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Pioneering Psychotherapy: knowledge-, class- and meaning-making in Uganda[1]

Julia Vorhölter[2]

Abstract

This working paper summarizes the main findings of my *Habilitation* project (2015–2021), which studied the recent popularization of psychotherapy and related practices, disciplines, and discourses in Uganda. I analyze why, how, and with what effects psychotherapeutic discourses and practices have started to proliferate in Uganda since the late 1990s, who can and wants to access them, and how the rise of psychotherapy both reflects and contributes to changing imaginations and experiences of suffering and well-being, especially among upper-middle-class Ugandans. Drawing on fieldwork among therapists in Uganda, I look at psychotherapy from three different angles: as a form of meaning-making and care, a form of knowledge-making and governance, and a form of class-making. This multimodal approach challenges assumptions that either simply dismiss psychotherapy as a neoliberal form of (self-)governance, view psychotherapy as un-African, or ignore the growing socio-economic diversity within African countries when thinking about mental health care. Instead I argue that in Uganda psychotherapy is not just an externally imposed medical approach to improve global mental health; rather, it relies on psychological knowledge co-produced by local practitioners. While deeply entangled with neoliberal ideologies, psychotherapy also offers new ways of critically reflecting on capitalist modernity and new imaginations of care.

[1] This text has been a long time in the making and several people have read and commented on it along the way. I would especially like to thank Ursula Rao, Mascha Schulz, and Jovan Maud for their detailed, critical, and constructive feedback on earlier versions, and Claudia Lang and Tabea Scharrer for their engaged reviews of this latest version and their valuable suggestions on how to 'make it work' as a working paper. I completed the fieldwork and most of the writing for the *Habilitation* project while employed as a lecturer at the Department for Social and Cultural Anthropology at the University of Göttingen (Germany) as well as during a one-year post-doctoral fellowship at Washington University in St. Louis (USA). Parts of the fieldwork were funded by the Fritz-Thyssen-Foundation; the fellowship was funded by Volkswagen Foundation.

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A Note to the Reader

This text was originally written as an introduction for my *Habilitation* thesis which I submitted to the Faculty of History, Art and Area Studies at Leipzig University in September 2021. It summarizes the main findings of my post-doc research project (2015–2021) and builds on previous publications that have come out of this project (especially Vorhölter 2017a, 2017b, 2019, 2020, and 2021). The format of the text is somewhat unusual: it contains elements such as lengthy ethnographic vignettes and detailed literature reviews that would not normally find a place in a conventional journal article. The working paper format allows me to weave together and connect different aspects of my research in a way that would otherwise only be possible in a book. Much of the analysis is foregrounded in, but also goes beyond, the previous publications, which I refer to extensively. In this sense, this text can be read both as an introduction to and as a concluding reflection on my project; it seeks to address readers familiar with my previous work as well as a more general audience interested in recent debates on care, middle classes, and global mental health in Africa.

In the text I talk about three closely related disciplines and fields of practice: psychology, psychiatry, and psychotherapy, referring to them collectively with the umbrella term 'psy' coined by Nikolas Rose (1996, 1999). Psychiatry is the branch of medicine focused on the diagnosis, treatment, and prevention of mental disorders. A psychiatrist is a medical doctor who can prescribe medication, but who may also apply psychotherapeutic methods in their practice. By contrast, psychology is the science of mind and behavior. A psychologist is not a medical doctor and cannot prescribe medication. There are various fields of psychology, not all of which have to do with mental health issues (organizational psychology and educational psychology, for instance). The two main forms of psychology I refer to in my research are counseling psychology (which deals with clients who seek therapy, coaching, or supervision for all sorts of challenges, but who are not mentally ill) and clinical psychology (which focuses on the diagnosis and psychotherapeutic treatment of people suffering from mental illness and thus overlaps significantly with psychiatry). Psychotherapy is not in itself a discipline but a practice (usually a form of talk therapy) based on psychological theories and methods that one can learn through professional training. Not all psychologists are psychotherapists, and many psychiatrists have at least some basic training in psychotherapy.

In practice, the lines between the three fields are extremely blurred and many non-specialists (including most Ugandans) do not really know how to distinguish them. The history of psychology and psychotherapy, which is the main focus of this working paper, is relatively recent. Psychiatry has a longer history in Uganda and other African countries – psychiatric asylums were first introduced during colonial times, and forms of psychiatric treatment (mainly medication, but also psychosurgery, electroconvulsive therapy, and basic forms of occupational therapy) have been available since at least the 1950s. Although understandings are gradually changing, many Ugandans still associate mental illness with madness, which is highly stigmatized; there are various ways of treating severely mentally ill or 'mad' people, including (home) confinement and traditional or faith-based forms of healing. Most people who *have* heard of psychiatric care associate it with Butabika, Uganda's only designated psychiatric hospital, which opened in 1955. Despite ongoing efforts to decentralize psychiatric care, Butabika is still often the first place Ugandans suffering from severe mental illness are taken to; as a result, the hospital is severely overcrowded. During the time of my research, Butabika had six psychiatrists, two clinical psychologists, and – despite an official bed capacity of 550 – an average of 860 in-patients.

The opening scene of this working paper gives an impression of Butabika, where the standard treatment to this day is medication. It shows how psychologists are trying to enter this field with new approaches and premises – and the challenges they face in doing so. Taking Butabika as a point of departure, the rest of the working paper analyzes more recent forms of psychotherapy which are emerging across Uganda.

Prologue

I arrive at Butabika just before 9 am. As always, I pause for a moment to look around. The area surrounding the hospital is beautiful, quiet, and much greener than most other parts of Kampala, Uganda's capital. Below in the distance I can see Lake Victoria. The city center is about a ten-kilometer motorbike ride away; but it feels much further. Even the hospital premises are strangely pleasant, clean, and almost peaceful except for the occasional screams of patients who are being involuntarily admitted or are otherwise unhappy about their treatment. As always, I have to think about the paradoxical nature of this place; how the price paid for the silence surrounding it is the medication and sedation which are, to this day, the main forms of treatment offered.

Stella,[3] one of my two research assistants, arrives shortly after me and we walk through the entrance gate together. A woman in her 40s, she is in the final stages of her MA degree in clinical psychology and has to complete 180 hours of voluntary counseling at Butabika as part of the program. In theory, these sessions should be supervised. In practice, the only two clinical psychologists at the hospital are so overworked that they often leave their interns, especially the more advanced ones, to counsel patients without guidance. Stella cannot find her supervisor in his office, so we start walking over to the children's ward where today's counseling sessions will take place.

We enter the ward, which is still quiet. Later, there will be a long queue outside with parents who have brought their sons and daughters for consultation. We find a few children of different ages running through the corridor, all dressed in red-striped hospital shirts. Some patients sitting in a small room stare at us as we walk past. A small boy, about six years of age, is sitting on the stone floor, nodding his head. Stella says his name is Josef and he suffers from severe autism. He nods his head when he is distressed – usually because he is cold or hungry. She hands him a piece of paper to distract him and says she always feels so sorry for him. He was brought in by his family for treatment, but has been at Butabika for years. No one ever came back to pick him up.

At first sight, the children's ward looks like a typical Ugandan hospital ward: simple, practical, soulless. There are a few small rooms and a dormitory with several beds. Stella tells me that they also have a play room, but it is only open at certain times. Mostly, the children can run around freely, and some of them greet us as we pass. We walk into a room with a leather sofa and a desk – it is the consultation room for the psychologists. Stella asks one of the nurses whether anyone is around to supervise them today. The nurse answers that Bosco, the occupational therapist who sometimes helps out with the supervision, may come in at 10 am, and that we should wait around until then. We sit down on the sofa and Stella starts talking about her work at the children's ward. I ask if most of the children who are sent to Butabika come from lower-class families. Stella nods. She says rich parents, 'those who have money', might bring in their children for initial assessment; but if their children need longer treatment, they usually take them to private facilities where they have better chances for recovery. I ask about the most common diagnoses: Stella says that some children have severe forms of brain damage; others have mental problems related

[3] Unless otherwise noted, all names in this working paper are pseudonyms. In the ethnographic vignettes, I present statements by my interlocutors as quotes for the purpose of better readability and 'flow' even though I did not voice-record our conversations. My presentation of these statements (both in terms of content and style) is based on detailed fieldnotes I took immediately after the research event.

to child neglect or abuse at home. Some, like Josef, are severely disabled, but many have treatable conditions. She pauses and then adds: 'All of the children here would profit from better treatment. Most of them are simply managed through drugs. Sometimes children are so sedated that it is impossible to work with them even when we offer psychological care.'

We sit in silence for a while. All of sudden, Stella starts talking about her recently failed marriage and the custody battle over her kids. I am surprised: she does not usually talk to me about her problems but rather performs the role of the stressed-but-tough working mum and academic, although I sometimes sense the cracks in this image. I knew that she and her husband, a successful business man, were going through a divorce, but this is the first time I hear more about the story. I am even more surprised when Stella admits that she has suffered from depression and that this is what led her to return to university to study clinical psychology.

'My husband is not a bad man,' she begins. 'He is the kind of father and partner who provides financially, but is never really there for his children or wife. I was always wishing for a friend, someone to feel close to rather than a provider. We were living in a nice house and had a really good lifestyle. He took me out to expensive places and bought me expensive gifts. So for a long time, I just tried to ignore my unhappiness, also because the people around me only saw the nice sides of my marriage. I thought they would not understand if I left him. But then my depression started. I always used to be so energetic and do everything for the kids; but then from one point on I just couldn't get out of bed anymore, I fell asleep during the day, and just had no energy and nothing to give anymore. I couldn't even be a loving mum anymore. That's when I realized that something needed to change. Although my husband didn't like it, I took up my studies again. And then it was in my clinical psychology classes that I learned more about depression and found how many aspects of it were related to my own behavior at the time. I learned about the kind of [depressed] mother that I didn't want to become. That stuff in class really helped me to cope with my situation. All in all, I think I feel relieved that I took the steps to get out of my marriage, because my husband is just not the kind of guy I want to spend the rest of my life with. We even went to see a counseling psychologist, but I didn't think this person did a good job. He didn't really help us with our problems.'

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It is 10 am and none of the supervisors have arrived. Instead, Sharon, one of Stella's classmates and my other research assistant, enters the room. As usual, she seems very cheerful and tells us enthusiastically that she has just counseled a friend on WhatsApp using acceptance and commitment therapy (ACT). Stella and Sharon tell me that they recently attended a workshop on ACT. They both seem excited about their newly acquired skills. Sharon explains to me: 'It is a new approach which is just being introduced to Uganda and we will be the pioneers working with it. It is based on cognitive behavioral therapy [CBT, the main approach taught in Ugandan clinical psychology], but comes with a number of really important differences. Rather than wanting people to change their behavior and get over negative thoughts by proposing homework exercises and the like, ACT is about making people accept their negative thoughts and learning to deal with them in their daily lives.' Stella adds: 'I really love it. It is much better suited to the African context, where CBT is sometimes difficult. CBT is a very Western theory.' She pauses and then goes on: 'I guess ACT was also developed in the West, but it is currently being successfully used in various different African contexts.'

Bosco, the occupational therapist, is still nowhere to be seen. But the nurse comes back and announces that there are patients who Stella and Sharon should talk to: a boy with a drug problem, a girl with conduct disorder, another girl who admitted herself to Butabika because of troubles at home, and a seventeen-year-old boy who apparently defiled a five-year-old girl. Stella sighs and says she always feels uncomfortable counseling patients without supervision. I ask them about the process of admission and how exactly patients are assigned to them. Stella explains: 'It is always a psychiatrist who does the initial

assessment and then admits the patient, if necessary. Most patients are put on drugs and then are usually not fit for psychotherapy until after they have stabilized. The psychiatrists check for both the physical and the psychological factors. In cases where they think therapy might be beneficial, they refer the patient to us. When one of the clinical psychologists is around, they usually do most of the counseling – and we interns watch and later discuss what we learned.' Today, however, the interns are left to themselves. Stella retrieves the patient files, which she and Sharon then try to make sense of. While the two are still discussing the cases and who they should see first, a teenage boy, maybe fourteen or fifteen, comes in and sits on the sofa. He seems heavily sedated, nearly falls asleep and can hardly get up by himself. We tell him, repeatedly, to leave the room and eventually he stumbles out again.

The nurse brings in the girl who ran away from home. Hers seems to be a complex case: she had been admitted to Butabika previously because of psychotic behavior, but this time she came to the hospital by herself, claiming that she was being mistreated and not getting any food at home. I watch Stella and Sharon as they try to assess what exactly her current problem is. Is she depressed, psychotic, or simply in need of shelter, food, and a place where she is not exposed to her stepmother's violence and neglect, as she claims? Should they use the BDI depression scale for clinical assessment? Or simply refer her to a social worker? Although I find the girl to be clear and confident, the whole conversation seems confused. The three mainly talk in English, but they mix in occasional Luganda[4] terms which I cannot understand. Without the help of their supervisor, Stella and Sharon seem overwhelmed and, after an hour of talking, send the girl out without a clear sense of her problem or how to help her.

Somewhat discouraged, they decide to see the girl diagnosed with conduct disorder next. Stella goes out to look for her – but comes back with an older woman, a Catholic nun in her late 50s, who was sent by the nurse for 'psychoeducation'. The nun is evidently from a low socio-economic background and does not speak English – an indicator of little formal education in Uganda. She starts telling her story in Luganda, which Stella quietly translates and summarizes for me as follows: The sister, as Stella calls her, has been taking care of a fourteen-year-old girl who was brought to their convent by the girl's father three years ago. The girl cannot speak and – in Stella's words – seems to be extremely mentally retarded. Her mother had long since abandoned her. Before the girl came to the convent, she had been running around in the community, causing trouble, because her father, a man with four wives and several children, was not taking care of her. Only when the police threatened to arrest him for child neglect did he bring the girl to the convent. But he never returned and has refused to answer any calls from the nuns. The woman seems desperate. She says the girl is aggressive (which is why she could not bring her along to the hospital), she always takes off her clothes and loves to climb trees and walls like an animal. At the convent, they have to keep her in a small cell. The sister feels exhausted and no longer knows what to do. She tried praying for the girl, but it didn't help. She went to see different faith-based healers, who told her that the girl was sent by Satan to punish the parents and that she would never get better. Since then, the sister has feared for her own well-being. Maybe Satan will punish her for taking care of the girl? One part of the healers' prophecy was certainly true: the girl was only ever getting worse. The sister had come to the hospital to see whether the girl could be admitted, but the psychiatrists had refused (mindful of their scarce resources, they tried to prevent people from 'dumping' relatives or community members at the hospital simply because no one wanted to take care of them). The sister talks for a long time. Stella and Sharon listen patiently before they respond. From the English terms that they use amongst the Luganda, I understand that they are trying to explain to the sister the concept of mental retardation. Sharon talks about 'brain processes' and even 'neurotransmitters'. Then she picks up a sheet of paper and draws a line, using it to explain the concept of IQ. She marks a point on the line, writes 100 above it, and seems to say: this is a normal IQ. She marks another point, 70, and says that anything below 70 is considered mentally retarded. Then she marks another spot: 25. From the nun's descriptions, this is where she sees the girl. Stella and Sharon try these and other explanations to convince the nun

[4] After English, the most important and widely-spoken language in Kampala.

that the girl's troublesome behaviors are not caused by Satan but probably by a combination of brain damage and trauma. The sister does not seem convinced or satisfied. Sharon turns to me and explains in a quiet voice that the nun does understand that there are medical reasons. But what everything comes down to, for her, is simply that the girl will probably never get better. In this sense, Sharon's and Stella's elaborate medical, psychological, and neurological explanations are no different from the prophecy of the healers. The nun talks in an agitated voice. Sharon whispers that she is saying how exhausted and hopeless she feels, that she doesn't know how to go on. Stella, clearly exhausted and hopeless herself, softly says to the nun that she can keep on praying. (Later she tells me that ACT theory taught her to respect and work with people's beliefs and habits.) She offers to show her some basic relaxation strategies, and we all close our eyes and breathe deeply while Stella keeps talking in Luganda to the sister. Finally, Sharon writes down the contact of a clinical psychologist she knows who lives near the convent and might be able to go and see the girl.

