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Emotion, Space and Society 40 (2021) 100824

Contents lists available at ScienceDirect

Emotion, Space and Society

journal homepage: www.elsevier.com/locate/emospa

"'Ninja' levels of focus": Therapeutic holding environments and the affective atmospheres of telepsychology during the COVID-19 pandemic

Leanne Downing *, Heather Marriott [1], Deborah Lupton

Vitalities Lab, Centre for Social Research in Health and Social Policy Research Centre, UNSW, Sydney, Australia

ARTICLE INFO

Keywords:
More-than-human theory
Telehealth
Telepsychology
Therapeutic holding space
Therapeutic alliances
Psychologists

ABSTRACT

The COVID-19 crisis in Australia led to a rapid increase in the use of telehealth services to offer psychological therapy (often referred to as 'telepsychology'). In this article, we discuss the intersection of the social psychology concepts of therapeutic holding spaces and containment with more-than-human theory as it relates to Australia's mental health sector during the COVID-19 crisis. Drawing on our recent qualitative survey research into Australian psychologists' use of telepsychology during the crisis, we consider the ways that they worked to build and maintain therapeutic holding spaces and alliances over teleconferencing platforms during this extraordinary time of social crisis and isolation. We explore and contextualise three important findings from our study: 1) the limited viewing area of a flat screen makes it difficult for therapists to read and respond to their client's body language and requires different forms of returned bodily gestures in order to show empathy; 2) most respondents implemented different affective and relational strategies online to ensure they were not missing important non-verbal cues from their clients; and 3) the traditionally 'safe' therapeutic holding space created in face-to-face therapy can be easily subverted by client-end interruptions, and concerns around safety or personal privacy in the client's home environment. In bringing these issues to the fore, we highlight the online therapeutic holding space as a temporally and socially situated human-technological assemblage in which a series of affective, spatial, relational and sense-making agencies coverage, opening or closing off capacities for therapists and their clients.

1. Introduction

After first being detected in the Chinese city of Wuhan in late 2019, COVID-19 has had a monumental impact on global health, economics and politics. Initially presenting as a highly infectious and atypical pneumonia-like condition, COVID-19 was declared a pandemic by the World Health Organization (WHO) (2020) on 11 March 2020. The social and economic impacts of the pandemic as it has spread rapidly worldwide have been immense, resulting in a crisis well beyond health effects. In Australia, as in most other countries worldwide, the implementation of lockdown restrictions, physical distancing measures and the closures of businesses from the early months of 2020 have resulted in widespread job losses, economic decline, school closures, study and work from home mandates and limitations to travel between regions and states. These measures have starkly exposed a raft of problems related to entrenched social inequalities and marginalisation (Centre for Social Impact, 2020). By mid-April 2020, nearly a third of Australians reported that their household finances had worsened due to COVID-19 restrictions (Australian Bureau of Statistics, 2020).

Such wide-spread socioeconomic changes inevitably bring with them an array of mental health consequences. Pandemics are known to have mental health implications for both individuals and societies at large (Minihan et al., 2020). Findings are beginning to emerge that demonstrate the mental health repercussions of the COVID crisis in Australia. The Australian Bureau of Statistics 'Household Impacts of COVID-19 Survey' showed that compared with a pre-COVID health national survey of Australians, twice as many people reported feelings of anxiety at least some of the time (Australian Bureau of Statistics, 2020). Research conducted on the mental health effects of COVID-19 on the Australian population noted that clinically-significant depressive and generalised anxiety symptoms, thoughts of being better off dead or of self-harm, had at least doubled in COVID affected areas (Fisher et al., 2020).

Anticipating a COVID-19 related surge in mental health support needs and dealing with the implications of restrictions in face-to-face

* Corresponding author.
E-mail address: l.downing@unsw.edu.au (L. Downing).
[1] Registered psychologist, private practice, Melbourne.

https://doi.org/10.1016/j.emospa.2021.100824
Received 15 November 2020; Received in revised form 13 July 2021; Accepted 23 July 2021
Available online 26 July 2021

consultations, in March 2020, the Australian Federal Government made the unprecedented decision to add telehealth psychology consults (often referred to as 'telepsychology') to the nationally funded Medicare system (Australian Government Department of Health, 2020). Prior to this date, Medicare-funded telepsychology services were only available to a small percentage of Australians who lived in rural or remote parts of the country and were located at least 15 km from a mental health professional (Australian Psychological Society, 2017). For Australia's cohort of approximately 5521 solo-practice psychologists, this rapid deployment of online service provision necessitated a swift and predominantly self-taught learning curve around best-practice professional use of teleconferencing platforms (Australian Institute of Health and Welfare, 2020).

