Family Trouble: Changing (Dis)Orders and Psychotherapeutic Interventions in Uganda

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Abstract The recent popularization of psychotherapy in Uganda, while reflecting a global trend, is also a response to the far-reaching political, economic, and social transformations the country has undergone since 1986. These have caused new forms of stress and uncertainty and triggered desires for new forms of sense-making and care, particularly among middle-class Ugandans who are struggling with lifestyle-related suffering and family conflicts. Psychotherapy in Uganda is intimately, but paradoxically, entangled with neoliberal capitalism. By helping individuals adapt to capitalist modernity, psychotherapists help to reproduce the very system whose ills they are treating. However, they also believe that psychotherapy can produce critical counternarratives and a new form of care that challenges conventional hierarchies, ideologies, and norms. Based on an ethnographic case study of a symposium on family therapy, this article investigates the complex position of Ugandan therapists as mediators of social change and translators of new forms of knowledge. [psychotherapy, Uganda, family relations, and social change]

In a nondescript conference room of a hotel in Uganda's capital, Kampala, I was watching a video clip of a family therapy session. The recording was part of a training series depicting the work of a US systemic family therapist and was already quite dated, probably from the late 1980s. It showed an American family (father, mother, and their only daughter—in her mid-20s and still living at home) who had come for therapy because of ongoing conflicts between the mother and the daughter. In the video, the daughter—portrayed as angry, aggressive, and disrespectful—accuses her parents of not treating her like an adult. At the same time, she refuses to partake in any household chores and is not even capable of cooking a simple meal for herself. The therapist, through his probes and skilled analysis, helps the family to see the dynamics and interactional patterns they have established throughout their family life, most notably that the parents failed to set clear boundaries and had always "pampered" their daughter when she was growing up. After about 20 minutes, Josephine[1]—the facilitator of the symposium on family therapy I was attending along with about 35 Ugandan psychotherapists—stopped the video and asked the group for reflections. Several of my co-participants were quick to respond, expressing disbelief: "In Uganda, a daughter would never speak to her parents like that. Also, she would not cry and scream and show her emotions so openly." "The girl is very spoiled. And I can't believe she cannot cook!?" "You would rarely find a family with only one child in Uganda." Others focused more closely on the therapy context: "When families come for therapy in Uganda, it is usually about problems with young children, or teenagers. Parents wouldn't bring an adult child." Another participant added, somewhat jokingly, "If the daughter was stubborn like that, parents here would

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get a stick and beat her, not take her for therapy." To which someone else replied: "Ugandan children are becoming spoiled, too, especially in the urban settings." Many agreed. Josephine intervened in the discussion and commented on some of the statements: "I think we can see some important shifts in Ugandan parenting styles. In middle-class families, fewer parents today use the stick. And there is, in fact, a growing interest and willingness to seek therapy. However, Ugandan parents sometimes think that therapists can just solve all of their problems like 'magicians.' Some happily send their children for counseling to 'get fixed'—which is obviously not the idea of systemic family therapy."

This scene occurred during my fieldwork on emerging forms of psychotherapy in Uganda in August 2015. It raises several questions: Who are these Ugandan therapists attending a symposium on family therapy? What does family therapy look like in Uganda? Why does psychotherapy seem to be becoming more popular, and for whom? It is the last question that I focus on in this article. Drawing on interviews with Ugandan psychotherapists and other ethnographic material, I show how new experiences of suffering and new challenges in interpersonal relations, both of which are intrinsically related to changing work–life regimes, have led to a growing interest in psychotherapy, particularly among members of the Ugandan upper middle class.[2]

People are often surprised to hear that my research focuses on psychotherapy in Uganda ("Really?" they ask. "That exists in Uganda? But what about traditional healing?"[3]). Yet Uganda is by no means an exceptional case. In recent years, psychotherapy—a "professionalized practice devoted to subjectivity" (Parker 2014, 167) that entails various assumptions about work, family, the individual, and society—has been gaining popularity globally, including many places in Africa where it was previously largely unknown (regarding this trend in East Africa, see Vaughan 2016). The worldwide expansion of "psy" (Rose, 1996, 1999)[4] and its underlying assumptions and ideologies are being driven by various actors and processes: (social) media, humanitarian "psychological interventions," and the global mental health movement, to name but a few. This trend entails new ways of thinking about health and new understandings of the self; it is related to new problems that people have to cope with; and it involves the global spread of middle-class values and aspirations, including conspicuous consumption and competition for status and jobs.

Over the last decade, several groundbreaking anthropological studies have critically analyzed the global rise of psy (e.g., Béhague and MacLeish 2020; Lovell, Read, and Lang 2019; Zhang and Davis 2018) and its manifestations in different world regions: for instance, Latin America (e.g., Duncan 2018 on Mexico), Russia (e.g., Matza 2018), the Middle East (e.g., Behrouzan 2016 on Iran), and Asia (e.g., Yang 2015 and Zhang 2020 on China; Tran 2018 on Vietnam; Kitanaka 2011 on Japan; Lang 2018 on India). Africa, however, has largely been neglected in these debates. Existing studies on psy in Africa have tended to have an applied orientation, focusing for instance on the benefits or harms of psychological interventions, how to improve such interventions, or more generally on the impacts of global mental health. African contexts, in these studies, are still commonly framed as "other"—as lacking "modern" psy facilities and knowledges, where people must, or prefer to, rely on so-called traditional

or faith-based healing systems (Cooper 2016). Overall, representations of mental health in Africa lack nuance and complexity and ignore the extent to which many Africans use and engage in global psy discourses and practices.

Although psychiatry, the older and more biomedical of the psy disciplines, was established in most African countries during the colonial period (McCulloch 1995), it has always had a somewhat marginalized status and limited influence on broader society because it was seen as only for abjectly "crazy" people. Generally, those who did come under psychiatry's gaze were confined and 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 mentally healthy and mentally ill, and thus has influence beyond the confines of the clinic and therapy room. Although psy is still strongly associated with the medical realm, it is increasingly being deployed by a range of different "actors" (e.g., companies or religious authorities) that seek to normalize, pathologize, or remodel particular subjectivities. Conversely, "clients" from different backgrounds seek it out as an exciting and potentially liberating form of support that offers new interpretative frames and ways of dealing with new manifestations of suffering for which older forms of therapy and healing seem partially or wholly ineffective. The uptake of psy thus incorporates a paradoxical blend of both care and control (Stevenson 2014).

In Uganda, professional psychotherapy[5] started to emerge in the early 2000s when the first private practices opened in Kampala, Ugandan universities started to offer master's degree programs in clinical and counseling psychology, and international "psychological interventions" were launched in the North (Vorhölter 2017a, 2019).[6] Since then, psychotherapeutic discourses, practices, and institutions have been steadily gaining prominence, at least among the urban and educated sections of the population. More people are seeking, and willing to pay for, private therapy; demand for psychology courses is increasing; and Uganda's professional counseling association, established in 2002, grew from 300 to almost 1900 members between 2012 and 2015. As noted, there are different global reasons for this recent expansion of psy, including efforts by the global mental health movement and the World Health Organization (WHO) to increase psychiatric services in low-income countries; the increasing focus in humanitarian interventions on voice, agency, and individuals' ability to articulate suffering; and images of mental health, talk therapy, and "the self" that are circulating through social media. However, the recent popularization of psychotherapy in Uganda is not just an externally driven manifestation of global trends. It is also a response to the far-reaching political, economic, and social transformations Ugandan society has undergone since 1986, which have caused new forms of stress, conflict, and uncertainty and triggered desires for new forms of sense-making and care.