After the nun has left, we sit in silence for a moment. I wonder, as I am sure Sharon and Stella do too, whether the session was in any way helpful for the nun, and whether – in the end – having medical or psychological explanations really makes any difference when faced with inexplicable forms of suffering.

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Introduction

This scene – which took place in August 2015 during my research on emerging forms of psychotherapy and changing discourses on mental health in Uganda – marks both an opening and a departure. It opens up a plethora of questions and themes that I discuss throughout this working paper and my other articles relating to this research: the desire to help and to make sense of suffering; problems of knowledge, learning, and translation; class dynamics in the Ugandan mental-health-care system, and – above all – the hopes attached to psychotherapy as a new form of care and the struggles, and sometimes failures, to realize these hopes. I will return to the scene in each of my three main analytical chapters – on psychotherapy as meaning-making, knowledge-making, and class-making, respectively. In important ways, however, my analysis also moves away from this scene and the well-rehearsed images it contains of an understaffed and underfunded African public hospital, drugged psychiatric patients, and ill-fitting foreign medical and psychological practices. Most of my research took place in the offices and private practices of Ugandan psychotherapists in Kampala who were treating upper-middle-class clients for various forms of what the therapists considered to be 'lifestyle-related' suffering, including relationship problems, stress, anxiety, and depression. I also visited student-counseling centers on university campuses, specialized treatment facilities (e.g. for those suffering from addiction), and NGO-supported mental health interventions, most of which were based in Northern Uganda and focused on trauma. While the lifeworlds of the people who came to these facilities differed considerably – in terms of their class background, occupation, family situation, and the kinds and the severity of the suffering they faced – all my field sites had one thing in common: they were places where psychotherapy, here broadly understood as a professional form of talk therapy that is based on psychological methods, was being offered to Ugandans as a new way of dealing with mental-health-related problems.

This working paper analyzes the recent emergence and popularization of psychotherapy and related discourses, practices, and institutions in Uganda. I discuss how the rise of what Nikolas Rose (1996, 1999) has called 'psy' – a framework for interpreting and acting on the self that is based on

psychological and psychiatric knowledge and carries particular assumption about mental health, illness, and normality – is linked to far-reaching socio-economic changes Uganda has undergone over the past decades, and especially since 1986.[5] These changes have brought about new forms of stress, conflict, and uncertainty which Ugandans are trying to make sense of and deal with in new ways. The popularization of psychotherapy, so my argument in a nutshell, is a response to changing experiences of suffering, for which older forms of therapy and healing seem ineffective or only partially effective. Psychotherapy is not just an externally imposed medical approach to improve global mental health, as many would claim (cf. Cooper 2016b), but also a form of care that seems meaningful and relevant to a small, but growing, sector of the Ugandan population.

While the beginnings of Ugandan psychiatry date back to the 1930s, psychology and psychotherapy only started to emerge on a broader scale starting in the early 2000s. Psychological mental health interventions have been expanding from two main centers which became the focal points of my research: Gulu, the most important town in Northern Uganda, and Kampala, the capital.

In Gulu, and Northern Uganda more broadly, psychotherapy has gained prominence in the form of so-called psychological or trauma interventions, which have been implemented by humanitarian organizations since the end of the 20-year civil war (1986–2006) between the Lord's Resistance Army and the Ugandan government.[6] These services usually target people from lower-class backgrounds who live in rural or semi-urban settings and are part of a larger global mental health effort by the World Health Organization to promote mental health in low-income countries. Clients are usually identified through NGOs, and, at least initially, few came of their own accord even though therapeutic offers were free of charge. Although over the years mental health services have become more known and accepted, there is still a general skepticism, among clients but also among practitioners, about whether psychotherapy can really help people with the issues they face. Many live in contexts of ongoing structural and/or acute violence and a lack of basic needs – conditions for which talk therapy provides only limited relief. A growing number of anthropological studies critically assess the history, challenges, and potentials of these psychological interventions in Northern Uganda (e.g. Lenhart and Whyte 2016; Meinert and Whyte 2017, 2020; Torre et al. 2019a, 2019b; Williams 2020). This literature provides an important backdrop and addition to my own work, which contrasts the developments of psy in Northern Uganda with those in Kampala.

In Kampala, professional forms of psychotherapy started to become institutionalized and gradually expand after Makerere University, the oldest and most prestigious in Uganda, offered the first MA programs in clinical and counseling psychology in the late 1990s.[7] The first designated private practice was established in 2001. Since then, psychotherapeutic discourses, practices, and institutions have been slowly but steadily gaining prominence, at least among certain – educated, wealthy, and cosmopolitan – sections of the population. More people are becoming interested in, and willing to pay for, private therapy, and demand for psychology courses is increasing. In contrast to Northern

[5] For several reasons, 1986 marks an important caesura in Ugandan history: politically, it marked the beginning of the current regime under President Museveni and the beginning of the war in Northern Uganda; economically, it marked the onset of neoliberal policies and donor-driven development interventions; the mid-1980s also marked the beginning of the HIV/AIDS crisis in Uganda. All of those factors had wide-ranging social implications.

[6] During the war, thousands of people in Northern Uganda were killed, several thousand abducted, and well over a million displaced. Since the mid-1990s, extensive international interventions have been taking place in Northern Uganda, initially predominantly focused on food aid, security, and economic support. Starting in the early 2000s, but especially after the end of the war, trauma-relief initiatives became a major part of these interventions.

[7] The first designated Institute of Psychology became operational in 1999. Twelve years later, in 2011, a School of Psychology was opened, reflecting the growing interest in and professionalization of psychology in Uganda (http://chuss.mak.ac.ug/schools/sp, accessed 20 Nov. 2017).

Uganda's international psy regime, the development and expansion of psychotherapy in Kampala has been largely driven by a small group of Ugandan psychotherapists, some of whom studied psychology and trained to become therapists in the US or UK. Typically, their clients are from upper-middle-class backgrounds and seek therapeutic support to deal with relationship conflicts, stress, and – broadly speaking – lifestyle-related problems, which are increasingly expressed through the popular idiom of depression. To date, this phenomenon of private psychotherapy in Africa has not been much studied, certainly not in Uganda, although it represents a larger trend across the continent. Therefore, it has been the main focus of my research.

Juxtaposing these two 'centers of psy', my work analyzes why, how, and with what effects psychotherapeutic discourses and practices have started to proliferate in Uganda in recent years, who can and wants to access them, and how imaginations of suffering and well-being – those of therapists and those of clients – shape psychotherapeutic interactions. In both settings, psy developments form part of a global trend and follow similar timelines; furthermore, even though the Northern Ugandan scene is still heavily influenced by international psy experts whereas most private practices in Kampala are run by Ugandan psychotherapists, the networks of psy practitioners that operate in the two settings overlap significantly, and there are many collaborations and exchanges, particularly in the education and training of future therapists. Yet both contexts also differ fundamentally in terms of how psy as a form of care operates and who is targeted for, or seeks, psychotherapy.

Comparing the two settings is thus complex, and the categories I evoke to represent their *different* realities are, necessarily, oversimplified: private therapy versus interventions in the name of global mental health, Kampala versus Gulu, center versus periphery, upper versus lower classes, trauma versus depression. Yet the interplay of these factors is not random but reflects both etic and emic classifications of social reality. Moreover, as I elaborate below, highlighting how psychotherapy takes on very different shapes as it enters different local lifeworlds helps to challenge stereotypical assumptions about mental health care in Africa. The reactions my work has provoked say a lot about such assumptions. When I talked about private therapy contexts in Kampala – in seminars, at conferences, or with friends and family – people were often surprised: 'Really, that exists in Africa?' No one ever expressed surprise when I talked about international trauma interventions. Yet, as I argue here, both private talk therapy and NGO-driven trauma counseling are manifestations of a similar phenomenon and both reflect ongoing changes in politico-economic dynamics, social relations, and forms of care – not just in Uganda but globally. These include changing forms and understandings of suffering, illness and pathology; changing ideals and imaginations of a good and healthy life; rising ambitions for self-determination; new technologies of (self-)governing and new subjectivities; and increasing class disparities and inequalities.

My work is situated in the field of critical medical anthropology and contributes to the ongoing, and by now extensive, debates on care. I discuss care as an aspiration that is never quite attainable, the double-edged nature of care, the tensions between care and control and between care and cure. I am interested in the multiple and complex reasons why Ugandans have become interested in psychotherapy as a new form of care and how they are struggling to realize the promises of psychotherapy. My work is about the various ways psychotherapy is imagined – by Ugandan practitioners and patients and by international mental health experts – as a desirable and relevant form of care that could help Ugandans in their 'search for meaning' in times of rupture and uncertainty. And it is about the care subjectivities and the ways of being valued and seen as a person that emerge when people engage in therapy – and how these differ from other forms of care and

healing (religious, traditional, biomedical, etc.) and related forms of control. Finally, it is also about the ways globally circulating ideas about care and techniques thereof become *differently* emplaced, appropriated, or rejected in vastly different Ugandan mental-health-care settings and lifeworlds.

In conceptualizing psychotherapy as a form of care, I follow my interlocutors' understanding of their work. Most, if not all, of the practitioners I interviewed saw psychotherapy first and foremost a *moral* practice. They were driven by the desire to help sufferers, and they believed that psychotherapy offered insights and strategies for dealing with problems that were different from those of existing healing systems, strategies that were, in some ways, better suited to contemporary struggles. Psychotherapy, for many, was not just about caring for individuals; it entailed a larger vision of creating a better – more just, more empathic, and more caring – society. Yet, for all of my interlocutors, psychotherapy was also a *professional* practice that was based on 'scientific' and, to some extent, universal knowledge which required comprehensive training and which was certified by academic degrees. In this sense, too, it was different from other healing systems (so-called traditional healing or faith-based healing, for instance) which were not based on standardized, 'evidence-based' knowledge and did not subscribe to the principle of value-neutrality. It was also different from other forms of counseling that existed in Uganda, most importantly VCT,[8] which – as my interlocutors repeatedly stressed – were not based on proper, professional psychological training.

For my interlocutors, being professional was an important aspect of providing good care. Yet the two were not always easily reconcilable. As a (moral) form of care, psychotherapy works through the shared creation of meaning and connection between therapist and client. In the encounter, clients are empowered to look at their lives, futures, problems – and at themselves – through a new lens. As a profession, however, psychotherapy is embedded in, and depends on, larger knowledge economies which regulate who can practice, how, and according to what principles. Becoming and being a professional psychotherapist also depends on access to financial resources – to pay for one's qualifications and to make a living. The latter, in particular, was a challenge for Ugandan therapists. As the introductory vignette indicates, and as I argue in more detail below, the way psychotherapy was practiced in Uganda was deeply entangled with global and local class dynamics: class affected who became a therapist, who sought therapy and why, what kind of therapy a client received, and even how someone was diagnosed (Vorhölter 2020, 2017a). Class dynamics sometimes interfered with therapists' struggles to combine their moral aspirations with the demands of the profession – for instance when sufferers sought their expertise but did not want to pay for 'just talking'; or when therapists advertised their services only to particular people – those with money – even though others were suffering more.[9]

In this working paper, I analyze psychotherapy, and psy more broadly, at the intersection of meaning-, knowledge-, and class-making. As will become apparent, all three processes are deeply

[8] Voluntary counseling and testing (VCT) for HIV/AIDS is in many ways an important predecessor of psychotherapy in Uganda and was first established in the early years of the epidemic in the late 1980s. Nowadays, the practice of VCT, in which people are tested for HIV and receive information and guidance on their (sexual) health, is omnipresent throughout the country and has fundamentally shaped people's imaginations of counseling interventions (cf. Moyer et al. 2013; Parikh 2015; Whyte 2014). HIV/AIDS counseling, however, as all of my interlocutors repeatedly stressed, differs from psychotherapy in important ways: it is often an obligatory part of testing, it is prescriptive (i.e. the counselor generally tells the client what to do), and most counselors have very basic qualifications as primary health-care or youth workers but have not studied psychology.

[9] Due to the lack of public employment opportunities, and the fact the few Ugandans had health insurance that paid for therapy, psychologists in Kampala were dependent on private clients who could pay their fees. Thus, to advertise their services, they went to banks, private schools, or larger companies – places they chose based on the financial capacity, rather than the needs, of potential clients.

entangled, and I only separate them for heuristic purposes: Psy-knowledge is created and made meaningful in class-specific ways; psy 'makes class' by fostering class-based health practices, knowledges, and subjectivities; psy mobilizes knowledge to make sense of suffering and thereby creates particular meanings, illness categories, and even futures – something I have called 'class-based chronicities' (Vorhölter 2017a). As a form of knowledge, psy in Africa is deeply entangled with colonial and postcolonial medical interventions, including the currently thriving field of global mental health. As a class-specific form of care, psy in its contemporary global manifestation is deeply entangled with neoliberal values and forms of governing. Yet despite its entanglements with capitalism and with established global medical institutions, psychotherapy also offers possibilities for meaning- and sense-making that challenge conventional hierarchies, ideologies, and norms. For my interlocutors at least, establishing psychotherapy in Uganda was more than just a job – it was a project to create better care and a better society.

Before discussing my findings in more detail below, I offer some brief reflections on my fieldwork. The three following sections – on psychotherapy as meaning-making, knowledge-making, and class-making – form the central part of my analysis and relate my empirical findings to larger anthropological debates on care, global mental health, and African middle classes. The first of these sections, 'Making Sense of Suffering: psychotherapy as meaning-making and care', conceptualizes psychotherapy in Uganda as a new form of care that helps people make sense of wide-ranging social transformations in ways that are different from existing healing regimes. I show how – through the efforts of a few dedicated 'pioneers' – psychotherapy emerges both as a new social institution and as a 'toolkit' which individuals make use of flexibly and selectively. The second section, 'Ugandan and/or Universal? Psychotherapy as knowledge-making and governance', deals with the challenges of professionalizing psy in Uganda and makes an intervention into ongoing debates about global mental health. I question conventional framings of psychotherapy as something external and foreign to 'Africa' that has been imposed by outsiders. Instead, I show how Ugandan therapists consider themselves part of a universal field of knowledge and how – through their efforts to make this knowledge relevant in Uganda – they actively engage in the production and negotiation of psy's universality. Nevertheless, they are confronted by powerful historical legacies and international institutional regulations which limit how and where they can practice and how their work is valued. The third analytical section, 'Great Expectations: psychotherapy as class-making', engages with recent debates on African middle classes. I show how, on the one hand, the recent popularization of psychotherapy is a response to the emergence of new middle classes – and the stresses, ambitions, and personal crises faced by those aspiring to be middle class. On the other hand, however, psychotherapy also actively promotes ideas of how to become a middle-class self and, as such, is itself a form of class-making. The conclusion connects the analytical approach developed in this paper to my previous publications on psy in Uganda and thus draws together the main findings from my research project as a whole.

