Struggling to Be a “Happy Self”? 
Psychotherapy and the Medicalization of Unhappiness in Uganda

by Julia Vorhöltter

This article is an ethnographic study of emergent discourses, practices, and institutions focused on mental health and psychotherapy in Uganda. It compares the recent rise of a psy-dispositif in two very different settings: postwar northern Uganda, which has become a hub for international trauma interventions, and Kampala, the capital, where a small group of Ugandan psychotherapists has established a number of private practices, which mainly cater to the (upper) middle classes. The article investigates the meanings of happiness and suffering in these different contexts and asks who seeks psychotherapy and why. It shows how in the context of novel discourses on mental health, and related to changing lifestyles and images of the self, new struggles to be happy are taking place, albeit in very class- and place-specific ways. Consequently, unhappiness and psychosocial suffering are becoming reasons for seeking therapy, at least for some. Such a medicalization of unhappiness, manifested most prominently in the popular idiom of depression, reflects a global trend and has led to the soaring consumption of antidepressants and rising popularity of psychotherapy, particularly in the United States. As such, this article seeks to make a contribution to recent anthropological debates on happiness, suffering, and global mental health.

A contemporary Western belief holds that the absence of happiness is a sign of ill-health and abnormality. This medicalization of unhappiness, manifested most prominently in the popular concept of depression, seems to have reached unprecedented levels—especially in the United States, where the American Psychiatric Association recently attempted to pathologize grief as a new mental disorder (Kleinman 2012). The idea of happiness as an important goal of human existence is already captured in the Declaration of Independence. Lately, however, happiness seems to have become even more: a fundamental marker of what it means to be a healthy and normal self. Subsequently, the absence of happiness is taken as a reason for medical and psychological interventions, which is reflected in the soaring consumption of antidepressants and the rising popularity of psychotherapy.

Ongoing debates on global mental health have contributed to the worldwide spread of Western medicalized notions of unhappiness and therapies to cure it. Based on ethnographic research, this article examines the case of Uganda. I analyze how, in the context of novel discourses and practices of mental health care, including a growing popularization of psychotherapy and related to changing lifestyles and images of the self, new struggles to be happy and new meanings of suffering have emerged. Discussed will be the following questions: What are the meanings of (un)happiness and suffering in different contexts? For whom does the absence of happiness become present? What kinds of strategies and therapies, if any, do people from different (class, age, gender) backgrounds seek to deal with suffering and unhappiness?

I will argue that meanings of and dealings with suffering have been reframed in Uganda through the recent emergence of a psy-dispositif; that is, new forms of knowledge, institutions, and practices that embody and represent psychological expertise. Suffering, a very broad term used to delineate various aspects of human misery and affliction, is now commonly understood as psychosocial suffering or, even more narrowly, unhappiness. Both are increasingly taken as reasons for medical and psychological interventions, indicated, for instance, by the spread of new diagnostic (and popular) categories such as depression.

1. It is important to note the difference between the broad popular idiom of depression and clinical definitions of depression as per DSM (Diagnostic and Statistical Manual for Mental Health) or ICD (International Classification of Diseases).
2. “Psy” is defined by Rose (1999) as the “heterogeneous knowledges, forms of authority and practical techniques that constitute psychological expertise” (vii). Dispositif is defined by Foucault (1980 [1977]) as “a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions . . . a sort of—shall we say—formation which has as its major function at a given historical moment that of responding to an urgent need” (194f.).

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as trauma and depression. Whereas discourses on suffering have long been commonplace when talking about African contexts—indeed, suffering is often portrayed as the status quo—it seems that discourses on unhappiness, a particular subcategory of suffering meaningful only when happiness is seen as the norm, have only recently started to emerge.

Drawing loosely on ideas from an emerging “anthropology of absence” (Bille, Hastrup, and Sorensen 2010), I will show how, once happiness is taken as the normal and desired state of being, the absence of happiness becomes meaningful and a reason for action. As Fowles (2010) states, “absences perform labor, frequently intensifying our emotional or cognitive engagement with that which is manifestly not present” (27). As has been demonstrated for Western societies, the “presence of absent happiness” increasingly leads people in Uganda, predominantly those who belong to the (upper) middle classes, to seek medical and psychological help, thus contributing to a medicalization and pathologization of unhappiness, at least in some contexts.

In Uganda, psy has been emerging from two different centers—northern Uganda and Kampala—and in very different ways since the early 2000s. Taking these two different centers as my starting point, I analyze why and how psychotherapeutic discourses and practices have recently started to proliferate in Uganda and who can and wants to access them. While in both contexts psy reconfigures meanings and responses to suffering, I show that it does so in very different class- and context-specific ways.

In northern Uganda there have been a number of so-called psychological interventions following the end of the 20-year civil war (1986–2006) between the Lord’s Resistance Army and the Ugandan government. These services, mostly funded by international donors and thus free of charge, mainly focus on trauma and target people from lower-class backgrounds living in rural or semirural settings. Clients are usually identified through nongovernmental organizations (NGOs), and few come from upper-middle-class backgrounds and seek therapeutic support to deal with stress- and lifestyle-related problems, which are increasingly expressed through the popular idiom of depression. To date, this phenomenon of private psychotherapy in Africa has not been much studied, certainly not in Uganda, although I believe it represents a larger trend across the continent. It reveals similarities to the expansion of a new regime of the self that Rose (1999) has identified in advanced liberal democracies, which has changed ways human beings understand and govern themselves, and how they are acted upon by authorities like doctors or therapists. The emergence of psy as a new technology of the self in Kampala is intrinsically related to a particular lifestyle centered on global middle-class values like happiness.

My ethnographic findings are based on four months of fieldwork, mainly in Kampala but also in Gulu, which I carried out in 2015. In total, I conducted 35 interviews with psy-professionals (psychologists, psychiatrists, and counselors). Among my interviewees were some of the leading figures who were driving the establishment and extension of psychology and psychiatry as academic disciplines and the popularization of psychotherapy as a practice. I also visited and carried out participant observation in different therapeutic institutions (e.g., private practices, the national psychiatric hospital, symposiums, NGO-funded mental health initiatives) as well as in health and lifestyle facilities (e.g., gyms). Furthermore, I analyzed current debates on mental health and psychotherapy in one of the major daily newspapers, the Daily Monitor. Both the process of my data collection as well as the data analysis were guided by the basic principles of grounded theory (Glaser and Strauss 1967). Moreover, my insights are informed by my previous research experiences in Gulu (12 months between 2009 and 2011) and the material I collected during that time for my PhD project (Vorhölter 2014).

In the first part of this article, I sketch recent debates on and contemporary notions of happiness (or well-being) and interventions are designed accordingly. However, as Meinert and Whyte (forthcoming) note, psychological trauma is as yet only one among various ways of reading suffering in northern Uganda, and psychotherapy is far from being the hegemonic form of dealing with it. Discourses on happiness, as I will show, are largely absent in this setting.

The second center from which psy has been emerging in Uganda is Kampala, the capital, which in recent years has seen the establishment of a number of private psychotherapy practices, with the first being established in 2001. This development is very much pioneered and driven by a small group of Ugandan psychotherapists. Typically, their clients are from upper-middle-class backgrounds and seek therapeutic support to deal with stress- and lifestyle-related problems, which are increasingly expressed through the popular idiom of depression. To date, this phenomenon of private psychotherapy in Africa has not been much studied, certainly not in Uganda, although I believe it represents a larger trend across the continent. It reveals similarities to the expansion of a new regime of the self that Rose (1999) has identified in advanced liberal democracies, which has changed ways human beings understand and govern themselves, and how they are acted upon by authorities like doctors or therapists. The emergence of psy as a new technology of the self in Kampala is intrinsically related to a particular lifestyle centered on global middle-class values like happiness.

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3. I use “middle class(es)” and “poor” not as absolute terms (as defined, e.g., by income) but as relative and commonsense categories in the context of Uganda. It will become obvious from my case studies that there is a fundamental and growing difference in the lifestyle of “the poor,” especially the rural poor, and those to whom I refer as (upper) middle class, predominantly urbanites living in Kampala whose lifestyles and attitudes resemble the “(young) urban professionals” described by Spronk (2012).