Much ongoing work in the social sciences, including my own, has criticized psy's intimate entanglements with neoliberal forms of governing. Inspired by the work of Foucault or his

followers (most prominently Rose, 1996, 1999), these studies use concepts such as technologies of the self, subjectivation, or self-government to show how the rise of psy is linked to new understandings and a new regime of the self. They also critically assess how psy has been complicit in medicalizing and depoliticizing suffering and pathologizing "deviant" subjects who do not conform to the dominant social order. Marxist critiques of psychotherapy (e.g., Cohen 2016; Kovel 2017; Parker 2014)—though less prominent in recent anthropological debates on global mental health, which tend to focus on "culture" rather than class—furthermore draw attention to how psychotherapy is embedded in, and helps to reproduce and normalize, capitalist ideologies, inequalities, and modes of exploitation. A common argument is that the rise of mental illness worldwide is related to the structural violence, inequality, and fierce competition inherent in capitalism, and so by helping sufferers cope with stress, depression, anxiety, and other "system-related" disorders, the psy industries maintain the productivity of the workforce (including, importantly, the middle classes) and thereby stabilize the capitalist system. Moreover, they are seen to profit from, and thus depend on, systemic suffering (Cohen 2016). Both Foucauldian and Marxist analyses offer important critiques of psy and global mental health. However, they do not account for psy's role as a much desired new form of care (Matza 2018; Zhang 2020).

Psychotherapy in Uganda is a form of care that is intimately, but paradoxically, entangled with neoliberal capitalism: one the one hand, it reflects and reinforces neoliberal ideologies and capitalist order as Foucauldian and Marxist critiques would predict. It responds to mental health problems that are related to, if not caused by, neoliberal transformations since the 1980s,[7] including rising inequality, performance pressures and anxieties, and the prioritization of economic success over family commitments. In this sense, the recent expansion of psychotherapy in Uganda is a *symptom* of neoliberal transformations. On the other hand, Ugandans also envisage psychotherapy as a *remedy* for the ills caused by these transformations and seek it out as a new form of care that can help them to critically reflect on their capitalist lifestyles and related problems. All the therapists I met were convinced that psychotherapy had something new to offer in the Ugandan therapeutic landscape: a science-based approach to healing that empowers sufferers to critically reflect on their circumstances rather than simply accept the diagnoses or follow the instructions of medical, political, economic, or religious authorities; a form of care that encourages sufferers to openly explore and talk about feelings, thoughts, or painful experiences, which many had been taught to hide; and a mode of conversation that challenges conventional hierarchies, rules, and norms regarding who can speak to whom about what. In short, by helping individuals adapt to capitalist modernity, Ugandan psychotherapists played a role in reproducing the very system whose ills they were treating. However, they were not simply the dupes of neoliberalism. Rather, they saw themselves as facilitating critical reflections, not only on the self but on society at large. They believed in and valued psychotherapy's potential to instigate critical counternarratives and new, meaningful forms of care.

Using the previously mentioned symposium on family therapy as an ethnographic case study, this article investigates the complex position of psychotherapists as crucial mediators of ongoing change. My ethnographic findings are based on four months of fieldwork,

mainly in Kampala but also in Gulu (Northern Uganda's largest town), which I carried out in 2015. I conducted 35 interviews with psy professionals (psychologists, psychotherapists, and psychiatrists), visited different therapeutic institutions, and analyzed current debates on mental health and psychotherapy in a major Ugandan daily newspaper, *Daily Monitor*. Moreover, I draw on my doctoral research in Uganda (12 months between 2009 and 2011; see Vorhölter 2014).

Social Change and the Rise of Psychotherapy in Uganda

The emergence of psychotherapy in Uganda in the early 2000s is a response to both the very real wide-ranging transformations that people in Uganda are grappling with *and* new ways of experiencing and interpreting them—as stress or mental health problems, for instance. I cannot do justice here to the complexity of these transformations and the dramatic impacts they have had on people's lives (for more comprehensive discussions, see Hansen and Twaddle 1991; Vorhölter 2014; Wiegratz, Martinello, and Greco 2018). What follows is a necessarily brief and incomplete summary of Uganda's "neoliberal" period since 1986.[8]

When the current president, Yoweri Museveni, came to power in 1986, after decades of political turmoil, war, and economic instability, he readily embraced Washington Consensus prescriptions, especially liberalization and privatization, imposed on the heavily indebted country by the International Monetary Fund and World Bank. He also introduced a new political system and a range of what were at the time quite progressive reforms regarding gender politics, poverty reduction, and the escalating HIV/AIDS crisis. Consequently, Museveni came to be considered a model pupil and donors' darling by international development agencies and—even though his rise to power also marked the beginning of several violent conflicts in the periphery and effectively caused the outbreak of the 20-year civil war in the North—Uganda began to receive massive amounts of official development aid (Fisher 2013). Western nongovernmental organizations (NGOs) effectively took over many key responsibilities of the state, especially in the health and education sectors. Meinert and Whyte (2014) refer to this process as "epidemic projectification," which NGOs have used to promote their own agendas, worldviews, and technologies (e.g., children's rights, gender equality, biomedicine). It is hard to overstate the (ambivalent) impact these development interventions have had on people's day-to-day lives, even in the most remote areas of the country.

Although Uganda has experienced significant economic growth over the last three decades, these benefits are unevenly spread and have resulted in growing economic inequalities between a small urban upper middle class and the vast majority of urban and rural poor. Various authors (e.g., Wiegratz 2016; Wiegratz, Martinello, and Greco 2018) have noted a pervasive economization of nearly all fields of social and political life accompanied by an ethical framework that increasingly emphasizes individualism, consumerism, and self-promotion. Among lower classes, particularly among the younger generation, one finds a toxic mix of precarious employment opportunities and poverty, on the one hand, and middle-class consumer and lifestyle aspirations, on the other (Vorhölter 2018). However, as I discuss next, even those

who have achieved middle-class status often suffer from new forms of stress, performance pressure, and anxiety (cf. Livingston 2009).

The ongoing social, economic, and political changes and their effects on people's personal lives were a huge topic of debate in Uganda. Most people I met were struggling in one way or another with changing gender and generational dynamics, related family and relationship crises, and concerns about economic well-being and uncertain futures. For some, looking at these challenges through a psy lens was helpful and enlightening; others rejected what they perceived as a "foreign" and unnecessary health approach. Nevertheless, psychotherapeutic concepts, terminologies, and techniques were gradually becoming more well known and reshaping, if subtly, people's understandings of well-being and suffering.

