been to show how the loss of physical spaces during the COVID-19 crisis was an event that radically deterritorialised in-person therapy—the totality of distance interrupted and transformed existing ideas of presence, distance, intimacy and control. The subsequent rise of teletherapy during the first UK lockdown was both a necessary and creative response to absence and contingency. Upon entering these new relations of technologically mediated care, many practitioners found themselves adapting to and experimenting with ‘things’ at their disposal. Telephones, mobile phones, messaging apps, computers, webcams and video conferencing platforms became vital components for reassembling care at a distance.

Analysis of practitioners’ experiences of teletherapy revealed two distinct assemblages of ‘caring through things at a distance’. Rather than remote technologies facilitating or denying human agency, I have shown how agency is distributed among a wider field of processes and things which are generative of care. What I have called ‘emergency care assemblages’ are descriptions of encounters where ordinary objects and devices form agile but highly unstable relations, often responding to the urgency of forces emerging from specific ‘sectors’ of inequality, deprivation and acute distress. What I have called ‘assemblages of intimacy’ are more stable arrangements of processes and relations that afford a higher degree of therapeutic control. Despite their truncated and flattened appearance on the screen, the signifying properties of faces are deployed via webcams to achieve an unexpected sense of relational closeness and affective intensity.

These findings suggest that remote technologies are not a straitjacket for creating more structured and responsabilising interactions (Oudshoorn (2009) nor do they confirm that mediated technology privileges information over intimate care (Mort et al., 2008). Following the work of Pols (2012) and others (Langstrup et al., 2013; Piras & Miele, 2019), the practice of teletherapy is consistent with claims that intimacy and presence are emergent properties of mediated interactions. In these circumstances, distance is not the opposite of presence. Presence and intimacy can occur at any distance and through any mode of expression and connection. As Zeavin (2021) argues in her historical account of teletherapy, therapy has always experimented with media to practice a variety of ‘distanced intimacies’. These ideas are antithetical to psychoanalysts who argue that mediated technologies erode and degrade intimacy and human connection (Essig, 2012; Russell, 2015; Turkle, 2011). These authors claim that while mediated therapy has a role to play in therapeutic culture, technology can only ‘simulate’ the shared embodied experience of being present in the immediate location. With the loss of the embodied setting, they argue that the core principles of therapeutic practice—presence, holding and containment—are undermined.

A materialist ontology takes the radical step of dissolving the physical body as the centre of experience. Embodiment is not degraded by mediated interaction but distributed among all the relations that a body has with its material world. Deleuze and Guattari’s concepts of ‘assemblages’, ‘territorialisation’ and ‘deterritorialisation’ offer an alternative to thinking of technologies as ‘tools’ that stand outside of human relations: ‘Even technology makes the mistake of considering tools in isolation: tools exist only in relation to the interminglings they make possible or that make them possible’ (Deleuze & Guattari, 1987, p. 90). This implies a different relationship between humans and mediated technologies. These are not technologies that fill the void of human absence with ‘flat’ representations of presence; presence is a dynamic and emergent property of assemblages, which is to say that bodies, technologies and their mediated artefacts ‘intermingle’ on the same ontological plane. From this perspective, it makes no sense to say that mediated therapy is a simulation of physical presence. A neo-materialist/post-humanist reading

maintains that presence, distance and mediated devices are components bound by a 'distributive agency' (Bennett, 2010) that interact with each other in a 'complex multiplicity' (Braidotti, 2019).

Far from being disembodied experiences, many practitioners described dynamic encounters with novel forces that flowed or erupted from physical spaces and from clients affected by their immediate circumstances. Kitchens, cars, garages, beds, cupboards and sofas, as well as various distractions and interruptions, were non-human forces that shaped and modulated therapeutic interactions. Even when the limited affordances of mobile phones accentuated the poverty of space and reduced the therapist to that of witness of social and digital inequalities (Halford & Savage, 2010), even then assemblages were plugged into forces normally absent from the therapy room. Many practitioners had low expectations of teletherapy and underestimated the creativity of these dynamic forces. Some experimented with the intensification of intimacies and proximities afforded by screens and webcams with the effect of not so much as enhancing 'communication' but deploying the signifying properties of faces to control therapeutic processes. In other cases, it was the freedom to use digital devices to move through different spaces that allowed clients to express and embody spatial intimacies in their world. The apparent fluidity of these encounters was creative because they deterritorialised conventional therapeutic enclosures to reveal novel aspects of client subjectivity.

But not all these encounters were therapeutically creative or even so much as resembled conventional therapy. It is true that mediated devices with their limited affordances accentuated the poverty of presence in ways that rendered traditional therapy unpracticable. In this sense, teletherapy itself was deterritorialised by the acute isolation and affective intensities erupting from the client's world, the mediation of which seemed to limit the therapist's range of material and affective interventions. In these assemblages, the priority became that of 'caring from a distance' rather than resuming or reestablishing a therapeutic relationship. Furthermore, it was the instability of these heterogenous arrangements of distributed devices, affected bodies and distressed sectors that deprived teletherapy of the power to incite processes of subjectification. In these cases, caring through things at a distance were territorialisations of forces constrained to the management of absence and contingency.

To say that teletherapy assemblages are 'territorializations' is not just a statement about distributive agency and embodiment, it is also a political statement about all the forces of the social that impinge on individuals outside the tranquility of the therapy room. Fox (2011, p. 363) explains that territorialisations are vectors of force and counter-force that 'involve some act of interpretation', meaning there are endless possibilities for resisting and organising matter in new ways. Perhaps, the same thinking can be applied to professionalised therapy with its territorialisation of roles and relations that are physically bound to a model of dyadic purity. Rather than teletherapy being an awkward interlude or a temporary adaptation to crisis, perhaps it offers a new interpretation of distance care. Telephones, mobile devices, laptops and webcams territorialise forces by connecting body relations together to form heterogenous 'helping' and 'caring' machines. These transient machines produce stable identities that transform individuals into 'clients' and 'therapists', but they also introduce forces from the client's environment that resist and challenge the parameters of therapeutic control. That practitioners felt constrained by technology when they were unable to control these forces resonates with Downing et al.'s (2021) finding that many therapists during the COVID-19 lockdowns struggled to control a 'holding space' when clients accessed therapy from home.

The findings of this study are partly sympathetic to psychoanalyst's concerns that digitally mediated therapy lacks the sensory richness of physically close encounters (Russell, 2015) and that practitioners may have fewer resources to make meaningful therapeutic interventions (Essig, 2012). But in agreement with Downing et al. (2021), there is evidence that during the COVID crisis practitioners experienced new ways of engaging with clients online. These findings

challenge the idea that digital experience is disembodied or that caring at a distance is the opposite of presence. The point of recasting teletherapy in terms of assemblages is to treat the representation of things as an ethico-political issue. Following what Puig de la Bellacasa (2011) calls ‘matters of care’, the task is to treat a previously marginalised and neglected form of mental health care and show how ordinary things matter in generating care. Caring through things at a distance is a speculative commitment to consider how the endless possibilities of human and non-human assemblages can reinterpret care and create new kinds of affective relations.

## AUTHOR CONTRIBUTIONS

**Michael A. M. Arribas-Ayllon:** Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Resources; Software; Writing – original draft; Writing – review & editing.

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