In this article, drawing on our qualitative survey research into Australian psychologists' use of telepsychology during the crisis, we consider the ways that psychologists worked to build and maintain therapeutic holding spaces and alliances over teleconferencing platforms during this extraordinary time of social crisis and isolation. In doing so, we have sought to move beyond the plethora of work of that has been conducted by medical and health services researchers around the uptake, operability and benefits of telehealth technologies and towards an understanding of telepsychology interactions that are at once affective and relational. Accordingly, this paper uses a convergence of theoretical perspectives from the fields of social psychology and more-than-human scholarship. In what follows, we provide a brief overview of the background and key theoretical concepts that informed our study, before discussing our methodology and findings.

2. Background

For Australian therapists and their clients during the COVID-19 pandemic, the physical space of the treatment room has quite literally become the locus for worry and concern around contamination and contagion. Procedures around hand sanitisation, physical distancing, cleaning, and mask wearing, have all emerged as daily rituals of infection control, with each one signifying the potential for contamination and contagion between both the client and the therapist. Indeed, it was precisely this worry of cross contamination within the physical spaces of therapeutic treatment rooms that necessitated Australia's unprecedented shift towards telehealth consults. Although psychology remained registered as an essential service during the pandemic, and practitioners were free to offer face-to-face services, many psychologists and their clients chose to self-isolate for medical or other reasons. As a result, Australia's mental healthcare system recorded a dramatic surge in telepsychology bookings, with 460,000 mental health consults being conducted online between March and May 2020; a figure which represents 52% of the nation's total mental health consults during this time (Snoswell et al., 2020). Mental health consultations have consistently recorded the highest percentage of telehealth adoption throughout the COVID-19 pandemic in Australia (Snoswell et al., 2020).

With little or no formal telehealth training behind them, many solo-practice psychologists took to social media forums to discuss their concerns. Member-only Facebook groups began filling with threads from psychologists who were worried about the efficacy and viability of taking therapy online, and a wealth of questions related to the sensory, affective, and embodied dimensions of these encounters began to emerge in these peer-to-peer conversations. Common questions included: What strategies can be employed when you can't see your client's body language or subtle emotional gestures? Does anyone else feel like they are missing important non-verbal cues over telehealth? What can be done when the therapeutic holding space is transgressed by client-end interruptions or safety concerns? And What are the implications for the therapeutic alliance between therapists and their clients?

Debates around the challenges and opportunities presented by telehealth and digital health technologies have occupied academic discourse for more than two decades, yet few discussions have adequately addressed the sensory, affective and spatial experiences of patients, caregivers and practitioners who are involved telehealth practices. This is a significant omission given that one of the key features of telehealth is its mediation of healthcare practices that traditionally involved not only vision, but also touch, hearing and smell in developing relational connections between providers and patients or clients (Lupton and Maslen, 2017). Nascent scholarship from the field of social psychology is now drawing attention to the lack of research in this area by raising pertinent questions around issues of embodiment, presence, and connection in telepsychology experiences. Isaacs Russell (2015), for example, asks 'what gets lost?' from the therapeutic relationship when consultations are conducted over the internet, Lemma (2017) explores the embodied 'interconnectivity' that occurs between therapists and their clients online, while Geller (2020) raises practical observations around strengthening therapeutic presence via telepsychology. The observations raised by these scholars helped to shape this study as they reflected what (co-author Heather Marriott) could see unfolding in psychologist-only social media forums, as well as in her own private practice. Given the dearth of research in this area, we deliberately designed this study to explore the seemingly ineffable, affective relationalities of what takes place between therapists and their clients during online consults.

In thinking through the dynamics of telepsychology, we have been struck by how infrequently existing scholarship on both telehealth and therapeutic holding spaces has engaged with notions of affective environments and more-than-human scholarship. While these fields of research have been a cornerstone of the humanities for over two decades, their utility for understanding telepsychology has not been adequately explored. This is surprising given that this type of scholarship has far reaching implications for understanding how psychologists may work into the future. In this study alone, our findings have touched on issues such as psychological safety and privacy, expressions of empathy and resonance, and psychologists' capacities to appropriately track client responses. All of these topics are worthy of further study in their own right.

For the purposes of this research, the concept of 'therapeutic holding space' proved to be an important point of cohesion between the sometimes-disparate fields of psychology and the humanities. As we will discuss, the term 'therapeutic holding space' is one which is often used in psychology to encapsulate not only the physical, sensory space in which therapy takes place, but also the psychological space in which issues such as the therapeutic alliance, therapeutic presence, trust and empathy are played out. Used together with the concept of a more-than-human 'affective environment', an exploration of the online therapeutic holding space can tell us much about what the digital therapeutic alliance may look like into the future.