The negative impact of social change on relationships, families in particular, was a topic that I constantly encountered in media discourses, my interviews with therapists, and everyday conversations. The following quote from an interview with a clinical psychologist is typical. Sitting in her spacious consultation room at an expensive private clinic, she reflected on her clients and the reasons they came to her for treatment:

> The predisposers [*sic*] to stress are changing. Back then, most people, most families were really working together. But as the country becomes more developed, there is a lot of financial strain; people are now becoming more individualistic; family cohesiveness is really broken, breaking down, everybody is there only for himself. And the extended family? It is no more. Today people only look at their nuclear family. Most marriages are breaking down, there is a lot of single parenthood. So yeah, there are a lot of predisposers to stresses today. (Interview, March 23, 2015)

The interviewee expresses a common sentiment, namely, that social cohesion was breaking down as people across the country were struggling, and competing, to find employment, money, and individual success. Even though Ugandans might have experienced similar tensions in previous times, the feeling that life today was more hectic, complex, and individualistic was widespread. A university student who participated in a group discussion I had organized on experiences and strategies of dealing with stress put it succinctly: "Basically, there is survival for the fittest now, which used not to exist before. There was a lot of togetherness in previous generations."

Although my interlocutors generally emphasized that people's specific problems differed greatly depending on whether they were wealthy or poor, rural or urban, or educated or noneducated, everyone seemed to agree that family relations, partnerships, and marriages across the country had become increasingly characterized by instability, mistrust, and conflict. Stories of divorces, (sometimes violent) partnership conflicts, and so-called dysfunctional families were widespread. The continuing HIV/AIDS crisis further exacerbated conflicts and uncertainties. International NGOs, community elders, religious institutions, and social media all promoted rigid, but conflicting, normative relationship models, which were often far removed from Ugandans' lived realties (Boyd 2015; Parikh 2015). Members of the younger urban generation, in particular, felt torn and conflicted as they both desired their

contemporary fast-paced and often individualized lifestyles but also longed for what they imagined to be a less stressful and more communal past (Spronk 2012; Vorhölter 2014).

Marriage, family, and relationship problems are not new in Uganda, and many long-established forms of support are available to those who are dealing with them: consultations with elders, so-called traditional healing, or religion-based marriage counseling. These forms of counseling and healing continue to be popular and relevant. However, because they perceive today's problems to be more complex than in the past, many Ugandans seek out new, or additional, forms of expertise. One of my interviewees, a church-based marriage counselor at one of Kampala's Pentecostal churches, explained this to me as follows:

> [Relationship] problems [today] are more sophisticated. . . . So what we've realized, and that's why we're going back to study, is that the way we were counseled is not the way we can counsel these [people today]. We call them dot-com era [she talks about the effects of the internet, smartphones, and social media on relationships, especially among younger couples]. The dot-com era is more complicated, so we need to be one step ahead. The counseling we used to use might not be applicable to them now, we need to understand their mindset, where they're coming from, so as to be able to help them at their own level. That is why we need to go back now and study. They are very complicated, very complicated. (Interview, April 14, 2015)

The rising popularity of psychotherapy must be seen against the backdrop of these "more sophisticated" challenges and struggles that Ugandans face today, particularly but not only in interpersonal relationships. Psychotherapy offers new interpretations of, and approaches to, dealing with personal problems and a new language for speaking about suffering—for instance, in terms of stress, depression, or emotional pain—which many Ugandans find relevant to contemporary problems. Psychotherapeutic concepts, techniques, and vocabulary have been increasingly taken up in the media, by laypeople, and by various kinds of counselors, especially by those from upper middle class Pentecostal churches (Van Dijk 2013). The interviewee quoted above, for instance, had recently enrolled in a psychology degree to enhance her marriage-counseling skills. Professional psychotherapy, however, as all of the "secular" therapists I talked to repeatedly emphasized, was different from these other forms of counseling: less dogmatic, patronizing, and moralizing. They saw the therapy room as a space in which clients could openly reflect on their problems without being judged or told what to do. While Pentecostal counselors, for example, forbade divorce or premarital sex, and HIV/AIDS counselors instructed patients on how to live their lives, professional psychotherapists, according to my interlocutors, helped clients find their own answers and solutions.

Basic counseling courses (particularly for HIV/AIDS counseling) have been available in Uganda since at least the early 1990s, and introductory counseling units have long been part of social science degrees. The first designated Institute of Psychology, however, was opened only at Makerere University in 1999. MA programs in counseling and clinical psychology started soon after. While not the only factor behind the expansion of psychology in

Uganda, the availability of these degree programs at home (rather than abroad) meant that more Ugandans could professionally study, and practice, psychological therapy.

Grace Akot was an early graduate in counseling psychology and subsequently opened one of Kampala's first private practices in 2001. She told me her story of becoming a therapist:

> Originally, I was working in a bank. My first degree was in social work and social administration, and there's a counseling unit in the curriculum. At the bank, I was in charge of staff welfare. I would see a lot of problems, but I was not equipped to help people deal with them. That's why I started taking short courses and reading widely about counseling. The more I read, the more I became interested and I wanted to do the master's degree [in counseling psychology]. I actually got a scholarship to do it abroad, but my children were teenagers and I couldn't leave them. So I waited until they opened up a program at Makerere University. I was on their neck, I said: "When are you starting counseling psychology? I can't get out of the country!" I became one of the pioneers. We were twelve, and I think eight of us graduated. That was in 2000. By that time, I was still working in the bank. I decided to quit and started this counseling firm. . . . That's how we began here. At the beginning it was tough; sometimes you would get only two or three people the whole week. . . . But as the years went by, our work has kept on growing. Now we fill a week in advance, we have a big influx of clients. We also work with organizations. They send their staff here for counseling. Sometimes we do workshops for them, for instance, on how to balance family and work, or on managing stress. (Interview, September 1, 2015)

Nowadays, several Ugandan universities offer academic degrees in counseling and clinical psychology. And even though employment opportunities for psychologists are scarce, these programs are attracting growing numbers of students. In conversations with students or recent graduates, I was always curious to hear about their motivations. Many had previously been working in other fields and had become interested in psychology after experiencing a mental health crisis—either their own or that of a loved one. John, for instance, had given up his successful career in information technology (IT) and decided to become a therapist after struggling with, and receiving treatment for, depression. He told me:

> It is a long story. I was trying to find out what to do with myself. IT—I wasn't passionate about it anymore. But my desire for change also came from my own personal experience with depression and drinking. Actually, the people who treated me are now my supervisors. It has been quite interesting: coming first as a service user for three years, and then now becoming a service provider. It gives you a very unique perspective on what needs to change, what doesn't work in mental healthcare. . . . A lot of the families, at least from my [upper middle class] background, have these issues: a son or a daughter or sometimes all the kids become drug addicts, the parents send them abroad, give them money for university tuition, they come back—with nothing, nothing, nothing. I have a cousin, I talked to his mum last week. She spent a lot of money sending him to Malaysia for education, but he never did well. She is crying; and he is abusing drugs, he is drinking, he can't find work. We really need therapeutic interventions in our families, our communities; efforts at prevention must be part of the healthcare package. (Interview, August 17, 2015)

Like John, many of my interlocutors felt that they wanted to be better equipped to help others, or themselves, deal with suffering, and they saw psychotherapy as a meaningful and much needed form of care. While most hoped to eventually find paid employment, many accepted that much of their work might end up being underpaid or voluntary counseling. Even experienced therapists like Rose, who had set up her own pro bono counseling center for students, told me: "Counseling is something that gives you satisfaction. I don't get paid here, but it's a joy to see someone getting out from there [a crisis], and they come back and say thank you. It's like in your mind you say: I made a difference in this person's life" (Interview, April 13, 2015).

