Sociology of Health & Illness

SOCIOLOGY OF HEALTH & ILLNESS

ORIGINAL ARTICLE OPEN ACCESS

Networked Care: Worlding Mental Well-Being in a Digital Age

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Received: 16 July 2024 | **Revised:** 30 March 2025 | **Accepted:** 4 April 2025

Funding: This work was supported by Intimacy in Data-Driven Culture, a research consortium funded by the Strategic Research Council at the Academy of Finland [Grant 327391], the Turku Institute for Advanced Studies, and by Networked Care: Intimate Matters in Online Mental Health Support, a research project funded by the Research Council of Finland [Grant 356256].

Keywords: digital technology | mental health | new materialism | science and technology studies (STS) | worlding

ABSTRACT

This article analyses mental health support through the lens of care. Drawing upon a study of various practices of teletherapy and remote counselling during the COVID-19 pandemic, it empirically analyses mental healthcare by tapping into the experiences of Finnish therapy and counselling professionals. In telecare, digital technology with its particularities brings forth particular forms of (networked) care: networked connectivity and the relations formed with and through digital technologies operate as 'worlding practices' that bring different modes of mental healthcare into being. Taking as its point of departure the assumption that networked connectivity has transformed and is transforming mental healthcare, this article seeks ways of incorporating networked connectivity into understandings of the enactment of care. By bringing together insights from science and technology studies, feminist materialism and research on networked connectivity, it is interested in asking and analysing how care comes to matter in networked societies. In particular, insights from studies of care networks and network connectivity are brought together to provide novel insights into these configurations and entanglements of care. Through detailed empirical analysis of interviews, the article further develops a concept of networked care.

1 | Introduction

This article analyses mental health support through the lens of care. Originating in a study of the various practices of teletherapy and remote counselling deployed during the COVID-19 pandemic, it empirically analyses mental healthcare by tapping into the experiences of Finnish therapy and counselling professionals. Drawing upon sociomaterial research, especially science and technology studies (STS) and feminist new materialism, it provides novel insights into the ways technology facilitates—or fails to facilitate—care. Technology's relationship to care is thus seen as open-ended and processual: technology in care work is often seen as 'cold', impersonal and instrumental, but this view relies on understanding care and technology as mutually exclusive and on a narrow view of technology as simply passive, inert matter, with only instrumental qualities (Mol 2008; Pols 2012). Conceptualising technology as 'agential' rather than instrumental allows for a detailed, nuanced understanding of its entanglements in the processes of care. In mental health technological world-making, along with humans, a variety of actors such as technologies emerge together and coconstitute each other in more-than-human worlds (Flore 2021). The ontoepistemologies of 'mental health' and 'mental illness' are thus reconfigured in the era of digital mental health (Flore 2021, 2045). The increasing digitisation in mental healthcare means that mental well-being is coconstituted with and through the relations formed with digital technologies, platforms and applications, and these also birth new caring relations and forms of support (I. M. Tucker and Goodings 2017; Kolehmainen 2022, 2024). For instance, such forms of remote therapy and counselling that are the focus of this article are coconstituted through and with networks of several actors, bodies, events and objects, such as the therapist, the client, therapy modalities, technological infrastructures, psychic conditions, particular affordances of different mediums and material venues (Kolehmainen 2022).

By bringing together insights from STS, feminist materialism and research on networked connectivity, this article seeks to shed light on the manifold operations of remote care in networked societies. In particular, my research aligns with (feminist) STS, where the COVID-19 pandemic revitalised interest in care, highlighting the importance of finding ways forward in thinking with care to help us respond to the worlds of crises and beyond (Lindén and Lydahl 2021). In STS, two perspectives on care that might be in tension at times have been especially influential: care-in-practice and critical care perspectives. The first emphasises care as situated material practice, and the latter interrogates care as an ethicopolitical commitment (Lindén and Lydahl 2021). Lindén and Lydahl (2021) suggest a double vision of care to connect aspects of these two perspectives together; a vision that is both situated and critical, staying with the practices, specificities and potentialities of care while simultaneously critically interrogating those practices when needed. This article's approach to mental health support aligns with this double vision of care: it is interested in networked connectivity as a 'worlding practice' that brings different modes of care into being and thus has a key role in providing—or failing to provide—care. In particular, this article aims at exploring how networked connectivity and the relations formed with and through digital technologies bring particular worldings—and thus different modes of mental healthcare—into being.

My understanding of the concept 'worlding' roots in Kathleen Stewart's (2010), (2011), (2017) work. Drawing on Heidegger's (1962) loose initial formulation on worlding, Stewart uses worlding to depict how something is coming into existence (Stewart 2011, 446). Worlding is thus about potential ways of living in or living through things, which accumulate and pool up in worldings (Stewart 2011, 452). At the heart of this concept lies an understanding that there are alternative worlds that may—or may not—emerge for an individual through their engagement with a number of interrelated phenomena (Stewart 2011; Palmer and Hunter 2018). In worldings, modes of existence accrue, circulate, sediment, unfold and go flat (Stewart 2011, 446). Stewart connects worlding in particular to atmospheric life and uses 'attunement'—a concept referring to individualised capacities to feel, register and resonate with these callings in everyday happenings and multisensory unfoldings of affective atmospheres—alongside worlding (Stewart 2010, 2011). There is a limited amount of previous research on digital mental health from the perspective of worlding. However, worlding has been used as a way to discuss the particular relations that bring the affective experiences of distance and closeness into being in teletherapy practice (Kolehmainen 2022), and attunement has been employed as a means to explore digital atmospheres of mental health apps (Simpson and Tucker 2024).