4. In this article, I use the terms “counselor,” “psychologist,” and “psy-professional” interchangeably to refer to people whose main profession involves non-HIV-focused counseling or psychotherapy and who hold at least a bachelor’s degree in a counseling-related discipline. The main focus of my research is on these practitioners and their perspectives on emerging forms of psychotherapy and related discourses in Uganda.
its "other"—suffering (or unhappiness). Furthermore, I look at the way medicalized ideas of suffering and unhappiness have spread across the globe, as have attempts to deal with them. My case study of Uganda forms the second part. Here, I contrast the very different ways psy and related notions of suffering and unhappiness are developing in northern Uganda and Kampala.

Of Happiness and Suffering—Recent Anthropological Perspectives

In popular perception, suffering and happiness, rather than being taken as historically situated and culturally specific concepts, have come to be taken for granted as timeless, universal concerns. The idea that humanity is united in its shared vulnerability to suffering (Robbins 2013:450), and in its search for happiness, has not only motivated an ever-increasing number of interventions seeking to reduce suffering but has also more recently inspired various attempts to quantify, compare, and evaluate states of happiness across societies. The Gross National Happiness Index or the World Happiness Report are indicative of this trend. Such measures and debates commonly ignore that the desire and need to be happy may be, as Bruckner (2011:3) argues, "a passion peculiar to the West since the French and American revolutions," and that the way we understand happiness in the West today—as a private individual and momentary good feeling and psychological state—has emerged in specific historical circumstances and is tied, in many ways, to the current economic regime of neoliberal capitalism (Walker and Kavedzija 2015a:4).

Emerging anthropological approaches to happiness and well-being (Ahmed 2010; Mathews and Izquierdo 2009; Robbins 2013:457–458; Walker and Kavedzija 2015b) have shown that there is no single idea, meaning, or pursuit of happiness or well-being, but rather that both are intersubjective and relational (Jackson 2013:163ff., 2011:195ff.) and have profound social, cultural, moral, economic, and political dimensions. While some authors (e.g., Thin 2009:31) have suggested that there are certain basic similarities in conceptualizations of well-being across societies, most anthropologists emphasize that there are significant cross-cultural differences in what meaning and importance are attributed to happiness, how and when it can be achieved, and who is responsible for it. A common distinction drawn between different types of happiness is a temporal one, distinguishing momentary happiness (hedonism) from long-term happiness (eudaimonia), short-term pleasure seeking from lifelong virtue (e.g., Robbins 2015).

Some scholars (e.g., Bruckner 2011) have argued that in contemporary Western societies, happiness has come to be understood predominantly as hedonism. At the heart of their critique is that happiness has become normalized, or neoliberalized (i.e., seen as largely self-made and inextricably linked to consumerism), and that both happiness and its absence have been commodified. This is reflected in expressions like “happiness industries” (Davies 2015), “markets of well-being” (Dekker and van Dijk 2010), or “markets for suffering” (Kleinman, Das, and Lock 1997:xi). Different authors have also commented on what I call the medicalization of unhappiness, reflected in attempts to create new diagnostic categories—grief and bereavement, for instance (cf. Kleinman 2012)—and the rapid expansion and popularization of existing ones, like trauma or depression (Fassin and Rechtman 2009; Robbins 2013:453; Watters 2010). Walker and Kavedzija (2015a:1), in fact, talk about happiness as a new form of diagnostics that can be applied both to the state of an individual and to the state of a nation.

The norm of happiness makes its absence—in situations where people feel unhappy—all the more present. Paradoxically, though, it is unclear what exactly it means or feels like to be happy. This uncertainty opens up a whole range of fields and markets for experts and interventions that help people to diagnose and evaluate their (un)happiness and to improve it. In this article I am particularly interested in psy-interventions, that is, interventions by psychiatrists and psychologists based on the idea that unhappiness and suffering may lead to psychosocial problems and (eventually) mental illness. While psy-interventions have been a major feature of social life in many Western countries, in the United States especially, they have only recently begun to gain prominence in non-Western contexts.

The Globalization of Psy: Spreading the Medicalization of Suffering?

Psy-interventions take as their starting point a particular conception of self and a particular understanding of suffering. From a psy-perspective, the reasons for suffering are (predominantly) attributed to the individual and thus taken to be amendable, at least to some extent, by targeting either the brain, as in the case of pharmaceuticals, or the mind, as in the case of talk therapy, or both (cf. Luhrmann 2000). Broadly speaking, such a way of conceptualizing suffering, one that has
become hegemonic in the West, differs considerably from the way suffering and ways to deal with it are seen in other parts of the world.

Three differences are worth pointing out: First, whereas a Western psy-perspective focuses first and foremost on the individual self, suffering in other contexts is primarily seen as a social and intersubjective experience. Second, and related, whereas the concept of psy is rooted in the Cartesian dualism of mind and body and a clear differentiation of the individual from the social, such clear-cut dichotomies may not exist in other contexts (Kleinman, Das, and Lock 1997:xi; cf. Jackson 2013:163–164, 215ff). Third, as outlined above, a psy-perspective has increasingly come to understand suffering as abnormal rather than as an essential part of being, as unwanted rather than meaningful, and as something to be abolished rather than endured (Summerfield 2004).

Taking these points into account, it becomes clear that the global spread of psy entails much more than just the export of a particular medical or psychological technology. Psy is contingent on a whole apparatus, or dispositif. For this dispositif to take root in previously non-psy contexts, there are at least two important preconditions: first, the reformulation of suffering from something that is relatively normal to something that is pathological, and second, a system of diagnostics that explains suffering in medical or psychological terms rather than religious, spiritual, or other, and attributes the cause of suffering to the individual rather than to some broader collective phenomenon or outside force. As I will show below, both conditions are currently being established in Uganda.

Western ideas of suffering and psy—both in its psychiatric form related to psycho-pharmaceuticals and in its psychological form related to psychotherapy—have gained increasing prominence across the globe. The former, in particular, has been driven by the pharmaceutical industry and global mental health movement and has been the subject of extensive debate and criticism (e.g., Summerfield 2004:237ff; Watters 2010). The latter, to date, has been somewhat less studied, although cultural sociologist Illoff (2008) argues that “therapy under many forms has been diffused worldwide on a scale that is comparable (and perhaps even superior) to that of American popular culture” (5f.). While there is some recent ethnographic work that focuses on the rise of psychotherapy in the non-West (e.g., Duncan 2017a; Tran 2015; Yang 2015; Zhang 2017), few anthropologists have studied the spread of “the therapeutic ethos” (Illoff 2008) to Africa, especially in nonclinical settings (notable exceptions are Abramowitz 2014; McKay 2016; Moyer, Burchardt, and Van Dijk 2013; Nguyen 2010; and Vaughan 2016). My own work seeks to make a contribution to this literature.

Most anthropologists tend to express skepticism about the global spread of psy and its underlying assumptions. Two points are commonly singled out: the medicalization of suffering, most popularly discussed in relation to the concepts and diagnostic categories of depression or trauma/PTSD (Hinton and Good 2016; Kleinman 2004; Obeyesekere 1985; Summerfield 2008:336; Watters 2010), and the commodification of suffering and healing (Dekker and van Dijk 2010; Kleinman, Das, and Lock 1997:xi).

In this article, I do not take a normative stance on the benefits or detriments of the spread of psy. As will become clear from my ethnographic examples, the issue is far more complex than just being a matter of good versus evil. Following Littlewood (2001), I treat psy as a new way of reading and dealing with distress which is not “necessarily inappropriate for comparing what looks to the European like ‘suffering’ or ‘madness’ in different societies, but is just one possible grid and one which carries with it particular assumptions about normality and abnormality” (22). In my analysis of emerging psy-interventions in Uganda, I am particularly interested in their underlying—and disparate—assumptions and imaginations of normality.