Psychological psychotherapy in Uganda is generally not supported by the public healthcare system, but it is increasingly being promoted in larger companies, organizations, and private schools, which cover the costs for their staff and students.[9] Furthermore, various forms of mental health support, including professional psychotherapy, are provided by NGOs, and most of the private practitioners I spoke to in Kampala offered at least some pro bono sessions for clients who could not afford their fees.[10] But although psychotherapy is becoming more widely accessible, most clients (as well as most therapists) continue to be members of the upper middle classes—who can afford it, value its quality and privacy, and are familiar with it through education, international exposure, and social media.

Class Relations, Family Conflicts, and Psychotherapy in Kampala

As I have argued elsewhere, class structures, family problems, and therapeutic interventions in Uganda are closely interrelated (Vorhölter 2017a). In Kampala, where most of my research took place, class differences are vast and visible. On the one hand, members of a growing upper middle class and a large expat community frequent an ever-increasing number of up-market shopping malls, restaurants, nightclubs, and gyms, send their children to expensive private schools, and seek medical care in private clinics and practices. On the other hand, Kampala has a large population of urban poor—often labor migrants from the rural areas—who struggle to access basic services, including education and healthcare. Most Kampalans, irrespective of their class background and even if they have lived in the city all their lives, consider their family home and place of origin to be elsewhere, usually in a rural area, where their family owns (or used to own) land and where they may have extended kin. This also means that most people come from multiclass families, which creates particular challenges, pressures, and conflicts, particularly for those who have achieved middle-class status and are expected to share their relative wealth.

Class influences not only who seeks psychotherapy but also how individuals understand and articulate their suffering. It also influences the dynamics between client and therapist—a point my interlocutors repeatedly mentioned. However, they also emphasized that some stressors—most importantly, family, partnership, and marriage conflicts—affected Ugandans from all class backgrounds, even if they were experienced differently. Almost every therapist I talked to in Kampala identified relationship struggles as one of the main reasons why clients

sought their help. Such struggles often contributed to depression, anxiety, and other mental health problems and were related to economic concerns, including financial worries, struggles to achieve upward (or avoid downward) mobility, jealousy, competition, and overwork. The following quote by a clinical psychologist is a typical depiction of problems experienced by middle-class families in Kampala:

> Depression, anxiety, there is a lot of stress around family issues, being responsible for a lot people financially, taking care, relational issues. . . . What is very difficult is the work and social life balance. What I see a lot is people work; they work the whole day, then after that they have wedding meetings, they have to go the gym, all that. So I see a lot of problems, also family-wise, like children with behavioral issues because they are basically brought up by the nannies. . . . I think that gives a lot of pressure to parents [having to cope with all these different expectations]. . . . Obviously, the children were more shared earlier, so if you had an extended household other people would look after them. But if it is always just the maid, it may not be enough. I think that has definitely changed. (Interview, March 25, 2015)

Similarly, a therapist who worked at an expensive addiction treatment center near Kampala stated:

> The clients here, most of them belong to the middle class, meaning those who are really earning something good, coming from good families, where the money is there and they can afford [things]. That is their class, their status. However, when you look at the type of families they come from, in the psychological perspective I can say they come from dysfunctional families. What happens in these families is that parents don't have time for their children as they are growing up, these rich families where people are out there to look for money. They don't have time for parenting, so they are looking for money here and there and the children are left with the maids. . . . Some come from totally permissive parenting styles, the parents are not bothered: "You want this? I will give it to you." They think that is the best they can do for their children, and then they come here and say, "I wish I had known that this is going to lead to this." (Interview, April 10, 2015)

As this statement shows, therapists were sometimes highly critical of their clients' lifestyles. They talked, with great concern, about how people supposedly belonging to the "elite"—those who were well educated and had money and opportunities that were unimaginable for the great majority of Ugandans—made choices and set priorities that were extremely detrimental to both their families and themselves. Yet all of my interlocutors also empathized with their clients and understood that many of the conflicts and mental health problems they witnessed were related to the large-scale social and economic transformations Uganda was undergoing. Take this statement by a child and family therapist:

> Especially, once again, the elite group, they want help for their children to choose the right career. . . . It's part of the culture here, that we need a doctor in the family [*rolls her eyes*]. So conflicts about children's career choices, that comes up a lot. But then also spiritual struggles, the search for meaning in life. There's a big search for meaning, related to economic changes and families becoming smaller, moving away from the big extended family. There's that shift of "Where do we belong and what do we need?" (Interview, August 11, 2015)

Despite expressing annoyance about clients' sometimes unreasonable and problematic expectations (here regarding children's career choices), the interviewee also shows compassion for their "spiritual struggles." In a country where many still lack basic needs, members of "the elite group" were living lives of plenty, which to them, however, often still felt empty. They were trying to escape from extended families who demanded a share in their wealth, yet without their kin they lost not only valuable social support networks but also a sense of belonging. From the outside, their lives seemed glamorous; they had achieved what many Ugandans dreamed of. This made it hard to admit, even to themselves, the confusions, anxieties, and existential struggles they experienced. Listening to my interlocutors describe the predicaments of their clients in such terms helped me to get a deeper sense of why especially upwardly mobile Ugandans turned to psychotherapy. Not only did it offer strategies for dealing with the stresses and problems they faced, it also helped them to develop an attitude of self-compassion, something that other forms of counseling, which prioritized practical advice, lacked.

Remaking "Modern Families": A Symposium on Child and Family Therapy in Uganda

In August 2015, I attended the symposium on child and family therapy that I described in the opening vignette.[11] The symposium provided many insights into how psychotherapy is being introduced to, translated in, and appropriated in Uganda, and I often reflected on it after my fieldwork. Here, it illustrates the complex position of Ugandan therapists as mediators of social change, "healers" of change-related suffering, and "cultural translators" (Zhang 2020) of new forms of knowledge.

The symposium was facilitated by one of the few experts on child and family therapy in Uganda, Josephine, who had received her PhD in counseling psychology in the United States. There were about 35 participants, mainly women, from different professional backgrounds and with different motivations: marriage counselors from churches, trauma and youth counselors from NGOs, teachers, university lecturers, and even a self-described freelance stress manager. For some, the symposium was part of their work: they wanted to upgrade their skills and/or needed the certificate.[12] Others were interested in learning about child and family counseling to deal with their own personal issues and conflicts. The woman sitting next to me, for instance, was a retired nurse who had become interested in psychotherapy when trying to support her son through painful years of drug and alcohol addiction. Some participants were experienced therapists with MA degrees, while others were relatively new to the profession and only had basic qualifications. Most came from upper middle class backgrounds and lived in Kampala.[13]

Over two days, Josephine introduced us to different interventions in the field of child and family therapy: systemic approaches, solution-focused therapy, art therapy. Furthermore, we learned about tools for conducting family assessments, such as genograms, puppet interviews, art assessment, and family sand tray portraits (see next). Didactically, Josephine alternated between giving presentations, which sometimes involved video recordings of therapy sessions,[14]

brainstorming and discussion rounds, and role-play exercises in which we were divided into "family" groups to practice the tools and approaches we had learned about.

