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ORIGINAL ARTICLE

Psychotherapy as care in Uganda: envisioning a "more-than-critique anthropology"

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Abstract Over the past two decades, care has become a key concept in psychological anthropology, and anthropology more broadly. Although the term generally evokes positive associations, anthropological studies mostly focus on the darker or ambivalent aspects of care such as paternalism, exploitation, or instrumentalism. This article rethinks anthropological critiques of care. Drawing on examples from my research on emerging forms of psychotherapy in Uganda, I argue that it is important to retain some of the hopeful properties of care: not because critiques of care are invalid, but because the contemporary global moment—characterized by widespread sentiments of powerlessness, futility, and paralysis in the face of climate change, pandemics, and war—calls for an anthropology that can do more than just critique. The article focuses on the struggles and achievements of a small group of Ugandan therapists, who were at the forefront of establishing psychotherapy as a new form of care in Uganda. For them, psychotherapy offered new ways of critically reflecting on social conventions, norms, and hierarchies in Ugandan society, as well as capitalist modernity more broadly. Even though they were aware of, and shared, various criticisms of psychotherapy—its colonial origins, cultural biases, and neoliberal tendencies—my interlocutors strongly believed that psychotherapy could be made relevant for Ugandans. Their dedication to this vision, and their considerable success in putting it into practice, figure as examples of how to move beyond critique.

Keywords Psychological anthropology · Global mental health · Africa · Social transformation · Neoliberal self

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Psychotherapie als Pflege in Uganda: Die Vision einer „Mehr-als-Kritik-Anthropologie“

Zusammenfassung In den letzten zwei Jahrzehnten ist Fürsorge („care“) zu einem Schlüsselkonzept der psychologischen Anthropologie, und ethnologischen Debatten insgesamt, geworden. Obwohl der Begriff im Allgemeinen positive Assoziationen hervorruft, konzentrieren sich ethnologische Studien meist auf die dunkleren oder ambivalenten Aspekte von Fürsorge wie Bevormundung, Ausbeutung oder Instrumentalisierung. Dieser Artikel überdenkt diesen starken Fokus auf Kritik, auch wenn diese oftmals berechtigt ist. Anhand von Beispielen aus meiner Forschung zu neuentstehenden Formen von Psychotherapie in Uganda, rücke ich bewusst positive Aspekte und Potenziale von „care“ in den Mittelpunkt der Analyse. Ein solcher Perspektivenwechsel ist wichtig, so mein Argument, weil die gegenwärtige globale Situation – gekennzeichnet durch weit verbreitete Gefühle von Ohnmacht und Sinnlosigkeit angesichts von Klimawandel, Pandemien, und Krieg – nach sozialwissenschaftlicher Forschung verlangt, die mehr kann als nur Kritik.

Der Artikel konzentriert sich auf die Mühen und Errungenschaften einer kleinen Gruppe ugandischer Therapeut*innen, die sich dafür einsetzten, Psychotherapie als neue Behandlungsform in Uganda zu etablieren. Trotz weitverbreiteter Skepsis und auch von den Therapeut*innen geteilten Kritik an Psychotherapie – einer „westlichen“ Praxis mit kolonialen Ursprünge, kulturellen Vorurteile und neoliberaler Tendenzen – waren meine Gesprächspartner*innen fest davon überzeugt, dass Psychotherapie für Uganda „relevant gemacht“ werden könnte. Ihre Hingabe an diese Vision und ihr beachtlicher Erfolg bei der Umsetzung sind hoffnungsvolle Beispiele für Denken und Handeln jenseits von Kritik.

Schlüsselwörter Psychologische Anthropologie · Global Mental Health · Afrika · Soziale Transformation · Neoliberales Selbst

1 Introduction

Over the past two decades, care has become a key concept in psychological anthropology, and anthropology more broadly. Studies of care cover a vast range of subject areas: medical care, environmentalism, interspecies relations, technosciences, governance, ethics—to name but a few. At first glance, care evokes positive associations: nurture, love, commitment. Anthropological studies, however, often draw attention to the “darker”—paternalistic, exploitative, or strategic—sides of care: naïve, if well-intentioned, western aid workers coming to care for local populations after war and disaster (Fassin and Pandolfi 2010), misdirected government programs offering care to vulnerable populations (Stevenson 2014; Ticktin 2011), or even military control disguised as care (Varma 2020). The idea that care is never unproblematic, always infused with power asymmetries, and often deeply entangled with political economies is a basic premise of anthropological analyses. However, this idea seems to have become so central that care has lost its potential to (also) signify “the good” and that any invocation of care is treated from the outset as suspicious.

