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Aaron Neiman
Stanford University Department of Anthropology, Building 50, 450 Serra Mall, Stanford, CA 94305
(E-mail: aneiman@stanford.edu)

Client States: Australia's Offshore Detainees and the Limits of Therapy

Mental health has become an exceptionally important social and public health issue in Australia. The government has invested billions of dollars in new services, while ubiquitous ad campaigns call on ordinary people to tend to their psychological well-being. This national valorization of mental health is striking, given the well-documented psychiatric harm suffered by refugees under Australia's offshore detention regime. This article draws on ethnographic work with a group of volunteer therapists who provide crisis counseling to these detained refugees over WhatsApp, allowing them to intervene in scenarios where therapy is inaccessible but badly needed. Highlighting the predictable challenges and surprising affordances of delivering care in this restrictive and high-stakes context, I show how my informants forge a genuine therapeutic connection with their clients. While this intervention is meaningful, I argue that the volunteers are aware that it is no substitute for winning political freedom. [mental health, refugees, Australia, therapeutic alliance, WhatsApp]

Introduction: Client States

In late August 2001, Australia was gripped by an international crisis unfolding off its western coast. A Norwegian container ship, the MV *Tampa*, had intercepted a distressed fishing vessel containing 433 Afghan refugees, rescuing everyone onboard. The ship's captain pleaded ineffectually with Australian authorities to allow the ship to dock at nearby Christmas Island, unwilling to safely move the ailing refugees back out to sea. Desperate, the captain made the decision to enter Australia's territorial waters and attempt to berth without permission. In response, the Australian Special Forces were dispatched to board the ship, and most of the refugees were taken to the tiny Pacific island nation of Nauru to be detained. The event, known as the *Tampa* Affair, was used to stoke racial animus domestically, and it pushed immigration to the foreground in the final weeks of the 2001 federal election. It also marked the beginning of the so-called Pacific Solution—a network of immigration processing centers operated by Australia but housed outside of its borders (see Figure 1), constructed to keep maritime arrivals off its shores. Over the past 20 years, largely shielded from public view, these camps on Nauru and Manus Island, Papua New Guinea, have housed thousands of men, women, and children for indefinite lengths of time.

For reasons of both inhumanity and impracticality, such a policy of offshore migrant detention has rarely been implemented. The few exceptions include other wealthy Western nations like Israel, Denmark, and, most recently, the United Kingdom. But only Australia combines offshore processing with a policy of mandatory indefinite detention—a legal requirement, implemented in 1992, for noncitizens without a valid visa to be detained indefinitely. In addition to this "weaponization of time" (Tofighian and Boochani, 2021), Australia is also set apart by its projection of regional power to establish this network: its offshore detention facilities are constructed in neighboring

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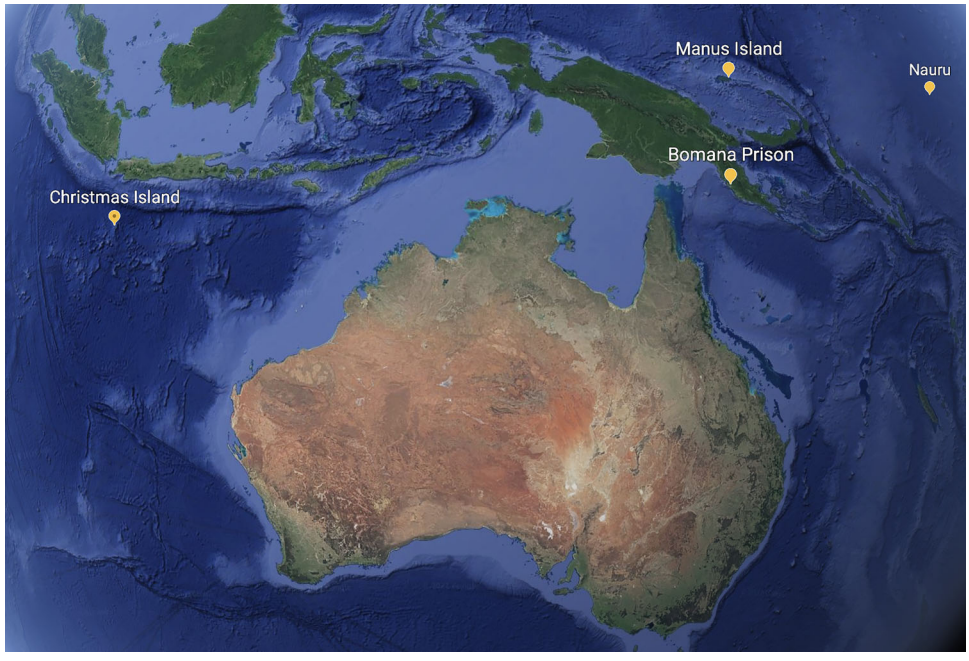

Figure 1. Mapping the Pacific Solution.
[This figure appears in color in the online issue]
Source: Created by Aaron Neiman with Google Earth.

sovereign nations like Nauru and Papua New Guinea in exchange for infrastructure investment and foreign aid (Maclellan, 2013; Morris, 2019). These countries have effectively become penal colonies to the former penal colony, further opening them up to neocolonial regimes of resource extraction (Grewcock, 2014; Walia, 2021, 172–73).