Emerging Discourses on Mental Health and the Rise of Psychotherapy in Uganda

In Uganda, the idea of mental “health”—and related discourses and practices of psy—is a relatively new one. A recently uploaded document on the website of Uganda’s Ministry of Health defines mental health as “the foundation for wellbeing and effective functioning for individuals and communities. It is not about disease but it is closely linked with virtually all global public health priorities and should be a concern for all of us, rather than only for those who suffer from a mental disorder.” While still largely an urban and elite concern, psy-discourses and mental health interventions are constantly expanding across the country, driven by various actors and institutions (e.g., local and international media, health professionals, NGOs). Currently, there are four main “regimes of expertise” (Vorhölter 2017:596ff.) in Uganda that deal with psychosocial suffering broadly defined: traditional healing, faith-based healing, psychiatry, and, most recently, psychology, which is the focus of this article.

An important predecessor of psychological psychotherapy in Uganda is HIV/AIDS counseling, which was first established in the early years of the epidemic in the late 1980s. Nowadays, the practice of voluntary counseling and testing (VCT), whereby people are tested for HIV and receive information and guidance on their (sexual) health, is omnipresent throughout the country and has fundamentally shaped people’s imaginations of counseling interventions (cf. Moyer, Burchardt, and Van Dijk 2013). Psychology, however, as an academic discipline and field of practice only started in the late 1990s and is still

7. Classic psychoanalysis may form an exception to this.

relatively unknown among the majority of the population. The first bachelor of arts degrees in community psychology and industrial psychology were offered at Makerere, the oldest and most prestigious university, in 1998. The first master of arts (MA) courses in counseling psychology and clinical psychology were offered in 1999–2000. Explicitly psychology-based discourses and practices, as noted, have started to evolve in Uganda since the early 2000s from the two main centers of northern Uganda and Kampala.

In the following sections, I contrast how psy has emerged and evolved in these two settings. Based on insights from my interviews with psy-professionals, I show how psy responds to different people with different problems in the two contexts and thus (re)produces different meanings of suffering and imaginations of normalcy.

The Emergence of Psy in Northern Uganda within Trauma-Focused Interventions

Most psychological interventions in northern Uganda started in the late 2000s in the context of postwar rehabilitation efforts after the 20-year war between the Lord’s Resistance Army and the Ugandan government (Baingana and Onyango 2011; for more details on the war, see Vorhötl 2014) and, unlike many other projects, have continued to this day. During the two decades of war, thousands of young people were abducted or recruited as fighters; civilians experienced and/or witnessed rapes, massacres, and brutal killings of loved ones; and large parts of the Acholi population were internally displaced and forced to live in camps in destitute conditions. These experiences continue to affect people’s everyday lives: problems like poverty, alcoholism, domestic violence, mental illness, marital and family conflicts, and land wrangles that people see as long-term consequences of the war are still widespread and have produced complex “syndemic” forms of suffering (Meinert and Whyte, forthcoming) to which psy-interventions, among other forms of intervention, seek to respond.

Professionalization and Expansion of Psy in the North—From Chaotic Beginnings to Structured Interventions

All the psy-professionals I spoke with in Gulu in 2015 emphasized that the initial attempts to provide psychosocial support had been uncoordinated and largely unprofessional. A common point of criticism was that many humanitarian organizations operating in northern Uganda in the 2000s had claimed to have a trauma-healing or psychosocial support component included in their programs, which were, however, mainly focused on other things (agricultural trainings, educational activities, youth activities, etc.). According to my interlocutors, none of these interventions were targeted to help people with more serious mental health issues. Not only was there a lack of professional knowledge, there was also little awareness of how to facilitate counseling programs and how these differed from other interventions. Over the past 10 years, psy-interventions in northern Uganda have not only expanded but also undergone significant professionalization.

The first professional counseling center was established near Gulu in 2004 by Caritas and the Catholic Church. In 2007, VIVO, a German organization with a very specific focus on PTSD, started its work. In 2008, the Ugandan Ministry of Health in cooperation with a local NGO launched an initiative to scale up mental health services in the North (Baingana and Onyango 2011). In the same year, the Peter C. Alderman Foundation set up a clinic focusing on PTSD within the mental health unit of Gulu Hospital (Meinert and Whyte, forthcoming). In 2010, an Italian psychological psychotherapist, who I will refer to as Marco, was employed by the Center for Victims of Torture to train local counselors and improve organizational resources in the field of psychosocial support. These programs constituted the first structured interventions explicitly focused on psy, and all were still operative during the time of my fieldwork. The following analysis is based on interviews with local and international psy-professionals involved in some of these initiatives.

Meaning of Psychosocial Suffering and Relevance of Psy in the North

Psy-interventions were not the only ones offering support to people in crisis. Indeed, most people tried a variety of other approaches like medication, traditional healing, or prayer to deal with their often intertwined problems (Meinert and Whyte, forthcoming, 2017). In this context of therapeutic pluralism, psy had to establish itself as a new therapeutic regime. Therefore, psy-practitioners were faced with the tasks of clarifying what exactly they had to offer and distinguishing their approach—which was by no means uniform—from other approaches.

A big point of contention among psy-professionals was the extent to which the problems people were facing should be medicalized: Were people mentally ill, or did they face overwhelming social problems (like poverty or gender inequalities)? Should psychological support services be very specific (e.g., focus only on PTSD with a specifically designed therapy), or should they take a more holistic approach?

Some organizations, like VIVO, claimed that mental health interventions should primarily target people suffering from mental illnesses. Accordingly, people’s suffering was framed primarily in medical diagnostic terms like anxiety, depression, or PTSD, which had all supposedly increased as a consequence of the war situation. In this widespread narrative, the North was represented as a place where trauma and PTSD were rampant or, as one of my interviewees put it, a place of “mass psycho-trauma” (M. O. H. interview, August 12, 2015).

Other psy-professionals, while acknowledging that some of their clients’ problems were of a medical nature and that much of the suffering in the North had been exacerbated by the war, strongly believed that most people who were in need of psychosocial support faced problems related to broader, structural...
conditions. Marco was a passionate advocate of this position. He maintained:

You know talking of PTSD is so sexy, but most of the suffering of our lives comes from current conditions . . . I should say among the 600 clients or so I have seen—there are many—I can say that maybe 8% was PTSD, and 70% was domestic violence. You see the contradiction, from one side we use the diagnosis, PTSD, it is a different classification than saying this client suffers from domestic violence . . . So for me the clients are not mentally ill; they are facing a problem that is overwhelming their resources. This is very different from saying this one is depressed, this one is bipolar. (G. M. interview, March 29, 2015)

Critics of the medical perspective often pointed to VIVO. While certainly appreciating the highly professional work VIVO was doing, they saw its narrow focus on PTSD as insufficient and ignorant of the complex realities on the ground. When I confronted the VIVO psychologist with this criticism in my interview, she was quick to acknowledge that VIVO’s narrow focus on PTSD sometimes seemed insufficient, especially when clients were dealing with several non-PTSD-related medical and social problems. In her words: “Sometimes it’s really difficult; you get the impression [of a client], she is a child mother, who has HIV and then also TB or maybe syphilis. And then she has a boyfriend who is an alcoholic and who beats her, and then her child is sick and she doesn’t even have 2,000 UGX [approximately 60 cents] to buy soap or go to the hospital” (A. P. interview, April 4, 2015). Yet she emphasized that VIVO was really the only organization that offered a systemic, much-needed professional therapy for PTSD and that “getting rid of their PTSD might be a first and important step for people to then be able to take care of other needs.