In this article, I reflect on this "care dilemma" in anthropology. Drawing on examples from a recently completed project (2015–2021), which studied emerging forms of psychotherapeutic care in Uganda (Vorhölter 2021b), I argue that it is important to retain some of the hopeful properties of care: not because the abovementioned critiques of care are invalid, but because the contemporary global moment—characterized by widespread sentiments of powerlessness, futility, and paralysis in the face of climate change, pandemics, and war—calls for an anthropology that can do more than just critique.

I first provide some background information on the project, then discuss psychotherapy as a meaningful form of care in Uganda, and finish with some broader reflections on a "more-than-critique anthropology".

2 The popularization of psychotherapy in Uganda

Psychotherapy has emerged in Uganda since the late 1990s from two main centers—Gulu and Kampala—in very different ways: Gulu is the largest and most important town in previously war-torn Northern Uganda and has been the center of large-scale humanitarian interventions, which, since the end of the war in 2006, have increasingly come to focus on mental health support and trauma relief. By contrast, Kampala has in recent years seen the establishment and growth of a number of therapeutic institutions and private psychotherapy practices, the first one in 2001. This development is driven by a small group of Ugandan psychotherapists. Typically, their clients are from upper middle-class backgrounds who seek therapeutic support to deal with stress and lifestyle-related problems—increasingly expressed through the popular idiom of depression.

Taking these two settings as my starting point and focusing on the perspectives of Ugandan therapists, my research analyzed how and why psychotherapeutic discourses and practices have recently started to proliferate in Uganda, who can and wants to access them, and how the emergence of psychotherapy is related to and reflects broader changes in politico-economic dynamics, social relations, and forms of care.

Throughout the project, I grappled with how to interpret the rise of psychotherapy in Uganda. The most readily available concepts and approaches—medicalization, global mental health imperialism, neoliberalization—were all centered on highlighting the potential problems of an emerging psychotherapeutic regime. But they did not seem to do justice to my interlocutors' motivations, visions, and experiences. Although I found it important to critically analyze how psychotherapy, in Uganda as elsewhere, is entangled with neoliberal values and forms of governing and how its emergence in Africa is bound up with colonial and neocolonial medical interventions, I also wanted to take seriously my interlocutors' perspective. For them, psychotherapy was not an uncritical "self-technique," or an externally imposed therapeutic approach, but a means of challenging conventional hierarchies, ideologies, and norms. It was not just a job to make money—often quite the contrary—but a project to create better care and a better society.

3 Making sense of crazy times: psychotherapy as care

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, poignantly summarized this as follows:

> There is no doubt that there is an increase in mental illness: wars (...), diseases like HIV/AIDS: they are affecting people, they themselves cause mental illness (...) poverty (...) And the modern times! Drugs are increasing in our countries like crazy. (...) Rural to urban migration, people leaving the countryside and coming to team up in the cities. (...) People hardly sleep in cities, booming noises everywhere (...) Domestic stress! (...) The other thing that caught up 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. (...) Those are challenges that we face, and those increase mental illness.' (Interview 01.9.2015)

Many Ugandans were 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. And although established institutions of healing—"traditional" or faith-based—were still important to Ugandans of all ages 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.

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 (such as marriage). Further commonly mentioned examples included increasing family conflicts, ruthless competition, and individualism, as well as rising levels of affliction.

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 the youth; the poor condemned the elites. Almost everyone blamed, in some way or other, Ugandan politics, social media, and "Westernization." Some desperately

tried to reestablish "the past," however imagined, in order to regain a sense of social control that they felt they had lost. Men who felt disempowered tried to reestablish "traditional" gender hierarchies. Cultural or religious authorities tried to save morality. And the NRM government under President Museveni, in office since 1986, has used increasingly violent measures to stay in power.