The Pacific Solution is based on a logic of "deterrence" of would-be boat arrivals (Zeweri and Eisenberg-Guyot, 2017). As shown in Figure 2, government propaganda reminds potential asylum seekers that "you will not make Australia home" if attempting a sea crossing, emphasizing the power and hostility of the natural world to migrant dreams (De León, 2015). Scholars have noted how this "total domination of space, perception and human life" (Chambers, 2015, 404) physically expands border sovereignty, violently shrinks the imaginative horizons of the asylum seeker, and symbolically separates refugee from polity (see Bar-Tuvia, 2018; Fassin, 2011; Walia, 2014; Zeweri, 2017). The physical isolation of Manus and Nauru, thousands of kilometers from the Australian mainland, takes to an extreme the observation by scholars that such processing and detention centers are often placed in the geographic periphery, minimizing access to social services and public scrutiny (Carney, 2021, 79; Crane, 2022).

While there is scant evidence for the efficacy of Australia's deterrence regime, the policy has proven remarkably effective at making life as difficult as possible for refugees who have already made the journey by boat. One former detainee on Nauru attests that "every single element in the centre was designed to torture the inmates" (Zivardar and Tofighian, 2021). Independent scholars and watchdogs have affirmed that Australia's treatment of refugees amounts to torture (Amnesty International, 2016; Macken, 2020; Méndez, 2015). Conditions at the facilities are notoriously inhumane: Exposure to scorching temperatures, rotten food, restricted drinking water, unsanitary living conditions, and verbal and physical abuse have been reported as common occurrences (Farrell et al., 2016; Lovejoy, 2017).

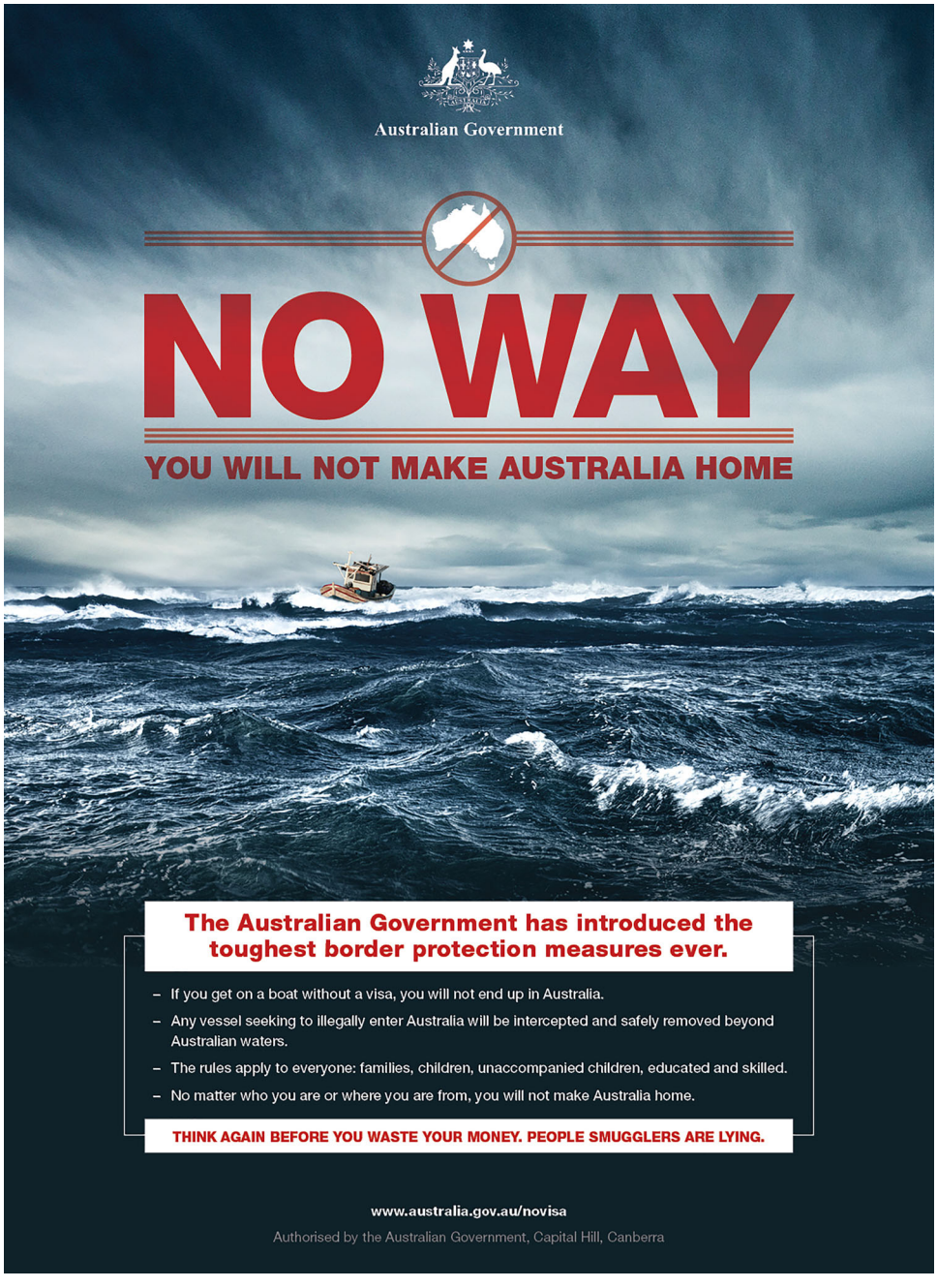

Figure 2. Government 'deterrence' advertisement from Operation Sovereign Borders. [This figure appears in color in the online issue]