The theoretical orientations of this article are inspired, first, by Deborah Lupton's (2019) invitation to research health-related experiences from such a more-than-human perspective that is inspired by feminist materialism. Although new materialisms incorporate a multitude of approaches, including new feminist materialism (often termed 'feminist new materialism', yet there is more continuity in theoretical development than this terminology suggests), they share a critique of and focus on interrogating the nature of the 'human' (Lupton 2019; Braidotti 2019). Although my focus is not on the gendered dimensions of the more-than-human worlds, my approach to worlding stays attentive to how particular worlds emerge as a result of multiple entanglements which entail both constraining and enabling power (see Lupton 2019). Thus, being interested in the entanglements of humans with nonhumans—especially digital technology—in more-than-human worlds, this article sees care as inherently more-than-human care. Second, this article is inspired by the work on more-than-human care by Puig de la Bellacasa (2012), (2017). Even if this seminal work focuses on neither mental health nor digital technologies, it offers an innovative framework beyond the more traditional notions of care where the categories of caring and cared-for play major roles (Puig de la Bellacasa 2012, 2017). In research on therapy and counselling, eroding dichotomies of this kind invites a rethink of caring relations, such as rather than foregrounding the relationship between service providers and service users, searching instead for alternative ways to map the manifold entanglements of caring relations at play in therapeutic encounters. Further, this article also departs from seeing care as a human matter only: although bacteria, fauna, soil or animals—among others—can also do 'care work' and are crucial parts of the entanglements of care (Puig de la Bellacasa 2012, 2017), so does digital technology (Kolehmainen 2024). I hence approach care as a relationship that maintains and repairs a world so that humans and nonhumans can live as well as possible in it in a complex life-sustaining web (Puig de la Bellacasa 2017, 62). My entry point to care in more-than-human worlds is to examine it from the point of view of networked connectivity, as I assume that digital technology and related connections also have intensifying relevance in the worldings of care.

Further, this article considers codependencies (Puig de la Bellacasa 2017; Tsing 2015) as essential for examining care and understanding that vulnerabilities are already interwoven with care relations. Recognising the centrality of dependency and interdependency is here seen as crucial from a care perspective, paving the way for sustainable living in more-than-human worlds: refusals to consider interdependencies, by contrast, are seen not only as lacking care but also as being substantially destructive (Chatzidakis et al. 2020). The notion of dependency has also been configured in relation to networked connectivity, being identified as a precondition of existence that modulates the shapes and forms of individual agency in a culture characterised by ubiquitous network connectivity (Paasonen 2015). In contemporary societies, it is almost impossible to withdraw from networked connections: even if one does refuse to use particular forms of digital connectivity such as social media platforms, personal information is still collected, datafied and capitalised on through life-sustaining platforms and applications such as patient data registers in healthcare or online banking (Mai 2016). Bringing together these various notions of dependency here, therefore, I will provide detailed insights into the manifold networks that both cocondition and vitalise mental healthcare in contemporary, digitalised societies.

2 | Rethinking Care

The use of digital technology is, in several ways, embedded in relational networks of human and nonhuman agencies—starting, of course, with the coronavirus that caused the pandemic and thus generated the policies prohibiting in-person sessions, thereby leading to the employment of digital technology in conducting therapy and counselling sessions. In my exploration of how networked connectivity and relations formed with and through digital technologies bring modes of care into being—the worldings that emerged with the transition to teletherapy and remote consultations—I bring together two strands of (feminist) research: studies on care networks (Mol et al. 2010) and network connectivity (Paasonen 2018). On the one hand, studies of care networks point out that caring is active, and several human and nonhuman actors (e.g., medical staff, patients, technology, drugs) participate in caring processes. On the other hand, networked connectivity stresses the infrastructural role that digital technologies (e.g., internet, technical devices, social media platforms, apps) play in our everyday lives. In this article, I bring together insights from these two strands of research in order to produce knowledge on networked care and its successes and failures. Particularly because the boundaries between 'digital' and 'nondigital' are often blurred, digitalised networks pose new challenges for understanding, conceptualising and researching care. By developing a novel conceptualisation of networked care, I wish to make visible the ways networked connectivity is configured in the relational networks of care but also requires (human) care.