3. Therapeutic holding spaces and containment

The concepts of therapeutic 'holding' (Winnicott, 1953) and 'containing' (Bion, 1984) are recurrent themes within psychodynamic theory and practice, with both terms being part of a common vernacular for therapists, social workers and many others in the helping professions. While different from each other, the spatial metaphors of holding and containing are sometimes used interchangeably in order to refer to a therapist's capacity to create a supportive emotional and/or physical space within which a client can work through and recover from affects which may be otherwise overwhelming. According to Winnicott (1953), the primary role of the therapist is to provide a safe 'holding environment' for the client so that they can begin to recognise and meet previously neglected ego needs and work towards the emergence of the true self. Winnicott believed that when the therapeutic relationship provides a 'good enough' holding environment for clients, they can then flourish and grow though the process of the therapy. Throughout this process, the therapist, through their own authenticity and empathy for the client, encourages the client to develop a sense of trust in the therapist and the

process. In contemporary psychodynamic practice, the provision of a safe holding environment continues to be an important aspect of good psychotherapy (Applegate, 1997).

Bion's (1984) theory of containment provides a similar, yet fundamentally different concept from that of Winnicott's holding space. For Bion, the notion of containment stems from the concept that an infant projects upsetting, fearsome and other intolerable feelings onto its mother. In turn, the mother feels the emotion herself and, rather than reacting to it, *contains* it and presents it back to the child in an adapted and manageable form. This allows the child to repossess the emotion and reintegrate it as their own. In the therapeutic context, containment provides a way of creating a safe space for the client to connect with emotions that they would otherwise find overwhelming and bewildering. Within the context of healing, containment creates an opportunity for individuals who have experienced significant pain, fear and anger to conceptualise and work through their emotions.

The metaphors of holding and containing are therefore sociomaterial, referring to how powerful relational affective forces can be generated, shared and controlled with and between people in a defined space as part of the therapeutic alliance. Discussions of therapeutic holding and containing invariably point towards and incorporate two very different kinds of 'spaces'. On the one hand, holding and containing spaces may appear as intangible intensities which are constructed entirely through the relational and affective resonances that exist between therapists and their clients. On the other hand, these spaces can also be decidedly material, and relate directly to the physical spaces (walls, décor, furniture and so on) of the therapeutic treatment room (Punzi and Singer, 2018). Indeed, as part of his object-relations theory, Winnicott himself divided the concept of the holding space into key physical and relational components, and extended his thinking to incorporate not only the need for the therapist to provide a safe psychological 'holding' space but also 'the provision of a setting that gives confidence' (Winnicott, 1953, p. 22). Similarly, Holmes has noted that 'there has to be a safe space both literally in the therapists' room and also an '"internal space: in his or her mind' (Holmes, 2010, p. 90).

Digitally mediated therapy raises a new set of issues of how to define the therapeutic holding space. In her 2015 book *Screen Relations*, therapist Gillian Isaacs Russell (2015) discusses the concept of the therapeutic holding environment within the context of UK and US based telepsychology. In posing the question 'what gets through the veil of technology and what gets lost?', she calls for mental health practitioners to think carefully about what she identifies as the limitations of 'technologically-mediated psychology' for the therapeutic alliance. Central to Isaacs Russell's concern about telehealth is the absence of both the client's fleshly body and that of the therapist. She contends that reducing the therapeutic relationship to a disembodied two-dimensional screen inevitably results in a loss of therapeutic quality and connection. She observes the difficulties in assuming that co-present treatment can be seamlessly transported into technologically mediated treatment and calls explicit attention to the fact that the traditional therapeutic holding space is intimately connected to the nuances of embodied relating.

4. More-than-human theory and the affective atmospheres of telepsychology

An important issue that contemporary scholarship into telehealth often overlooks is the fact that digital media is already enmeshed into the daily lives of many of today's psychologists and their clients. Far from being a stand-alone communication tool, digital communication technologies such as Zoom, Skype and FaceTime already infiltrate our daily lives. Moreover, as we move towards a future in which the distance between bodies, emotions and digital spaces is being rapidly reduced, new ways of thinking about online therapeutic connections are desperately needed.

The work of feminist materialism scholars such as Braidotti (2019), Haraway (2016), Barad (2007) and Bennett (2010) is helpful in this regard. In reminding us that humans are perpetually engaged in complex relational interplays with other humans as well as nonhuman objects, technologies, spaces and places, these scholars provide a sound theoretical basis from which future discussions of telepsychology can depart. As we seek to unravel the affects and intimacies that occur between clients and therapists within digitally mediated environments, we would do well to remember Braidotti's (2019, p. 1) assertion that 'What or who is the human today can only be understood by incorporating the post-human and non-human dimensions'. This more-than-human perspective sees affective forces, connections and agential capacities as relational and distributed between the agents in human-nonhuman assemblages (Bennett, 2009). It is also what Barad (2007) refers to in the subtitle of her influential book *Meeting the Universe Halfway* as 'the entanglement of matter and meaning'.