Such degradation exacerbates existing mental illness and can generate both chronic and acute psychopathologies, particularly in children (Fazel and Stein, 2002; Kronick et al., 2011; McCarthy and Marks, 2010). High-profile cases of self-harm and suicide on Manus and Nauru, including self-immolation, have been widely reported in the media and documented by scholars (Newman et al., 2008). There have also been documented cases of "resignation syndrome" (Sallin et al., 2016), a catatonic form of depression in which children in desperate circumstances refuse to eat and essentially lose the will to live (Doctors Without Borders, 2018). Medical services in detention are run by the private contractor International Health and Medical Services (IHMS), whose provision of general refugee healthcare—let alone psychological and psychiatric care—is deliberately inadequate (Amnesty International, 2016; Marr and Laughland, 2014).

However, one fragile law affords these refugees a tenuous link to the outside world and the possibility of some psychic healing: As affirmed in Australian courts, the detainees—who have not been charged with a crime—have a legal right to a mobile phone. This allows volunteers on the mainland to use chat-based mobile applications to skirt the legal, financial, and logistical obstacles preventing ordinary Australians from physically visiting offshore detention centers. (For example, the application to be considered for a visa to Nauru from Australia costs AUD 6000; almost all applications are denied with no explanation or refund.) The purpose of this article is to examine the possibilities, and necessary limits, of using this lifeline to provide professional mental healthcare to these offshore worlds of neglect and abuse. Drawing upon interviews with a group of volunteer clinicians in Australia who use WhatsApp to provide crisis counseling to refugees, I ask what happens when therapists try to use electronic technologies to intervene in scenarios where so-called real therapy (involving a one-on-one meeting with a clinician) is inaccessible but badly needed. Which aspects of the standard therapeutic encounter are lost, and which are maintained, when providing care in a scenario of such extraordinary deprivation? Is it possible that there is something to be gained, clinically, from the strictures and affordances of a WhatsApp conversation? And finally, what can the inadequacy of such an intervention tell us about the limits of therapy to intervene in politics and address psychosocial injury?

Previous Research in Immigrant Mental Health

Issues of migration and refugeeism have long been of interest to medical anthropologists (see Morrissey, 1983), and anthropologists of borders, detention, and asylum have conceived a variety of ways to approach immigrant mental health as an object of ethnographic study (Sangaramoorthy and Carney, 2021). Broadly, recent efforts share the observation that the structural violence experienced by many migrant populations results in "internalized feelings of hopelessness, fatalism, a lack of control, abjectivity, and otherness" that lead directly and indirectly to poor health outcomes of all kinds (Sangaramoorthy and Carney, 2021, 592). This contrasts with earlier work that construed such health disparities as the result of cultural differences (see Chapman and Berggren, 2005; Sargent and Larchanché, 2009; Viruell-Fuentes et al., 2012).

Ethnographies of the lives of displaced and migrating people provide a wealth of empirical evidence for this relationship between political exclusion and psychosocial harm, ranging from acute psychopathology to nonspecific feelings of anguish and despair. Recent notable work has considered these dynamics of nonbelonging in a variety of contexts including US–Mexico borderlands (Holmes, 2013), the migration centers of the Mediterranean periphery (Carney, 2021; Lipatova, 2022; Zavaroni et al., 2021), and the transitory refugee communities of East Africa (Oka, 2014), among others.

Much theoretical work has also been done to explore the mechanisms by which migrant populations become seen as disposable human beings. Anthropologists have called special attention to how language and the law function to cast the noncitizen as profoundly other, most significantly through the category of the illegal (De Genova, 2002; Menjívar and Kanstroom, 2013). Relatedly, critical scholarship has called attention to how discourses privileging humanitarianism (Fassin, 2005) and refugee innocence (Ticktin, 2017) can comfortably coincide with increasingly

harsh migration policies. Together, these findings build a textured picture of the basic connection between state violence and mental health problems, broadly construed. I have found little in my own research or in existing ethnographic literature to contradict this view in the case of Australia's offshore refugees, whose minoritized status and psychiatric deprivation are undeniable and clearly linked.

However, less is known about attempts to systematically undo or counteract this pathogenic exclusion, which this article details. A wide range of scholars have questioned both the appropriateness and applicability of Western biomedicine for the context of refugee mental health (Smith, 2020), as well as the framework of refugee mental health itself (Richaud and Amin, 2019). Particular attention has been paid to the diagnostic concept of trauma (Fassin and Rechtman, 2009), where anthropologists have argued that diagnoses of post-traumatic stress disorder fail to capture the cultural aspects of the acute suffering of the marginalized (Das, 1990; Kleinman, 1987; Priya, 2018).