Care is always enacted in networks, as care research inspired and influenced by actor–network theory underscores. In STS, agency is seen as distributed, and the influential actor–network theory (ANT) in particular has conceptualised agency as enacted through networks of different actors by viewing individuals as actors defined through the networks to which they belong—through their connections to and reverberations within networks of people, technologies and practices (Latour 2011, 806). The enactments of care described in the seminal STS scholarship could be seen as world-making practices. The ontological approach within ANT does not assume a singular reality upon which there are variable perspectives. Annemarie Mol (1999) summarises this with how reality is 'done and enacted rather than observed'. ANT stresses how actors associate with other actors, thus forming networks in which they are all made into 'actors', as the associations allow each of them to act. Within those processes, actors are enacted, enabled and adapted by their associates while in turn enacting, enabling and adapting these (Mol 2010). Here, human agency is shaped and conditioned by a range of networks and forces beyond individual control, such as economy, climate and law (see Latour 1999). Aligning with this, technologies are seen as actors that do things within their network or practice, whereas the other actors are doing something in return (Pols 2011). Further, 'networked codependence' provides a crucial site for enabling and constraining human contemporary action (Paasonen 2015), speaking to the importance of thinking networked agencies in relation to internet connectivity and digitalised technologies of all kinds.

Research focusing on care in practice has pioneered a view of distributed care, where a notion of distributed agency that does not privilege one particular activity or actor over another is foregrounded. As Mol (2008, 107–108) remarks in her pioneering work, in the logic of care, the action is more important than the actor: the action may be shared or shifted around. Consequently, actors in care do not act alone because the action moves around: one moment you care, the next you are taken care of (ibid., 92). Care is thus seen as processual and enacted by a whole bunch of actors. The care process involves a team of, say, professionals, machines, medication, patients and relevant others, and tasks are divided between the members of that team (Mol 2008, 21). Here, 'doctoring' is not just done by doctors: the entire care team is involved (Mol 2008, 64). Care activities—Mol discusses examples around diabetes—move between doctors, nurses, machines, drugs, and needles, as well as the patients themselves, who need to do a lot, from eating and drinking to injecting and measuring (Mol 2008, 32). Importantly, from this perspective, patients are crucial members of the care team, not a target group of care (Mol 2008, 26). Further, care is an interactive, open-ended process that may be shaped and reshaped depending on its results (Mol 2008, 23). In those processes, digital health technologies are used in several ways, from delivering medical care and diagnosing illnesses to monitoring bodies and communicating information (Lupton 2018, 14). Technologies are not obedient 'means' because they are unruly and have unexpected effects; they do not subject themselves to what we wish them to do but interfere instead with who we are (Lupton 2018, 54–58).

However, the particularity of networked connectivity has transformed and is transforming healthcare, mental care included. Networked connectivity has grown into a matter of infrastructure, reminiscent of civic utilities (Paasonen 2018). It thus forms a constitutive element of contemporary everyday life to the extent that being cut off from networked connectivity translates as being cut off from the multiple networks, reconfiguring the available ways of being in the world (Paasonen 2015). Technological connections, interactions and dependencies are elementary parts of everyday life and crucial in terms of the multiple networks in and through which individuals operate (Paasonen 2015). Regarding healthcare, people search for information online and different platforms, blogs and social media sites provide sites for learning about others' experiences, as well as for expressing one's own feelings in case of illness (Lupton 2018, 95–97). Consequently, mental healthcare takes diverse forms from digitised psychotherapies to AI-generated chatbots and from peer support on social media to organisational data mining, all enabled by networked connectivity.

Finally, I think that discussing mental healthcare through the lens provided by theories of care in itself aligns with the double vision of care: it allows for exploring the networked, technomaterial practices of mental healthcare as well as recognising the dis/entanglements of care emergent in those networks, providing an ethicopolitical stance. The seminal work of critical care theorists such as Tronto (1993) has highlighted that care for others has traditionally been feminised and devalued and that care work is often invisible and unpaid, being seen as requiring little skill or training. This has been pivotal for understanding the complexities of care. Building on these insights, feminist research on care has focused on physical care work (e.g., Pols 2011), as care is indeed often associated with activities such as washing, feeding or dressing wounds (Mol 2008). Yet this article also departs from the humanist perspective of the critical care theory in its acknowledgement of nonhumans and of the fact that even human-to-human care has implications for nonhuman others (Lupton et al. 2021). It also 'thinks with theory' (St. Pierre and Jackson 2014) by engaging with more concrete studies on caring as well as with the more abstract configuration of mental healthcare. Rather than setting physical care work and mental healthcare in opposition, I anticipate that an approach that attunes both to their potential differences and similarities might prove fruitful for understanding the complexity of remote therapy and counselling in networked societies. This is particularly the case here as this article seeks to discuss mental health beyond 'treatment'. Treatment of mental issues is a part of care practices, but not all of it: Mental healthcare, therefore, refers here to the wider networks and more-than-human assemblages where mental well-being is situated.