Irrespective of whether my interlocutors were in support or critical of medical diagnostic labels, they all mentioned similar underlying problems that clients came to them with, the most common among them being sexual and gender-based violence (SGBV), poverty, and HIV/AIDS. Overall, they painted a gloomy picture of postwar society in which violence, disease, and poverty were widespread—and indeed normal—and emphasized that in their therapy encounters they mainly dealt with extreme forms of these problems. There is reason to be skeptical of the broad generalizations my interlocutors sometimes drew from their clinical encounters, especially about Acholi men and the structural inequalities inherent in Acholi society, which, I believe, are more complex than these portrayals would suggest (cf. Vorhölter 2014:271ff.). But while I do not want to uncritically reproduce generalizations about women’s victimhood or the cruelties of postwar society, I do feel that the experiences the psy-professionals shared with me provide compelling, often shocking, and sad perspectives on and meanings of suffering. The following is such a case related by Marco:

Most of my clients are women affected by cultural conditions that don’t allow them to make choices for their lives. [He describes at length the problems that women face due to patriarchal residence and widespread patriarchy in Acholi society, whereby women do not have a say in property, marriage, and sexual decisions.] . . . The legal institution is the clan, but the clan is the clan of the husband. Often those women who have a weak family in the back are those who come to counseling, those who do not have living parents or brothers, so they are completely in the hands of a man . . . I have a case: a woman . . . you know, men, sometimes we are really like animals . . . She found that the husband has abused her 4-year-old child, or both of them, while he was drunk . . . They brought it to the clinic, the doctor checked and said go to the police. She reported the case to the clan, but she would not go to the police, because the clan would really crucify her, and for her she has nowhere to go . . . If they arrested the man, she is living in the place of his clan . . . Even for me as a therapist these are big ethical issues to deal with . . . . I do believe that most of my clients suffer from SGBV, and it is related to the unbalanced power in the African culture. [When he sees my skeptical look at this crude generalization, he laughs and continues.] Okay, let’s say in Luo . . . [and adds] Maybe this is not the right closing for an anthropologist to hear [winks] but this is what I experience . . . [Most of my clients] are women in this condition of being strangled in a life where they don’t have control. And they don’t have control not because they have a mental illness, they don’t have control because they are living in these conditions. That is why again for me it is ridiculous when you start saying “this patient has depression” . . . I don’t agree with this category, this person is oppressed and she is hopeless like any human being when the possibilities of the moment are very, very limited. (G. M. interview, April 3, 2015)

When hearing cases like this, one wonders whether psychotherapy can really provide what people need most. The relevance of psychotherapy to the lives of the people in northern Uganda was certainly much debated. All of my interlocutors mentioned that initially nearly all the clients referred to them were skeptical of talk therapy—because it was foreign, largely unknown to them, or stigmatized due to its similarity to HIV counseling, and because people’s most pressing needs were, if anything, of a more material nature.

Themes regarding the cultural appropriateness of psychotherapy came up in all of my interviews. Both local and foreign counselors had been confronted with the widespread belief that in Acholi culture, problems are not explicitly and openly spoken about, and negative events are best kept silent. They had also been told that it was uncommon to speak about personal issues with strangers and that the (relatively) egalitarian speech situation desired in therapeutic encounters would not work in a setting where (most) interactions were guided by gender-, age-, and status-based hierarchies. In practice, however, my interviewees found that many clients—once they had agreed to try talk therapy—were very open and appreciated it. The VIVO psychologist told me that many of their clients felt
relieved to be finally asked and able to speak about their traumas, something they felt they could not do in the social settings they came from (A. P. interview, April 4, 2015). Marco stressed that it was especially the attention given to the client as an individual in his sessions that was often well received. He acknowledged that “socially, clients may have learned [other] messages” but found that it was actually for this very reason “that they are so eager to have someone ask them: ‘What do you like? What is your favorite food?’ you know things really related to you as an individual, not you as a member of a community” (G. M. interview, March 29, 2015). Marco saw the benefit of counseling precisely in the way that it empowered the individual to know him/herself, to learn to identify one’s needs and act on them irrespective of authority figures (parents, teachers, community leaders, etc.). He believed that while the community and its social conventions were important factors of stability and guidance, individual members should also be encouraged to trust in their own abilities to solve problems. In his words:

Now it is very true that alone we cannot survive for one second . . . But I do believe that we have more power as human beings than we are prone to believe . . . I found healthy for me and the clients I met in my life, trying to achieve what you aim to, rather than believe that someone else, or the drugs, the ritual, the prayer from outside, can change your life. (G. M. interview, April 4, 2015)

The biggest problem was convincing people of the benefits of going to see a counselor. What stood in the way was often not so much clients’ refusal of psychotherapy as such, but rather a very realistic self-evaluation of their (material) needs. As one psychotherapist from Kampala who had briefly worked in the North stated very compellingly: “Income is very low, and people earn very little. I mean therapy is not a priority; no, you can’t look for therapy when you have no food” (D. O. interview, August 11, 2015). Thus, even though most of the counseling services were provided free of charge, people did not take up the offers unless they were promised incentives like money, food, or school fees for their children. One local counselor explained: “They say, ‘I don’t need it; it wastes my time.’ You know someone comes with an expectation but [is offered] only talking, talking. Talking will not give you school fees, food; it doesn’t help with those kind of things” (J. L. interview, March 29, 2015).

The interviewee saw much need to combine counseling services with those that would cater to people’s material needs: “Most of our clients, the depression, so many things, is linked to material support, so I would say for counseling to be successful, there should be a component of something” (J. L. interview, March 29, 2015). At the same time, however, she also saw the need to clearly separate counseling from material provisions and to not make the latter dependent on the former: “It will not work. They will just come and stay because they need material things, and in the end you fail to understand which direction you are going towards” (J. L. interview, March 29, 2015). The same feeling was expressed by Marco. When he first started working in Gulu, there had been some incentives provided to the clients. However, this confounded the situation because people would primarily be interested in the material rewards and only endured the counseling as a necessary prerequisite. Ever since, he has refused to mix counseling with other services and sends away people who feel they do not need counseling rather than lure them there with incentives. He explained to me:

It is the most important aspect of counseling in northern Uganda [to be clear about the respective expectations of counselor and client]. . . . To say to someone, “look, you are here for school fees, but I don’t have school fees.” . . . I may explain what counseling is and then leave the responsibility to the client. . . . Once he finds his motivation, the session will be successful. But it has to pass through this moment of risk. This is one simple but very important part of the training that I am doing: for our counselors to take this risk of losing the client. (G. M. interview, March 29, 2015)

An Empire of Trauma in Northern Uganda?

All my interviewees stated that the majority of clients appreciated their psy-services. Some started referring relatives and friends or even became interested in becoming counselors themselves. Similarly, Marco’s trainees, many of whom had started their counseling training without any previous experience or knowledge of psy, were often amazed by the successes they could achieve through just talking. Some even went on to study psychology.

Nevertheless, it seems that psy has a long way to go before it can be considered an established part of the therapeutic landscape in the North. As of yet, there is no all-encompassing “empire of trauma” (Fassin and Rechtman 2009). My interlocutors felt that despite an increasing awareness of concepts like trauma and psychological and psychiatric dimensions of suffering, everything related to mental illness and counseling was still highly stigmatized. Furthermore, all counseling services currently offered in the North, to my knowledge, are pro bono services and heavily dependent on donor funding. It remains to be seen whether private practices like those in Kampala, which I discuss in the following section, will eventually take root in places like Gulu—where there is, after all, a small but growing (upper) middle class that could pay for such services.

Narratives on happiness were largely absent among counselors in the North. Psychotherapy was about helping people to cope with what seemed to be unimaginable forms of distress. They framed northern Uganda as a place of suffering where happiness seemed to be not the norm but the exception. And although there certainly are many people in the North whose experiences do not resemble those described by the psy-professionals, and whose lives are not primarily about suffering, many have indeed lived and continue to live with hardship. Presumably very few of them would seek counseling for anything but a major crisis. Given the history of war and the widespread narratives of horrors and desperation, the threshold of what counts as a major life crisis in the North is very
high. Ordinary unhappiness, as I learned during the time I lived in Gulu, is mostly related to material needs and broken social relations rather than being experienced as a problem of the individual psyche, and thus it cannot be fixed by talking.

The Emergence of Private Psychotherapy in Kampala

The development of a psy-dispositif in Kampala during the same time period occurred under different circumstances from those in the North. While it has multiple facets, here I only focus on one of its most striking and little-studied features: (private) practices offering psychological psychotherapy. These exemplify the emergence of therapy as a new technology of thinking about and acting on the self or, as Wright (2010) puts it, “as a strategy to deal with fundamental dilemmas of modern life, from problems of mental health to a range of other difficulties arising from or exacerbated by, various aspects of social change” (11). While it would certainly be revealing to look at psy-practices in public psychiatric care facilities, such a discussion would go beyond the scope of this article.