In this article, I side with the universalizing discourse of the psy disciplines and the dignifying though inadequate power conferred by the provider–client relationship. I give an empirical account of how the basic principles of Western therapy can be productively brought to bear on the most extreme cases of abjection. By showing how a volunteer organization can creatively but professionally intervene in a humanitarian crisis, I build on existing ethnographic literature that focuses on more lay, street-level solidarity with migrants (e.g., Carney, 2021) and practices of care that rely on the ad-hoc "kindness of strangers" (Smith, 2020) rather than a coordinated organization of skilled laborers. Additionally, this research builds on social science literature on the "global smartphone" as an essential component of contemporary subjectivity (Miller et al., 2021), and particularly on WhatsApp as a "technology of life" in the twenty-first century (Cruz and Harindranath, 2020).

Background and Methods

The use of Australia's main offshore processing centers has waxed and waned with changing political tides throughout the twenty-first century. The Pacific Solution as it once existed—a security measure exploited to stoke a roiling culture war during the 9/11 era—has become uncomfortable, if not unpalatable. This is largely due to changing public opinion, advocacy work, and the dissemination of images of their detention captured by refugees themselves (Cooper et al., 2017; Rae et al., 2018). Accordingly, the past five years have seen a gradual winding down of operations. Most detainees have either been sent to community detention on the Australian mainland, or resettled in the US, Canada, or New Zealand. A small number remain detained in the notorious Bomana Prison in the Papua New Guinea capital of Port Moresby.

The period that saw the offshore detention system quietly tailing off coincided with my time in Australia, where I spent 18 months in 2019 and 2020 conducting ethnographic research for my dissertation on the use of electronic, self-guided treatments for psychological issues. Such e-mental health programs enjoy substantial government funding and public support in the nation, and my fieldwork consisted of interviews and participant observation with researchers developing these apps and websites. I was interested in how they responded to criticisms that their digitally mediated programs were ruining or otherwise cheapening so-called real therapy, and how the programs were framed as cost-effective public health measures by the state. During this time, which also coincided with the devastating Black Summer bushfires and COVID-19 pandemic, I became aware of how much the language of mental health was being operationalized in Australia as a civic priority (Neiman, 2020). Simultaneously, I was aware of the state-sanctioned psychiatric disasters that continued to take place offshore. As waves of lockdowns ground my other e-mental health research to a halt, I began to look for a way to empirically investigate this obvious and violent contradiction.

I am trained in ethnographic methods, experienced in healthcare settings and peer mental health support, and have a strong familiarity with psychiatric nosology and therapeutic

methods. However, I do not have a clinical background, and I lacked the resources and training to responsibly interview past or current detainees about their experiences. I chose instead to focus on efforts *within* Australia to provide mental healthcare *to* them. The necessary use of electronic communication to achieve this both complemented and darkly contextualized my other research on e-mental health programs in the country.

Methods

I began by spending time on Facebook groups used by mainland Australians to coordinate donations, legal aid, and other material support for detainees. I reached out via private message and short phone conversation to some key organizers, who in turn put me in touch with others. I eventually learned about a working group known as Therapy 4 Refugees (T4R), an assortment of roughly 35 credentialed therapists, social workers, and other professional clinicians who volunteer their free time to provide crisis counseling to detainees via WhatsApp and Facebook Messenger. I contacted Ruth, the founder and head of T4R, who was enthusiastic about my project and introduced me via email and Zoom to several other volunteers. Shortly after I began this work, I successfully applied for a small grant (about USD 3800) from Stanford University's Office of Community Engagement, with a letter of support from T4R. Most of the funds went to T4R's parent organization to purchase six months of phone credits for 12 detainees to allow for continued mobile connection. A small sum was also put aside to build the organization a rudimentary website and secure a domain name (https://therapy4refugees.care).

Over the course of approximately nine months in 2020, I conducted a half-dozen semi-structured interviews with several of the therapists, which were audio-recorded and subsequently transcribed. I also attended nonclinical portions of team meetings via webcam, leaving when it came time for volunteers to collectively discuss their caseloads. I was not privy to any discussion regarding the identity or private health information of any clients. I did not personally see, in part or in whole, any conversations between my informants and their clients, nor did I attempt to learn the identity of, or contact, any past or present T4R clients.

Instead, the data I use came exclusively from what was shared with me in these interviews with T4R volunteers, all but one of which were conducted via Zoom. Any stories about the lives of specific clients were related to me secondhand, and I use them sparingly and advisedly, omitting any potentially identifying details. While in a real sense these stories belong to vulnerable subjects who remain strangers to me, they are also indelible parts of my informants' personal and professional lives. It is this focus on their experience, attempting to provide care in these extraordinary circumstances and build real human connection, that I wish to highlight.

Organizational Norms

Given the stringency of the requirements and the intensity of the work, the T4R team is a small but dedicated one. During the time I worked with the organization, it consisted of roughly half a dozen Australian mental health practitioners ranging from psychologists in private practice to school counselors to social workers. All of those within the core group were women with postgraduate degrees, ranging in age from their late 20s to late 60s. They were all residents of Australia, living mainly in the handful of large metropolitan areas on the east coast. They were not close friends outside of their volunteer work and did not see one another regularly in person. However, they were all friendly and valued being able to unburden themselves around their colleagues about topics they couldn't share with partners or family. This practice of holding space for one another allowed them to process the difficult and disturbing things they encountered in their cases. As one volunteer put it, "If I'm held, I can hold the refugees" (Interview with author, Zoom, June 2020).