The notion of 'affect' plays an important role in these conversations because it provides a way of understanding how emotions can be either triggered or created through the complex interplay of human/more-than-human dynamics. It is important to note, however, that affect is conceptualised differently across the fields of psychology and critical materialism or posthuman theory. Traditionally, scholars of psychology and neuroscience, such as Tomkins (1966) identify affect as a neurologically hardwired component of emotion which can be triggered by an external stimulus. This approach differs from that of posthuman critical theory scholars such as Massumi (1995) and Thrift (2007) who see affect as an 'intensive force' located within an individual's encounters with the world. In this study, we adopt a Sara Ahmed's (2014) approach to affect, which considers affect to be contextually created through an 'economy' of emotion in which objects, interactions and other humans are 'sticky' with affective meaning (Ahmed, 2014).

Recent explorations into the 'sticky' affective dynamics of more-than-human theory are useful for the analysis of digital health experiences because they consider human health practices in relation to the people, places, spaces and objects that are encountered along the way. For this reason, important forays are now being made to connect more-than-human theoretical orientations with the lived dynamics of health, wellbeing and space. The field of health geography has recently undertaken a significant ontological turn towards more-than-human theory, and in doing so is coming to recognise that 'health is not solely a human condition, but one created within assemblages of multiple human and nonhuman actors and forces' (Andrews, 2019, p. 1109). This more-than-human turn in health-related social sciences represents nothing less than an epistemic shift in how we think about and engage with issues of health in the contemporary fast-moving, multi-sensory and increasingly digitised world of health provision, consumption and recovery (Andrews and Duff, 2019; Lupton, 2019).

In seeking to account for the complex interplay of human and non-human agents within unique space-time assemblages, some scholars have turned their attention towards digitised mental health technologies such as apps, platforms, YouTube videos and telehealth services and how they can contribute to people's recovery from distress (Brownlie, 2018; Smith and Snider, 2019; Tucker and Goodings, 2015). The concept of affective atmospheres is particularly useful in helping us to illuminate the various spatial, relational, embodied, and multisensory dynamics that can be part of therapeutic assemblages of people with other people and with objects such as digital technologies (Lupton, 2017; Barnfield, 2016; Fletcher and Barroso, 2020). In building on scholarship developed within the fields of affect studies (Anderson, 2009) and cultural geography (Brennan, 2004), the concept of affective atmospheres is used to refer to a collection of feelings and experiences that are produced by the movements and interactions of human and non-human agents within specific times and spaces. Rather than being directly observed or represented through words or images, affective atmospheres tend to be *sensed* or *felt* by humans engaging with them. As diffuse and emergent 'spaces', affective atmospheres are largely shaped by their multisensory properties, with experiences of sight, sound, touch, taste and smell all commonly contributing to the feelings

generated within a particular space or place (Lupton, 2017; Fletcher and Barroso, 2020).

Unlike bio-medical or technological approaches to telehealth, which tend to reduce their focus to issues of efficacy or technological capability, the concept of affective atmospheres offers us a way to account for the sensory and relational affects that are created when human and nonhuman actors converge within specific times, spaces and places. In keeping with the sociomaterialist perspective, most scholarship on affective atmospheres assumes that experiences, affects and agencies are not centred within the human subject, but are instead constituted through an interactive engagement with other human and non-human agents that happen to be at play within a particular space/time assemblage (Slaby et al., 2017). In recent years, a growing body of scholarship has emerged which connects the concept of affective atmospheres to both physical and digital healthcare spaces. For example, Sumartojo et al. (2016) have addressed digitised self-tracking by cyclists and Lupton (2017) has wondered 'how does digital health feel?'. In regards to mental distress, scholars such as Tucker and Goodings (2017) have developed the concept of a 'digital atmosphere' in order to analyse the affective experiences of social media in the practices of care and support for people living with mental illness.

The above explorations of affective atmospheres, therapeutic holding spaces and more-than-human healthcare practices have been influential in shaping the research questions, methodological approach and discussion components of this paper. In understanding that the practices of sensing and emoting 'in place' are shared components of both therapeutic holding spaces and affective environments, the impetus behind this paper is to bring these rarely combined, yet seemingly obvious elements into dialogue. Like the holding and containing spaces envisioned by Winnicott (1953) and Bion (1984), affective atmospheres are both tangible and abstract spaces that are at once open to conscious identification while also capable of functioning at a pre-conscious level (Ellis et al., 2013). When used together, the notions of therapeutic holding spaces and affective atmospheres allow for a way of thinking about online psychology consults as containing a rich spectrum of affective, relational and multi-sensory interactions.