Professional, voluntarily sought psychotherapy as offered by private practitioners is only affordable to a small, wealthy segment of the Kampalan population. A one-hour session costs between 50,000 and 150,000 UGX (approximately US$15–$50).1 However, to expand and popularize their services, most private practitioners also offer reduced rates for those who cannot afford the regular prices. Furthermore, some institutions (e.g., universities) and companies have made counseling available to their clients or staff free of charge. While there is still a lack of awareness about and/or a resistance to seeking psychotherapy among Kampalans—for similar cultural and economic reasons as in northern Uganda—psy in various manifestations is becoming increasingly known, accepted, and actively sought, especially by the upper middle class.

My data stem from interviews with psy-professionals—many of whom were psychotherapists with MA degrees in psychology also involved in teaching at universities—who were among the very first to offer professional psychotherapy in Kampala. To my knowledge, the first private practice was established in 2000–2001. Since then, private practices have expanded and continue to do so, but their overall number is still very small, approximately 10, according to one of my interviewees (D. K. interview, August 21, 2015). My sample does not include all existing private practices but represents the bigger and more important ones that existed at the time of my research in 2015.

Professionalization and Expansion of Psy in Kampala

The rise of psy in Kampala has been especially noticeable in the past 10 years. There are different reasons for this, and I will discuss four that were most commonly cited in my interviews: (1) community sensitization and awareness raising through face-to-face talks and (new) media, (2) a new attentiveness to (mental) health and an expansion of markets of well-being and promotion of technologies of the self, (3) a trend for companies and NGOs to provide regular counseling services to their staff, and (4) a decline in other, more communal support structures.

I. Several of the psychologists I spoke to were involved in awareness campaigns and regularly gave talks—at schools, universities, companies, NGOs, and churches, and in other community settings—in which they informed attendees about the benefits of seeking psychotherapy in moments of crisis and about the difference between psychotherapy and HIV counseling. Some also wrote columns or answered readers’ questions in Ugandan daily newspapers, which featured regular supplements focusing on all types of life problems (most prominently, relationships). Others tried to engage with religious leaders, school counselors, or other self-styled counselors who were often approached by people seeking advice but did not have a psychology background and little or no professional training.

All the therapists I talked with told stories about clients who had come to them after hearing one of their talks or reading about counseling in the newspaper or who had been told about their services by former clients. As one therapist explained: “We have not only gone on the radio to advertise, but we have gotten advertisement from our [former] clients. Those who have seen [the benefits of therapy], they go and advertise” (INT RN, 15.09.2015).

Another source of information on psy was the internet. Different interviewees told me that categories like depression were becoming well known because people heard about them on TV or from people who had traveled abroad and then started to look them up on Google. An MA student in clinical psychology told me:

People are getting more informed through that [internet services] . . . Google can give you simple tips of how to take care of yourself, even tell you when you are getting depressed, what are the signs. Someone can just mention one word and someone else becomes intrigued: “what is that?”, and will go back and Google. . . . People now want to know more. Even you guys coming [referring to Western foreigners], you tell us this, we come to your side, we come back home with reading . . . Clips on the television, they talk about mental illnesses . . . On Facebook, some people can give a small talk on a mental disorder . . . , so if you are intrigued you will ask what is this. (S. M. interview, August 24, 2015)

10. They emphasized this difference to avoid the stigma and notions of illness attached to HIV counseling but also to distinguish client-centered psychotherapy from what they perceived to be standardized, top-down HIV counseling approaches.

11. These untrained counselors were regarded with some degree of skepticism by established psy-professionals, because of their often very authoritative and dogmatic approaches, which were clearly opposed to the psy-ideology of encouraging people to self-reflect and self-govern.
Thus, a certain psy-vocabulary was becoming increasingly prevalent especially among the (upper) middle classes. One psychologist told me how amazed and somewhat shocked she was when one of her clients, a 9-year-old girl, told her that she was depressed.

II. Driven by awareness campaigns and media reports, mental health was gradually being discursively established as a new value and norm among certain sections of the Kampalan population. People started to recognize the differences between (images of) “serious mental disorders” like schizophrenia, which needed clinical attendance, and less serious forms of psychosocial suffering or “minor psychiatric disorders” (Littlewood 2001:xiii), which could be treated by psychotherapy or self-help. It seemed that members of the (upper) middle classes were becoming increasingly health conscious. Correspondingly, markets of well-being were rapidly emerging in the form of gyms (which seemed to have popped up all over Kampala since I had last been there in 2011 when there were still few), self-help literature (which now takes up several shelf rows in the big Kampalan bookstores) usually imported from the United States, and food supplements (in fact, there was a whole store just for food supplements in one of the newly opened malls). My two research assistants, MA students in clinical psychology, explained to me: “There is a whole new wave of self-help and gym practices; it is the thing. People are paying more attention to their bodies and working out; it is like a whole new wave going on” (L. K. and B. K. interview, March 12, 2015).

Mental health, self-analysis, and self-control were important parts of this trend. Different therapists mentioned that well-to-do parents brought their children in for psychological checkups during their school holidays—even if there was no obvious concern. Assessments (e.g., for diagnosing learning difficulties or measuring intelligence) were especially popular ways of scientifically evaluating one’s state of being. One psychologist pointed out: “I think many people like doing assessment—it is a medical thing here too, like everybody goes for MRI and CT scans—when you think: ‘Is that really necessary; is there an indication for that?’ But as long as you pay, you get it, so they come and just want to know” (F. B. interview, March 25, 2015).

The idea of being able to self-manage life problems and take control of one’s own happiness—rather than depending on parents, religious authorities, or community elders—was well received, especially among the younger generation of upper-middle-class Kampalans (cf. Spronk 2012 for a similar trend in Nairobi). Some of the students enrolled in psychology degree programs mentioned that their original interest in the course had come out of a life crisis they were trying to resolve and that the techniques they had learned throughout their studies had been helpful in overcoming their feelings of depression and strengthening their ways of coping. Others pointed out that everyone would benefit from having some psychological skills.

In two group interviews I carried out with university students who did not study psychology, most participants favored the expansion of counseling services and therapy as ways of dealing with problems. One of the female students insisted: “We need these services from the professional people to get over our stresses and to know how to deal with our bodies, our growth, our changing lives, because these other people (relatives, friends, traditional authorities . . . ) are not professional; you do not get good quality. Because everyone can counsel you, but the quality of that counseling differs” (M. U. K. girls interview, April 16, 2015).

III. In line with this trend, a number of companies and NGOs have started to provide counseling services to their staff. Some even make it compulsory for their employees to see a counselor once a year. Others bring in psychologists to give talks on stress management, for instance, or when there is a particular need. I was told about a case of emergency counseling, whereby psychologists were deployed to help staff cope with grief after the manager of their company had died suddenly in a car crash (L. O. interview, September 1, 2015). In another case, a psychologist was called to prepare staff for massive layoffs by the company (R. N. interview, September 17, 2015). One psychologist described the economic logic behind such interventions: “People have come to the realization that when you go for therapy, your productivity increases, it becomes better, so they make their staff go for counseling. When you keep issues within yourself, it affects you . . . but when you have talked out those issues, they become lighter. And so it is becoming more common” (R. N. interview, September 17, 2015). The economic rationale behind the increasing popularity of counseling as a technology of the self has been discussed in relation to counseling in the West (e.g., Glauser 2016) and is an interesting topic to analyze further for the case of Uganda—which, however, would go beyond the scope of this article.

IV. Another important reason for the rise of psy in Kampala is related to the more individualist lifestyle of the educated and wealthier classes that often goes along with a decline of family- and community-based support structures. As one interviewee pointed out: “It [seeking psychotherapy] is definitely becoming more common . . . because obviously social structures have changed, a lot more people live a more urban lifestyle now, and have less support. They are also less religious and also less into traditional networks of health care” (F. B. interview, March 25, 2015). She went on to emphasize:

I do think still family is a big part . . . and being happy as a person involves other people around you. But there is definitely more individual goals, because of the types of jobs they do, so there is their goal-setting, traveling . . . And they are more aware about themselves as an individual person than people maybe in the villages, because they also function like that, in interactions. (F. B. interview, March 25, 2015)

The argument that weakened communal support structures and the declining importance of religious or “traditional” authorities have led to the “triumph of the therapeutic” (Rieff 1966) in the West has been extensively discussed (for a good
overview, see Wright 2010:chap. 1) and would make another interesting topic for comparison with the Ugandan case.