In running T4R, Ruth insists on many of the formalities and procedures that apply to therapy given under more ordinary circumstances, and which render subjects legible to the psy professions. This is evident in the term the volunteers use to refer to the detainees they care for: "clients." The

term implies a kind of agency, a relationship of remuneration and employment rather than desperate humanitarian appeal and volunteerism (see Wing, 1997). The unorthodox delivery of the therapy and the heightened political and emotional stakes also do not compromise the duty of care: T4R requires all applicants to be fully qualified social workers, counselors, or psychotherapists, and to have professional liability insurance.

Those who meet the requirements go through an orientation, where they learn to write up standardized reports on their clients' mental and physical status, prepare letters in support of medical evacuation and transfer, and to navigate the byzantine system of detainee medical records that need to be organized, managed, and followed up on. After onboarding, Ruth told me that some would-be volunteers simply find it too harrowing to ever reach out to their first client, given the intimacy of the encounter and abjection one is confronted with: "I've had people that never made contact with that person. They just totally didn't get over the line right at the point of contact. And yet I couldn't pick that up in the orientation. It was the actual doing it that screens people out" (Interview with author, Zoom, March 2020). Even those who make it past this first conversation require ongoing support getting used to the entirely different set of clinical limitations:

> There's a lot of holding people through the process of contacting their person. Then they feel totally out of their depth, like 'What do all these things mean?' and 'How come I can't just call an ambulance for them, or a mental health service?' So, there's a lot of coaching about how to deal with crises. (Interview with author, Zoom, March 2020).

Therapeutic Modalities

As I came to know this group of practitioners over the course of our collaboration, I appreciated what Ruth meant when she had frequently referred to the organization's diversity of backgrounds. Not only did different occupations bring different strengths, as she explained (e.g., counselors tend to have better interpersonal skills, while social workers excel at advocating for their clients), but these women also practiced a wide array of therapeutic modalities. From psychodynamic therapies to more traditional psychoanalyses of varying stripes, practical psychoeducation, acceptance and commitment therapy, as well as cognitive and dialectical behavioral techniques, the T4R volunteers I spoke with described using a range of practices both in their day jobs and over WhatsApp with "the guys."[1]

At times, my interlocutors differentiated between therapeutic techniques used in their day jobs and those used over the apps. One of the newer volunteers, Jessie, a school counselor from the greater Brisbane area in her late 20s, characterized her approach to psychology as "taking bits and pieces from everywhere" (Interview with author, in-person, March 2020). She makes heavy use of behavioral activation with the detainees, a technique borrowed from cognitive behavioral therapy (CBT) in which the patient tries to actively break the cycle of depression and inactivity. She also told me about an app she likes to use with schoolkids struggling with self-harm, which uses the visual metaphor of *riding the wave* of the intense emotion until it passes. While she felt that the tone of the app was inappropriate for her clients, she described using the same basic technique with refugee clients who cut themselves, helping them to ride the wave and wait out the powerful urges.

In contrast with Jessie's highly pragmatic and behavioral approach, others leaned on some of the most literary, quasi-mystical aspects of psychoanalysis. Monika, a therapist with a bilingual and binational background, recounted to me one experience when she fell back on her intuitive understanding of Jungian archetypes. One of her client families had been medevacked to the mainland from offshore detention after their young had son refused to eat for weeks. With the family now living in community detention following the boy's discharge from the intensive care unit, Monika learned that he had taken to watching animated videos of Noah's Ark. She connected the biblical flood to trauma experienced during the family's sea journey to Australia:

> Now when I spoke to him, what he was doing, he was watching videos about Noah's Ark. Now when they made the sea journey. . . . it was horrible. They almost drowned. And when this young man was watching Noah's Ark, in a way I thought he was trying to digest what he had experienced on an archetypal level. Of course, I didn't go into detail with him about this, but I think an understanding of archetypes is very helpful. (Interview with author, Zoom, June 2020)

Despite T4R's small membership, volunteers represent large swathes of the spectrum of talk therapies. All these modalities, however, rely intensely on some notion of the therapeutic alliance—the active ingredient of talk therapy based in mutual recognition and interpersonal rapport that remains a popular hypothesis but has proven difficult to pin down scientifically (see Elvins and Green, 2008). The possibility of such a transcendent connection occurring in online or automated settings has been the subject of further research and speculation (e.g., Lederman and D'Alfonso, 2021)

Primary Findings: The Therapeutic Alliance

Placing traditional phone calls presents difficulties for clients who struggle with a language barrier, and the landlines provided in the camps may be unreliable or located outdoors exposed to the elements; video chat applications like FaceTime are bandwidth-intensive and require expensive smartphones. WhatsApp, on the other hand, allows for simple text communication, and has features for sharing photos, documents, and brief voice recordings. It is reliable, so long as the refugees' phones remain topped up with credits, and it can easily accommodate the uncommon country codes of Nauru and Papua New Guinea (+674 and +675, respectively). WhatsApp is at once flexible and borderless while also keeping interactions highly restricted and mediated. This interplay of stricture and affordance, and its sometimes surprising implications for forming a traditional therapeutic alliance with clients, constitute the primary findings of my research.