Right from the outset, Josephine stressed that most of the theories and concepts of family counseling were developed in the "Western world" and thus needed to be adjusted to fit the "African" context.[15] Before describing specific approaches, she asked participants to brainstorm important differences between Ugandan families and those on which the therapy models were based. This generated a lively debate in which important distinctions were raised, including family size, gender- and age-based roles and hierarchies, language and communication styles, taboo topics, spiritual beliefs, knowledge about psychotherapy, and willingness to seek psychotherapy. While everyone agreed that there were noticeable differences between a typical Ugandan family and what they imagined to be a typical Western family, people also spoke of the massive urban–rural and class divides within Uganda and the related differences in parenting norms and styles across the country. It became clear that most participants thought that Ugandan society and families were undergoing rapid transformation and that this was causing many conflicts and problems. They seemed to share an implicit assumption that the changing economic and social demands required a different type of family, and that the task of family therapists would be to help their clients learn and negotiate new roles, values, and ways of relating.

Participants commonly differentiated between "traditional" and "modern" families when trying to pinpoint the exact problems Ugandans (including themselves) were struggling with and potential ways therapists could intervene. Throughout the two-day course, this was passionately discussed both in class sessions and during break-time conversations.

A frequent reference point was the "traditional" Ugandan family, which was largely characterized as belonging to the past, although people believed that remnants were still found in rural areas. Participants imagined it in broadly similar terms: family structures were rooted in patrilineal systems. Marriages, often polygamous, were arranged and created social and economic bonds between patrilineal clans, not just between two individuals. Families and households were large, usually multigenerational, and headed by an adult male. Family relationships and roles were complementary and centered on clear gender- and age-based hierarchies and role expectations. Fathers were portrayed as dominant, authoritarian, and emotionally distant, especially toward children; mothers were seen as caring and hardworking; children were expected to be well behaved and obedient. Traditional families were further described as "enmeshed," meaning that their members were socially dependent on each other. There were "no boundaries between self and other," as Josephine put it.

All participants seemed to agree that most families today no longer fully resembled the "traditional family model," especially those in urban areas. The role and importance of the extended family was changing, and the trend was toward nuclear family households. Among middle-class Kampalan families (a category most participants included themselves in), it was common for both parents to work in salaried jobs. In addition to long and stressful workdays, parents also had an active social life, which meant that they spent less time at home

and often left the children in the care of housemaids or sent them to boarding schools. To compensate for the lack of family time, children often received material things, and many workshop participants noted that urban children were "spoiled and disrespectful." Although their parenting was perceived as less authoritarian, "modern" parents were felt to lack emotional involvement. Families were becoming increasingly "disengaged"—family members were keeping more to themselves and often did not even share meals anymore. The symposium participants also commented on "modern" marriages, which they portrayed as short-lived, conflictual, and thus as the epitome of declining commitments to and valuing of social ties and family responsibilities. Such descriptions were a common feature of my interviews, talks with friends, and public debates. They expressed both a critique of a socioeconomic system that drove people to prioritize wealth and status over family commitments and an acknowledgment that everyone was implicated and there was no simple solution. Although the participants perceived "modern" families to be problematic, they did not romanticize former times and families. "Traditional" families were viewed as backward, patriarchal, and undemocratic; and while they might have been more stable due to their stronger social bonds and clearer role and hierarchy definitions, people definitely did not strive toward or want to promote this model in therapy.

Most symposium participants shared a clear understanding of the ideal Ugandan family. This became most obvious during a group exercise in which we experimented with an assessment method called family sand tray portrait. Participants were split into "families" of six, and each member had to pick plastic figures from Josephine's large collection, which were then arranged in the sand tray to portray their imagined (ideal) family. Afterward, each group was asked to describe their sand tray. This process revealed broadly shared family ideals, many of which reflected global middle-class values and aspirations. Nearly every group described their (ideal) family as having a spacious and safe family home; having money; valuing education and having high goals in life; loving leisure activities, sports, and personal time; enjoying cooking and healthy food; going for vacations abroad; going to the zoo and to national parks to have a "relaxed mind"; having big extended families; and valuing God. While these family ideals might have seemed within reach for the symposium participants, they were far removed from the lifestyles and realities of most Ugandan families, who struggled to meet even basic needs, often could not afford to send all their children to school, let alone to a good one, and who could not have obtained visas for traveling even if someone had covered the costs.

Without reflecting on this class gap, everyone seemed to agree that the ideal modern family combined aspects of the traditional African family (importance of social bonds and values such as respect and manners) with those of the emerging family model (centered on the nuclear family and values such as "self-realization," wealth, health, education, and equal opportunities). The question then became how to guide families in the therapy process. Thereby, the goal was less to prescribe specific family models than to help clients find ways to reconcile the problems, desires, and challenges of a modern capitalist lifestyle with healthy social relationships.

According to Josephine, a big challenge for modern families was negotiating hierarchies, roles, and boundaries. Therapy was about helping people to find the right balance between closeness and distance, enmeshment and disengagement, self and other, and authoritarian and lenient parenting styles. She sometimes compared Ugandan family culture and parenting styles with those she had encountered in the United States. She noted particular "cultural shortcomings" in the former, which made Ugandans less well equipped for the demands of capitalist society. For instance, she said that Ugandans were not good at expressing emotions and had been trained to hide both positive and negative feelings. Furthermore, they had a low capacity or willingness to express empathy. Josephine also felt that Uganda had a very "linear learning culture": children were not taught how to creatively solve problems as individuals, only to follow clear models and authorities. Both at home and at school, children were not encouraged to experiment, because most parents and teachers lacked the skills to creatively engage them. Creativity and the ability to experiment, however, were increasingly demanded in the complex, globalized work and social environment, which put Ugandan children and adults at a disadvantage.

Thus, in her therapy work, Josephine tried to foster her clients' capacities to express emotions and be creative and to explore and gain awareness of their inner selves. She taught them how to separate thoughts from feelings and how to differentiate intrapersonal and interpersonal stress. She considered it important for everyone to "know oneself" and to be able to feel "where one's self ended without losing the self." She also encouraged clients to reflect on their family histories and understand how past experiences shaped their personalities and present-day interactions with others.

Josephine emphasized that this capacity was not only important for clients, it was also crucial for therapists to avoid countertransference in their therapy encounters. At different points, she asked the participants to reflect on their own personal and family lives. Questions that came up included: Do you compliment yourselves and your children? Do you enjoy spending time with your children? What are your worries? What makes you angry? What makes you sad? What do you need from and what can you give to your family?

The participants readily and very seriously took on and even enjoyed these sometimes very intimate self-analysis exercises. Many wondered whether they were good parents and spouses and whether they were setting the right boundaries between enmeshment and disengagement, personal freedoms, protection, and overprotection. Some enthusiastically suggested that all Ugandans should have the chance to reflect on family in this way and to experience therapy more generally. However, while most symposium participants celebrated what psychotherapy had to offer, everyone also knew that most Ugandans were either critical or unaware of it.