3 | Data and Methodology

This article empirically draws upon interview data gathered for a research project on counselling professionals' experiences of technology use. The project was an independent subproject as a part of the research consortium Intimacy in Data-Driven Culture (IDA). I conducted interviews with 39 psychotherapists, family counsellors, psychologists, crisis workers, sex therapists and other counselling professionals during the COVID-19 pandemic. The first wave of the pandemic hit Finland in March 2020, and the government declared a state of emergency lasting for 3 months. The government implemented the Emergency Powers Act, which involved various measures, although not the strict national lockdowns seen in some countries. The exception was a 3-week shutdown of the Uusimaa region, during which movement between the capital region and the rest of Finland was restricted as Uusimaa's epidemic was more advanced than elsewhere in the country. The more general measures varied from closing all schools (except early education), shutting down public facilities such as libraries and museums and exempting critical personnel from the Working Hours Act and Annual Holidays Act to increase the capacity of social and healthcare in the private and public sectors. Restrictions were also placed on social distancing and recommendations made concerning remote working in the public and private sectors, meaning almost all therapy and counselling services went remote because of COVID-19. During this period, preceded by my interest in online counselling (e.g., Lahti and Kolehmainen 2020), I became interested in the experiences of counselling professionals concerning the shift. The research participants were recruited in different ways to reach a wide pool of potential interviewees, including by an open call on social media (e.g., on both my personal Twitter and personal Facebook accounts, as well as on the home page of IDA) and contacting several national organisations providing counselling services in Finland. Thus, the interviewees self-selected for participation. Aligning with the ethical guidelines of the Finnish National Board on Research Integrity (TENK) and the guidelines by the ethics committee of the University of Tampere, no statement of ethical approval was requested because the research design did not fulfil the criteria for requesting ethical review: all the participants were adults and all of them gave their informed consent.

All but one of the interviews were conducted via Zoom in 2020—the exception was conducted by phone—partly due to the pandemic and also because it provided a convenient way to schedule interviews with participants across the country. The interviews lasted about one to one and a half hours with a wide variance in duration. The shortest interview lasted approximately 45 min. The longest one lasted over 3 hours (in two parts): I interviewed two professionals twice because I felt that we could not go through all the basic themes at once. Altogether I interviewed 39 individuals, resulting in 41 interviews altogether. The interviewees self-identified as female ($N = 30$) and male ($N = 9$). Two of the interviewees were aged 25–29 years; three were aged 30–34 years; seven were 35–39 years; six were 40–44 years; six were 45–49 years; nine were 50–54 years and six were 55–59 years. The questions asked in the semi-structured interviews were structured around three themes: background information, client work, and the impact of the COVID pandemic on work. The questions ranged from the perceived pros and cons of the interviewees' job escriptions to the characteristics of client groups and from the interviewees' experiences of technology use to the changes brought by the pandemic. The research participants' familiarity with and expertise of technology use for work purposes were varied. Yet for most of them, regularly occurring remote client work was an unforeseen experience (Kolehmainen 2022, 2024).

The first analytical strategy applied in processing the data was thematic analysis (Braun and Clarke 2014). The procedure at this stage was to extract accounts and sort them into various categories in order to identify emerging patterns in the data through systematic engagement with the transcripts. I found that reading and familiarising myself with the extensive number of interviews and related rich data was a fruitful way to start my research and that identifying themes provided a valuable means of mapping the interviews (see Lupton 2019). Although the categories often overlapped, I assigned a single account to one category at that time. The themes that I first identified were manifold, for example, COVID-19, the shift to telework, regional issues, home surroundings and family members, in/visibility, the pros and cons of remote therapy and counselling, different media formats, technical difficulties and glitches, cybersecurity, the question of anonymity and collaborations between different service providers.

In the second stage of the analysis, I read the data again from a new perspective through the lens provided by my vitalised interest in care. Here, I adopted a theory-driven analytical strategy towards the data, employing a method best described as 'thinking with theory' (St. Pierre and Jackson 2014). In practice, I narrowed my focus and interpreted the transcripts from the care point of view, seeking to decentre such binaries as carer/cared for and professional/client—as suggested by the chosen theoretical approach to the topic of this article. I started paying attention to the different care networks, networked care, collaborations, connections and interdependencies that sustain or degrade care and extracted accounts again from this specific viewpoint. Indeed, from the perspective of care, the methods we use have effects for how we can analyse and do care. Following Haraway, it is possible to understand each method as providing 'a wonderfully detailed, active, partial way of organizing worlds' (Haraway 1997, 90), making it clear that methods also participate in producing active, detailed and partial versions of care (Lindén and Lydahl 2021). In my research, the theoretical idea of networked care has thus guided my engagement with the data. 'Thinking with theory' is about allowing theoretical concepts to guide analytic focus (Jackson and Mazzei 2012; Mazzei 2014; Lupton 2019): working with the data and this proposed concept here allowed me to develop it further.

I will next identify the particular ways in which networked connectivity and relations formed with and through digital technologies bring (or fail to bring) modes of care into being—the worldings that emerged alongside the transition to teletherapy and remote consultations. I will also introduce and develop the concept of networked care with the help of my rich empirical material. The accounts are not chosen to be representative of the data but, as explained above, to provide stimuli for thinking and developing an understanding of networked care. The interview accounts have been slightly edited and shortened for readability. To preserve anonymity, I do not provide detailed background information about my interlocutors in connection with the data accounts. I will also only use general occupational titles because exact combinations of education, background and job description might jeopardise their anonymity. This aligns with my interest in more-than-human care because within this choice, less emphasis is placed on 'who' the interlocutors are and more on the doings and entanglements of different care assemblages as suggested by feminist materialist health research (see Lupton 2019).