Fragments And Snippets

Perhaps the most obvious obstacle to a thriving therapeutic relationship is the simple inability to understand what, exactly, is happening with one's client, and at times my interlocutors described feeling frustrated by a lack of clarity afforded by the app. Since WhatsApp messages allow for short and irregular bursts of communication and many clients do not speak English conversationally, T4R therapists described getting confusing and disjointed fragments of information, often in moments of crisis. For example, Jessie explained that inaccurate Google translations were often difficult to distinguish from the frenetic speech patterns associated with her client's diagnosis:

> I think especially the Arabic to English on Google Translate must be really bad. And then, so there's one client I have who has some history of thought disorder, so it's really hard for me to tell whether he's experiencing some thought disorder or if it's just the translation app. So there's difficulties with that sort of thing, mostly just not being in the room with them. (Interview with author, in-person, March 2020)

This challenge of "not being in the room with them" is a political problem that WhatsApp and the smartphone are not technologically powerful enough to overcome—they cannot, for example, physically manipulate objects in the detainee's immediate surroundings, nor project the physical presence of the therapist into the space as a companion or advocate. But in moments of desperation, it can serve as a reliable vessel for simple human connection. During our conversation, Monika provided a compelling but harrowing real-world example. The mother of one of her clients—a woman detained offshore with her family—had been severely affected by a recent traumatic event in detention. She was eventually admitted to the detention center's small hospital,

semiconscious and unresponsive. Unable to comfort the client as she sat by her mother's side and unsure of the specifics of the situation, she resolved to ask, "How could I relate to the snippets that she gave me through her WhatsApp?" Acting on instinct, she suggested the client sing a lullaby to her mother that she had sung her as a child:

> I sit there, I think of the person even though I don't know what they look like, but I try to feel my way into that person. And I try to feel, "What's coming up for me?" And then when I had this particular session with the young woman whose mother was in hospital, I didn't [have to] think about asking her if she could sing a lullaby. This is transference. This came to me as we were in conversation via WhatsApp.

The piecemeal nature of these interactions, occurring in fits and starts over multiple hours and days, gave the volunteers occasion to go back to the basics, both returning to the fundamentals of their training and relying on the barest forms of human connection: simple unidirectional witnessing. T4R volunteers described receiving barrages of photos from clients in the middle of the night, sometimes twenty or more at a time, of self-inflicted wounds, attempted hangings, empty pill bottles, and vomiting or unconscious people. Often the photos were sent without clear captions or accompanying descriptions, glimpses of accidents or attacks with only hazy details. In these instances, WhatsApp brought horrifying, contextless images that upset volunteers unsure of what was happening or how best to intervene for their clients. The physical limitations of the app at times left T4R volunteers struggling to understand precisely what their clients are experiencing, or indeed even knowing what to say.

Affordances Of Intimacy And Dignity

T4R volunteers repeatedly told me that somewhat counterintuitively, they found WhatsApp accelerated and deepened the therapeutic alliance. The preponderance of text over video at times made picturing life in detention difficult, but it also allowed refugees the ability to maintain their dignity, concealing from the therapist an unkempt appearance or living conditions that were not up to their own personal standards of cleanliness or hospitality. Amy, a social worker and psychodynamically trained family counselor from Canberra, described the WhatsApp session as a site of disembodiment, a place of nonbeing, that afforded her clients a "blank space where there's no judgment about looking like something, feeling like something." She reminded me,

> A lot of the men are quite sick, have a lot of medical [problems], a lot of them aren't showering, so if I was to see them face-to-face, a lot of the photos I've seen of them—they look really unwell. There's none of that though, so they kind of just meet you on this really core-of-who-they-are level. It's different. So you kind of take away all those extra things that impact the relationship, and are just like, "I'm here for you. Do you need this, and what will that mean for you?" So it kind of takes away all those extra things, of me looking at them and then—those superficial things as well. (Interview with author, Zoom, June 2020)

For Amy, the text-based session strips away "superficial" niceties that might distract from what she calls the "core" of who the client is and what is ailing them. Conversely, the camera feature and the ability to send photos makes the revealing of one's visage an opt-in activity, and many volunteers did report receiving photos of clients and their loved ones. Because the phone can go anywhere with both the client and the therapist, and because the usual temporal and spatial limits of the therapeutic session are made impossible, in some ways the app brings each of them into the other's most intimate spaces.

The beginning and end time of a traditional therapy session are prescribed periods of consistent contact, known in advance by both parties, but providing therapy for the refugees

detained offshore frequently means typing on and off throughout the day. This prolonging of the clinician's workday is not only because crises can (and do) occur at all hours of the day and night in the camps, but because WhatsApp allows for asynchronous conversation; one person may send a message and reply immediately or, as is often the case, wait until they have a free moment later to respond. The T4R therapists I interviewed described an increased intimacy that came with literally bringing their refugee clients home with them, via their phone, messaging them while cooking dinner, watching TV, or doing the dishes.