With every method we discussed, the question of whether psychotherapy was suited to the Ugandan context, and whether people would be willing to try it and pay for it, was raised again. All participants who worked as therapists could recount experiences or conversations from their professional lives in which Ugandans expressed great skepticism toward

psychotherapy, at least initially. People not only characterized therapy as Western, foreign, and unnecessary, they also considered it shameful to seek the help of a psychotherapist. Josephine reported how some children or families who had been forced to see her by schoolteachers or administrators had felt ashamed and weak that they could not handle their problems alone. Many were hesitant to open up to her, though that often changed throughout the therapy process.

Josephine repeatedly emphasized the importance of acknowledging the Ugandan context and how it differed from the therapy setting assumed in Western textbooks and teachings. Children and adults needed to be carefully prepared, because in a therapy setting "normal" rules of communication and interaction might be broken. She encouraged participants to carefully explain the concepts of psychotherapy to their clients by relating them to more familiar local practices, beliefs, and principles. For instance, in a situation in which a child was asked to speak out and give his/her opinion on the family situation, one could draw on the Baganda proverb "when a child beats the drum, an adult can dance" to show that children's actions can be meaningful for adults and that this does not go against cultural beliefs or hierarchies.

Despite these words of caution, Josephine was adamant that child and family therapy could be very successful in Uganda if approached correctly. In her own experience, it had worked in different class and regional settings, and people had generally appreciated her efforts and the insights they had gained. She gave examples from her work in camps for internally displaced people in Northern Uganda, where she had been involved in humanitarian interventions on a short-term basis as a child therapist. Because she did not speak Acholi, one of the main languages in the North, Josephine had encouraged the children to use local materials (stones, sticks, banana leaves, etc.) to visualize and express their wartime experiences. She had also used drawing, music, puppets, and other art-based forms of therapy. To her surprise, the children, many of whom had suffered through displacements, abductions, and other forms of violence, were willing to open up through these playful interactions. Josephine thus experienced these therapy sessions as meaningful, engaged, and productive.

All symposium participants believed in the benefits and meaningfulness of therapy. Some, like Josephine, had experienced success in their own work; others were optimistic about the novel skills and insights they had gained during the symposium. At least implicitly, everybody seemed to agree that changing times and changing struggles called for not only new types of families but also new healing practices.

The Ambiguous Potentials of Psychotherapy in Uganda

This ethnographic case study shows how psychotherapy in Uganda, on the one hand, offers new insights into and approaches for dealing with family conflicts that are seen as valuable and invigorating but, on the other hand, also promotes ideologies of the self, family, and society that consolidate a neoliberal social order and inherent class-based inequalities. Rather

than offering yet another reading of psy as a foreign cultural import that challenges local value systems and relationship structures, the following discussion emphasizes the larger structural processes underlying shifts in therapeutic regimes.

As Mullings (1984) argued in her seminal work, *Therapy, Ideology, and Social Change: Mental Healing in Urban Ghana*, new therapies tend to emerge and prosper in contexts in which enough people feel that existing therapies no longer adequately address their forms of suffering. Unsurprisingly, therefore, new therapies tend to emerge during periods of fundamental change, when the roles, demands, and desires of individuals vis-à-vis society at large are being renegotiated. In these contexts, people seek new ways to make sense of their changing circumstances and the suffering it causes, and new ways to achieve well-being. All therapies—whether involving rituals or medication—mediate between the individual sufferer and the social whole (Mullings 1984, 195–96). While their more proximate effects are on individual clients or groups of clients, therapeutic ideologies—if they become widespread—can also penetrate and change larger society. In this sense, therapy has a dialectical relationship to the social order (Turner [1969] 1995). But while all therapies have transgressive elements—they offer experiences and interpretative frames that break with the status quo—their predominant aim is to help individuals become "normal," functioning, and accepted members of society (again). Therefore, in the end, most therapies tend to be "system-conforming" rather than revolutionary. Contemporary mainstream psychotherapy is no exception (Totton 2000).

In Uganda, families were struggling with a range of problems that were related to and exacerbated by wide-ranging social change. While many people still utilized established therapeutic options ("traditional," spiritual/religious, psychiatric), psychotherapy was becoming attractive because it offered new ways of assessing and interpreting problems and new strategies for dealing with them. For instance, unlike other forms of therapy, it aimed to foster open, nonhierarchical conversations in which all relevant voices could be heard, to promote self-reflexivity and self-care rather than reliance on authorities (like healers, priests, or doctors), and to teach new parenting, interpersonal, and emotional skills. Even though psychotherapists were critical of the contemporary capitalist work–life regime, which they saw as partially responsible for many of the struggles people were experiencing, they promoted values, skills, and ideologies—emotional competence, creativity, self-assertiveness, etc.—designed to help people adjust to, function in, and compete in that very system,[16] not to challenge it. Moreover, and largely unintentionally, therapists reinforced class-based images of a "normal," successful individual: someone who is able to maintain work–life balance, is economically successful without neglecting social responsibilities, is emotionally connected but recognizes individual boundaries, consumes quality commodities without being excessive, and manages stress and conflicts by openly talking about them. While such ideals may be achievable, and desirable, for a middle-class person or family, a category to which the great majority of therapists belonged, they are far removed from the lived realities of most Ugandans. One could think about these ideals as forms of "cruel optimism" (Berlant 2011),[17] which harm those struggling in vain to realize them and thereby fuel and reinscribe class antagonisms.

Nevertheless, many of the practicing therapists attending the symposium, and others I spoke to throughout my research, reported stories of people from across the class spectrum who had come to appreciate psychotherapy as a helpful and revealing way of gaining new insights and dealing with problems. They reported that clients, especially from lower class backgrounds, valued the particular attention and care psychotherapy gave to them as individuals and not *just* as parts of a collective (family, kin group, church congregations, etc.) in which roles, speech positions, and problem configurations were always to some extent predetermined. In this sense, psychotherapy differed from "traditional" or religious forms of healing in that it created a unique space outside of the usual social and normative orders in which people could reflect on personal problems, relationship dynamics, and aspirations for well-being 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-described homosexuals who had come to speak to them confidentially (Vorhölter 2017b). Some wanted to be "cured" or 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 their assault to the police, or anyone else, because the perpetrator was their spouse or a family member on whom they were dependent. According to my therapist interlocutors, such clients often felt 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 allowed them to question conventional hierarchies and moralities, and it placed them as individuals in a position of power, responsibility, and self-care/control.