Relevance of Psy in Kampala

Despite the trends described in the previous section, there were several reasons why psy was still mainly taken up in upper-middle-class circles but had not really spread to mainstream society (yet). Two in particular were mentioned by my Kampalan interviewees: (1) a lack of recognition and therefore of job perspectives and (2) a general preference for quick-fix solutions in dealing with problems.

I. One of the first problems mentioned by my interviewees when asked about the challenges they faced was usually the widespread lack of awareness about and/or appreciation for psychological services by the majority of the Ugandan population. A related challenge was that culturally seeking professional help for personal problems was seen as shameful, especially for men, because it meant that they had failed to solve their own problems (D. O. interview, August 11, 2015). One interviewee told me: "Our culture, basically we have grown up being told that you do not express that you are suffering, you have to keep it to yourself . . . Because if I talk that I am depressed or that I do not feel well, people are going to think that I am whining . . . that I can’t solve my problems, so people don’t come for help" (S. M. interview, August 24, 2015).

Quotes like these point to understandings of cultural norms regarding the ways that suffering can or cannot be legitimately expressed and addressed. One can easily imagine how a greater legitimacy of seeking counseling might also transform understandings and representations of suffering. Depending on the case and the perspective, it could mean that people have to suffer less because they can seek help earlier; however, it could also lead to a growing pathologization of simple unhappiness.

In any case, the general lack of awareness and acceptance had wide-ranging consequences for the psychologists and their profession: there was little demand for their services. As the Ugandan government was also skeptical of the benefits of psychology and, with very few exceptions, refused to create government-funded positions, finding paid employment was a big challenge. Even those who had successfully opened private practices still often found themselves struggling to convince people of the appropriateness of pay-for-talk therapy. Some mentioned that clients would try to call them or chat via the internet in the hope of getting their services without being charged.

Humanitarian work was the one field in which services of psychologists were increasingly sought, especially by NGOs operating in the North. However, many psychologists from Kampala were reluctant to work upcountry because they found the working conditions unfavorable or did not want to give up their urban lifestyle. Overall, the lack of satisfactory job perspectives was one of the major inhibitors of the spread of psy. The refusal by the Ugandan state to promote psy and create more employment opportunities reveals an important difference to Rose’s (1999) analysis of psy as a state-supported modernizing and governing project in Europe (cf. Vorhölter 2017:574).

II. I was often told by my interviewees that while mental health services were generally looked down upon in Uganda, it was worse with psychology. When being convinced that a problem was mental, people would rather turn to the medical system than to psychology, and this primacy of the biomedical over the psychosocial was also reflected in institutional support—or lack thereof (D. K. interview, August 21, 2015). As in other places (cf. Luhrmann 2000), there were tensions between psychiatrists and psychologists, as those of the former profession rarely acknowledged the work of the latter. One psychologist stressed: "I think in this country the psychologists are still really stuck on the medical model; they are like: 'you psychologists keep away; we shall just give them medication and that is it.' So their belief in psychology is very minimal, and I think that affects how things have been happening” (D. O. interview, August 11, 2015).

One reason for the preference of psychiatric treatment was that people believed it to be faster and less painful. Taking medications was a very common response to just about any form of pain in Uganda, and drugs were easily accessible. Although modern psycho-pharmaceuticals like newer-type antidepressants were still relatively unknown, and few would seek or be able to afford them for self-medication, they were becoming more popular among members of the upper middle class. The clinical psychologist at an upscale medical practice explained:

The big challenge in Uganda with pharmaceuticals is that you can buy anything anywhere. That is really a big issue for us, because we often get people like: "oh yeah, I am already self-medicated; I am on antidepressants," or worse: "I have been on Diazepam," and one time it didn’t work anymore, so now I take three every night and I’ve done that for the last year." (F. B. interview, March 25, 2015)

Not long after this interview, I found an article in the Daily Monitor (Nakakande 2015) that warned against misusing psychotropic drugs for anxiety.

Another interlocutor, a professor in the Department of Psychiatry at Makerere Medical School (Interview, March 6, 2015), spoke about the increasing marketization of drugs:

If someone has money, they can easily get all the problems of daily life to be managed pharmacologically . . . I have 12. In fact, President Yoweri Museveni had on various public occasions expressed his skepticism about psychology and, while speaking about courses that should or should not be taught at public universities, emphasized that "psychology is a science that has nothing to offer Uganda" (Bangirana 2006).

13. Diazepam is a benzodiazepine that has sedative effects and is often used to treat anxiety disorders, alcohol withdrawal symptoms, or insomnia.
seen, not just in psychiatry, a lot of marketing going on in this country, especially with food supplements. They say, “This one is for high blood pressure,” but you are not even sure you have high blood pressure. But they say ‘control your pressure levels, keep mentally alert . . . ’ The cost is astronomical, and they have this network marketing, everywhere. I feel like this is ripping off people; this is not necessary. But I realize this may be the power of the pharmaceutical companies, [making people believe that they can] manufacture a magic bullet for all diseases.

According to my interlocutors, people in Uganda generally favored and demanded quick-fix solutions and magic bullets for their problems. This was a challenge for psychotherapy, because clients often expected to come for just one session and leave fixed. During a symposium I attended on family therapy, the facilitator, an experienced child therapist, told the participants that while she was definitely seeing an increased willingness among middle-class parents to seek therapy for their children, she often found that parents held the belief that therapists could just solve all of their family problems as if they were magicians.

Meanings of Psychosocial Suffering in Kampala

Given all these recent developments, what were the reasons for which people sought therapy in Kampala? How did psychosocial problems differ from those in northern Uganda? From my interviews and participant observation among Kampala’s (upper) middle class, I developed some insights into people’s daily struggles and stresses and the reasons for which some sought therapy. Obviously, the problems I describe in the following paragraphs are not representative of Kampala’s very heterogeneous population as a whole, but very specific to age, class, and lifestyle. I will discuss narratives about (1) children, (2) university students/recent graduates, and (3) married adults.

I. As described above, children were increasingly becoming subjects of therapy and taken to psychologists by their parents. Some were also sent by the (private) schools. From my interviews and numerous conversations with parents, teachers, and friends living in Kampala, I developed an understanding of the way middle-class children were growing up in Kampala today and the problems they were seen to be facing as a result. I will give a somewhat standardized version of a common narrative I encountered:

Most people emphasized that children spent very long hours at schools and were put under immense pressure to study. Those who attended boarding schools were woken up at 4 or 5 a.m. to start their day and came home only for the holidays. Those who attended day school spent several hours each day sitting in the traffic jams of Kampala on their ways to and from school. On weekdays, some of these children hardly saw their parents, as they were often taken to school by the drivers and received at home by the maids. For upper-middle-class families, it was common to have both parents working full time in addition to having several social responsibilities (like meeting friends, organizing weddings, or going to the gym) to fulfill as part of their lifestyle. Thus, even on weekends, parents sometimes opted to leave their children to themselves or with the maids. The following extract from my interview with a therapist gives a good impression of discourses on modern parenting—and its problems:

Parents have become so busy that they don’t have time for their children. You find that a child of two years is taken to a boarding school . . . Media has become a problem, [there is] no parental guidance, the children are watching every junk and they begin to think that is what life is supposed to be. That is why we [therapists] are telling parents that there is the formative age that you need to spend with your children; if you fail to put values in your children in this age, it is going to be very difficult . . . Then the problem we have in this country is: everyone can afford to have a house girl. House girls have taken over the role of the parents—house girls and drivers. One of the headmistresses of a school I go to give talks told me that there are parents she sees only on the day they look for a school; after that she sees only the driver and the maid. (R. N. interview, September 17, 2015)

While children were taken to psychologists for a number of reasons—learning difficulties, attention deficit hyperactivity disorder, or even depression—one of the most common was behavioral issues (acting out, taking drugs, being antisocial, etc.), which the therapists saw as related, in some way or other, to the way they were growing up. In the words of a clinical psychologist: “The work and social life balance [is very difficult]. Parents work the whole day; after that they have wedding meetings, they have to go to the gym, all that. So I see a lot of problems, like children with behavioral issues because they are basically brought up by the nannies” (F. B. interview, March 25, 2015).