4 | Holding and Supporting Infrastructures

Networked connectivity—becoming an infrastructural part of care networks—plays a central role in the ways mental healthcare was enacted during COVID-19. The possibility of digitally reaching out and connecting was essential for many in their search for support when the pandemic first hit Finland (Kolehmainen 2022, 2024). Below, a psychotherapist who works in an organisation providing various services nationwide described remarking a shift caused by the pandemic. The organisation, where a variety of technological tools were used to reach out to potential clients, was particularly invested in the hotline, but the chat services became the most popular route for seeking professional support. The use of chat does not require audible contact with a mental health professional and was thus considered especially convenient:

> There were more visits than the whole last year, and many put it in words like I need to write, there are so many challenges, I need to write as I cannot talk about these issues since my family is around me. When there's a child and a spouse next to a person, then writing is easier. [--] Regarding the hotline, it was interesting to notice that the crisis, the topics, were more difficult. Earlier the topics were about different kinds of things, and now clearly major child welfare concerns or couple relationship issues have been visible during COVID.
>
> (Psychotherapist, I25)

The interviewee notes how the pandemic caused changes in the well-being of the population, worsening their situation—'the topics were more difficult'. The pandemic indeed is more than a health problem, being a global crisis (Lupton 2021, 17). Of course, people experience it in diverse ways, but the psychotherapist notes observing exactly the effects of the large-scale crisis in her remark about the shift in topics, as there have been major concerns related to child protection, and they have had to initiate more child welfare reports than before.

Although it has been remarked that providing and sustaining a holding, safe environment in digital psychotherapy, in particular, requires consideration (Downing 2021), the relevance of 'holding' reaches beyond particular therapy settings. Indeed, during a time of crisis, networked connectivity provided psychically holding infrastructures as the account illustrates. Where several services were suspended or shut down as a precautionary measure, those operating online provided support, thus at least partially contributing to the experiences of being psychically held. This account illustrates how networked care also 'repairs' gaps, ruptures and closures of more institutional networks of care. The possibility of writing about one's situation or feelings by using the chat application, for example, might have provided a life-sustaining practice during the crisis. Here, networked connectivity, chat service and suitable technology coconstitute the relations through which the worlding of care becomes possible in situations where clients are predominantly bound to their homes during the pandemic.

When other services were either less accessible or the social imaginary of the pandemic made potential clients think that access to social and healthcare was restricted, networked connectivity was able to provide an infrastructure for providing access to remote services and thus maintain care during the crisis. Below, a violence worker recalls how the initial impact of the pandemic first made clients disappear but a few weeks later, there was a flood of clients hoping to get support. The modes of care that were accessible in the pre-COVID era now withered and flattened (Stewart 2011, 446), yet networked connectivity enabled the worlding of alternative care practices:

> We have an online contact form which the majority of clients, aspiring clients use [--] Well the period between March and April was very quiet, after there was a shift to remote work and a dome was placed above the Uusimaa region, but I think also the talk about how all workers in social and healthcare sector are harnessed to fight corona and that many units were practically closed, so somehow an image that one cannot get any support, got stronger perhaps. But then, around mid-April, everything turned upside

> down [--] like you hoped that not that many clients would contact you today.
>
> (Violence worker, I32)

Interestingly, the interviewee mentions online contact forms. The contact form is an example of digital forms of support that can be accessed via personal digital devices at any time (I. Tucker 2024), even if there might be asynchrony between the temporalities of seeking support and receiving a response as this account suggests. Further, although online contact forms have proved to facilitate contact between potential service users and providers, they might be especially fruitful during a pandemic when various services have shut down, have limited capacities to operate or have been transformed into remote services: under these conditions, online contact forms directing clients to contact available services could generate a wave of new clients. This interviewee also seems to interpret the increase in the number of clients as partly resulting from the many closures or restrictions affecting health and social care services. Even if he does also consider non-COVID-related reasons for the shift in client numbers, he nevertheless mentions that soon after the pandemic reached Finland, there was a peak in client-initiated contacts.

Moreover, the distanced therapeutic encounters enabled by networked connectivity were seen as particularly suitable for certain groups of clients by many of the research participants. For instance, severe and long-term mental illnesses have disabling effects in regard to competencies for engaging with digital technology (Ennis et al. 2012; McGosker et al. 2024). Aligning with this, a psychotherapist suggests that with clients who have a high sense of self-coherence, the shift to teletherapy is hardly notable, whereas the remote model would not suit those who struggle with severe mental health issues:

> The kind of folks who are quite coherent [--] with them one hardly notices any difference. [--] Thinking of like, psychosis and borderline [personality disorder] and neurotic, like the more we throw into the difficult end the more essential one's presence becomes. [--] There's probably a reason to consider those diagnostic criteria too, like whom it is suitable for [--]. Yet then, if compared to not getting any help at all, then we can think that any support is better than no support at all.
>
> (Psychotherapist, I40)

In terms of worlding practices, be it attunement acquired through practice and cultivation or openness to immersion in new envelopments (Stewart 2011; Brown et al. 2019), clients from 'the difficult end' cannot reach the particular form of attunement—sense of self-coherence—to the degree required for engaging in teletherapy sessions in a meaningful way, and thus, the accessible modes of care remain limited. However, despite scepticism towards how remote consultations would work with clients with severe mental distress, it is concluded that compared to 'not getting any help at all', teletherapy makes a viable option. Networked connectivity is also recognised here as a means to 'world' mental health support when in-person support is not available and is thus seen as essential in maintaining life-sustaining caring relations in times of crisis.