Fieldwork Reflections

I arrive at the East African Professional Counseling Institute a few minutes after my scheduled appointment, sweaty and slightly embarrassed. I had missed the nondescript sign on the multistory building and was walking along the busy, dusty road in the wrong direction when I received a phone call from Elizabeth, my therapist-to-be. 'Are you still coming for the appointment?' she asked in what I interpreted to be a slightly annoyed voice. Once again, I notice that – unlike many other contexts in

Uganda where being late is the norm rather than the exception – therapy does not work according to what people jokingly refer to as 'Ugandan time'.

The entrance to Elizabeth's therapy institute is located between two commercial shops on the ground floor of an apartment building at the outskirts of Kampala. Upon entering, I am surprised to find a reception area and a receptionist who welcomes me and then asks me to pay for my session: 80,000 Ugandan shillings (approximately 25 euros at the time). Elizabeth comes out to greet me: she is a small, elderly woman who seems friendly and confident. 'I am glad you found us,' she says with a smile. After I have signed the visitors' book, I follow Elizabeth into her 'office': a small, dark room with a concrete floor and three plastic chairs – one for the Kleenex box. The only other piece of furniture is an empty desk in the corner. There are no pictures or decoration. A steel door at the back connects the room to a courtyard; later during the session we hear children playing there, laughing and occasionally banging against the door.

Elizabeth asks me to pick a chair and then sits down opposite me. She introduces herself: 'I am Elizabeth, counseling psychologist, I have trained up to Master's level in the UK. My approach is the person-centered approach. You should know that everything we say in this room is confidential.' Then it is my turn. I tell her that I learned about her practice and institute from another Ugandan therapist and that I am here to experience psychotherapy as a participant observer.

*

My ethnographic findings are based on roughly four months of fieldwork, mainly in Kampala, but also in Gulu (the biggest town in Northern Uganda) as well as a brief three-week stay in Tanzania (mainly Iringa), which I carried out over two periods (February to April and August to October) in 2015.[10] In total, I conducted 35 interviews[11] with psy-professionals (psychologists, psychotherapists, and psychiatrists),[12] visited various therapeutic institutions and also analyzed current debates on mental health and psychotherapy in articles from one of the major Ugandan daily newspapers, *Daily Monitor*. Moreover, my insights are informed by my previous research experiences in Gulu (12 months between 2009 and 2011), and the material I collected for my PhD project during that time (Vorhölter 2014).

Most of my research consisted of identifying and visiting psychotherapeutic locations, chasing after usually very busy psychotherapists for interview appointments, and talking to Ugandans (research interlocutors, friends, and random acquaintances) about their experiences and ways of dealing with stress and suffering. Among my interviewees were some of the founders of the first and most established private psychotherapy practices in Kampala; the director of Butabika Hospital; Uganda's first psychiatric nurse, who had played a crucial role in the history of Butabika (see Vorhölter 2020);

[10] After finishing my second research period in Uganda in late September 2015, I flew to Tanzania, where I had been invited to teach a one-week intensive course at Iringa University. The topic I chose was 'Mental Illness and Therapeutic Practices in Historical and Cross-Cultural Perspective', and the course was open to BA and MA students from the anthropology and psychology programs. I closely cooperated with a Tanzanian colleague from the psychology department, Heriel Mfangavo, who himself was one of the pioneers of Tanzanian psychology and psychotherapy. In my conversations with him and our discussions with the students in class, I learned a tremendous amount about healing practices, perceptions of mental health and illness, and the nascent field of psychology and psychotherapy in Tanzania. These conversations helped me to gain a broader perspective on my research topic and provided me with new insights into the past and contemporary developments of psy in East Africa.

[11] Average length about one hour.

[12] I use the term 'psy-professionals' to denote people whose main profession involves non-HIV-focused counseling or psychotherapy and who hold at least a bachelor's degree in clinical or counseling psychology, psychiatry, or another counseling-related discipline (social work, for instance).

one of key figures in the emerging Ugandan mental health 'service-user' movement; as well as the principal medical officer in the section of mental health at the Ministry of Health. I also interviewed students and lecturers of clinical and counseling psychology about their motivations for becoming therapists and their aspirations for the field more broadly. I visited private practices, participated in a symposium for child and family therapy, and decided to experience psychotherapy as a participant observer or 'research-client' myself (see vignette at the beginning of this section).

I conducted most of my research in Kampala. The majority of the people I met through my fieldwork (psy-professionals and university students), or those I came to know through private contacts in the expat community, belonged to what I would call the upper middle class.[13] I was often struck by how different their lifestyle seemed to that of the people I had worked with and befriended during my PhD fieldwork in Gulu – mostly unemployed youth from peasant backgrounds – and it made me aware of the enormous class divide in Ugandan society. The upper-middle-class Kampalan lifestyle, as I came to experience it, was characterized by what seemed to me often excessive forms of partying and conspicuous consumption, but also by relentless time and performance pressures, high levels of stress, countless hours stuck in traffic jams, and feelings of alienation, frustration, or even loneliness. I frequently encountered stories of family crises, relationship break-ups, financial struggles, and drug or alcohol problems, which my interlocutors attributed to the 'modern urban lifestyle'. As such, my observations and experiences of Kampalan life were immediately relevant to my research topic because they helped me to understand what led some people to seek therapy. I hung out and met with different people in restaurants, cafés, bars, clubs, gyms, private schools, and shopping malls and, whenever it seemed appropriate, I asked them about their lifestyle-related stresses and how they dealt with them.

During both fieldwork periods, I spent one or two weeks in Gulu – to visit old friends and to explore the expansive 'trauma-counseling scene', which was frequently mentioned in Ugandan discourses on psy interventions. As I had expected, psy contexts in Gulu were very different from those in Kampala – in terms of their practitioners (mostly international psychologists who had trained local co-counselors and were working in collaboration with them), institutional structures (mostly project-based, time-limited, and externally funded interventions), and clients (mostly people from low-income backgrounds who had been referred through NGOs engaged in post-conflict development and humanitarian work). I felt inspired to explore these differences – and their discursive (re)production – more systematically.

In addition to my own observations and interviews with Gulu-based counselors, I also explored representations of the psy-regime in Gulu, which frequently came up in my conversations with therapists in Kampala. They seemed to think of psy in the North as their 'Other' and reproduced widespread imaginations of Northern Uganda as a place of suffering, trauma, and trauma interventions.[14] When talking about the dire job prospects for psychologists, for instance, most of my interlocutors mentioned that most of the available work for therapists was with NGOs working in Northern Uganda – but that they could not really imagine moving 'upcountry' and thus preferred the risks and uncertainties of private practice in Kampala. The differences between psy in the North

[13] I provide a more detailed discussion of class categories and positionalities in Uganda below.

[14] Uganda is often portrayed and perceived as a divided country: The historically evolved North–South divide has been reinforced through the 20-year civil war. Furthermore – like in many African countries – one finds a substantial rural–urban divide and increasingly also a class divide. While these divides do not neatly map onto each other, they correlate to some extent, at least in the popular imagination, whereby the North is generally seen as more rural and poorer than the South. As noted, these (real or imagined) divides are also relevant when talking about psychotherapy.

and in Kampala also frequently came up in conversations about why Ugandans seek out therapy. My interlocutors would often mention trauma – and then specify that this was predominantly an issue in the North because of the war. In a similar vein, the therapists I interviewed in Gulu – although often critical of the 'trauma category', which did not always capture the nature of their clients' problems very well – labeled their work as trauma counseling in order to gain funding or other forms of recognition. As one of my interviewees, an experienced European psychotherapist who was responsible for setting up and carrying out large-scale programs to train local counselors, told me: 'Every year I offer a training for 'trauma counseling' that goes for twelve months. The reality is that the training is about counseling and therapy, but we have this trauma brand' (interview 29.03.2015).

While there was hardly any anthropological literature on psy in Uganda when I started this project, it is now becoming a growing field of study, particularly in Northern Uganda (see above). By tracing the incipient popularization of psychotherapy based on my conversations and interactions with its pioneers, my research lays the groundwork for further explorations of a field that has surely already continued to further expand and professionalize. In essence, I provide an ethnography of local and international psy-practitioners in Uganda – a small, loosely connected, but nevertheless clearly identifiable group of people with a shared belief in and commitment to psychotherapy – and their attempts to create and popularize a new therapeutic regime and form of care. My work is about their motivations, their visions, and their reflection on their profession and its challenges. It is also about the rapid economic, political, and social transformations Uganda has been undergoing since the mid-1980s and the effects of these changes on interpersonal relationships, lifestyles, and ethics. Here, it links up most clearly with my previous research in Northern Uganda (Vorhölter 2014). It draws attention to the vast and growing internal diversities and divides within Uganda and how they are mirrored and reproduced in health-care practices. Finally, my work is not just about Uganda but about psy as an increasingly universal phenomenon that shapes people's imaginations of suffering, well-being, and what constitutes a happy, healthy, and normal self.

Making Sense of Suffering: psychotherapy as meaning-making and care

When looking for online information on the East African Professional Counselling Institute (EAPCI) – founded in 2010 as one of the first training institutes for psychotherapy in Kampala – the following statement on the institute's Facebook homepage caught my attention:[15]

> "Africa as a continent is going through a transition from traditional systems to modern arrangement. Significant changes that have occurred in the recent past include the move from the rural to the urban environment, increased awareness of the importance of family structures that address reproductive health needs of their members, a redefinition of the nuclear family different from its form in popular parlance, and a transformation to more diverse family forms including single parenting. The region's geopolitical set-up[,] with neighbours often at conflict with each other [and] with intermittent threats of terrorism, wars, rape, child abuse, commercial sex, human trafficking, sexual and gender based violence (SGBV), drug abuse and addiction, destructive social media, divorce and separation, globalization, absentee parents, the increasing population[, a] majority of whom are below thirty years, and the high levels of unemployment all have psycho-social impact on individuals and the families. (…) Unfortunately, the psychosocial element of development has not been adequately addressed.

[15] https://www.facebook.com/East-African-Professional-Counselling-Institute-Limited-104914894366362/, accessed 14 April 2021.

> (…) East African Professional Counselling Institute was set up to address this gap, by training professionals in different mental health, counselling, and psychosocial issues. EAPCI's major objective is to offer mental health, psychosocial and counselling trainings and services to the public to promote wholeness, maturity, and self-esteem. The philosophy underlying the institute's professional services is simple: 'A shoulder to lean on' (…)."

As this statement succinctly suggests, people in 'Africa' are struggling to cope with the wide-ranging transformations the continent is currently undergoing: urbanization, globalization, changing family dynamics, violent conflicts, economic destitution, inequality, political conflict and violence, negative impacts of social media – and many others. With the exception of social media, few of these developments are truly new but have been ongoing in one way or another for decades, if not centuries. What is new, however, is that they are now being read as having a 'psycho-social impact on individuals and families'. This is not to say that previous generations did not suffer from social upheavals in similar ways, but that their suffering was experienced 'under different descriptions', to borrow Ian Hacking's (1995) formulation.

The EAPCI statement resonated with my fieldwork encounters. For my interlocutors, the necessity of establishing psychotherapy as a new healing regime in Uganda was inseparably related to ongoing experiences of social change. They saw the fast-paced nature of social life as a major contributor to what they considered to be a massive increase in mental health problems. One of my interviewees, a highly-respected professor of psychiatry at Makerere University, poignantly summarized this as following:

> "There is no doubt that there is an increase in mental illness, there are about four reasons why: One, the wars are increasing in Africa. (…) Two, diseases like HIV/AIDS: they are affecting people, they themselves cause mental illness, they create orphans who are very distressed, widows, and poverty, there is a lot of poverty. (…) And then come the modern times! Drugs! These are increasing in our countries like crazy. (…) Then we have problems like urban to rural migration, or rather rural to urban migration, people leaving the countryside and coming to team up in the cities. (…) People hardly sleep in cities, booming noises everywhere, people not following driving regulations, having car and *boda boda* [motorbike] accidents (…) Domestic stress! And then we have this funny academic curriculum which wakes up children at 4 am to go and study in primary school. How do you take kids to boarding schools who are ten years old? And less! These are things we have to deal with every day. And then the other thing is people wanting to make money, leaving their countries, their young children, and going to Europe. Maybe people in Germany hope to get a job, get a mortgage, buy a house, pay it off in 25 years, whereas in this country people build five houses in five years. So with that kind of suffering, what do you think is going to happen? People break down, people get stressed (…). It is a continent in transition, and this has to be understood, just maybe like Europe went through the Industrial Revolution, before things slow down. So those are challenges that we face, and those increase mental illness." (Interview 01.9.2015)

Ugandans were not only grappling with growing inequality and competition, diseases and disease-related family transformations, political conflict, and violence; younger generations in particular were also struggling to reconcile their imaginations of capitalist modernity (regarding, for instance, material belongings, lifestyle practices, or relationship models) with prevailing values, institutions, and ways of life. Their individual aspirations (for economic wealth, happiness, and love) often clashed with limited educational or professional opportunities, social obligations, or other structural constraints (Vorhölter 2014; Parikh 2015). And while established institutions of healing –

'traditional' or faith-based – were still important to Ugandans of all age and class backgrounds, the answers and the solutions they offered to people's questions, problems, and desires were sometimes experienced as inadequate: as too rigid, too conservative, or unsatisfying in other ways. Ugandans were looking for new ways to make sense of suffering, and of life more broadly. And the language and practices of psy seemed compelling, at least for some. For instance, Stella, who I talk about in the opening vignette, found meaning and a new sense of agency once she started to analyze her marriage-related unhappiness through the lens of depression. Learning about the symptoms of depression helped her to make sense of her otherwise incomprehensible and unacceptable behaviors – like failing to be a loving mum. And knowing that she suffered from an illness which could be understood and managed empowered her to change her life. Yet, as other scenes in the opening vignette show, having a new framework was not always enough to ease or 'make sense' of suffering. For the nun, who was exhausted and wanted to be relieved of her care duties, the 'discovery' that the girl she had become responsible for was suffering from (incurable) brain damage and psychological trauma did not seem to provide any meaningful relief.

Psychotherapy's potential to offer new forms of meaning-making was not the only reason people turned to it, however. As the therapists I spoke to emphasized, it also created a new kind of care relationship that was different – less hierarchical, more empathetic, and more self-reliant – from those of other healing regimes. The image of a 'shoulder to lean on', used in the Facebook statement above, captures the idea of this relationship well. The image suggests companionship and equality. To lean on someone's shoulder literally implies that one has to be of a similar size to the person one is leaning on. One is supported by, but not carried or held by the care-giver; one has to be capable of standing (or sitting) alone. While care, as I discuss below, is never free from power, paternalism, and forms of control, in psychotherapeutic encounters such dynamics were subtler, my interlocutors suggested. This sometimes proved to be a challenge for clients who were used to being told what to do and say by 'therapeutic authorities' like doctors, healers, or pastors. For others, however, especially those who were critical of or did not live according to established gender and generational hierarchies and related social identities, psychotherapy's more liberal approach was attractive, and indeed, imperative.

The following two sections discuss how psy emerged in Uganda in the context of ongoing processes of and debates on social change and how – through the efforts of a small group of 'pioneers' – it became embedded in and entangled with existing healing regimes.

Care and Control in Times of Social Change

Ever since I started doing fieldwork in Uganda in 2009, I was struck by the intensity with which Ugandans – in the media, in day-to-day conversations, and in politics – discussed matters of socio-cultural change. Although people embraced some aspects of change, there seemed to be an overall and shared sense that 'modernization', as it was often called, also came at a high price: a loss of social cohesion, of shared morals and values, and of respect for established authorities (elders for instance) and institutions (like marriage). Further commonly mentioned examples included increasing family conflicts, ruthless competition, and individualism, as well as rising levels of affliction (Vorhölter 2014).