5. Details of the study

The 'Navigating the Therapeutic Alliance with Teleconferencing Technologies During the COVID-19 Pandemic' project comprised of a qualitative online survey in which 50 Australian-registered, solo-practice psychologists shared their experiences of offering telehealth consults during the COVID-19 crisis. A call for participants was distributed nationally with the assistance of the Australian Association of Psychologists Inc (AAPi), which is one of two professional bodies for Australian registered psychologists. While the AAPi is open to all Australian registered psychologists, its mission is to represent the industry needs of non-clinical psychologists who utilise a range of psychodynamic, behavioural, cognitive behavioural, mindfulness and humanistic therapeutic approaches. We chose to approach the AAPi for this study as their membership base largely works with and understands the concepts of 'holding and containment' and they are supportive of qualitative research enquiries into these topics. Between 1 July and 21 August 2020, the AAPi shared our online open-ended survey with their 4715 Facebook followers as well as in their fortnightly electronic newsletters. During the same period, respondents were also sought through weekly posts in the Australian Psychologists Private Practice Peer Support Facebook page, which has approximately 1800 members, all of whom are registered psychologists in private practice.

Our aims for the survey were two-fold. First, we wanted to identify whether solo private practice psychologists experienced any changes to their sensory and embodied practices when they took therapy online. Second, we wondered if therapists had noticed any differences in their creation of holding spaces and therapeutic alliances over telehealth during the pandemic. Participants who took our survey anonymously responded to 12 questions related to the topics of bodily experience as well as building and maintaining therapeutic alliances and holding spaces over telehealth. The first two brief questions asked for details about respondents' geographical location (states or territories in which the therapist practices) and preferred teleconferencing platforms. The remaining ten questions were open ended, with participants invited to type in their responses concerning technological issues, changes to therapeutic alliances, differences between face to face and telehealth consults, changes to eye contact, changes to facial and body gesture, issues of focus and concentration, what therapists were doing differently in their online consults, the emotional depth achieved over telehealth, perceived changes to the therapeutic holding environment, and experiences of reading subtle emotional changes on-screen.

As Australian regulations do not currently stipulate which video-conferencing platforms must be used, in the survey we defined 'telehealth' as any online video-conferencing platform that our respondents chose to use during this time. Ethics approval to conduct this research was provided by the human ethics research committee at University of New South Wales, and all participants were provided with project information and gave their consent prior to participation. In order to limit the parameters of our research, provisional psychologists, child psychologists, psychologists working in community mental health settings and those working outside of private practice were excluded from this study.

We set a target of 50 participants as a manageable sample size for our project and achieved this within the seven-week period of recruitment. The participants' answers to our open-ended questions were then analysed via an interpretive thematic analysis that was informed by concepts we drew from the theoretical literature reviewed above: specifically, affective experiences, therapeutic alliances and holding spaces, and more-than-human theory. We read through the responses looking for how the psychologists described their embodied, affective, relational and sensory experiences and engagements with their clients during telepsychology encounters, sharing our interpretations with each other and iteratively building our analysis. This approach is innovative in that it uses sociomaterialist perspectives as a lens through which to interpret research material on telepsychology practised during a pandemic, building on an approach for analysing these dimensions of digital health outlined by Lupton (2019).

6. Reading body language over teleconferencing platforms

As Australian-based psychologists made the rapid transition to telehealth during the COVID-19 pandemic it became apparent that adjusting to telehealth psychology sessions involved far more than simply having access to a teleconferencing platform and a Medicare item number. Indeed, it required a concerted effort from both psychologists and their clients to determine what worked across a broad range of interconnected technological and body-centric matters.

For most of our respondents, the physical absence of the client's fleshly body during treatment was an issue of concern that needed to be carefully renegotiated in the online space. In traditional face to face settings, the therapist's ability to read a client's body language and interpret their non-verbal communication is key to understanding what is happening for the client. For this reason, several respondents noted that teleconferencing platforms reduced their capacity assess and respond to their client's somatic presentations. As one therapist wrote:

> the lack of visual information about the client's body impacts my ability to accurately pick up on their emotional state, and [technology] glitches can result in missing subtle physical cues or missing important information.

Similarly, another respondent noted:

> It's difficult to get a sense of the client's initial presentation via Zoom. I have to be super alert to the client's body movement / facial

> expressions when undertaking telehealth … two of my clients have noted that they feel more 'distant'. It contributes to fatigue.

While several therapists reported these difficulties as an inconvenience that needed to be worked around, others encountered them as a serious issue that adversely affected their practice. As one respondent noted, not being able to see the physical gestures of self-harming clients posed significant obstacles for effective therapeutic treatment as digitally mediated visuals made it 'harder to assess the injuries of clients who cut and burn themselves'. Analogously, another therapist noted that when therapists and clients are not together in the same physical space, it was 'harder to provide comfort when a client becomes distressed particularly if the person is having suicidal ideation'. Therapists who ran couples or family therapy over digital platforms also expressed significant difficulties in navigating the body/technology issue, noting that it is 'almost impossible to keep track of two bodies on the screen at the same time'. More than one therapist indicated that they were no longer taking on new couples or family clients over telehealth for this reason.