II. According to my interlocutors, behavioral issues like taking drugs were also common among university students and recent graduates. The student counselors I spoke with, and even some of the students themselves, framed them as negative coping mechanisms to deal with stress and life problems. Everyone seemed to agree that the main problems students were facing, and for which some sought counseling, had to do with relationships, followed by financial struggles (paying for tuition but also maintaining a respectable lifestyle, i.e., having the right phone, eating the right food, etc.) and (academic) pressures to perform well to be competitive on the job market. Family issues and clinical problems like depression or trauma were also mentioned occasionally. Stress was another big topic. It came up in two interviews I conducted with students who saw stress as the result of living a modern and urban lifestyle:

This generation of ours is much [more] stressed than the past generation. . . . It’s because our lifestyle differs from theirs; you may find that things we consider very [stressful] . . . used not to stress them at all . . . . Today, if you got to know your guy is flirting with someone else, you feel so stressed
you can’t take it. But those days, people would marry three wives and they would live in the same house without getting stressed. People used not to mind about phones . . . but now if you don’t have a phone, you feel like you are out of the world. (M. U. K. girls interview, April 16, 2015)

I think in town there is a lot of stress compared to the villages because people are competing. Everyone wants to be the richest, and yet being the richest in town is harder than being the richest in the villages. (M. U. K. boys interview, April 16, 2015)

Most of the eight participants could tell stories about fellow students whose lives had taken very negative turns because they could not cope with their stresses (some even mentioned cases of suicide14), and all agreed that counseling services should be better advocated and made accessible for students.

III. Although students were also among the clients of the therapists in the private practices, most dealt primarily with (married) adults. As mentioned above, the challenges of combining work and family life, maintaining a good lifestyle (which included having a good house, sending the children to good private schools, owning luxury items like cars and media equipment, going for regular social outings, etc.), and still earning enough money to support (or finding other ways of dealing with) extended family in the village were major causes of stress that affected people’s health and happiness.15

Most clients, however, came for therapy to deal with marriage problems. Marriage counseling was also offered by the churches, especially the Pentecostals, but they were often very dogmatic in their advice, so people increasingly sought and were willing to pay for professional secular psychotherapy. Marriage problems were mostly related to the difficulties of combining modern lifestyles and costs with having (many) children, to the infidelity of one or both spouses, but also to feelings of love—or lack thereof. Women in particular expected marriages to be more than functional units. While most were seeking financial security, they also expected their partners to be romantic lovers, good fathers to their children, and trusted companions (cf. Spronk 2012). A friend of mine, who was just going through a divorce (despite marriage counseling), told me how her husband “was really not a bad man,” but that she had always wished for him to be a friend and someone to feel close to rather than merely a provider. She said they were staying in a nice house, had a good lifestyle, and that he took her out to expensive places and bought her gifts. For a long time she had tried to “ignore her unhappiness” also because the people around her only saw the nice sides of her marriage. But then her depression started, and she decided that there was “more to life than getting stuck in an unhappy relationship” (field notes, August 26, 2015).

Depression was seemingly becoming a common idiom for expressing feelings of unhappiness and distress. In the words of one psychologist: “The affluent class, when they go to see a psychologist or psychiatrist . . . that language is there right now for depression” (D. O. interview, August 11, 2015). She also noted that coping with grief was becoming an issue for which people sought therapy, while previously they would have turned to cultural coping mechanisms: “Grief is big; we have a lot of deaths, and [although] within the culture there’s a very strong process of dealing with grief, I must say that now, especially the middle class is seeking out for more support when there’s grief in the family.”

Overall, it seemed that being happy among Kampala’s (upper) middle classes—which involved particular forms of material, physical, and emotional well-being—was increasingly seen as a norm, as something that people expected from life. Consequently, deviations from this norm were felt and expressed as states of unhappiness and increasingly framed as reasons for unhealthiness and for seeking professional help. This impression is captured very compellingly in the following closing quote from my interview with a trainee clinical psychologist. Talking about her passion for psychology, she said:

I just love depressed people [she reflects on how this might sound mean and then explains]. They intrigue me because they tend to put life upside down. Like, a normal person would want to hang out, would want to enjoy life, but for them they tend to shut in, they feel withdrawn. It’s like . . . *vice versa of a normal person*. I like the experience of making them turn from the opposite side to normal, when they tell me that “Today I went out,” and we share the experience . . . it’s as if they are seeing the world for the first time . . . I also like their road to normality when they have become a better person and then they are thanking you. You see someone before, when they were so down, and then by the time you say goodbye, you see a happy person, so that turning from abnormal to normal it makes me so happy. . . . It is very rewarding when you see them and they are now happy. (S. M. interview, August 24, 2015; italics added)

**Conclusion**

This article has traced how the emergence of a *psy-dispositif* in Uganda has reconfigured meanings of suffering in two different settings: northern Uganda and Kampala. In particular, I analyzed whether one can identify medicalized notions of unhappiness—an increasingly common feature of psychodiscourses in Western societies that carry particular assumptions about happiness as a value and norm—in contemporary Uganda.

In Kampala, one can certainly find indications for such a trend, for instance, the emergence of depression as a popular

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14. Suicide was becoming an issue of concern. I was told about a workshop for counselors that had been organized to focus specifically on suicidal tendencies among students (*INT JK, 24.08.2015*).

15. As discussed by other anthropologists (e.g., Livingston 2009; Van Dijk 2013), upward mobility across African countries has been accompanied by rising demands, social pressures, and increasing competition, leading to widespread uncertainties, conflicts, and anxieties.
category and the conflation of its clinical meaning with unhappiness. One can also observe the emergence of new health markets and new professions that have an interest in marketing (un)happiness. Happiness often came up as a topic in my interviews with Kampalan psychotherapists, and some saw it as a norm and a goal to be achieved for those who were lacking it. For many of their upper-middle-class clients, being happy involved wealth, health, and fitness; a good job; an active social life; and good family relations—and their reasons for being unhappy, stressed, or even depressed were often related to the difficulty of or failure in combining all these demands.

In northern Uganda, by contrast, most of my interviewees talked about suffering, which seemed to be seen as the normal state rather than the exception. Therapy focused mainly on those who faced extreme suffering, and it was mainly about giving clients skills to cope, or a brief moment of attention and relief, rather than making them happy as such. While ideas of mental health and psy are promoted by some actors, they have not yet become influential ideologies. One cannot speak of mental health markets in a commercial sense, because all psy services are pro bono.

The way the different therapists talked about their work and their clients may tell us little about how people in Kampala and northern Uganda actually experience happiness or suffering. However, their narratives do give us some idea about what is understood as normal in a particular context and who is seen to be in need of therapy. While in the North this is clearly the poor suffering subject, in Kampala it increasingly seems to be the stressed-out, depressed, or unhappy middle-class person.

Looking at the different contexts in which psychotherapy unfolds in Uganda tells us a lot about the vastly different circumstances in which people live; the different expectations they have regarding their lifestyles, futures, and desires; and the different ways they position themselves and are being positioned by others. The way people frame and experience happiness, or suffering, and for whom they take it to be achievable, or normal, thus gives us some insights into much broader social phenomena as a norm of or failure in combining all these demands.

While experiences of suffering or happiness are always to some extent individual and subjective, they are shaped by contexts and authoritative voices. Increasingly, these are global voices—after all, happiness is now being measured and compared across societies. Ideals of what it means to be happy and how to achieve it travel across contexts, as do interventions targeting suffering. The way we talk about and frame the absences and presences of happiness or suffering reveals what figures as a norm—and what deviation from the norm means.