5 | Collective Decisions and Devices

Although in the previous section I demonstrated how networked connectivity became an essential part of care networks during the pandemic, the mere existence of internet connection and suitable devices and applications did not always translate into worldings of effective or accessible care. For instance, although the restrictions placed upon social distancing protected the population from a contagious disease, these practices also meant weakened mental healthcare for many individuals. For instance, moving psychotherapy sessions online can foster certain forms of care but may constrain others—such as enabling therapy at a distance but not supporting conditioning work that is identified as crucial for improving a client's mental well-being by a psychotherapist:

> I've had one rehabilitation psychotherapy client in family therapy, and their condition has gotten worse during this Covid period, like there's a need to consider intensive medical rehabilitation and else, like for them working on this fear of social situations and anxiety got badly bogged down. We couldn't really do conditioning work.
>
> (Psychotherapist, I30)

Care always operates through asymmetrical relations of power (Martin et al. 2015), which become visible in the ways that the policies enforced to protect the population as a whole at the same time restricted the individual agency of the interviewed psychotherapist as well as the client's possibilities to conduct rehabilitation exercises. Therefore, the activities conducted in order to protect communal survival in times of crisis may come with harmful consequences for individuals (see Kinnunen and Kolehmainen 2019), stressing the ambiguities between self-care and caring for others (I. M. Tucker and Goodings 2017).

The tensions between collective and individual care are also visible in the account provided by a group psychoanalyst, who voices frustration at shifting recommendations and policies. Kela, the Finnish state pension office providing rehabilitation psychotherapy and financially supporting those granted access, initially forbade group psychotherapy online, even if individual psychotherapy was allowed remotely. Kela later reversed this, which the interviewee found a burden both for himself and for the group members:

> It was burdensome for the group as well, since when all the changes came along, I of course had to again send all group members an email explaining that well, now the guidelines are like this [--] this group nevertheless didn't want to. I thought that each must, there needs to be 100% commitment like all must find it okay to meet online, a psychotherapy group cannot

> continue like we'll continue without you two until you join again. In my professional thinking, it just cannot go that way.
>
> (Psychotherapist, I1)

In Western countries, 'one person/one device' assumptions are predicated on the idea that an individual controls access to, for example, a phone (Pinch et al. 2022, 9). However, such individualistic notions of technology use do not accurately depict the relational networks in which the everyday lives of individuals are embedded. In group psychotherapy, every single member of the group should be committed to remote therapy for the group meetings to move online. This brings life to the words of Mol (2008, 68), who has argued that the logic of care does not start with individuals but collectives, from the fact that the collectives to which we belong frame the care we receive. Here, access to remote therapy, then, is a matter of the relational assemblages in which COVID-19 policies, Kela's decision, the professional view of the interviewed group psychotherapist and the majority vote all collectively enable or disable access. Different codependencies play a significant role in defining not only how, but also whether remote therapy may or may not take place at all.

This example illustrates how networked care is not similarly accessible to everyone and how care teams may literally disentangle themselves from digital options. The entities, practices and ways of being that are foreclosed when other entangled realities are materialised stress the importance of the ethics of exclusion (Giraud 2019). Here, even if virtual group psychotherapy remains an unrealised option for this particular group, the practice of worlding care becomes concerted in the ways one version of care is materialised at the expense of another. Here, a particular version of care (Lindén and Lydahl 2021)—one that supports the decision-making rights and autonomy of individual patients—becomes enabled, and a concrete alternative—one that would embrace continuation—disabled. In this way, one can depict tensions between different forms of care, such as between the right to self-care and respect for individual autonomy and the well-being of a group or the majority view. This reminds us that self-care does not always sit unproblematically within communal care (see Varfolomeeva 2021).

Another research participant recalls clients who were reluctant to have remote consultations. The data entailed very little description of difficulties regarding internet connectivity in itself, which aligns with the high number of internet users and access in Finland (Kolehmainen 2024). Here, the interviewee, though, mentions clients facing or anticipating technological glitches. The failures, he sums, result from disruptions and delays in connectivity as well as from users' inability to operate and understand technology (Paasonen 2015):

> There were some technical issues, like if one had an employer's equipment one perhaps was afraid of having one's own problem revealed, and then, Teams for instance eats astonishing amounts of battery in portable devices. So, there were practical reasons, and also with wireless connection some tried to participate from their summer cottage or from a car, or so on, and then the picture started to break up and perhaps the connection they had was not as fast as needed.
>
> (Violence worker, I32)

The interviewee mentions Teams as an application that 'eats battery' to a surprising extent and clients having too slow a connection to maintain a video view; disruptions that can shatter particular modes of worlding care. These glitches lay bare the interdependencies and codependencies, as well as their networked nature. For instance, the energy from batteries that allow global digital, social and commercial networks (Hohti and Osgood 2020) is a reminder that networked connections are not only 'virtual' but deeply embedded in material politics—starting from the minerals used in battery construction to the material infrastructures required to maintain (fast) internet connectivity. Both the materiality of the digital and the materiality of time (Kolehmainen 2024) also manifested in ways in which the clients are described as encountering issues such as image collapse and slow connections.