My interlocutors' passion for psychotherapy and their stories of success might seem performative, or even naive. However, it is important to remember that many of them had experienced psychotherapy themselves during their own crises, or those of loved ones, and had found that it offered valuable new perspectives and insights beyond those provided by existing therapeutic regimes. Furthermore, all my interlocutors also mentioned failures and the limitations of therapy: some clients attended only one or two sessions but expected magic, quick-fix solutions; many liked having a new frame to analyze their problems but were less willing or able to change their lives accordingly. The latter case, in particular, was a widespread challenge. It is well captured in this statement by a clinical psychologist who described her difficulties in trying to help parents whose children had developed psychological problems:

> My challenge with it, always, and that is what I also ask the parents when they come, is: "What do you want to do when you know?" . . . If it is about spending more time with their child, I ask: "Are you going to stop meeting your friends, or do your gym, or work less? Is that something you are going to sacrifice?" Because I think many people like doing assessment. [But then changing their lifestyle,] it is very difficult, because most of them have never seen how you can spend time and play with your child outside of the

> larger family setting, whereby the children play together and sort themselves out. It is a challenge when it is only one or two children in a compound with a fence. . . . Some parents really try, but for others, even if they try, it is still very hard to learn and to give up on the other social pressures. (Interview, March 25, 2015)

Paradoxes of Psy

The growing popularity of psychotherapy in Uganda is both a symptom of and a remedy for the ills caused by neoliberal transformations since the 1980s. On the one hand, as Foucauldian and Marxist critiques of psy have demonstrated in other contexts, psychotherapy in Uganda helps to stabilize the capitalist order because it performs "ideological work"—it imagines a particular kind of subject (self-reflective and self-responsible), a particular form of family (nuclear, middle class), and a particular kind of society (rooted in capitalist production, distribution, and consumption ethics). Thereby it not only reinforces but also conceals class-based inequalities and subjectivities. On the other hand, however, psychotherapy also creates new and potentially liberating spaces—ones in which established hierarchies, communication rules, and ways of interpreting problems are temporarily suspended—for pausing and critically reflecting on neoliberal change and its far-reaching effects on social roles, values, and ways of relating.

Ugandan psychotherapists occupy complex positions as mediators of ongoing change. While critical of contemporary work–life regimes and the economization of social life, they also supported these very regimes by promoting parents' and children's subjectivities and behaviors that conformed to, rather than challenged, neoliberal ideologies. However, one could also reverse this formulation: even while profiting from and contributing to neoliberal change, therapists also provided a much desired form of social support and "real care" for their fellow citizens and were driven by the desire to create a better society.

The case study of the family therapy symposium revealed the very sincere attempts of therapists and therapists-to-be to find the right balance between individual and social responsibilities and a way to accommodate global middle-class consumerist aspirations without losing touch with local moral worlds. They discussed questions that went to the heart of their own quests to be moral and happy human beings: How should I raise my child? What is a normal family? How can I and others be content and healthy? Finding answers to these complex questions required them to imagine past, contemporary, and future social and moral orders and to envision ways of "healing" different and changing Ugandan families. Their reflections on psychotherapy also revealed its potential to challenge existing hierarchies, authorities, and forms of knowing and caring in Uganda—even if not the capitalist system as a whole.

According to Derrida's conception of the *pharmakon* (for an insightful discussion, see Wilson 2015, 142–46), therapeutic interventions are always ambiguous; not only is their potential for healing deeply entangled with harm, it is structurally dependent on it. In other words, all therapies have multiple and paradoxical effects—harmful and beneficial, individual and social, normalizing and pathologizing, liberating and confining—which cannot be

disentangled because they form a "grammatological field" in which no one mode or function "can be radically detached from any other mode (or from the system itself) and so reign supreme" (Wilson 2015, 146). For psychotherapy under capitalism, this means that the former's healing potential (i.e., to help the individual be or become a functioning member of society) also contains the potential for harm by stabilizing an unjust and exploitative system. Maybe only by accepting this paradox can we start to ask new questions that go beyond conventional critiques.

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Notes

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1. All names used in this article are pseudonyms.

2. I do not use class designations in absolute terms (as defined, for instance, by income) but as relative and "commonsense" categories. Ugandan society is becoming increasingly stratified along class lines, and even a casual observer will notice a fundamental difference between the lifestyles of "the poor," especially the rural poor, and those whom I describe as upper middle class—predominantly urbanites who resemble the "urban professionals" described by Spronk (2012). Rather than thinking of classes as homogeneous, fixed, and polarized groups, I follow Wright (1997, 19–36) who uses the concept of class *locations* in his attempt to accommodate the "problem of the middle class" within a Marxist framework.

3. So-called traditional forms of healing continue to be an important part of the medical landscape in Uganda—even if their status is complex and contested. They are, however, not the focus of my research.

4. Rose (1999, vii) defines psy as the "heterogeneous knowledges, forms of authority and practical techniques that constitute psychological expertise," which are based on the human sciences, especially psychology.

5. Professional psychotherapy designates forms of therapy that are offered by practitioners who hold at least a master's degree in clinical or counseling psychology. Given the newness of psychotherapy in Uganda, most therapists eclectically combine different approaches (psychodynamic, behavioral, humanist) and teachings in their work rather than belonging to one particular school or tradition. Professional psychotherapy differs from other forms of counseling—such as HIV/AIDS counseling, practiced in Uganda since at least the mid-1980s—which are usually carried out by counselors who have basic qualifications as primary healthcare, youth, or social workers but have not studied psychology.

6. My previous work has shown in more detail how psychotherapy emerged in Uganda in two very different regional centers: 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 international humanitarian organizations since the end of the 20-year civil war. While they are relevant to my larger argument, I do not discuss these interventions here. Instead, I

concentrate on Kampala, where the recent expansion of psychotherapy has been driven by a small group of Ugandan psychotherapists.

7. Wiegratz, Martinello, and Greco (2018, 6–7) describe Uganda's far-reaching neoliberalization since 1986 as a "process of systemic and substantial transformation of Ugandan state, economy and culture towards a 'market society', i.e. a society characterized by marketization of social relations, a general empowerment and hegemony of capital . . . , and the corresponding restructuring of people's subjectivities, relationships, and everyday practices so as to make all realms of society operate market-like."

8. 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.

9. One therapist noted: "A number of people have come to the realization that actually when you go for therapy, your productivity increases, it becomes better. When you keep issues within yourself, it affects you. . . . But when you have talked out those issues, they become lighter" (Interview, September 17, 2015).

10. At the time of my research, most private practitioners charged between 50,000 and 100,000 UGX (approx. US$18–27) per session. According to the World Bank, the gross national income per capita in Uganda in 2018 was US$750. See https://databank.worldbank.org/views/reports/reportwidget.aspx?Report_Name=CountryProfile&Id=b450fd57&tbar=y&dd=y&inf=n&zm=n&country=UGA (accessed November 4, 2020).

11. I had asked the facilitator for permission to participate and disclosed my role and interests as anthropological observer to all participants on the first day. My description and analysis of the symposium are based on several pages of detailed field notes, sometimes including direct quotes, which I wrote during and immediately after the event.

12. Certificates are an important form of cultural capital in Uganda, which people use to market their skills to potential clients or employers. At the symposium, however, and compared to other workshops I have attended in Uganda over the years, everyone seemed genuinely interested in the topic, and no one seemed to be there *just* for the certificate.

13. The symposium was quite expensive by Ugandan standards (175,000 UGX, about US$50), and most attendants, except those working for NGOs, paid out of their own pockets.

14. Most of the material came from the United States, but Josephine also presented videos that she had recorded with a Ugandan family.

15. Generalizing terms such as "Western," "African," "modern," "traditional," etc. are very common in Ugandan discourses (Vorhölter 2014), and I relate them here as they were used in the discussions during the symposium.

16. Illouz's (2007) analysis of emotional capitalism springs to mind here.

17. According to Berlant (2011), a relation of cruel optimism exists when something you desire is actually an obstacle to your flourishing.