Being unable to read and respond to body language also significantly affected a therapist's ability to assure the client that they were listening and understanding. For several respondents, this issue was identified as a concern around how and when they extended expressions of empathy. As one therapist noted: 'sometimes it is hard for the client to "feel" the empathy. I think this may be because on these platforms the more nuanced imprecisions are missed or flattened out through the screen'. Correspondingly, another respondent stated that telehealth afforded far fewer opportunities to be 'intuitive, connected and empathetic'.

Despite these difficulties and limitations, far from dismissing telepsychology as a form of 'therapy lite', or as a temporary inconvenience during the pandemic, the vast majority of our respondents indicated that they were taking proactive steps to make therapy 'work' for the betterment of their clients and their practices in real time. Indeed, for several respondents, the desire to actively create alternative ways of sensing and relating online was a key part of their experience of offering telehealth psychology consults. As one psychologist noted, 'rapport building requires adaptation in this new medium'. It is precisely this effort to build rapport differently and to make the most of a challenging situation that seems to have led many therapists to explore different ways of engaging with their clients. These changes have, in turn, resulted in new forms of affective interconnectivity and relational negotiations via telehealth devices.

7. Implementing different affective and relational strategies

A key finding from our survey was that online therapy sessions necessitate specific kinds of body work and sense-making, which are unique to both the online medium and the client themselves. Far from being a disembodied or emotionally distanced event, the majority of our respondents reported putting extra time and effort into embodied interactions over telehealth, particularly when it came to communicating affects such as empathy and understanding. In fact, 81% of our respondents noticed differences in their own facial and body gesturing during telehealth sessions, with issues of eye contact, physical movement, and posture being top of mind for most of the therapists that we surveyed. In almost all cases, our respondents also reported that technology glitches such as stalled audio and video streaming impacted on the quality of therapy that could be delivered, as they disrupted the easy flow of communication and the therapists' ability to 'read' the client's demeanour and state of mind.

While the particular movements and gestures employed by therapists were ultimately unique to themselves and their contextual relationship with the client, many respondents claimed to have consciously implemented different affective and embodied relational gestures to ensure that their clients felt heard and understood. Of these, gestures such as leaning forward towards the screen, asking more questions than usual and relying on verbal minimal encouragers such as 'mhm' and 'I see' featured prominently. As one respondent stated:

> When we initially went into lockdown and I was offering telehealth for the first time, I noticed that I used bigger facial expressions and fewer body gestures. I think I was worried about my body movements being distracting. Sitting in front of the computer all day means that I do tend to shift my weight and lean forward more than I would in my regular consultation room. It's harder to use nonverbal expressions of empathy. I'm resorting more to verbal minimal encouragers, now that I think about it.

In their efforts to create new and positive holding spaces for their clients, some therapists reported increasing their physical gestures while others consciously reduced them to only those that could be detected by the camera. In at least two instances, our respondents identified this work as a kind of embodied 'performance'. For example, one therapist noticed that they were: 'Using larger facial and body gestures, speaking more loudly and filling the space with words rather than sitting in a companionable silence of understanding', while another noticed that they tended to 'use larger hand gestures … smile larger or tilt my head more than I might in a face to face meeting'. In contrast, one therapist observed that they used fewer upper body movements: 'I noticed early on that moving my arms around was distracting to some clients. I tend to lean forward towards the camera more, and some clients have mentioned that they notice that'.

Eye movement and eye contact was also a significant issue for the therapists that we surveyed. Often this came down to the respondents being unaccustomed to conducting therapy over teleconferencing platforms and thus being unsure about 'where' to look. As one therapist noted:

> I think in face-to-face we are not eyeballing each other all the time, and so natural drifting of gaze is common and accepted. However, in telehealth I worry when I am writing notes that they may think I am not paying attention. Also having the client see themselves and be 'preening' their hair etc., is distracting!

Similarly, another respondent noted: 'It has been difficult to know how to interact with the camera and focus my eyes. It feels more comfortable to look at the client but I'm aware this might not translate to the client as eye contact'. For others, eye contact during the session came down to the personal preference of the client:

> I've had a conversation with each client about what type of eye contact they prefer. Some prefer that I just look at the screen, others prefer I look at the camera, so I go with whatever they prefer, but that's hard sometimes because I can't see their face and expressions as much.

The self-conscious regulation of eye and body movements reported by the psychologists that we surveyed is significant because it shows us that they are implementing different modes of embodied interactions in order to build and maintain the therapeutic alliance and holding spaces online.