Depending on their position in society and the particular struggles they faced, Ugandans blamed – sometimes humorously, but often with serious implications – a variety of actors for the problems of change: men accused women; elders blamed youth; the poor condemned the elites. Almost everyone

blamed, in some way or other, Ugandan politics, social media, and 'Westernization' (Vorhölter 2012). And sometimes, for example, during the height of debates on the so-called gay bill, marginalized groups – in this case homosexuals – became the culprit behind all kinds of social problems: the breakdown of morality, the crisis of the traditional family, and Western imperialism (Vorhölter, 2012, 2017b). Across Uganda today, one can find many individuals and groups who want to reestablish 'the past', however imagined, or regain a sense of social control that they feel they have lost or are in the process of losing. For example, men who feel disempowered try to reestablish 'traditional' gender hierarchies; cultural or religious authorities try to save morality; and the NRM government under President Museveni, in office since 1986, uses increasingly violent measures to stay in power – as the recent 2021 elections testify (Akinwotu and Okikor 2021; BBC 2021; Martinello et al. 2021). One of my articles (Vorhölter 2017b) discusses these ongoing power struggles between men and women, youth and elders, state and citizens in more detail. Focusing on recent legal measures aimed at regulating sexual conduct, it shows how both state and non-state actors exploit popular concerns about recent processes of social change and instrumentalize 'sexuality' to extend their control and reinforce a normative order based on patriarchal values.

In this context, psychotherapy has emerged as a different form of engaging with social transformation and personal crises, one that is not centered on blaming, punishing, or censoring desires but which aims to provide a space for Ugandans to reflect and talk about their problems in new ways. For some clients, the therapy room was indeed the only space where they could open up: for instance, several of my interlocutors mentioned self-designated homosexuals who had come to speak to them in confidentiality (Vorhölter 2017b). Some wanted to be 'cured' and made 'normal' again; others accepted their homosexual desires but were suffering from fear, depression, stigmatization, and loneliness and needed someone to confide in. I was also told about rape victims who did not want to, or could not, report to the police or anyone else, because the perpetrator was a spouse or family member they depended on. According to my therapist interlocutors, clients like these often felt that they could not approach other institutions of healing and care – kin-based, faith-based, 'traditional' – because the latter were so closely entangled with established, conservative forms of authority and control. For these clients, but also for others with less severe problems, psychotherapy was indeed liberating because it was set up to question conventional hierarchies and moralities, and because it placed the individual in a position of power, responsibility, and self-care/control.

Like other forms of care (cf. Han 2012; Mol 2008), psy has been deeply and problematically entangled with capitalism, colonial medicine, and neoliberal forms of governing. It promotes particular values (individualism, anonymity, liberalism, non-judgmentalism), a particular type of self (productive, self-reflective, self-responsible), and a particular kind of society (rooted in capitalist production, distribution, and consumption ethics). It responds to mental health problems that are related to, if not caused by, neoliberal transformations, and by helping people cope, it stabilizes the capitalist system and its inherent inequalities.[16] But psychotherapy also creates a space for Ugandans

[16] As Smail (2017: 13) writes: "For if therapy offers a magical solution to the majority who suffer the world's cruelties, it also provides handy advice for them to be given by the minority who inflict them: suffering is to be lessened not by attacking social injustice, but rather by personal readjustment of the disadvantaged themselves. (…) the message is (…): wealth and privilege have nothing to do with a brutally unbalanced social system, but are available to all who achieve the right psychological balance and act "responsibly". It is surely no coincidence that the increasing disparities in wealth and power, both within and between countries over the past twenty-five years or so, have been accompanied by an explosion in the advocacy and provision of therapies and political prescriptions that have magical voluntarism at their core."

to critically reflect on these problems and, sometimes, empowers them to make meaningful changes (Vorhölter 2021; cf. Kovel 2017).

Care, as recent anthropological debates on the concept reveal,[17] is always intimately bound up with control; yet it cannot be simply reduced to control. Even the most 'deadly' or 'murderous' forms of care (Stevenson 2014) have at their core a well-meaning, if fundamentally misguided, intention. Care, as I understand it, is always about the preservation of something – life, nature, the body, the species, sanity, memories, ideas, relationships – and it implies recognizing an 'Other' in a particular way: not necessarily as equal, but as worthy of existence and engagement (cf. Tronto 1994; Puig de la Bellacasa 2017: 3ff.; Browne et al. 2021b). In talking about psy in Uganda as a form of care, I want to highlight that it is driven by a particular motivation and vision – to create possibilities for well-being – that cannot be reduced to financial interests, neoliberal health-care politics, or forms of governance, although all those factors play a role.

Care relations are never really equal; but inequalities in care can take on very different manifestations. Feminist scholarship, in particular, has drawn attention to the often vulnerable, subordinate, and precarious situations of *care-givers* – nurses, housemaids, cleaning staff, plantation workers, prostitutes, and many others, who tend to be predominantly poor, non-white, and/or female – in the international labor economy (e.g. Glenn 2010; Hochschild 2000; Sevenhuijsen 1998; Tronto 1994). At the other end of the scale, research on pastoral, bureaucratic, military, and/or bio-political systems of care (e.g. Stevenson 2014; Garcia 2010; Ticktin 2011; Varma 2020) emphasizes the subordinate position of *care-receivers:* colonial subjects, drug addicts, asylum seekers. These studies analyze how powerful actors (social elites, governments, international organizations, companies) design and enforce forms of care for the less-powerful, often as a way of disciplining, managing, or otherwise controlling certain sectors of the population. However, as these studies also show, top-down care systems are often met with resistance from, or appropriated by, recipients who reconfigure 'local' care relations in sometimes unexpected ways.

The comparison of my two research settings, Gulu and Kampala, shows how a particular form of care can take on very different manifestations and produce different power dynamics and care subjectivities. Psychotherapy in Northern Uganda, at least from the outside, is driven by an international humanitarian regime that offers a standardized, global model of care for victims of disaster and trauma, one that often depoliticizes suffering and patronizes sufferers (Fassin and Rechtman 2009). Care-receivers in Northern Uganda are in many ways in subordinate positions – regarding their socio-economic, educational, and health status. They are imagined in particular ways – as traumatized[18] – by international designers and providers of mental health care (who often know very little about local lifeworlds), and they have little say in how care programs are conceptualized. Yet, this is not the only way of looking at the emerging psy-regime in Northern Uganda. Care-receivers are not powerless: some reject psychotherapeutic offerings; others incorporate them into their health-seeking strategies (Meinert and Whyte 2020). And some even decide to become psy-

[17] Care has become a key concept in anthropology over the past two decades. Studies of care cover a vast range of research and subject areas: medical care, environmental care, interspecies relations, technosciences, political governance, ethics – to name but a few (for a comprehensive overview see Buch 2015; Alber and Drotbohm 2015; Thelen 2015; Puig de la Bellacasa 2017). My main interest lies in the ongoing debates on the politics of care which analyze how larger structural inequalities and power relations are reproduced in care arrangements (for a recent thought-provoking contribution, see Browne et al. 2021a).

[18] Lisa Stevenson (2014: 66ff.) provides a compelling account of what happens when a whole population is read as being chronically ill – suicidal, in her case of Inuit Canada, or traumatized in the case of Northern Uganda – and how this affects care interventions. She discusses how impossible care subjectivities emerge when people are both expected to seek help for their condition (suicidality or trauma) but are always expected to fail: to kill themselves (or remain traumatized) anyway.

carers themselves – because they have been convinced of the benefits of talk therapy and/or because trauma counseling is a sector with expanding employment opportunities in a context where jobs are scarce (cf. Abramowitz 2014).

Private psychotherapy in middle-class Kampala works according to different logics: it is mostly a form of care by elites for elites; a form of care that is chosen and paid for by care-receivers who feel entitled to have a say in how they want to be cared for – even if their expectations and demands conflict with psychotherapeutic principles. Somewhat paradoxically, even though psychotherapy seems more suited to the Kampalan middle-class context, employment opportunities are in some ways more uncertain than in NGO-funded trauma and mental health projects in Northern Uganda and, increasingly, other peripheral regions of Uganda. Few of the Kampalan therapists I met could make a living just from their private practice; therefore, they were also involved in teaching, consultancy work, and other income-generating activities. Apart from two positions for clinical psychologists at Butabika and a few positions for student counselors at public universities, government appointments for psychologists were extremely rare at the time of my research.[19] Nevertheless, several of my interlocutors had rejected job offers in Northern Uganda[20] or stated that they could not imagine working upcountry. Instead, they engaged in voluntary or short-term forms of counseling in the capital – which they hoped would eventually materialize into longer-term employment. Some worked in school- or church-based mental health programs; others worked in the growing field of HIV/AIDS-related mental health care.[21] Many were involved, in one way or another, in advocating for and promoting professional forms of psychotherapy to a larger public.

As these examples show, Ugandan psychotherapy is a form of care 'in the making' that is shaped by complex moral, medical, and politico-economic motivations. Structurally, it is linked to funding priorities, international medical trends, and neoliberal forms of (self-)governing. At the individual level, it is driven by financial interests and needs, but also by the desire to help sufferers and to create a better and healthier society. All of the therapists I met were deeply convinced that psychotherapy had something to offer that was otherwise lacking in the Ugandan therapeutic landscape: a science-based approach to healing which empowers sufferers to critically reflect on their circumstances rather than being told what to do by medical, political, or religious authorities; a form of care that encourages sufferers to openly explore and talk about feelings, thoughts, or painful experiences that they had been taught to hide; and a form of conversation that challenges conventional hierarchies, rules, and norms regarding who can speak to whom about what. As such, psychotherapy was more than a profession for these therapists: it was a larger project of creating meaning, care, and a more empathetic society.

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[19] The Ugandan government, though trying to upscale mental health services across the country, was skeptical about the value of psychological therapies. Rather than creating positions for professional psychotherapists – and in line with international global mental health policies – it focused its efforts on decentralizing psychiatric care by training staff at local health-care centers in psychiatric diagnostics, deploying psychiatrists to the regional hospitals, and improving access to basic psychopharmaceuticals.

[20] For some this was because Northern Uganda felt too 'foreign' – linguistically, socially, culturally. Others simply could not imagine working with trauma victims.

[21] This field is different from, though of course related to, standard forms of HIV/AIDS counseling, which focus on educating people about HIV/AIDS and advising those who test positive on how to live with the disease. In contrast, HIV/AIDS-centered mental health care is usually offered by trained psychologists or psychiatrists who seek to address the physiological and psycho-social interrelations between HIV/AIDS and mental illnesses such as depression, anxiety, or psychosis (Musisi and Kinyanda 2009).

> "Psychiatry [was] a virgin area, someone could go and adventure there. So I picked interest." (Rwashana Selina, interview 14.09.2015)

Sitting in her small home, not far from Butabika Hospital, Rwashana Selina told me about how she first became interested in psychiatry, a moment which sparked her life-long passion for the field. As I discuss in Vorhölter (2020), she was the first Ugandan nurse to be sent to the UK in the 1960s for psychiatric training. After her return, and driven by her vision to improve care for the mentally ill, she played a key role in the history of Butabika and became a pioneer of Ugandan psychiatric nursing.

Throughout my research, I met a number of people like Rwashana Selina: leading figures in the Ugandan mental health scene who have been instrumental in developing and promoting psychiatric and psychological forms of care and who I have come to call the 'pioneers of psy'. People like Grace Akot, who founded the first Ugandan private practice for psychotherapy in 2001 (Vorhölter 2021), Edward Nkurununngi, who was among the co-founders of Uganda's first service-user organization in 2008,[22] or Marco, an Italian psychotherapist, who has set up, coordinated, and continues to run the first comprehensive training program for trauma counselors in Northern Uganda (Vorhölter 2019).[23] All of them ventured into unknown territory in a context that was full of skepticism, if not hostility, towards their mission.

As in many African countries, mental health care in Uganda has never been a key area of health politics. It has always been severely underfunded, highly stigmatized, and has mainly targeted – through medication and confinement – the severely mentally ill. While this is gradually changing, and more resources are being channeled into broadening and improving *psychiatric* care, the Ugandan president has continued to express his disregard for psychology and psychotherapy – which he considers unnecessary, un-Ugandan, and unworthy of funding. All of my interlocutors repeatedly emphasized that promoting a hitherto neglected and largely unknown form of care came with many challenges. They faced a lack of resources, of secure employment opportunities and income, but also a lack of respect for their profession – from family members, friends, and other healing professionals. Even the recipients of their care were often skeptical and unappreciative, at least initially. In short, 'working with crazy people', as many Ugandans thought of mental health care, was not highly regarded.

Establishing psy in a country where it was highly stigmatized and, in the case of psychotherapy, largely unfamiliar required endurance, resilience, and determination. My interlocutors described it as a process of trial and error without clear guidelines. The notion of pioneering captures the challenges, hardships, and uncertainties they faced. But it also conveys the excitement, passion, and motivation that was driving them, and the moments of success and euphoria that sometimes followed long periods of doubt or struggle. Edward Nkurununngi, the pioneer of the service-user movement mentioned above, related one of those moments to me in our interview. With a big smile, he remembered the beginnings of their initiative:

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[22] I do not discuss Edward's case and the history of the service-user movement in any of my publications. Some information on both is available online, for instance: https://www.mhinnovation.net/peer-support-groups-opportunities-and-challenges-uk-and-uganda, accessed 30.06.2021.

[23] Although all of the people mentioned here are public figures, I have anonymized some of their names in the articles I published. Here, I use the names (some real, some pseudonyms) that I also used in the articles.

> "So we started saying 'let's have an organization', but we didn't know how to start it. (…) What we were trying to do was peer support, (…) it was a new thing here, we had never heard of it. So we would go on the internet, read about Scottish recovery [initiatives], read about Wellness in the Woods in the USA, read about peer-support recovery, stuff on Facebook and all that. We tried to search around, we came up [with ideas] and we tried: we would go and visit peers, support them, take them to hospital. (…) So we formed a kind of buddy group, to support one another. (…) And so we did peer support sporadically, not formally, just sporadically. But it was fun! (…) Eventually we tried to apply for a grant. (…) We tried three times, until [we were finally] supported. That was November 2011, we started in 2012. We had our first grant! Aahhh that was amazing. It was amazing! I felt like dancing." (Interview, 30.08.2014).

Pioneering connotates struggle and success; it also comes with the notion of conquering, displacing, and driving away. In Uganda, psychological concepts and medicalized explanations of suffering (like trauma, depression, or addiction) were certainly becoming more popular (Vorhölter 2019 and 2017a). My therapist interlocutors, but also other highly educated Ugandans, considered them more scientific and thus superior to other forms of knowledge. Nevertheless, at least at the time of my research, psy did not seem to be replacing or driving out other forms of healing and care. Rather, it was seeking a niche among them. Traditional and faith-based forms of healing continued to be hugely popular, and for many *help-seekers*, combining different healing approaches seemed to be a resource rather than a problem.[24] However, relations between *practitioners* were more complicated: although everyone recognized the need to accommodate medical pluralism among their patients and clients, most of my therapist interlocutors could not imagine more formal or systematic cooperation between different healing regimes. Psychiatrists, for instance, complained about pastors and traditional healers who had interfered with their patients' medicine regimes; some also complained about psychologists who were apparently not properly qualified to handle mentally ill patients. Traditional healing was a particularly delicate subject for my psy-professional interlocutors. While many thought that mutual learning and exchange could be beneficial in theory, few could actually imagine how this might work in practice. Some expressed sharp criticism, or even fear, of traditional healers and their practices.[25]

Because of the important role of religion in Uganda, relations between psy-practitioners and faith-based healers were generally less problematic. Most therapists I talked to said that they could easily relate to clients' religious beliefs (even if they belonged to a different faith-group) and sometimes made use of this in therapy. Some professional therapists had previously been religious practitioners (usually Christian) or, like Rwashana Selina, turned to religion after their official psy-careers had ended. However, relations between psy and religious healing – as practiced in Pentecostalism in particular – were also contested. Several of my interlocutors were openly critical of Pentecostal pastors, whom they described as extremely dogmatic and intolerant of other healing approaches (especially biomedicine and traditional healing) and whom they accused of trying to cure their followers from suffering in ways that were actually harmful to them. Somewhat paradoxically,

[24] Meinert and Whyte (2020) provide an insightful analysis of this in Northern Uganda.