Jessie noted the similarity between this way of messaging the refugees (on and off, sometimes synchronous, sometimes asynchronous, during moments of rest or tedium) and how people, especially those in their 20s and 30s, talk to their close friends all day:

> I think in some ways I've built that alliance really quickly through the e-[mental health], like more so than in person. Because the communication's spread throughout the day. So you're kind of talking all day long . . . because we're all in a generation where that's how we communicate with our friends, so it's kind of an intimate way of communicating in a way that you wouldn't normally have in a formal appointment sort of setting. So in some ways it's a "stronger alliance in that setting." (Interview with author, in-person, March 2020)

Amy, who has young children, similarly described incorporating her texting with the guys into her everyday domestic life, adding that she usually prefers to check the messages at "6 or 7 [p.m.] because that's when my kids are getting ready for bed. So sometimes if I get a message, I might say, 'One of mummy's friends who are refugees just needs me to write back a message'" (Interview with author, Zoom, June 2020). When the stakes are heightened and the session is extended late into the evening, tight bonds can be quickly forged between client and therapist. But this acceleration of an alliance that may otherwise take weeks or months comes at a price to both parties: tensions and mismatched expectations can come to dominate such intimate interactions.

Setting Boundaries and Missing Connections

Unsurprisingly, caring for victims of torture and political violence on top of existing caseloads, family responsibilities, and social obligations can make for stressful work. Jessie spoke of the potential pitfalls of this 24-hour availability, compounded by her sense of obligation to her clients and the relative ease of her life compared to theirs:

> Just that context of sitting at home in your personal time, texting with someone. And often there might be an emergency late at night, and when I wanna be asleep or I'm in bed, and then sort of getting up out of bed to deal with their emergency is so different from any other situation. But it can be hard to put in place boundaries. Like sometimes I'll think to myself, "Ah, I won't respond after 9:00 p.m." But then in practice, just because of the seriousness of the situation, that's really hard to do. And it's hard for me to see a message pop up and not be like "Oh, but what if it's an emergency? I better check." (Interview with author, in-person, March 2020)

Ruth similarly lamented that others can see if you are online and therefore available through WhatsApp:

> If you're on, people can see you're online, then I'd start getting a whole lot of people messaging at the same time. So that's one of the challenges, I feel this high stress about answering everybody's messages in a reasonable timeframe. . . . That's one of the downsides of WhatsApp, is people jump online when you're online. (Interview with author, Zoom, March 2020)

Like Facebook Messenger, Instagram, and Apple Messages, WhatsApp features "read receipts," visual indicators that let the other person in the conversation know their message has been received and read. Knowing this can make the receiver feel a sense of obligation to respond, creating a fraught meta-game on top of the clinical work.

Monika proved to be the exception in her preference for regularly scheduled meetings with clients, but explained that she always told her clients that they were free to message her whenever they needed—though in her experience few ever took her up on her offer. For her, reminding clients that this boundary was okay to cross was itself a kind of therapeutic gesture, one that paradoxically upheld the boundary itself:

> When we do this, it's a psychological intervention as well. Telling that person you're holding that person in mind. "You matter to me. Call me when you need me." That in itself is a psychological intervention that for people who have regressed that far, it's enormously important. And it means you not only matter when I speak to you once a week or whenever. These are professional boundaries that are really important. (Interview with author, Zoom, June 2020)

At times, such professional boundaries were disregarded by clients entirely, either because they were not familiar with the specific cultural expectations around psychotherapy, or because they were extremely upset or in danger. At other times, the issue was something more banal: The vibe was simply off. Because people are indeed able to connect with and know one another on deep levels over a messenger app, they are also able to sense the absence of such a connection by the same means. Like standard face-to-face therapy in an office, WhatsApp therapy is subject to the vagaries of people failing to click. Amy described being able to quickly pick up on this lack of chemistry, both in her own practice and over the app:

> Even recently, I've had a few clients that have come and I'm like, we just do not click. They come for a few sessions and you can tell they don't relax, they're not comfortable in the setting. And the same is when, [in] Therapy 4 Refugees, I'll have some people that I'll message and I'll be like, "Hey, how are you going?" and they get shitty with me straightaway. And they're just shut down, and it never goes anywhere. (Interview with author, Zoom, June 2020)

The reasons why a refugee might "get shitty" with a T4R volunteer are overdetermined, beyond the obvious fact that their mistreatment is simply conducive to low mood and agitation. Occasionally, clients mistake volunteers for government spies, or IHMS employees, or just generally conflate them with the Australians visiting violence upon them and their families. Drug use and abuse is common among the detainees, which may also contribute to emotional volatility. But what Amy also gets at here is a natural variation among human sociality—and by extension, among therapists and patients—by which people find the company of some more compelling and agreeable than that of others. This intuitive process of clicking with one person and not another is one of the basic human activities denied to the refugees.

Discussion: Therapy at the Limits

This research supports the notion that digital communication technologies *do* allow some essential spark of therapeutic intersubjectivity to survive. As a document of caregiving among extreme abjection, it testifies to the existence of a basic human connection that thrives even in hostile conditions. As an ethnography of mobile communication, it shows some of the surprising ways technological constraint affords psychic freedom. But it is also revealing about therapy *as such*, regardless of the conditions in which it is delivered.