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 is aimed at providing 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 2017).[1] Some wanted to be "cured" and made "normal" again. Others accepted their homosexual desires but were suffering from fear, depression, 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 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.

As hinted at above, psychotherapeutic forms of care have been problematically entangled with capitalism, colonial medicine, and neoliberal forms of governing (e.g., Fanon 2004; Rose 1999). Psychotherapy promotes particular values (individualism, anonymity, liberalism, nonjudgmentalism), 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. By helping people to cope, it stabilizes the capitalist system and its inherent inequalities. But psychotherapy has also created a space for Ugandans to critically reflect on these problems and, sometimes, empowers them to make meaningful changes.

Care 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, relationships—and it implies recognizing an "Other" in a particular way: not necessarily as equal, but as worthy of existence and engagement (Tronto 1994; Puig de la Bellacasa 2017; Browne et al. 2021). In my research, I took my interlocutors seriously and followed their understanding of psychotherapy as a form of care in order to highlight that it is driven by a particular

[1] Uganda is known for its draconian anti-homosexuality legislation and widespread homophobia. Some of the therapists I met tried to provide support to homosexual clients, even though this put their own practice at risk.

motivation and vision—to create possibilities for well-being—that cannot be reduced to financial interests, neoliberal health politics, or forms of governance, although all those factors play a role.

The comparison of my two research settings, Gulu and Kampala, shows how psychotherapeutic care can take on very different manifestations and produce different power dynamics and care subjectivities. Psychotherapy in Northern Uganda 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. 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—by international 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-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.

Private psychotherapy in middle-class Kampala works according to different forms of logic. 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 demands conflict with psychotherapeutic principles. Somewhat paradoxically, even though psychotherapy seems more suited to the Kampalan middle-class context, employment opportunities are more uncertain than in nongovernment organization-funded projects in Northern Uganda. Apart from two positions for clinical psychologists at the National Psychiatric Hospital and a few positions for student counselors at public universities, government appointments for psychologists were extremely rare at the time of my research.[2] 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, or they engaged in voluntary forms of counseling—which they hoped would eventually materialize into longer-term employment.

I came to see Ugandan psychotherapy as 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 convinced that psychotherapy had something to offer that was otherwise lacking in the Ugandan therapeutic landscape. They saw it as a science-based approach to healing that empowers sufferers to critically reflect

[2] The Ugandan government, though trying to upscale mental health services, was skeptical about *psychological* therapies. Rather than creating positions for professional therapists, it focused on decentralizing *psychiatric* care, for instance, by deploying psychiatrists to the regional hospitals and improving access to psychopharmaceuticals.

on their circumstances rather than being told what to do by medical, political, or religious authorities. They valued it as a form of care that encourages sufferers to openly explore and talk about feelings, thoughts, or experiences that they had been taught to hide. And they emphasized that it was a form of conversation that challenges conventional hierarchies, rules, and norms regarding who can speak to whom about what. Taking this seriously, without relativizing it through critical analyses, was important to me—not just as a form of respect toward my research participants. It was a conscious decision to choose a perspective, one among many equally valid, that emphasized possibility rather than suspicion.

4 A "More-Than-Critique Anthropology"

When anthropology first emerged as an academic discipline and for a long time thereafter, its main mission was to document "culture"—even though what this entailed exactly was debated. Over time, as anthropological research interests became more diversified, but especially since the Writing Culture debate in the 1980s, this mission came under increased scrutiny. Since then, and for methodological, political, and analytical reasons (Lentz 2017), anthropology has been gradually moving away from culture, and towards "cultural critique" (Marcus and Fischer 1996). One could argue, in fact, that mainstream anthropology's raison d'être today is to be critical of power and to emphasize the complexity (and insolubility) of social problems—what Sherry Ortner (2016) has termed "dark anthropology."