[25] An extreme example of this happened when I was teaching a course on mental health and illness to a group of anthropology and psychology students in Iringa, Tanzania. As part of a research exercise, the students had all been assigned to different working groups; each group was supposed to interview a local mental health expert, including a traditional healer. Two of the (Christian) psychology students refused to join the group which was to meet with the traditional healer. They said they were terrified of such people and would rather fail the course than take part in the interview. Similarly, for some of my Ugandan interlocutors, coming face to face with a traditional healer was unimaginable. For complex historical reasons, traditional healing a very sensitive and secretive topic in many African countries, including Uganda and Tanzania. Although studies (e.g. Okello and Musisi 2015) suggest that most Africans make use of it, this is rarely openly acknowledged and public discourses on traditional healing are often quite critical.

however, Pentecostal counselors in particular were becoming extremely interested in psychological concepts and methods, which they selectively integrated into their work (see Vorhölter 2021; van Dijk 2013).

As these examples show, and the next section elaborates, pioneering psychotherapy in Uganda was a muddy and contested struggle for meaning, knowledge, authority, and respect. The contexts in which psychotherapy was practiced, how it was perceived, and how it became translated into different Ugandan life worlds were deeply entangled with global knowledge economies and past and present forms of medical governance in Uganda, and in Africa more broadly.

Ugandan and/or Universal? Psychotherapy as knowledge-making and governance

The problem of translating psychotherapy – not just verbally but epistemologically – and making it relevant and desirable in Uganda was something that all the therapists and therapists-to-be I met struggled with. As Stella's and Sharon's experiences in the introductory vignette reveal, it was particularly challenging for those in training: their psychology textbooks came from the US or the UK and thus did not really speak to Ugandan therapy contexts;[26] their supervisors – while generally extremely dedicated and competent – were overworked and had very little time. Most of the lecturers belonged to the very small circle of Ugandans with advanced degrees (Master's or PhD) in psychology[27] who were spearheading attempts to professionalize and expand the field. Alongside their teaching roles, they often also ran private practices, did consultancy work for international NGOs, carried out research, or were involved in trying to manage and professionalize the Ugandan Counselling Association (UCA).[28]

From my observations, interviews, and conversations with therapists, I learned that successfully practicing psychotherapy in Uganda required not only knowing psychological methods and theories but also being able to creatively adapt them and to improvise – two skills one could only gain through practical experience. All of the more experienced therapists told stories of how they had adapted psychotherapy to make it work for individual clients. This sometimes involved breaking some of the ground rules – like going over time in a session, or relating to clients in a more personal way than normally expected of a therapist–client relationship. Ugandan psychotherapy, in this sense, was still a profession in the making with standards and best practices that were being negotiated between the expectations of Ugandan clients – most of whom did not have a clear sense of what talk therapy entailed and why it should be guided by such rigid rules – and the highly standardized international frameworks of professional ethics, regulations, and assessment tools.

Most of my interlocutors generally believed in the value of a universal psychology – which, paradoxically, they sometimes called 'Western psychology'. They were fascinated by 'scientific'

[26] Obviously, the translation from theory to real-life practice is a challenge faced by all psychology students, not just those in Uganda. However, as I show in more detail in Vorhölter (2021), Ugandan students and therapists were faced with a double translation: not just from theory to practice, but also from British or American therapy contexts to Ugandan ones. Many of the examples given in textbooks and training materials, for instance, are modeled on 'typical' British or American cases, clients, and problems which are different from those in Uganda. Instructions on how to use family genograms do not consider the large and often polygamous family constellations in Uganda. Terms for feelings and emotions that are a taken-for-granted part of everyday language in the US or UK sometimes have no equivalent in Ugandan languages. And the list goes on.

[27] Some of these 'pioneers' had obtained their degrees abroad, usually in the US or the UK. Others were among the first to have completed their MA degree in Uganda. The first MA program for psychology in Uganda was started at Makerere University in the late 1990s.

[28] The Uganda Counselling Association was founded in 2002 as an umbrella organization for a broad range of counselling professions. https://ucaug.org/index.html, accessed 26 January 2021.

assessment tools like depression scales or IQ tests – even though the actual questions used in these assessments often made little sense in the Ugandan context. And they were curious about different therapeutic approaches (established ones like cognitive-behavioral or person-centered therapy, but also newer ones like acceptance and commitment therapy or EMDR[29]) and how to use them with Ugandan clients. Adaptation was a challenge, but one that the more experienced therapists in particular readily took on and often enjoyed. A much bigger struggle was gaining access to particular tools or certificates, which were usually expensive or simply unavailable in Uganda, but which were crucial forms of 'professional capital' – as the following ethnographic vignette demonstrates.

*

The day after my visit to Butabika, I have another appointment with Stella. This time we meet at one of the international schools where Stella and Sharon had until recently assisted a European psychologist in setting up a program to assess and support students with autism and other special needs. Stella and Sharon have been trying to continue some of the work after the European psychologist's departure, but it has been difficult because the school usually works only with internationally certified psychologists. Nevertheless, the parents of one student have privately employed Stella to help their daughter, who suffers from autism, with school work and to teach her basic social skills. Today, Stella is here to talk to the special-needs teacher about the girl.

I wait for Stella at the gate. The school is unlike anything I have ever seen in Uganda: a little world of its own, separated – visually, materially, atmospherically – by high stone walls from the Uganda outside. The gate is patrolled by security officers, and almost everyone entering or leaving drives a big, expensive car. A mzungu father who has come to pick up his child walks up to the gate and apologizes for coming on foot – his car is being serviced in a nearby garage and was not ready for pick-up yet. It seems that coming without a car is unthinkable in this place.

Stella pulls up next to me in her small SUV and winds down her window. We both have to sign into the visitors' book and get a 'visitor's tag' before we are allowed to enter. The inside of the school confirms my impression of a separate world. I feel like I have been 'beamed' from the dusty, noisy, traffic-heavy, and lively Kampalan streets into this secluded elite-school campus with brick-building architecture, well-kept little pathways, gardens and roads, and a huge carpark. Everything seems quiet, too quiet for a school, and – although the two places are worlds apart – I have to think of the sedated atmosphere at Butabika. We see a few children in expensive-looking uniforms walking over to the carpark with their parents. Most of them are internationals; very few look Ugandan. When I later ask a teacher about the percentage of Ugandan students she avoids giving me a straight answer: 'Below 50 percent, probably below 30 percent, maybe 10 percent, I don't really know'.

Stella tells me that the school charges 6,000 US dollars per term (!). The figure seems unreal, especially in a country where many parents still cannot afford to send their children to fee-free public schools because they don't have enough money to buy books, pens, or uniforms. But it also seems unreal to me as someone coming from Germany, a country without much of a private school culture where free education is considered a right that is taken for granted. Stella – whose three children all attend Ugandan private schools which are cheaper than this school, but still expensive – nods in agreement when she sees my puzzled reaction, but then adds: 'I have always dreamed of sending my children to a school like this. If you can afford these fees, it means you have really made it financially.'

[29] Eye movement desensitization and reprocessing – a therapeutic approach designed especially for trauma treatment.

The special-needs teacher is still busy so we sit on a bench and wait. Stella tells me how she used to come here with David, the European psychologist, to assess the students using the WISC (Wechsler Intelligence Scale for Children). Reminiscing about 'those days', she tells me how they always went to eat at the cafeteria, which resembles a fancy restaurant more than a Ugandan school canteen, after finishing their work: to eat apple pie and cheesecake.

A woman with a strong British accent walks up to us, greets Stella, and introduces herself to me as Diana, the special-needs teacher. I briefly tell her about my research and that I came along because I was curious about the psychological assessments they had been doing here at the school. Diana sighs: 'The two international psychologists we were working with have left the country. These days, whenever we need to assess a child, we have to fly in a certified psychologist from abroad. At the moment we are looking at flying in an international expert from Zambia, which will cost parents 1,200 US dollars for the assessment, plus flight and accommodation.' I am not sure how to respond.

We walk up a set of stairs and enter Diana's spacious office. I am allowed to sit in while Stella reports about her therapeutic work with the student, who continues to struggle with school and often shows disruptive behavior. The girl's family comes from the US, her mother has a high-ranking job in the aid industry, and it seems that both parents refuse to recognize and accept the full scale of their daughter's problem. Stella, who feels intimidated by the girl's resolute mother, asks for Diana's assistance in communicating with the family. Later she tells me that some of the international families at the school don't take her seriously, or even refuse to work with her, because she is 'just a Ugandan psychologist.'

A few days after this visit, I return to the school by myself for an interview I have arranged with Diana. I am curious about the school's reluctance to work with Ugandan psychologists and ask her about it. Diana explains:

> 'There have to be certain standards of qualification, and some of the psychologists here are not trained to the standard that our board wants. (…) There have to be certain things written in these reports to justify why [a child with learning difficulties, for instance] needs additional time, or a laptop. If that's not in the report, then the report means nothing. So there have to be practical solutions. Some of the difficulties we have here… Well, because the Ugandan education system is so different to the international system, what a Ugandan has experienced in a classroom is miles away from ours. (…) So the kind of ideas [for therapeutic intervention] that we need, like getting a laptop or extra time, we won't get that from their reports. So then you end up with, possibly, a diagnosis, but no support for teachers, you just end up with a label.'

I ask Diana whether she thinks this might change in future, as MA programs for psychology are becoming more common and more professional at Ugandan universities. She replies:

> 'I honestly don't know. Because the problem we have is that lots of locally-trained people have not necessarily been out of the country, and so they don't… They come to our school and it is so different to what they know. For example, I know there was one instance when Stella was working with this expat family, and she felt that the behavior of the child was inappropriate, but wouldn't tell the family because she felt maybe that is what expats do. So rather than pursue what could have been an uncomfortable cultural conversation, she just didn't say anything. I think sometimes there is the perception that what you see on American TV shows is how all expats raise their families, and so you see the Disney cheeky kinds of teenagers with no parents around and people here assume that's what all expats must do.' She pauses and then adds: 'So, sadly, unless you go and travel, or you have a network of people you can check with, there is no other way to find out really.'

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This scene exemplifies, in an extreme way, class and cultural divides that are common in Uganda. It also exemplifies the limits of improvisation and local adaptions of psychotherapy, which is embedded in an international knowledge economy that regulates, to a degree, how psychotherapy should be practiced, and by whom. I often recalled this school and my interview with Diana. And I wondered about all the international psychologists – most of whom have only very little knowledge of Uganda, 'which is so different to what they know' – who had come to Northern Uganda after the war to assess and counsel the supposedly traumatized local population. Diana's statements point to a paradoxical status of psychology and psychiatry as, on the one hand, universal disciplines – with standardized tools, methods, and theories – which are, on the other hand, intimately bound up with, and in fact dependent on, particular cultural experiences. However, while in some contexts (e.g. Ugandan private schools) and for some psychologists (e.g. those trained in Uganda) a lack of cultural knowledge about clients' lifeworlds was considered an impediment, in other contexts (e.g. NGO-driven trauma interventions in Northern Uganda) international psychologists' lack of cultural knowledge did not seem to be a problem – or at least did not constitute a reason for excluding them from practicing.

How, then, can we grasp this paradoxical status of psy? Are psychology or psychiatry and the knowledge they govern universal and thus the same everywhere? Or are there various local or 'cultural' psychologies and psychiatries with their own histories and canons of knowledge – and if yes, how do they relate to each other? Such questions have been debated in the field of cross-cultural or transcultural psy since at least the 1950s; but they have become particularly pertinent in the context of recent political struggles to decolonize knowledge which I discuss below. To approach these questions, one can look – as I do in the next two sections – at the political history of the psy-disciplines, which originated in a very particular place and time (late nineteenth-century Europe) but have since traveled across the globe – through colonial missions and global health interventions, through social media, transcultural university networks, and travel and migration processes. As a 'traveling model' (Rottenburg 2002; Behrends et al. 2014), psy contains certain 'blueprints' which, however, become appropriated and translated at different sites and by different actors within particular global and local power constellations. In other words, the universality, or particularity, of psy knowledge is not a given, but always negotiated and produced in practice.

Global Mental Health and the Rise of Psychotherapy

There is, by now, an enormous field of literature – in history, critical psychology, sociology, and more recently anthropology – which discusses the political history of psy: from its emergence and initial popularization at the beginning of the twentieth century, mainly in Europe and the US, to its contemporary global spread. Much as I have characterized the history of psychotherapy in Uganda, many authors relate the rise of psy to changing forms of governing, new socio-economic formations and the ever-expanding demands, desires, and problems of capitalist modernity which created new feelings of uncertainty and vulnerability (Rose 1996, 1999; Giddens 1991; Furedi 2004; Lasch 1979; Rieff 1966). Wright (2011) states that the large-scale social upheavals throughout the twentieth century (such as industrialization, urbanization, and the two World Wars), and the evident difficulties of individuals and societies to cope with them, led to a rising awareness of psychological problems among 'normal people' – as opposed to the insane – and the broader legitimacy of seeking therapeutic treatment. Illouz (2008) claims that a 'therapeutic emotional style' emerged in the first half of the twentieth century and solidified after the 1960s – especially in the work sphere as part of efforts to

enhance productivity in the "the increasingly complex structures of the emerging corporate capitalism" (ibid: 15). In summary, a central tenet in this literature is that psy emerged and proliferated as a response to new forms of suffering, new understandings of the individual self, and new challenges of governing – a process that Wright (2011) has aptly labelled 'the rise of the therapeutic society'.

For a long time, the vast majority of research on psy focused on its manifestations in the so-called West. Recently, however, in the wake of the Movement for Global Mental Health (Patel and Prince 2010), scholars have turned their attention to the global circulation of psy discourses, practices, and institutions to regions where they had previously been largely unknown.[30] The worldwide expansion of psy and its underlying assumptions and ideologies is being driven not only by the World Health Organization and related networks but also through media and social media. It is related to new ways of thinking about (mental) health, new understandings of the self, new problems that people have to cope with, and the global spread of middle-class values and aspirations, including competition for status and jobs and conspicuous consumption. While psychiatry, the older and more biomedical of the psy-disciplines, was established as a discipline and field of medical practice in most countries during the colonial period, it has always had a somewhat marginalized status and limited influence on broader society because it was seen as only for abjectly 'crazy' people. Those few who did come under the gaze of psychiatry were put in custody and largely silenced through medication – and there was little effort and limited means to engage with their 'selves' or 'minds' (Vaughan 1991: 125). The more contemporary emergence and popularization of psy in the form of self-help literature, talk therapy, and mental health discourses is very different: it is centered on processes of subjectivation, introspection, and a thorough engagement with the individual self. Moreover, its focus is much broader because it targets both the mentally healthy and the mentally ill, and thus has influence beyond the confines of the clinic and the therapy room.