The Limits of Psychotherapy

The case of T4R lays bare what I call the limits of psychotherapy—those structural, material interventions that might be made in the patient's world to better alleviate their suffering or improve their life but that are outside the therapist's remit, training, or power. The extreme example I have explored in this article brings these limits into sharp relief; there is only so much that can be done when one's client is being illegally tortured by the government. The obvious solution to the patient's chief complaint ("Get me out of here") is made impossible because my informants lack the authority and power to do so.

Scholars have described such actions, which fundamentally fail to address the underlying political problem but persist nonetheless as a matter of dignity, variously as "hypo-interventions" (Tironi, 2018) and "Band-Aids" (Sangaramoorthy, 2018). But similar limitations can also be found in much more common and less extreme therapeutic contexts; they are already baked in to the intervention itself under normal conditions. In the case of CBT, for example, the point is to identify patterns of irrational thought ("I'm a failure") that lead to unhelpful or harmful behaviors; in other words, to correct a thinking error. The limit to this, of course, is that if one's problem (e.g., "I have no future" or "Someone will harm me") is not the result of irrational thinking but an accurate appraisal of one's circumstances, the intervention is unlikely to do the patient much good.

Most psychotherapy training is done, and most therapeutic methods are developed, with a particular patient subject in mind—namely one with a future, life chances, and, at a minimum, membership in a society with social attachments and possibilities for living. We might call these the "pretheoretical assumptions" (Lloyd, 1993) of a given therapeutic modality, none of which are met in the case of the refugees. But one need not look to victims of political torture to see this at play. Consider administering acceptance and commitment therapy to an unhoused person or offering psychoanalysis to someone in an actively dangerous relationship. In fact, my informants used the analogy of intimate partner violence to make this point. Amy likened the situation with the guys to

> working with a woman in a domestic violence relationship who's screaming, saying, "I need to get out; how can you help me?" and you'll say "No, you have to stay there. We actually can't let you get out." And that's why mindfulness or whatever—what the fuck would that help with? You're in this traumatic situation. You've got a client who's screaming, saying, "I can't help; I'm suicidal; this is too much," and then saying, "I'm angry because you're keeping me here." (Interview with author, Zoom, June 2020)

Amy compares the situation of the woman to that of the detainee: The intervention is useless because it is targeting some finer point of mental life that cannot be mastered until other, more pressing concerns are addressed. I conceptualize the best possible outcome for a given therapy as its *ceiling*, which is to say that the technique (e.g., to master fears, correct irrational thoughts, or practice gratitude) has been successfully applied to some person whose life chances make this a plausible goal in the first place. The patient cannot have success with the intervention if their other physiological and psychological needs are not being met, because the intervention was not meant for those living under conditions of extreme abjection.

In response to this fact, my interlocutors were often forced to abandon the long-term goals of life improvement boasted by the techniques they had been trained in. Instead, they described radically lowering this ceiling, keeping their clients in a kind of holding pattern of survival, of deferring suicide. As Ruth told me,

> Most of the times when they're offshore, we're just instilling hope or getting them to wait a bit longer. And tell them to hold on to life, and not to try and kill themselves that night. And you know, to replace self-harm with writing on their arm, or talking to their therapist,

> or something else. . . . We're just getting them to live long enough to get past the next stage. "That's what we were helping them do." (Interview with author, Zoom, March 2020)

Jessie similarly characterized the job as playing for time and instilling resilience:

> [What we can do is] so limited. We're just helping them to feel a little bit better in this horrible situation they're in, and to be resilient and get through it. To hopefully—there's this day where they're not in detention, or not on Nauru. And none of us know when that day will come, or if it will. (Interview with author, in-person, March 2020)

She summarized the plight of her clients to me with a kind of antidiagnosis: "They don't have mental illnesses; they have a really awful situation." My work stresses both the altogether human nobility, and the painfully obvious lack, of bringing psychological tools to bear on political problems. It suggests that those who engage in such undertakings, far from being dupes, may persist in their actions despite being well aware of their inadequacy.

Conclusion: In Defense of the Self

The resources of the psy disciplines have been marshaled for populations whose most basic political and material conditions are largely met; these are the techniques that my informants have been trained in and the same ones the Australian government has championed for its domestic population over the past 30 years, as life for its offshore refugees has become increasingly unbearable. Their woeful inadequacy shows that there are people in the world whose suffering is beyond the ability of therapy to significantly abate, where the best outcome that can be hoped for is continued biological survival. Therapy is no substitute for emancipation.

But my findings also rebut critiques that go too far in the other direction. Here, I refer to those who call attention to the rise of therapeutic selfhood and the repressive function it serves in recasting political problems as personal ones. In this conception, psychotherapy has turned individual conduct into the basic unit of moral reasoning. This focus on the self is a way of "governing the excluded" (Rose, 2000, 334) by keeping their gazes fixed inward. But one struggles to find this logic at work in the case of T4R, where it is precisely the basic tenets of therapy (interiority, behavior, and a map of the psyche) that afford spaces of alliance and survival. Among some of the world's most governmentally excluded, the self necessarily serves as the site of some small relief.

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1. *Guys* is the general collective term used by my informants to refer to detainee clients (i.e., "the guys," "our guys," "one of my guys"). While some have been around long enough to remember having women clients, most joined more recently, after it became politically unpalatable for the government to continue the detention of women and children offshore.

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