Documenting complexity and being critical remains crucially important. But I wonder whether instead of simply reproducing by now well-established critiques—of colonialism, neoliberalism, capitalism, biomedicine, etc.—anthropologists need to find analytical perspectives that allow us to think more openly about the world, and possibilities for the future. Can we imagine forms of care that are not shaped by control, forms of global health interventions that are not shaped by legacies of colonialism and biomedicine, or forms of politics and economics that are not shaped by capitalism? What is needed is both, a hopeful anthropology that can imagine a better future and a realistic anthropology that can tolerate deficiencies, imperfections and failures. Critical perspectives remain important, but not as ends in themselves. Most importantly, we need an anthropology that commends experimenting and tinkering—without naïvely celebrating our interlocutors and their life worlds.

In recent years, many scholars, not just in anthropology but across the humanities and social sciences, have taken up this challenge and started looking for ways to move beyond critique and toward alternative ways of reflecting on the world. Robbins (2013) has prominently called for an "anthropology of the good" to counter the predominant focus on matters of power, suffering, and inequality. More recently, experimentation—understood as collaboration, practice, innovation, and indeterminacy—has emerged as a new paradigm of anthropological research (e.g., Xiang 2022; Fischer 2018). Science and technology scholars, marked by the absurdities of the science wars, have called for more careful and empathetic forms of critique (e.g., Puig de la Bellacasa 2017). Philosophers such as Braidotti (2019) encourage

us to think creatively and fearlessly about the potential of the "posthuman condition." And even in feminist and queer studies—known for their radical critical stance—scholars, inspired by the work of Sedgwick (1997), have turned from the "paranoid" to the "reparative."

A thought-provoking example of how to move beyond conventional critique has been formulated by Wilson (2015). Taking issue with the fact that feminist theory has long defined itself against biology, she proposes a new methodology of engaging biological data—taking it seriously, but not literally—which she calls "gut feminism." Furthermore, Wilson wants to draw attention to the damaging aspects of politics that cannot be repurposed to good ends. "Feminist politics," she argues, "are most effective (...) not when they transform the destructive into the productive, but when they are able to tolerate their own capacity for harm" (2015, p. 6). Using the pharmacology of depression as an example, she shows how conventional feminist critiques of antidepressants and the pharmaceutical industry are, in fact, severely limiting for antidepressant politics. Instead, she demonstrates how seriously engaging with the pharmacokinetics of selective serotonin reuptake inhibitors[3] can be a "source (rather than an obstruction) for alternative stances on the body, mind and depression" (ibid.: p. 99)—one that opens up a whole new field of thinking and theorizing. Wilson impressively demonstrates how clinging to standard critiques and desiring to be "on the good side" (rather than accepting that there is no such thing) are fundamentally constraining to social science interventions.

Studies of care reflect well the crucial dilemma that Wilson points to and that also lies at the heart of the anthropological mission: the desire to do good while often (also) doing harm. Rather than seeing this as a problem, accepting Wilson's painfully realistic evaluation that this tension cannot be resolved seems refreshingly sobering. It points to the impossibility of a purely "good anthropology," and thereby frees us to think harder, and more openly, about what anthropology is and has to offer. When I look at my research in Uganda through this lens of potential, rather than that of critique, new things come to mind. Above all, I have to think about the pioneering spirit of my interlocutors who had a vision, however small and imperfect, of establishing a new form of care in Uganda that they have put into practice with dedication.

It is easy to criticize, but much harder to envision, "alternatives." To this end, I learned something from the people I met during my fieldwork: people like Rwashana, the first Ugandan psychiatric nurse, who became a pioneering figure of Ugandan psychiatry in more than challenging post-colonial circumstances (Vorhölter 2020); international experts such as 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 (Vorhölter 2019); or Josephine (Vorhölter 2021a) who passionately advocated for the benefits of family therapy, even though many of its underlying premises were foreign to Uganda.

[3] Selective serotonin reuptake inhibitors are a widely prescribed class of drugs used to treat depressive disorders.

All of my interlocutors were aware of the limitations of psychotherapy. They did not think that 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' problems were related to capitalist dynamics and aspirations. They were certainly not uncritical. Yet, they were not afraid to have a vision for what they considered to be a new and relevant form of care, and to try to put it into practice—with all the failures and frustrations that entailed. Taking seriously such projects of care is important for anthropology: not because they are simply good, but because they offer a sense of possibility. Such a perspective is much needed, and indeed radical, in a world in which many who once celebrated the end of history are now paralyzed by their fear of the end of life as we know it.

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