In anthropology, psy has only recently become a significant topic of research. The growing subfield of what I call psy anthropology[31] has a strong – and for anthropology quite unusual – regional focus on countries in the Global North, the US in particular, as reflected in the work of leading authors in the field (e.g. Estroff 1985; Young 1995; Luhrmann 2001; Martin 2007; Garcia 2010; Lester 2019; Jenkins and Csordas 2020). However, over the last ten years or so, several groundbreaking studies have been published which critically analyze the global rise of psy (Watters 2010; Hinton and Good 2016; Zhang and Davis 2018; Lovell et al. 2019; Béhague and MacLeish 2020; Bemme and Kirmayer 2020; Martin 2020) and its manifestations in different world regions: for instance in Latin America (e.g. Duncan 2018 on Mexico; Biehl 2013 on Brazil), Russia (Raikhel 2016; Matza 2018), the Middle East and North Africa (Behrouzan 2016 on Iran; Pandolfo 2018 on Morocco), and especially in Asia (e.g. Yang 2015, 2018 and Zhang 2017, 2020 on China; Tran 2015, 2016, 2018 on Vietnam; Kitanaka 2011 on Japan; Lang 2018; Pinto 2014; Naraindas et al. 2014 and Ecks 2013 on India).

[30] I should note here that there are regions outside of the traditional 'Western' homeland,where psy has been around for a long time. In India and Argentina, for instance, psychoanalysis has long been an important part of the therapeutic landscape (Kumar et al. 2018; Lakoff 2003).

[31] I use the term psy anthropology to refer to approaches that critically analyze discourses, practices and institutions in the field of mental health that are related to the academic disciplines of psychiatry and psychology. As such, it overlaps but is not synonymous with medical or psychological anthropology. According to Kohrt et al. (2015: 22), medical anthropology mainly focuses on human pathology and the myriad ways different societies and individuals deal with illness and suffering, while psychological anthropology is interested in 'normal' patterns of thought and behavior and how people think about and categorize their worlds.

Anthropological studies of psy in Africa have focused on HIV/AIDS counseling (e.g. Nguyen 2010; Moyer et al. 2013); the benefits or detriments of trauma interventions (e.g. Abramowitz 2014 and recent work in Northern Uganda, see above); global (mental) health (e.g. McKay 2018; Vaughan 2016; Read 2019), and post-colonial psychiatry (especially noteworthy is Kilroy-Marac 2019). Compared to other world regions, however, Africa has so far been largely neglected in the cutting-edge, theory-oriented, ethnography-based debates on psy.[32]

Many of the existing studies tend to have an applied orientation, focusing for instance on the benefits or detriments of psychological interventions, how to improve them, and more generally the implications of the Movement for Global Mental Health in Africa. In these studies, African contexts are still commonly represented and framed as 'other' – as places which lack 'modern' psy facilities and knowledges, and where people rely on so-called traditional or faith-based healing systems either by choice or out of necessity (Cooper 2016a). In fact, one of the most common questions I encountered when presenting my research to anthropologists was why I did not study traditional forms of healing – as if studying psy in Uganda was somehow not an adequate subject for anthropological investigation. Such reactions suggest to me that representations of mental health in Africa lack nuance and complexity[33] and ignore the extent to which many Africans make use of and engage in global psy discourses and practices.

Including African psy in larger anthropological and global mental health debates without reproducing its status as essentially 'other' (*and* without assuming that it is simply the same as everywhere else) is a challenge. This requires paying attention to the differences within African states and societies and situating recent developments in Africa within broader global and historical trends, albeit without suggesting that external forces or doctrines are the sole drivers of change. How to tell the history of psy is part of this challenge. The origins of psychiatry and psychology in Africa were intimately entangled with colonial and eugenic politics. Psy was used to 'scientifically' justify the colonization of those who were deemed psychologically inferior, and it thus entered their lifeworlds in this context. Increasingly, the singularity of this history – and the ascriptions it entails regarding what psy is and who introduced it to Africa – is being challenged (see below). Nevertheless, I consider it relevant when trying to understand contemporary debates.

Colonial Psy in Africa: governing through science

Both psychiatry and psychology entered Africa as part of the colonial mission. Colonial psychiatry dominated research on mental illness and 'abnormal' behavior in Africa and of Africans between 1900 and 1960 (McCulloch 1995: 1f.). Most theories in this field were based, in one way or another, on clinical work and were promoted by a small number of European psychiatrists working in African mental asylums and hospitals. All of them were locked into a discourse on racial difference, and most were openly racist (Vaughan 1991: 115). While earlier works such as those by Gordon and Vint (cf. McCulloch 1995: 46ff) explicitly focused on biological differences – e.g. in brain size or weight – to 'prove' apparent African mental inferiority, later works were also, and increasingly, embedded in discourses of cultural differences. Three key beliefs promoted by colonial psychiatrists were that the African is similar to a lobotomized European (esp. Carothers 1953) or a European child, that mental

[32] A small number of anthropological publications apply a psychoanalytic perspective to African phenomenon – an approach, however, that is quite different from the one I am discussing here. These sometimes very sophisticated analyses use insights from psychoanalysis, but they are generally not concerned with studying psy in Africa. Prominent examples include the older studies by Parin et al. (1963, 1971) and the more recent book *Spirit Children* by Aaron Denham (2017).
[33] Mkhwanazi (2016) argues that this is true for medical anthropology in Africa more broadly.

illness in Africa is largely due to acculturation and reflects failed attempts by 'primitive' Africans to cope with 'modern' civilization, and that depression is rare in Africans due to their underdeveloped sense of individuality and moral conscience (Akyeampong et al. 2015: 3f.). Colin Carothers in East Africa (whose work has been well-summarized by McCulloch 1995) and Antoine Porot, with his Algiers School of Psychiatry, came to be the most influential figures in colonial psychiatry, albeit in different ways (see Keller 2007: 4ff. on the specificities of French colonial psychiatry). Both were heavily criticized by Frantz Fanon, especially in his seminal chapter 'Colonial War and Mental Disorders' (2004 [1961]: 181–233). Since the early 1990s, there has been an increasing interest in colonial psychiatry by historians who give detailed and complex accounts of the debates, institutions, and practices of psychiatry in Africa at the time (e.g. Bullard 2005; Bell 1991; Mahone 2006, 2007; Parle 2007; McCulloch 1995; Vaughan 1991; Sadowsky 1999; Jackson 2005; Keller 2007), including those in Uganda (Pringle 2019).

Discourses and practices of colonial *psychology* overlapped significantly with those of psychiatry, especially as the latter moved away from biological theories of mental pathologies towards more 'cultural' ones. One important reason for this convergence was the fact that both psychiatry and psychology were concerned with understanding the 'normal' African as much as they were concerned with the mentally ill. As Vaughan (1991) has pointed out: "To put it simply, whilst the history of insanity in Europe is the history of the definition of the mad as 'Other', in colonial Africa the 'Other' already existed in the form of the colonial subject, the African" (101). She further notes: "Though it would be wrong to imply that colonial psychologists and psychiatrists were in any way a homogenous group, they were all grappling, in one way or another, with the question of who 'the African' really was" (ibid.: 115).

To a certain extent, however, the research foci and interests of psychologists in Africa differed from those of psychiatrists, and they are discussed as distinct fields in at least in some of the literature (see e.g. Wober 1975). Psychological work in Africa at the time of colonialism was heavily influenced by Freud and psychoanalysis, and often encompassed both practical and theoretical approaches. Among the most prominent early studies are Laubscher (1937) on sex, custom and psychopathology, Ritchie (1943) on African childrearing, and Sachs (1937), which depicted his attempt to psychoanalyze an African healer in what was then Southern Rhodesia (McCulloch 1995: 82ff.).

In the early 1960s – amid wide-ranging calls for decolonization and after the horrors of the Second World War, which rendered eugenic politics (officially) unspeakable – the work of colonial psychiatrists and psychologists, with their racial theories about African brains and minds, became the subject of profound criticism and were soon dismissed. However, 'cultural othering' continued. In the postcolonial era, psychiatric research was replaced by largely apolitical, clinical and epidemiological studies which sought to assess (the prevalence of) African mental illnesses and their treatment on the basis of Western psychiatric concepts and nosologies (for an overview of this type of research, see Corin and Murphy 1979 and Corin and Bibeau 1980). The new sub-discipline of

transcultural or cross-cultural psychiatry[34] emerged; influenced by anthropological perspectives,[35] it continues to produce important research on psy in Africa.

While psychology largely disappeared as a discipline and field of practice, the immediate post-independence era saw a relatively brief period of what is sometimes referred to as 'African psychiatry', i.e. distinct attempts to initiate a culturally appropriate form of psychiatry in Africa, most prominently reflected in the engagements of Thomas Adeoye Lambo in Nigeria and Henri Collomb in Senegal (Bullard 2005, 2007; Heaton 2013; Kilroy-Marac 2019). The first Pan-African Psychiatric Conference was held in 1961 in Nigeria and was organized by Lambo. However, due to larger politico-economic dynamics (political conflicts, economic decline, structural adjustment, etc.) starting in the 1970s, attempts to set up widely accessible psychiatric services and include these in the general medical system soon ran out of steam across the continent and often stalled completely (Akyeampong et al. 2015: 5ff.). Health-care provision was reduced to a minimum, and in many countries, including Uganda, it was effectively taken over by international organizations, which focused primarily on communicable diseases, malaria, and the HIV/AIDS pandemic – but not on mental health care.

Only recently has there again been a renewed interest in psychiatry and mental health in Africa.[36] One of the drivers of this new interest, as discussed above, has been the Movement for Global Mental Health and related efforts by WHO since the early/mid-2000s to increase psychiatric services in low-income countries (for critical overviews of these efforts, see Ecks 2016 and Kohrt et al. 2015: 24ff.). While most of these interventions have a strong biomedical and psychiatric focus (i.e. they aim to expand services and improve access to essential psychopharmaceuticals for the mentally *ill*), they have also helped to raise awareness of and popularize psychological psychotherapy and the broader concept of mental *health*. However, as my own research in Uganda demonstrates, the increasing attention given to mental health care is not just related to international trends; it has also been propelled by African psychiatrists and psychologists who see the need for broader and more diverse forms of mental health support in their countries. The contemporary (re)emergence of psy in Africa raises far-reaching questions regarding who gets to define what psy is and how it can be extricated from its colonial past.

Contemporary Debates on Psychology in Africa: decolonizing knowledge

Most chronicles of psy in Africa – including my summary above – reflect a particular, linear and Eurocentric, way of writing history and of thinking about how disciplines like psychiatry and psychology are related to, or distinguished from, other healing approaches. Even if written from a critical standpoint, these histories tend to emphasize that psy is foreign to Africa and was imposed on, rather than shaped by, Africans as a form of control or care, or both. Furthermore, these histories

[34] In the 1950s, the discipline of transcultural psychiatry was established at McGill University (Kohrt et al. 2015: 23). Later, Kleinman (1977) called for a new 'cross-cultural psychiatry' which was to be more interdisciplinary and less Eurocentric than the existing transcultural psychiatry. For a more recent outlook on the state of cross-cultural psychiatry, see Kirmayer (2006).

[35] Early important works included those of Margaret Field (1955, 1960) and Fortes & Mayer (1966), which explicitly linked African witchcraft and healing cosmologies to Western notions of mental illness and psychotherapy.

[36] As noted above, one of the main reasons behind this renewed interest is that mental illness has been identified as one of the key contributors to the global burden of disease (Whiteford et al. 2013; Collins et al. 2011). Not just Africa, but low- and middle-income countries across the globe, have experienced an upsurge in mental health interventions driven, most prominently, by WHO through its Mental Health Global Action Programme (mhGAP, see https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme, accessed 12 December 2021).

suggest that psy can be compared to and placed in the same category – medical care – as what is often called African traditional or faith-based healing. This is not necessarily wrong, but it is only one of many possible ways of interpreting 'local' institutions. Susan Whyte formulates the latter point well when she discusses how the rising popularity of medical anthropology in the 1970s led to a shift in focus of anthropological work in Africa – from religion to medicine (Whyte 1989: 289):

> "Affliction, which was once dealt with in monographs on African religion and cosmology, now seems to belong to the realm of medicine and medical anthropology. What we knew as divination now appears to be diagnosis; what we analyzed as ritual is termed therapy. The victim of supernatural forces is called the patient, and his or her relatives – the therapy managing group. Rituals specialists have been discovered – by both development aid organizations and the African press – to be 'traditional healers'. One is tempted to speak of the medicalization of African religion."

While the history of psy in Africa as I recount it above is still relevant because it explains, to a certain extent, how things are today, it also limits our understanding of what psy in Africa is, or can be, in future. In recent years, African scholars, including those in the field of psy, have stressed the need to rewrite the history of their disciplines, which would entail highlighting different founding figures, key findings and events, and plot lines (Lamola 2021; Nyamnjoh 2012). Such calls raise important and far-reaching questions regarding the universality of academic knowledge and who gets to define it.

Inspired by these broader calls for decolonizing knowledge in African universities (Mbembe 2015),[37] psychologists in Africa have started debating the necessity and feasibility of creating a distinctly 'African psychology' – how exactly the term should be delineated is a matter of ongoing debate – as a new academic discipline and field of practice (Nwoye 2015, 2017, 2018; Makhubela 2016; Moll 2007; Ratele 2017a, 2017b). Some view this idea, either skeptically or enthusiastically, as a primarily political move; others are more concerned with the philosophical question regarding the possibilities and the boundaries of universality within sciences. While critics warn of the risks of exoticizing and further marginalizing 'African' psychology from what they see as a universal discipline,[38] proponents argue that mainstream 'Western psychology' has so far been harmful, or at best irrelevant, for Africans.

For the time being, these controversies are mainly driven by South African(-based) psychologists and largely confined to South Africa, where psychology as an academic discipline and field of practice has a much longer, and very specific, history compared to other countries of Sub-Saharan Africa (Cooper 2013). While some East African universities in Tanzania and Kenya now include the study of 'African psychology' within their psychology curriculum (Nwoye 2018: 39), such developments did not (yet) seem to be a major topic in Uganda during my fieldwork.

A Psychology Multiple? Alternative frames for analyzing global psychotherapy

The situation today, then, is paradoxical: although psychology is more universal and popular than ever, its claims to universality are increasingly challenged by emerging 'local' psychologies. People

[37] For a good overview of these debates see the online bibliography 'Decolonizing the African University', available at: https://worldpece.org/content/full-bibliography-decolonizing-african-university, accessed 2 July 2021.

[38] Similar debates have been fought in other academic fields, most prominently African philosophy (cf. Hountondji, 1996; Dübgen and Skupien, 2019; Diagne, 2016).

speak of 'Western' psychology to demarcate its Euro-American origins and contrast it with, for instance, African or Ugandan psychology. Thereby, the latter terms define themselves both in consonance with, and in contrast to, the former. While terms such as Western or African psychology can be politically meaningful to draw attention to the situatedness of all knowledge(s) (cf. Haraway 1988), they also reproduce simplistic, misleading, and hence problematic dichotomies (Cooper 2016a, 2006b; Wendland 2010).