It should also be noted that these intense embodied practices of creating safe and responsive online holding environments in a time of crisis was identified as both tiring and demanding by almost all our respondents. Headaches, eyestrain, fatigue and exhaustion were repeatedly reported as daily impacts of offering multiple telehealth sessions. This resulted in several respondents indicating that they needed to cut down on the number of sessions that they offered each day. One respondent was quite clear about their experiences on this topic, stating:

> I find it absolutely draining and exhausting. I feel sick (like travel sick) at times especially when the client is using their phone, and

moves around or is in their car with the phone at a weird angle - not driving, just sitting in their car for some privacy.

Similarly, another respondent stated: '[Telehealth] requires "ninja" levels of focus! Which is extremely draining. I've had to cut back on number of appointments I can do for self-care, but my waitlist is growing'.

8. Transgressing the holding space

In addition to creating new affective and relational strategies on screen, one of the most significant findings from our study was the fact that many therapists noticed that they were unable to control the holding space when the client accessed therapy from home. In fact, most (91%) of the therapists that we surveyed stated that having the client access the therapy session from home changed the affective and relational components of the session is some way. Whether these changes were regarded as positive or negative by the therapists ultimately came down to how safe the client's home environment was, and whether there were regular interruptions. For clients with safe home environments who were not interrupted, most of our surveyed psychologists reported the holding space as being easy to maintain, with some observing it as a positive and sometimes more intimate connection:

It can be more intimate. Sometimes I get introduced to pets and spouses and there is a greater sense of connection between the client and I. Often I will introduce my cat and many clients say they like that. There is more of a connection when we talk about the pandemic too. It's a shared experience in that way. That said, when clients are not used to doing therapy and they are distracted by what's happening in their immediate environment it's much more challenging.

For clients who were either new to therapy or did not have a safe or private place within which to access the session, therapist observations around holding spaces and therapy efficacy were far less favourable. In particular, concerns around the client being interrupted by family members, housemates, deliveries, and digital devices were commonly reported. For other respondents, apprehensions around domestic violence situations were raised in relation to client safety. These concerns led several therapists to report that they regularly needed to instruct their clients to either sit still, move rooms, or look at the camera.

In not being able to provide a safe and distraction-free physical environment for their clients, many of our respondents used words such as 'disrupted', 'distracting', 'harder' and 'dissatisfying' to describe the online holding environment. In this way, a significant dynamic of the therapeutic alliance is challenged and transgressed. Rather than the therapist being in control of setting the parameters of the holding space, the client becomes responsible for creating a safe and private physical environment for themselves; a situation which, as many of our respondents pointed out, is wholly dependent on a range of external factors.

In the context of the COVID-19 lockdowns, access to safe, private spaces became even more tenuous. As family members, housemates and couples were required to stay within close proximity to each other, the mere act of 'creating a safe space' was itself difficult for many clients. Indeed, several of our respondents reported clients accessing therapy from small mobile device which they then moved around the house, or having to resort to accessing therapy from their beds or cars; a point which reflects Isaacs Russell's (2015, p. 13) contention that 'a bed is not a couch and a car is not a consulting room'. This in turn, had implications for the depth of therapy that could be provided, as well as the psychologists' concern for the wellbeing of the client after the end of a therapy session. As one respondent noted: 'there were implications when working with traumatic material, as there was a degree of safety/containment provided by the physical boundaries of the office. Finding sufficient privacy at home was also an issue for some clients'. Similarly, another therapist noted that when a client access therapy from home it becomes 'harder to provide comfort when client becomes distressed particularly if the person is having suicidal ideation'.

The need to regularly reassess the therapeutic space for each client appeared as a continuing concern for our respondents. In addition to having to ensure that their own home/work environments were distraction-free, most therapists that we surveyed needed to regularly interpret the safety of the client's home or access point; a task that was made difficult with a limited screen view. In constantly accounting for and responding to different client environments in this way, most of the therapists that we surveyed appeared to be engaging in a perpetual loop of spatial and affective negotiations. Over the period of a day or a week, our surveyed therapists were engaging with clients across dozens of different home environments, with each environment and client requiring their own kind of sense-making interaction and engagement.

9. Discussion and concluding comments

Our findings contribute to contemporary sociomaterialist discussions around more-than-human theory and affective atmospheres in the context of digitised therapeutic relationships, mental health and recovery (Lupton, 2019; Brownlie, 2018; Smith and Snider, 2019; Tucker and Goodings, 2015), but with an emphasis on the experiences of therapists rather than their clients. Fears of contagion within the physical spaces of therapeutic treatment rooms and the swift uptake of teleconferencing platforms have invariably had an impact on the ways in which therapists are able to create and maintain safe therapeutic holding spaces for their clients during the COVID-19 crisis. In the absence of a material consultation room in which trust and understanding between the client and therapist can evolve as part of inter-embodied interactions, many psychologists have had to re-evaluate how to best create meaningful engagements with their clients via teleconferencing technologies. This issue that goes to the heart of our investigation into how therapeutic holding spaces have been built and maintained over telehealth technologies during the pandemic. In bringing these issues to the fore, we highlight the online therapeutic holding space as a temporally and socially situated affective environment in which a series of emotional, relational and sense-making agencies converge.