References

Béhague, Dominique, and MacLeish Kenneth, eds. 2020. "Special Issue: The Global Psyche." *Medical Anthropology Quarterly* 34 (1): 1–147.

Behrouzan, Orkideh. 2016. *Prozak Diaries: Psychiatry and Generational Memory in Iran*. Stanford, CA: Stanford University Press.

Berlant, Lauren. 2011. *Cruel Optimism*. Durham, NC: Duke University Press.

Boyd, Lydia. 2015. *Preaching Prevention: Born-Again Christianity and the Moral Politics of AIDS in Uganda*. Athens, OH: Ohio University Press.

Cohen, Bruce M. Z. 2016. *Psychiatric Hegemony: A Marxist Theory of Mental Illness*. London: Palgrave Macmillan.
Cooper, Sara. 2016. "Research on Help-Seeking for Mental Illness in Africa: Dominant Approaches and Possible Alternatives." *Transcultural Psychiatry* 53 (6): 696–718.
Duncan, Whitney L. 2018. *Transforming Therapy: Mental Health Practice and Cultural Change in Mexico*. Nashville, TN: Vanderbilt University Press.
Fisher, Jonathan. 2013. "The Limits—and Limiters—of External Influence: Donors, the Ugandan Electoral Commission and the 2011 Elections." *Journal of Eastern African Studies* 7 (3): 471–91.
Hansen, Holger, and Michael Twaddle, eds. 1991. *Changing Uganda*. London: James Currey.
Illouz, Eva. 2007. *Cold Intimacies: The Making of Emotional Capitalism*. Cambridge, UK: Polity.
Kitanaka, Junko. 2011. *Depression in Japan: Psychiatric Cures for a Society in Distress*. Princeton, NJ: Princeton University Press.
Kovel, Joel. 2017. "Therapy in Late Capitalism." In *The Political Self: Understanding the Context of Mental Illness*, edited by Rod Tweedy, 43–68. London: Karnac.
Lang, Claudia. 2018. *Depression in Kerala: Ayurveda and Mental Health Care in 21st Century India*. London: Routledge.
Livingston, Julie. 2009. "Suicide, Risk, and Investment in the Heart of the African Miracle." *Cultural Anthropology* 24 (4): 632–80.
Lovell, Anne, Ursula Read, and Claudia Lang, eds. 2019. "Special Issue: Genealogies and Anthropologies of Global Mental Health." *Culture, Medicine and Psychiatry* 43 (4): 519–47.
Matza, Thomas. 2018. *Shock Therapy: Psychology, Precarity, and Well-Being in Post-Socialist Russia*. Durham, NC: Duke University Press.
McCulloch, Jock. 1995. Colonial Psychiatry and "the African Mind.". Cambridge, UK: Cambridge University Press.
Meinert, Lotte, and Susan Whyte. 2014. "Epidemic Projectification: AIDS Responses in Uganda as Event and Process." *Cambridge Anthropology* 32 (1): 77–94.
Mullings, Leith. 1984. Therapy, Ideology, and Social Change: Mental Healing in Urban Ghana. Berkeley, CA: University of California Press.
Parikh, Shanti. 2015. *Regulating Romance: Youth Love Letters, Moral Anxiety, and Intervention in Uganda's Time of AIDS*. Nashville, TN: Vanderbilt University Press.
Parker, Ian. 2014. "Psychotherapy Under Capitalism: The Production, Circulation, and Management of Value and Subjectivity." *Psychotherapy and Politics International* 13 (3): 166–75.
Rose, Nikolas. 1999. *Governing the Soul: The Shaping of the Private Self*. London: Free Association Books.
Rose, Nikolas. 1996. Inventing Our Selves: Psychology, Power, and Personhood. New York: Cambridge University Press.
Spronk, Rachel. 2012. *Ambiguous Pleasures: Sexuality and Middle-Class Self-Perceptions in Nairobi*. New York: Berghahn.
Stevenson, Lisa. 2014. *Life Beside Itself: Imagining Care in the Canadian Arctic*. Oakland, CA: University of California Press.
Totton, Nick. 2000. *Psychotherapy and Politics*. London: Sage.
Tran, Allen. 2018. "The Anxiety of Romantic Love in Ho Chi Minh City, Vietnam." *Journal of the Royal Anthropological Institute* 24 (3): 512–31.
Turner, Victor. [1969] 1995. *The Ritual Process: Structure and Anti-Structure*. Hawthorne, NY: Aldine de Gruyter.
Van Dijk, Rijk. 2013. "Counseling and Pentecostal Modalities of Social Engineering of Relationships in Botswana." *Culture, Health & Sexuality* 15 (4): 509–22.
Vaughan, Megan. 1991. *Curing Their Ills: Colonial Power and African Illness*. Cambridge, UK: Polity.
Vaughan, Megan. 2016. "Changing the Subject: Psychological Counseling in East Africa." *Public Culture* 28 (3): 499–517.
Vorhölter, Julia. 2014. *Youth at the Crossroads: Discourses on Socio-Cultural Change in Post-War Northern Uganda*. Göttingen, Germany: Göttingen University Press.
Vorhölter, Julia. 2017a. "Class-Based Chronicities of Suffering and Seeking Help: Comparing Addiction Treatment Programs in Uganda." *Culture, Medicine & Psychiatry* 41 (4): 564–89.
Vorhölter, Julia. 2017b. "Homosexuality, Pornography and Other 'Modern Threats': The Deployment of Sexuality in Discourses on Social Change in Uganda." *Critique of Anthropology* 37 (1): 93–111.
Vorhölter, Julia. 2018. "Loyalties for Sale: Youth as 'Identity Entrepreneurs' in Post-86 (Northern) Uganda." In *Uganda: The Dynamics of Neoliberal Transformation*, edited by Jörg Wiegratz, Guiliano Martinello, and Elisa Greco, 318–33. London: Zed Books.
Vorhölter, Julia. 2019. "Struggling to Be a 'Happy Self'? Psychotherapy and the Medicalization of Unhappiness in Uganda." *Current Anthropology* 60 (2): 194–223.
Wiegratz, Jörg. 2016. Neoliberal Moral Economy: Capitalism, Socio-Cultural Change, and Fraud in Uganda. London: Rowman & Littlefield.
Wiegratz, Jörg, Guiliano Martinello, and Elisa Greco, eds. 2018. *Uganda: The Dynamics of Neoliberal Transformation*. London: Zed Books.
Wilson, Elizabeth. 2015. *Gut Feminism*. Durham, NC: Duke University Press.

Wright, Erik Olin. 1997. *Class Counts: Comparative Studies in Class Analysis*. Cambridge, UK: Cambridge University Press.

Yang, Jie. 2015. *Unknotting the Heart: Unemployment and Therapeutic Governance in China*. Ithaca, NY: Cornell University Press.

Zhang, Li. 2020. *Anxious China: Inner Revolution and Politics of Psychotherapy*. Oakland, CA: University of California Press.

Zhang, Li, and Davis Elizabeth, eds. 2018. "Special Issue: Global Side Effects: Precarity, Responsibility, and Mental Health." *Medical Anthropology* 37 (1): 1–16.