Cooper (2016b: 696) has pointed out that studies on mental health in Africa fall into two main categories:[39] those that see the existing mental-health-care landscape as deficient, backward, and inhumane and advocate for large-scale external intervention to provide psychiatric treatments and psycho-education based on a biomedical paradigm (this type is common in a lot of the recent literature on global mental health); and those that condemn biomedical interventions and celebrate and romanticize traditional healing as a sufficient and equally valid alternative.[40] While the two types reveal differing values, they are in fact structurally very similar because they dichotomize alleged 'African' cultural beliefs and 'Western' biomedical science. Given that this line of thinking and arguing has dominated research on mental health, psychology, and psychiatry in Africa for so long, Cooper (2016b: 708) asks:

> "The question then is, can we find other ways of understanding help-seeking for mental distress in Africa based on alternative kinds of systems of classification which are neither Eurocentric nor Afrocentric? Might we be able to change the frame, rather than just the content, of conversations on help-seeking? And could this transform the ways in which we understand how people seek support for mental illness in Africa?"

Cooper clearly identifies the problem of assigning regional (i.e. African, Western), and by implication cultural, designations to medical systems that are inherently dynamic and diverse. Medical pluralism and 'alternative' healing regimes, for instance, are features of all societies across the globe and not a specifically African characteristic. In a similar vein, biomedicine itself cannot be convincingly framed as a solely 'Western' field of practice because it has been and continues to be shaped by the various contexts and countries in which it is practiced, including those in Africa (cf. Wendland 2010; Livingston 2012).

Throughout my work on this project, I have struggled with the paradoxes of global psy and have not found easy answers to the questions and terminological difficulties that arise from them. In essence, I focus on what Ratele (2017b: 319f.) calls 'African psychology as psychology in Africa',[41] i.e. forms of psychology in Africa, concretely Uganda, that accept to a certain extent that the discipline of psychology is universal, even though its theories, assumptions, and practical guidelines

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[39] Cooper (2016b: 708ff.) also mentions a small number of studies that do not fall into these boxes.

[40] Although not specific to Africa, the ongoing controversies and tensions between a public health approach to mental health and a 'culturally based' approach which favors local 'solutions' are a good example of the kind of deadlock that emerges when researchers get stuck in binary oppositions between culture and medicine, cf. http://somatosphere.net/2012/07/global-mental-health-and-its-discontents.html, accessed 27 February 2017.

[41] Ratele distinguishes between four orientations to psychology in Africa, namely, psychology *in* Africa, cultural African psychology, critical African psychology, and psychological African studies. According to his definition, the psychology in Africa orientation 'is fundamentally informed by the belief that the discipline of psychology is universal. And even though there is acceptance that psychology was born in Europe, dominated by U.S. interests, and has historically supported the dehumanization of Africans, the field is considered to be scientific. Psychology from this perspective is also considered to be objective, value-free, and apolitical. It is also conservative – in the sense of conserving the "nature" of psychology. This approach to African psychology entails asking the same questions, asked by others elsewhere in the world, in Africa' (Ratele 2017b: 319).

have to be adapted to fit local contexts and clients. The psy-practitioners I worked with recognized the biases inherent in, and the limitations of, what they sometimes called 'Western psychology', not only in its standardized diagnostic tools, but also in its underlying assumptions about the individual or the family. And they were well aware of the widespread skepticism about and criticisms of 'Western psy' in Uganda and Africa more broadly. While through their ongoing creative practices of enactment and translation a distinctively Ugandan, though not yet consolidated, form of psychology was gradually emerging, my interlocutors did not generally see themselves as 'cultural' or 'critical' psychologists (cf. Ratele 2017b: 320ff.) but as part of a universal discipline which can offer relevant, if partial, insights and ways of caring – for Ugandans no less than people elsewhere.

To escape the conundrum of assigning regional designations to at least partially universal disciplines, one could think of psychology in Uganda (or elsewhere), following Mol (2003), as a 'psychology multiple' – a partially universal, partially coherent, and partially coordinated discipline which is constantly being (re)created through diverse localized practices and situated knowledges. Translation of psychological knowledge occurs not just in Ugandan universities where universal models, theories, tools, and approaches are selected, taught, discussed, and partially 'Ugandanized'; the knowledge 'Ugandanized' in this way then also needs to be translated into particular Ugandan lifeworlds which differ depending on language, healing ideologies, and – importantly – class.

Great Expectations: psychotherapy as class-making

Class is a category that disrupts conventional framings of mental health care in Africa, which tend to emphasize 'cultural' or geopolitical differences between Africa and the West or the global and the local, but often gloss over internal diversities of African societies. Fields like cross-cultural psychology/psychiatry or global mental health often implicitly or explicitly promote the idea that psy is *culturally* foreign to African societies – a framing that, as discussed above, is becoming increasingly inaccurate and problematic in a globalized and postcolonial world. Looking at psy in Africa through the class lens changes this frame, while not dismissing the importance of cultural translations between globally circulating traveling models and the local contexts they become embedded in. Foregrounding class, as I do in some of my articles (especially Vorhölter 2017a, 2019, and 2021), draws attention not only to the vast differences within African countries and societies but also the similarities in help-seeking among people of particular class strata *across the globe* – people who seek psychotherapy because they are struggling with the competitive, high-paced, and individualized lifestyle that seems to have become such a normal part of capitalist modernity.

Class 'imposed itself' as a relevant category for my research right from the start when I returned to Uganda in 2015 for my fieldwork. While there were many differences between my previous field site in Gulu and the Kampalan setting I was about to explore, I was particularly struck by the class differences between the people I had worked with for my PhD – mostly youth from peasant backgrounds whose families were struggling to make ends meet – and those who I came to know now in Kampala – successful professionals with university degrees who spend more money going out on one evening than what the average family I knew in Gulu could spend in a month. Moving through Kampala, I was also struck by the urban developments that had taken place there during the four years since I left Uganda in 2011. Several new and expensive shopping malls had been built (previously there was only one that I knew of), gated housing precincts were becoming more visible in different parts of town, and expensive restaurants, bars, and night clubs had opened up and were

full of patrons most days of the week. In short, there seemed to be tangible evidence of the emergence of 'new middle classes' – a phenomenon that scholars, investors, and journalists have noted across the African continent. The psy developments I set out to study, at least those in Kampala, seemed to be closely related to the dynamics around these new middle classes and people's struggles to become, remain, or be seen as middle class. The need for private therapy, for instance, was tightly bound up with middle-class aspirations, the stresses they caused, and their failures.[42] In this sense, class developments contributed to the expansion of psychotherapy. But, as I discuss below (see also Vorhölter 2021), psychotherapy also helped to create ideas of middle classness and of how to become a middle-class self. As such, it was itself a form of class-making.

Poverty, Wealth, and Aspiration: Ugandan class identities real and imagined

There have been longstanding discussions as to how one might conceptualize and define class in African contexts (for a good summary see Thomson 2010: 84–107). Up until recently, however, class did not constitute a central analytical concept in African studies because social cleavages were mainly studied in terms of ethnic, regional, or religious difference. This has changed significantly: class-based distinctions and inequalities have become increasingly visible and pertinent, both in the lived realties of Africans and in academic analyses. In particular, the hype and hopes associated with the 'emerging middle classes' and the related difficulties of conceptualizing and defining them in Africa have become matters of extensive – and unresolved – debate (e.g. Melber 2016; Lentz 2015, 2020; Ncube and Lufumpa 2015; Neubert and Stoll 2015; Spronk 2012; Kroeker et al. 2018; James 2019; Mercer and Lemanski 2020; Noret 2020).

In Uganda, as noted above, class is certainly becoming an increasingly important marker of social identity and there is a growing and widely recognized gap between an emerging urban upper middle class and the great majority of rural and urban poor. In my writing, I have used these terms – 'poor' and 'upper middle class' – to draw attention to this growing class cleavage. Obviously, this is an oversimplification. Many Ugandans do not fit into either one of these two categories, instead belonging to what the African Development Bank has prominently termed 'floating classes' or to the lower middle classes (e.g. Ncube 2015: 2; Lufumpa et al. 2015: 10) – terms which capture the inherently unstable, relative, and precarious position of 'those in the middle'. Conceptions of middle-class in the African context are notoriously confusing and vary considerably from study to study. For instance, while the African Development Bank claimed that the Ugandan middle class (including the floating class) made up 18.7 percent of the total population in 2010 (Ncube et al. 2011), a recent report on Uganda, using a different definition, puts the number at 8 percent.[43] These discrepancies show both the fluidity of the middle-class category and, perhaps, the futility of trying to define it *exactly*. Thus, rather than entering the well-rehearsed debates on definitions, my own reflections on class in Uganda started from emic conceptualizations and 'local' ways of talking about, performing, and distinguishing class (cf. Bourdieu 1987).

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[42] I hint at this with the reference to Dickens' novel *Great Expectations* – which thematizes the desires and the pitfalls of achieving upward mobility – in the title of this chapter. For a good analysis of class dynamics in the book, see https://www.bl.uk/romantics-and-victorians/articles/great-expectations-and-class#authorBlock1, accessed 13 July 2021.

[43] Importantly for my analysis, the report points to the extreme regional differences in wealth: 'Whereas the percentage share of citizens earning 1 million UGX and above in Central Uganda counts 13.8 percent, it counts only 7.3 in Western, 5.1 in Eastern and 3.6 in Northern Uganda. Overall, the most striking aspect is the discrepancy between urban and rural regions. In urban areas the percentage share of people earning more than 1 million UGX amounted up to 23.5 percent, while it was only 5.3 percent in rural areas' (Brandt and Okello 2019: 3f.).

Throughout my research, class frequently came up as a meaningful category to describe different Ugandan lifeworlds. While my interlocutors had a nuanced conception of different social classes, the main distinction they made was between what one might call the 'haves' and the 'have-nots'. Words used, often interchangeably, to describe the former included: middle class, high class, rich, elite class, well-to-do, upper class, corporate people, affluent, high-income people, and, interestingly, also working class (i.e. the class of people who have official employment and regular income as opposed to the large group of Ugandans who are peasants, or who work in the so-called informal sector, or who do not have any designated occupation at all). The 'have-nots' were mostly simply referred to as the poor, low-income people, or lower classes. While class belongings or ascriptions were based on widely-recognized and largely uncontested criteria (see below), class was also, fundamentally, a relative and dynamic category.

Typical attributes of belonging to the 'haves', i.e. those who I have labeled 'upper middle class'[44] were: urban residence in a good neighborhood (as opposed to urban 'slums' where the poor resided); high levels of education (completion of secondary school and beyond); having a job and a regular income; living in a 'nuclear' family household; being able to consume 'luxury items' and own status goods like the latest mobile phones, computers, or cars; being able to send one's kids to good private schools; and being able to engage in a particular lifestyle involving regular outings with friends, vacations, or regular trips to the shopping mall.

Typical markers of being poor included: struggling to regularly ensure one's basic needs (food, shelter, school fees); living in a rural area (or in an urban slum); being a peasant or unemployed; and having low levels of education, including low levels of English-language proficiency. As these 'markers' indicate, class designations often overlapped and intersected with other categories, such as level of education, place of residence (i.e. urban or rural, Kampala vs. 'upcountry', North vs. South), and even race or ethnicity.[45]

In Northern Uganda, for instance, where the majority of the population identifies as Acholi, people have shared 'cultural values', including understandings of well-being (Vorhölter 2014), and they share experiences of political marginalization, ethnic discrimination, and violence. Yet, those from higher class backgrounds had very different capacities to cope during the war (including migration) and have had very different opportunities to deal with the post-war situation. For instance, they can send their children to boarding schools in Kampala and are not dependent on local public schools that were heavily affected by years of war; they can access private health-care facilities to deal with sickness and suffering when and however long they need it (and not when NGOs happen to provide it); and they can imagine their future in ways that is different from those who feel stuck in poverty, joblessness, and 'syndemic suffering' (Meinert and Whyte 2020; cf. Singer and Clair 2003). Yet, as my examples from upper-middle-class Kampala show, having money does not prevent suffering – although being able to afford food, children's education, and health care certainly makes a big difference – and can create new worries and constraints: constant demands from extended family members which often lead people to cut ties with poorer relatives; subsequent loneliness; pressures

[44] By using the term 'upper middle-class', I want to stress that this is a small but growing category; one that is much smaller than what is generally referred to as middle class, but one that includes more than just the super-rich.

[45] White people, for instance, were automatically classified as belonging to the upper class. Some ethnic groups like the Baganda and the Banyankole were seen as generally better off than others, particularly Northern ethnic groups, because they dominated and controlled important political and economic positions and because their 'traditional' homelands were closer to the capital.

to perform and maintain a particular lifestyle even if it conflicts with family responsibilities; stresses related to work und urban life, etc.

Class in Uganda, as I came to understand it during my research, is both a very 'real' economic category but also an ideational or aspirational one. As a 'real' economic category, class is rooted in a person's capacity, or lack thereof, to make, distribute, and spend money. And it determines, to some degree, a person's standing and opportunities in society.[46] As an ideational category, class shapes what people (can, should, and do) aspire to: in terms of material possessions, lifestyle, health, and future in the broadest sense. These two different aspects of class – economic and ideational – often overlap. But not always. In fact, many Ugandans, especially youth from peasant backgrounds who – unlike previous generations – were constantly exposed to images of capitalist modernity through social media, were driven by the desire to leave their villages and 'become middle class'. They (or their parents) invested all they could in education (cf. Meinert 2009), moved to Kampala in search of (better-paying) jobs, and tried to perform (through status markers like phones, hairstyles, or gym-trained bodies) a middle-class lifestyle. Yet, in terms of wealth and well-being, they were often not better off, and sometimes worse off, than those who stayed behind as farmers, who, though poor, had access to land and food and could rely on the village community for support.

Class belonging and identities, both real and imagined, were emergent rather than fixed. Especially those 'in the middle' constantly had to reaffirm their middle-class status – which was itself still a category in the making – through particular practices. Health and well-being were important fields, in which class membership not only became visible but was also made and un-made. Trying to disentangle the interplay between class-, health-, and therapeutic subjectivities became a major part of my research project (see Vorhölter 2017a, 2019, 2021).

Class, Career, and Chronicity: emerging psy-subjectivities in Uganda

The introductory vignette hints at the many ways that access to mental health care and related knowledge in Uganda is highly class-specific – not just for patients, but also for practitioners. Public establishments like Butabika, the oldest and for a long time only place where mental health treatment was available, were frequented predominantly by Ugandans who could not afford private psychiatric care. Patient subjectivities at Butabika were marked by stigma, heavy medication, and otherwise very limited treatment – due to a lack of resources and a very unfavorable staff-patient ratio. The most common diagnoses were alcohol and drug addiction, bipolar disorders, clinical depression, and schizophrenia; however, as the vignette indicates, people showed up at Butabika for all sorts of socio-medical reasons and diagnosis was not always straightforward. The chances of longer-term healing – rather than short-term management of illness – at Butabika were slim, and many patients relapsed. Although this is in itself not unusual for severe forms of mental illness, all the patients at Butabika 'would have profited from better treatment', as Stella put it in the introductory scene.