The interviewee also briefly mentions that having devices owned by one's employer triggers hesitation over remote attendance. If the motivation for seeking support is rooted in criminalised or morally stigmatised behaviour (e.g., being a perpetrator of violence), using an employer's devices could be considered risky. The clients may want to keep their 'own problem'—as the expert puts it—hidden from their employer. In this way, the relations that potential clients maintain with their employers may disable (access to) caring relations without any intended restrictions but simply through the provision of devices and connections. The ownership of technological devices becomes a defining issue, which pinpoints the complex web of different socio-legal-technical issues that cocondition the modes of care that can be brought into existence. The assumptions concerning personal access to and control over one's devices are complicated here too. The codependencies that cocondition networked care reach to the core of employment and related economic relationships, such as the ownership of technology and the right to know why and how this technology is used.

6 | Networked Connections, Interoperable Information Systems and Data Registers

Although in the previous section, I showed how the mere existence of (even 'suitable') digital infrastructures does not erode the tensions and ambivalences concerning networked care and access to it, it is worth recognising that the networked character of care itself also limits the materialisations of care. A psychotherapist pointed out how the networked everyday lives of clients may pose challenges for remote sessions. During the first wave of the pandemic, many clients started to work from home. Although earlier these clients perhaps went to therapy after their work or school days, during the pandemic they were able to schedule therapy sessions during the daytime. Yet this novel kind of 'flexibility' positioned therapy sessions in a line of several videocalls, which did not support the clients' well-being:

> Many clients have remarked that the minus side of this is that it has been more difficult to express one's emotions. [--] This is something that becomes verbalised this way, like 'Well I would've already cried, but no I didn't here in front of my laptop'. [--] They started to notice that they have to hold back their emotions because there's a next Teams meeting awaiting them and they cannot attend with a tearful voice.
>
> (Psychotherapist, I34)

The difficulties in 'expressing one's emotions' observed by this psychotherapist entangle with the transition to digitalised psychotherapy sessions, which during the pandemic were just some among the many daily videocalls for many clients. These identified difficulties can be seen resulting from clients orienting themselves towards upcoming work meetings, during which they wish not to have 'a tearful voice', for instance.

Another interviewee discusses employment and its complicated relationship to healthcare, as some clients who are concerned about traces in national patient records bring up their occupational status and situation. This interviewee (who does regular client work despite an occupational title that might suggest otherwise) has no obligation to report to Kanta services, a national patient record system to which even private practitioners in social and healthcare are now obliged to report if they use digital patient registers and databases. However, legislation concerning the obligation to notify is still in place, demonstrating how networked care is entangled with laws and regulations:

> Well, there are people who perhaps wouldn't like to have any of these things recorded because of their occupation, so then we also tell them that these issues are not visible in MyKanta services and these are between us. [--] Only the obligation to make a child welfare notification would then come into question and probably, of course, if someone confessed a murder or suchlike, but I have always concluded with a client that in a case where further concerns arose, we would talk with you first.
>
> (Coordinator, I14)

Here, digital patient registers can be seen as parts of care teams. Allegedly, those registers improve care because they are designed to ensure the timeliness of information, as well as its secure storage and use. Digital patient registers occupy an ambivalent position in healthcare because some patients wish to have more control over their personal health information, especially when discussing permanent digital imprints around mental health or other matters experienced as private and sensitive. However, digital patient registers may also hinder care if people try to avoid digital imprints, again highlighting the importance of recognising exclusion and the related processes of materialisation (see Giraud 2019). Moreover, unlike digital patient registers, which one can avoid, the interviewee mentions an obligation to notify, which would potentially require sacrificing confidentiality. Interestingly, 'care' here expands itself to the potential children of the clients, as well as to potential victims of crime. This again points to the importance of considering the relations of care as part of wider more-than-human assemblages, where digital technologies play a crucial role.

The patient register MyKanta above demonstrates an example of a digital health assemblage, from which humans are separable or removable (Flore 2021) inasmuch as they can at least try—possibly successfully—to avoid or refuse this particular data-driven system by seeing professionals who are not obliged to report to it. However, the production of data in itself is very difficult to refuse because the question of the networked connections is not bound to remote therapy and counselling. As a sex therapist explains, the issue of paying either in cash or with a card might prove crucial for clients who wish to remain anonymous. Nevertheless, the pandemic has limited the possibilities of meeting face to face, removing the option of paying in cash. The only option available is invoicing, leading to a situation where a transfer must be made, which unavoidably leaves a trace:

> The reasons for seeking support with us are often considered very sensitive, so leaving a footprint is something one might ponder about at the beginning. [--] Then again regarding technology it's a challenge if one pays with a card, or now during these exceptional circumstances we use invoicing, then it is more difficult to remain anonymous. Well if one pays in cash then one can remain anonymous in therapy.
>
> (Sex therapist, I31)