As Lupton (2019) and Andrews and Duff (2019) have pointed out, more-than-human theory offers social researchers interested in health, wellbeing and recovery an opportunity to analyse qualitative research materials via the concepts of relational connections, capacities and affective forces, all of which were key foci in our research. Our findings also draw attention to the more-than-digital elements (Sumartojo et al., 2016) of the telepsychology encounter as it is experienced by therapists. Elements such as the physical spaces in which the telepsychology sessions took place and the other human and nonhuman animals (for example, companion animals) present in the spaces contributed to opening or closing capacities for relational connection and feelings of safety or comfort for therapists and their clients.

It is from this perspective that we can explore three important themes from our research: body language, relational strategies, and therapeutic holding space transgression. Far from being a purely technological and disembodied experience, our research findings indicate that the rapid uptake of telepsychology consults in Australia during the COVID-19 pandemic required psychologists to engage in and deploy a novel range of embodied, affective and multisensory interactions with their clients. From negotiating screen size, sound quality and eye contact, through to consciously adjusting bodily gestures, seated postures and verbalisations, telepsychology provided our survey respondents with an opportunity to actively reassess how they work with individual clients across a range of embodied and technologically mediated variables. Our respondents drew attention to aspects such as the holding space being subverted by distractions and interruptions at the client end; the perceived difficulties involved in sustaining a therapeutic alliance when the therapist cannot see the client's body; and the psychologist

worrying that they were missing important non-verbal cues. The limited viewing area of a flat screen prompted many respondents to enact different forms of bodily gestures to show empathy and understanding. Most respondents said that they implemented different affective and relational strategies online to ensure they were not missing important non-verbal cues from their clients. They noted that the traditionally 'safe' therapeutic holding space created in face-to-face therapy can be easily subverted by client-end interruptions, and concerns around safety or personal privacy in the client's home environment.

In returning to the concept of affective atmospheres, we are reminded that affective atmospheres are ultimately shaped by conscious and unconscious multisensory intensities, which in turn have profound effects on how individuals think and feel about the spaces that they inhabit and through which they move. For many people, these re-negotiations have, in turn, led to the creation of a new type of therapeutic holding space, or affective atmosphere: one in which the clients themselves have become (inter)active players in the creation of their own sensory and affective experience during the therapeutic hour. For others, the traditional therapist-client spatial dynamics have been altered or subverted, with the client now having more ability and responsibility to control the spatial setting of each session. In this way, many of our surveyed therapists have reported becoming *differently* engaged with their clients via digitally mediated technologies. Being privy to client's home environments, getting introduced to family members, housemates or pets, and being taken for a 'virtual walk' into the client's garden or out onto the veranda for a cigarette, were all reported as clear subversions of traditional therapeutic spaces which therapists needed to account for and negotiate on an almost daily basis.

In order to understand this situation, we need to move beyond the long-held contention that the digital experience is always inherently disembodied, and towards a more-than-human understanding of the ways that bodies, spaces, digital technologies and affective forces open or close agential capacities. The findings offer a challenge to prevailing biomedical and technology-focused paradigms and instead, requires a reassessment of telepsychology as a more-than-human – and indeed, a more-than-digital – experience in which both the therapist and the client must negotiate the vagaries of a temporally and socially situated human-nonhuman assemblage in which a series of affective, relational and sense-making agencies converge.

Corresponding with yet moving beyond Gillian Isaac Russell's (2015) concern that telepsychology is an entirely disembodied (and therefore lesser) experience, our findings suggest that while many therapists and their clients were challenged by the loss of multisensory engagement in the digitally mediated mode of video conferencing, they quickly found new ways of connecting and engaging online. In both responding to their clients, and seeking to create a safe and accepting space, these therapists are effectively forging new opportunities for affective relations to occur between themselves and their clients. They are opening up capacities for configuring a beneficial therapeutic alliance that can take place online and therefore offer greater access in a sector where there are higher levels of unmet demand for psychological services than ever in the wake of the COVID crisis. Expanding on this previous scholarship, a more-than-human theoretical perspective offers a distinct paradigm shift through which it is possible to consider the absence of the clients' fleshy body, not as an indicator of 'reduced connection', but as an opportunity to forge new forms of intimacy online. Indeed, there is now some evidence to suggest that online therapy has the potential to offer innovative ways to form robust and intimate therapeutic relationships (Geller, 2020; Kocsis and Yellowlees, 2018). By adopting a more-than-human conceptual approach to therapeutic holding spaces, we can understand that the digitally mediated space of online therapy need not be considered a lesser experience, void of gestures and meaning, but rather, one that is already ripe with dynamic interactions between humans, objects and technologies.

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