Private psychiatric care, which had only started to become available around the year 2000, was very different. When I asked one of my interviewees, a psychiatrist who had been among the first to

[46] In this sense, I my understanding of class as an economic category is inspired by Marx. However, the two broad categories – poor and upper middle class – that I use to talk about class in Uganda differ from Marx's concepts of proletariat and bourgeoisie in that they are based mainly on people's ability to access, distribute, and 'consume' money and not on their relationship to the means of production. What unites the people that I refer to as upper middle class is not the fact that they own the means of production. In fact, most of them are employees – of the state apparatus, of corporations, or the 'development industry'. Some are self-employed, others are students. What unites them is their ability to access particular services (especially education and health care) and their capacities to consume particular luxury goods that clearly distinguish them from the majority of the Ugandan population.

set up private clinics, about the status and relevance of private psychiatric treatment, he bluntly explained:

> "Ahh – that is high end. You are talking high end in the service. Yeah, we had to provide that, because illness is illness. Ministers get sick, lecturers get sick, professors get sick, doctors get sick, lawyers get sick, where do they go? (…) I have treated so many doctors, so many lawyers, so many teachers, so many nurses, the whole workforce; ministers, members of parliament, university professors, yeah. (…) There are many members of parliament who I have treated – I can't tell you their names (…) They break down, and they come, and I fix them, and they go back. I have known some people who broke down, especially with these bipolar types of disorders and depressions. They get better, they run for parliament, they win, they go in there. But when they're about to get a big post like a ministry, somebody puts out a word [about their history of mental illness]. (…) The stigma of mental illness is very much alive in this country, and we have to deal with it. Unfortunately, it goes beyond just the clinic, it goes into funding, we are the least funded medical service, mental health." (Interview 01.09.2021)

Even though private treatment could not provide a cure for severe mental illness, it increased the chances of recovery and thus improved the life opportunities of patients. And even though they could not prevent patients from being 'found out', private services placed a lot more emphasis on confidentiality than was possible at public places like Butabika. These brief examples reveal that, as in other fields of medicine, treatment (and sometimes even diagnosis, cf. Vorhölter 2017a) were tailored to a person's class background and financial capacities, at least to a certain extent, and became markers of social distinction. It also hints at the well-established fact that medical regimes are always embedded in larger political economies which determine which treatment should be made available, and – by implication –which conditions become chronic, how, and for whom (Whyte 2012; Cazdyn 2012; Wahlberg et al. 2021).

In my two field sites, Kampala and Gulu, the different reasons why people suffered and sought psychotherapy reflected not just their belonging (or aspirations of belonging) to different social classes but also the different socio-political contexts in which they lived. The latter affected how and under what labels therapy entered people's lifeworlds – as a humanitarian intervention, or as a cosmopolitan form of self-care – and how it was received. While people from upper-middle-class backgrounds in Kampala also sought other forms of relief from their suffering and stress (by attending church, taking psychotropic or other drugs, and maybe even visiting traditional healers – although the latter was not openly discussed), psychotherapy, with its focus on the individual psyche, seemed to offer a new and desirable approach to address the particular problems they were having. This was certainly very different from how psychotherapy was practiced and taken up in Northern Uganda, where it mainly targeted clients who were experiencing problems related to larger forms of structural violence and poverty, for which therapy does not offer a solution. While clients in Kampala were willing to pay for therapy, help-seekers in Northern Uganda sometimes requested economic incentives or 'rewards' for attending therapy sessions (see Vorhölter 2019). The different idioms of distress which therapists used to characterize clients in the two contexts, and which came to represent psychotherapeutic interventions there, were telling: while depression was the most prominent category that came up when talking about the problems and stresses of upper-middle-class clients in Kampala, discourses on therapy in Northern Uganda all revolved in some way or other around the notion of trauma.

Strangely, class is both a very obvious and an often-underestimated variable when studying health regimes. Class not only affects access to health care services, as is commonly assumed; it also shapes experiences of illness, expectations of treatment, the type and severity of suffering, and the chances of recovery and the ways this is imagined. Class membership furthermore largely predicts who becomes a professional therapist – which in turn has tangible implications for the doctor–patient or therapist–client relationship, as the following exchange between me and my research assistants reveals:

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Sharon, Stella, and I are chatting in the psychologists' office at Butabika while waiting for their supervisor to arrive. Sharon asks me how my interviews with their classmates went. She is particularly interested in what I thought of Janet, one of the few students in the clinical psychology program who does not come from an urban middle-class background but from one of the rural areas, or what Ugandans refer to as 'upcountry'. In previous conversations, Sharon and Stella had 'warned' me that Janet was 'a bit different', and they had been worried that I would not be able to understand Janet's 'less sophisticated' English. I tell them that the interview went well and that I had the impression that Janet was really dedicated to her work as a (trainee) psychologist. Sharon nods her head in agreement: 'It is really unbelievable: she comes to Butabika every day of the week. Maybe she feels comfortable here because there are so many people from upcountry?' (I cringe at this comment and the stereotypes it entails, but I say nothing.) Sharon continues: 'I hope they will give her a job because this is where her counseling work can really be of use. We even sometimes refer cases to her, especially when we need her Luganda language skills.' I am a little surprised to learn that neither Sharon nor Stella feel confident speaking Luganda in therapy, even though they are both ethnic Baganda.[47]

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Like Sharon and Stella, the vast majority of therapists that I met during my research came from urban, middle-class backgrounds. Not only did they know about psychotherapy through international exposure (either travel, social media, or through contacts with expats in Uganda), they also had the freedom, financial support, and self-confidence to choose to study psychology – a degree with extremely uncertain career prospects.[48] Students like Janet, who came from a non-cosmopolitan, lower-class, upcountry background had to struggle much harder to justify their career choice vis-à-vis their relatives, to finance their studies (Janet could only pursue her studies because had a church scholarship), but also to be respected among their peers. Yet, in some ways these students were also much better equipped to translate psychotherapy to a broader Ugandan public precisely because they intimately knew non-urban and non-middle-class life worlds and could speak to, better understand, and empathize with clients from these contexts.

In summary, looking at the different contexts in which psychotherapy unfolds in Uganda reveals much about the – vastly different – circumstances in which people live, the different expectations they have regarding their lifestyle, future and desires, and the different ways they position themselves

[47] For complex political and historical reasons, English is the only widely-spoken official language in Uganda. Swahili also has the status of an official language but is not spoken by most Ugandans. Besides these two national languages, there are over 40 local languages, of which Luganda is the most widely spoken, especially in and around Kampala. Because it is sometimes difficult to translate psychological terms and concepts into local languages, therapists generally prefer to counsel in English, although most also offer sessions in their mother tongue or work with translators.

[48] Although psychiatry, too, was an underfunded sector of medicine, as the interview points out in the quote above, career prospects for psychiatrists were slightly better than for psychologists. Major attempts were being made by the government, pushed and often financed by global mental health actors, to expand psychiatric services and create new posts for psychiatrists at the regional hospitals. Psychological forms of treatment, as noted before, were largely neglected in these plans.

and are positioned by others in a global context. How people frame and experience psycho-social suffering, for whom they take it to be achievable, or normal, and where they go to seek help, tells us a lot about what they feel they can expect (or not expect) from life, and thus gives us some insights into much broader societal dynamics.

As my ethnographic examples reveal, my fieldwork took me into very different Ugandan lifeworlds: of the rich and the poor, the sick and the healthy, the locals and the internationals. And I sometimes struggled to reconcile the vast differences between them. While class is not the only factor that affects health and health-care preferences or opportunities, a key aim of my work has been to draw attention to the growing class divide in Ugandan society which – just like the emergence of psychotherapy itself – is intimately bound up with capitalist dynamics and the transformations the country has been undergoing over the past decades.

Conclusion: Ugandan psychotherapy in the making

Psychotherapy is not simply a preconfigured healing regime that is imposed on Uganda from the outside; it consists of a flexible set of tools and techniques that are appropriated, transformed, or rejected in different ways in different local lifeworlds. Ideas of what psychotherapy is, how it works, and for whom are shaped by historical legacies and powerful actors and institutions in the international knowledge economy (NGOs, universities, professional associations, WHO, etc.). Yet, in a given setting, psy is also always entangled with particular power structures, epistemologies, and social relations which affect how it is situated (for instance as a health technology), practiced, and valued. In my research I have analyzed how psy – as a profession or form of care 'in the making' – is '(re-)made' in different Ugandan settings, but also how psy actively creates new meanings, forms of knowledge, and social categories and thus 'makes up people' (Hacking 2006) and contributes to shaping society at large.

The three themes I discuss in this working paper – psychotherapy as meaning-making and care, as knowledge-making and governance, and as class-making – also run through my previous publications on this project. As noted, all three processes are deeply entangled and separating them only makes sense for heuristic purposes. This is particularly evident in relation to knowledge-making and meaning-making – two processes which are, in fact, inseparable, but which I distinguish to draw out different aspects of psy.

Meaning, as I have used the term, relates to more open, more flexible, and perhaps more individual ways of sense-making. Meanings are less codified and fixed by institutions and authorities, and result more from personal ways of assigning purpose or value. Meaning, in this sense, is a moral rather than an analytical category. Individuals, both practitioners and clients, can find meaning(s) in psychotherapy – even if these differ from professional definitions, guidelines, or diagnostics. In section one, I brought together the terms meaning and care to emphasize that psychotherapy in Uganda is more than just a new form of health governance or self-governance, and that its expansion is not just driven by powerful governmental and non-governmental institutions but also shaped by dedicated, curious, and passionate people who care for their fellow citizens and the community at large.

This lens is different from more conventional readings of psy as a neoliberal governing technique (common in the social science literature) or a science- and evidence-based medical regime (common in the global mental health literature), which I discussed in the second section. Here, I have looked

at psychotherapy as a form of knowledge that is defined and 'guarded' by experts and professionals, rooted in academic disciplines (psychology and psychiatry), and promoted through specific, and often exclusive, institutional networks. Although practitioners and clients – in Uganda and elsewhere – constantly remake psy knowledge *in practice*, redefining psychotherapy *in theory* is a much slower and much more conflictual and politized process – as recent attempts to 'decolonize knowledge' demonstrate.

These two analytical clusters – 'meaning/care' and 'knowledge/governance' – have informed my thinking on this project more broadly, and they come up in other articles, although they are not always neatly disentangled. Their inherent tension points to the multiple forms and paradoxical status of psychotherapy, which can be a practice of individuation and a social institution; a calling and a profession; a flexible toolbox and a highly regulated medical regime; liberating and constraining; universal and particular; something that is created by people, institutions, and histories and something that creates new ways of being, doing, and knowing along with new futures. Looking at psy as a knowledge regime and form of governance is helpful when trying to understand how it is entangled with colonialism, neoliberalism, or biomedicine, and how it controls, subjects, or medicalizes. When framed as an institution of care and meaning-making, it becomes easier to see why people (in Uganda, for instance) desire and actively shape psy, and how it creates possibilities and can become a means of resisting other forms of governance and authority. In Vorhölter (2017b), I provide an analysis of such other forms of governance and authority in Uganda, which stand in stark contrast to the ideologies promoted in psychotherapy: rigid hierarchies rather than equality; conservative social roles rather than diversity; government control rather than self-governance. The article, which does not deal with psy per se, presents a broader picture of ongoing contestations of socio-cultural changes and the resultant conflicts, anxieties, and attempts to regain a sense of control – a theme that connects all of my work on Uganda.

My four other main publications from this project (Vorhölter 2017a, 2019, 2020, 2021) analyze how psy historically emerged as a new therapeutic regime in Uganda and introduced new forms of knowledge that enabled new ways of interpreting and dealing with problems and people: madness could now be reconfigured as mental illness; suffering and unhappiness could be read as mental health problems; socially problematic forms of drinking could be relabeled as addiction; and family conflicts could be reframed as emotional struggles. Some Ugandans became patients, or clients, or therapists; some became depressed, or traumatized, or addicts; some actively sought and others became involuntarily subjected to therapy; and many were simply not affected by psy at all. The ways psy became entangled with and meaningful in different Ugandan lifeworlds was shaped by local particularities and by larger socio-political contexts (colonialism, independence, civil war, neoliberal capitalism, global mental health). Importantly, it also depended on particular actors (doctors, nurses, therapists, help-seekers) and institutions (hospitals, private practices, universities, NGOs). The four articles analyze how the universal but multiple phenomenon of psy was selectively appropriated to fit different places and people and how social categories (like class, illness, or region) were reproduced, transformed, and created in the process.

Three publications (Vorhölter 2019, 2017a, and 2021), in particular, focus on the interplay between psy, region, and class. They show that psy, and the people who became affected by it, were different in Northern Uganda than in Kampala. Picking up topics explored in section 3 of this working paper, these articles examine psychotherapy as a class-specific practice. In Uganda, as elsewhere, psychotherapy is most attractive (and useful) for those who have money and time, who know about

and believe in the principles of talk therapy, and who suffer from specific problems for which therapy can offer a 'solution'. However, psychotherapy and the categories it promotes (depression or trauma, for instance) not only reflect but actively produce regional and class distinctions. Not (just): because I live in Northern Uganda, I am traumatized; but (also): being traumatized can mark me as being from Northern Uganda. Not (just): because I am middle class I am depressed and seek psychotherapy; but (also): because I seek therapy and am diagnosed (or self-identify) as depressed, I can claim to be middle class. Not (just): I am addicted because of my middle-class lifestyle; but (also): I am diagnosed as chronic addict because I am able to afford lifelong treatment. Not (just): my middle-class aspirations bring about particular family problems; but (also): having these problems and dealing with them by seeking therapy is what actually makes me, or marks me as, middle class.

In summary, my research makes an intervention into ongoing debates about psychotherapy – and how it is becoming an increasingly universal phenomenon. But it also contributes to the burgeoning field of Ugandan studies. All my publications engage with the dramatic political, economic, and social transformations Ugandans have experienced since the end of the colonial era – changes which have caused stress, uncertainty, and conflict, but also brought about new desires, aspirations, and ways of being in and thinking about the world. My work explores how the emergence of psy in Uganda is not simply part of a global trend but inherently related to these Uganda-specific processes of change. Ugandan therapists – when viewed through this lens – have become important mediators of social change, ones who offer new ways of thinking about the relationship between the individual and the social and new strategies for engaging with the self and the world.

The process by which new social practices and institutions emerge is not abstract; it fundamentally depends on specific people who are committed to an idea and are not easily deterred from putting it into practice: people like Rwashana Selina, the first Ugandan psychiatric nurse, who became a pioneering figure of Ugandan psychiatry in more-than-challenging post-colonial circumstances (see Vorhölter 2020); international experts like Marco in Northern Uganda, who set up a network for trauma counseling because he believed in the small changes that psychotherapy had to offer even for people suffering from structural violence and marginalization (Vorhölter 2019); people like Esther (Vorhölter 2017a), whose son's addiction disorder made her want to help others with similar problems, even though therapy could not cure her son; the anonymous therapists (Vorhölter 2017b) who were willing to listen to and help clients with non-normative identities and desires even though this put them at risk of government sanctions; or Josephine (Vorhölter 2021), who passionately advocated for the benefits of family therapy even though many of its underlying premises were foreign to Uganda. People like Stella, Sharon, Janet, and their classmates, who – despite less-than-ideal learning conditions, uncertain job prospects, and unsympathetic popular opinion – believed in the value of psychology and wanted to become good therapists.

All of my interlocutors were aware of the limitations and criticisms of psy. They did not think it would fix structural problems or that introducing it to the Ugandan context was unproblematic. They were aware of colonial legacies and ongoing power asymmetries in global health. They often talked about the fact that many of their clients' struggles were related to capitalist dynamics and aspirations and were annoyed when clients wallowed in self-made problems. They were sometimes doubtful, skeptical, and discouraged. And they often encountered considerable resistance – not only from fellow Ugandans, who saw therapy as a Western imposition, or the Ugandan government, which considered psychology irrelevant and refused to create positions for therapists in the public health sector, but also from international expats who questioned their competence. Yet they were not afraid

to have a vision for what they considered to be a new and relevant profession and form of care, and to try to put it into practice – with all the failures, frustrations, and futilities that entailed. In this sense, I think of them as pioneers. Pioneering comes with ambivalent connotations: it suggests hope, adventure, bravery, curiosity, innovation, and endurance, but it also evokes images of conquest, displacement, and destruction. As such, it captures the essence of contemporary struggles for a different world and, essentially, a different future.

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