This account also offers an example of how proximity with media and communication technology can generate sources of anxiety when the user has no control over technology, rendering them an outside observer rather than a 'governor' of technology (Paasonen 2015). As it is, of course, impossible to control technology; even more so if one would like to use digital technologies completely anonymously, the remaining option is to enrol for in-person meetings and sidestep the invoice by paying in cash. Here, the implementation of one technology—remote connection—excludes the use of another—payment by card—illustrating the ambivalences and contradictions of care as they emerge through technological world-making. The payment procedure exposes how in contemporary societies the digital becomes so inescapable and 'environmental' that several scholars have termed these 'post-digital' societies (Evans and Ringrose 2025). Further, the account reminds us how the networked character of care is a wider phenomenon than just the most obvious examples of digital healthcare, such as remote appointments.

7 | Conclusions

Care is always enacted in networks, and this article has shed light on how networked connectivity particularly comes to matter (Barad 2003) in these networks. Being interested in how networked connectivity and the relations formed with and through digital technologies bring particular worldings—and thus different modes of mental healthcare—into being (Stewart 2010, 2011, 2017), I have analysed examples of different worldings of care through an examination of interviews with psychotherapists or other counselling professionals. As the data were gathered in the wake of the first wave of the COVID-19 pandemic in Finland, it was perhaps not very surprising to find out that networked connections were seen as essential in the provision of mental healthcare during the pandemic. Networked connectivity provided psychically holding infrastructures, supporting clients at a distance. However, the mere existence of digital infrastructures did not always translate into accessible or effective means of care, but tensions between alternative forms of care were tangible in the data. For instance, aspiring clients could not always access individually suitable forms of care because of collective policies regarding COVID-19 procedures. Furthermore, the networked everyday lives of clients posed challenges to the provision of distanced care, and, in particular, the interconnectedness of different digital records and information systems was a major motivation for clients to refuse care.

To allow a nuanced exploration of these worldings of care, I brought together insights from research on care networks and network connectivity and proceeded to propose that an understanding of Networked care is helpful in grasping the nuanced operations of care—including its successes and failures—in digitalised societies. Networked care is here perceived as continuous doing, with agency distributed across various human and nonhuman actors: from professionals and clients to therapy venues, from psychic conditions to legislation and from state-led policies to economic factors—not to forget internet connectivity. For instance, access to remote therapy or counselling is shaped by the interaction of policies, laws and regulations, which also define which client or patient groups are entitled to public healthcare—a question that is not only ethical or political, but also economic. Hence, with a conceptualisation of networked care, I have demonstrated how networked connectivity comes to matter in mental healthcare in a digital age. Of course, the maintenance of these manifold wide-reaching connections in healthcare itself requires care, which is another reminder of the more-than-humanness of care. Alongside different modes of mental healthcare, worlding practices, though, bring into being 'mental health' and 'mental illness', illustrating the ways in which the ontoepistemologies of 'mental health' and 'mental illness' are reconfigured with and through technological world-making.

Finally, this article has advanced an approach that aligns with the double vision of care (Lindén and Lydahl 2021), where situated and material practices of care are examined and where there is also an ethicopolitical commitment to interrogating care. In particular, this article has highlighted how agencies emerge with and through the entanglements of actors as they be/come together in assemblages and respond to and enact each other (Barad 2007; Lupton 2019). Further, it depicted how the networked care is embedded in relational often asymmetrical networks of power, which may further renew or produce inequalities and social injustices. Previously, actor–network theory in particular has been criticised from feminist perspectives for its refusal to take political or ethical stances (Lupton 2019) and for its object-oriented ontology (Åsberg et al. 2015). Feminist scholars have noted that if the focus is placed more on objects and less on subjects, the subject/object distinction will be remade and differences will appear only horizontally (Åsberg et al. 2015). This article has highlighted how networks are never in fact 'flat' in digital mental healthcare, as there are always a variety of transitory power relations that cocondition the possibilities of caring relations to emerge and flourish. Similarly, there are asymmetries regarding the degree to which professionals and clients can enter and exist within these networks—stressing how codependencies make the shared condition of all living (Chouliaraki 2021; Koivunen et al. 2018).

Author Contributions

Marjo Kolehmainen: conceptualization (lead), data curation (lead), formal analysis (lead), funding acquisition (lead), methodology (lead), writing – original draft (lead).

Acknowledgements

I would like to express my warmest thanks to my research participants who shared their thoughts and experiences, as well as to the two anonymous reviewers whose comments were highly beneficial in the revision of the manuscript.

Ethics Statement

The interviews were collected in 2020 during my employment at Tampere University. The Ethics Committee of the Tampere Region does not require ethical review for studies of this kind. This research follows the principle of informed consent. I am committed to follow the ethical guidelines of the Finnish National Board on Research Integrity (TENK) in my research.

Conflicts of Interest

The author declares no conflicts of interest.

Data Availability Statement

Regarding those interviewees who have given their permission for subsequent data archiving, the transliterated interview data analysed in this article will be made available for scholarly use at the Finnish Social Science Data Archive.

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