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Accelerating Medicalization for Everyday Stressors: Professionalizing Access to Happiness among War Affected and the Upper Middle Class in Uganda

In a 2018 meeting, academics and global research funders discussed extensively a trendy demand for academics to disseminate policy briefs as a principal approach to attaining sustainable development goals (SDGs) in developing and developed countries. An emphasis on a policy briefs approach to attain SDGs appeared context free, and dissociated from local social, political, and economic circumstances in developing countries. For example, Uganda has an evidence-based health policy but still struggles with dysfunctional health centers; less motivated, poorly remunerated health workers; and ultimately poor health outcomes. In response, one participant from a wealthy country shared his experience with influencing major state spending, only through sharing evidence-based insights with policy makers.

The foregoing resonates with my 12-month ethnographic experience (2004–2005) among war-affected people in northern Uganda, where I observed with dismay how more than 265 registered international and local humanitarian organizations implemented trauma-focused projects to alleviate suffering among war-affected people. To ensure mass scaling up of trauma-focused psychosocial interventions for 1.7 million distressed people, professional psychotherapists trained institutional support staff to conduct counseling. It was argued that counseling, including talk therapy, dance therapy, and play therapy, enabled distressed people to deal with the impact of war on their psyches (Akello 2010, 2015a; Akello et al. 2008, 2010). The wartime population lived in fetid displaced persons camps frequently exposed to infectious diseases and epidemics; had lost their livelihoods; and many witnessed killings and had their relatives abducted and forcibly conscripted in armed rebellion. Not only did war affect their psyches, war had damaged the social, economic, health, and political systems in Acholiland.
Critics of prioritizing trauma-focused interventions during complex emergencies (Akello 2010, 2015a, 2015b; Akello et al. 2008, 2010; Bracken et al. 1995; Herman 1997; Kirmayer et al. 2010; Kleinman 2012; Summerfield 1999, 2002, 2004), questioned the efficacy of this approach—but not necessarily its assumptions of bringing short-term happiness. Authors (Akello et al. 2010; Herman 1997; Kirmayer et al. 2010; Kleinman et al. 1997; Summerfield 1999) describe the psycho-trauma approach as offering technical solutions for complex social, economic, and political issues. And yet the resulting distress/suffering due to exposure to extreme war events is not necessarily a pathological response but may be a normal (expected) response (Jones 2004). By observation, Acholi people prioritized their safety instead of going to dance therapy centers (Akello et al. 2010) and preferred engaging in income-generating activities to keeping appointments with psychotherapists—who will help them deal with the effect of extreme events on their psyche (Akello 2010, Akello et al. 2010). Furthermore, Acholi approaches of dealing with the psychological impact of war violence include praying and culturally informed approaches such as placing the shrub atika (Labiate species) on the doorstep for nightmares or if one is frightened, worried, or anxious (see Akello 2010; Akello et al. 2008, 2010; Igreja 2003; Marsella, 2008).

Julia Vorhölter’s Struggling to be a “happy self?” psychotherapy and the medicalization of unhappiness in Uganda is not only adding to this debate, it is also a novel and seminal contribution that enriches our understanding of why some globally conceived technical solutions for the upper middle class in the West may not be meaningful among resource-poor people living in complex emergencies. Additionally, through making a distinction between the two types of happiness—namely, hedonism, which is momentary happiness, and eudaimonia, which is long-term happiness—it is clear that psychotherapists offer clients hedonism. It then becomes confusing particularly if clients think the technical fix is eudaimonia, which is principally what distressed people are seeking. To accelerate access to hedonism when distressed people need eudaimonia resonates with various globally conceived short-term, context-free, technical fix and apolitical solutions for complex problems (see Akello 2010, 2015b; Chambers 2017; Green 2016; Kirmayer et al. 2010; Kleinman et al. 1997; Parker and Allen 2014). That some upper-middle-class Ugandans willingly pay to access hedonism is consistent with what is happening in contemporary Western societies, whereby happiness has come to be understood predominantly as hedonism. This short-term happiness can be accessed through talk therapy, gym work, and psychotherapy. An emphasis on psychotherapy as the main way of accessing hedonism, particularly for the affluent, signifies a commodification, a medicalization, and a psychologicalizing of happiness. Furthermore, my experience is that hedonism can also be accessed through—particularly for the poor war-affected people—material support (Akello 2010, 2015a, 2015b; Akello et al. 2008; Bracken et al. 1995; Kleinman 2012; Kirmayer et al. 2010; Summerfield 1999, 2002, 2004). Academics, global health practitioners, and humanitarians alike will appreciate Vorhölter’s article, and they might choose to minimize cognitive dissonance and avoid the pretension that distressed people living in complex emergencies must primarily access trauma-focused interventions to make them happy. That is why the end result, as Vorhölter puts it beautifully, is that the rural poor, having been targeted for psychosocial counseling will inquire if there is a monetary incentive—then s/he will endure going through the process in order to receive the money at the end. Therefore, it is the money that is a useful intervention in this dynamic characterized by an influx of psycho-trauma interventions in northern Uganda since the late 1990s to enable traumatized, war-affected people to deal with the impact of exposure to extreme events.

Furthermore, if trauma is not only a consequence of large-scale events, but also a common occurrence in domestic life (see Kirmayer et al. 2010), then the Ugandan elite could be paying psychotherapists for purposes of seeking solutions for complex socioeconomic and historical circumstances. Instead, these complex problems are reinterpreted as psychological problems. Therefore, in addition to offering technical, short-term, and magic-bullet fixes, professional psychotherapists in this commoditized process are ignoring clients’ local contexts. The outcome will be accessing hedonism, or ordinary, superficial,-short-term happiness. Ultimately, however, wealthy people’s obsession with hedonism shows how they reinterpret suffering as abnormal rather than an essential life process that must be managed rather than endured (Summerfield 2004). Suffering is a social experience that involves an interpersonal engagement with pain and hardship lived in intimate and communal social relationships and therefore requires a fundamental awareness of corresponding moral responses (Kirmayer et al. 2010).

Accessing real happiness/eudaimonia, however, requires a thinking that transcends the psychotherapist-client interaction. For instance, it is well-known that simple and effective ways of accessing real happiness starts from within the individual and not from outside. These include making other people happy, putting others above self, sharing, self-sacrifice, and not necessarily focusing on individual selfish needs. The only weakness I see in the Vorhölter article is the plotting of the argument in a rural/urban divide. This is because in Uganda, the upper-middle-class elite in both rural and urban areas are likely to share similar characteristics. Likewise, the poor have more similarities regardless of whether they reside in urban or rural areas in Uganda.

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Happiness is slippery and overdetermined. Across cultures, there are diverse ways of defining happiness if such an equiv-
alent exists. Although we may encounter the movement of Western or neoliberal conceptions of happiness, we remain far from being able to treat happiness as a universal. Attending to the proliferation of a psy-dispositif, Vorhölter compares how psychological interventions reconfigure meanings and responses surrounding suffering, happiness, and unhappiness in northern Uganda and among upper-middle-class people in Kampala. Vorhölter took on a significant task. I see this paper as an important step in building a larger research project that ideally aims to understand local notions and transformations of the self and emotions while critically engaging these categories and the impact of the psy-dispositif ethnographically.

When ethnographers invoke the self or terms of emotion, I look for descriptions of the people’s constituent ethnotheories and contexts. Without these, we have to make assumptions about what people’s experiences of emotional states are and what they denote. Comparative approaches and multisited projects on topics that concern the self and emotions are difficult to write about because paper length limits how much depth and context the author can include. A narrower version of this paper, perhaps sacrificing comparison, would offer this needed engagement with emotion terms, the voice of non-psych professionals, and a nuanced ethnographic context. What languages did people speak during interviews? How were emotion terms translated and interpreted? With what cultures or languages did participants identify? As a psychological anthropologist, I wanted these moorings to understand the manifestation, experience, and local meanings of the psy-dispositif.

Vorhölter describes psy as a new technology of the self that is related to lifestyles centered on “global middle-class values like happiness.” While happiness language likely circulates alongside neoliberal ideals and models of selfhood, I am uncertain whether happiness is a global middle-class value, at least in the way that a stereotypical middle-class American conceives it. My impression is that when psy constructs travel, or when we examine them over time, what they signify can shift. For example, Vorhölter points to the Declaration of Independence as indicative that happiness is an important goal of human existence. If so, what sort of happiness is this? What does it mean? Is the sentiment that happiness indexes have changed since 1776? Arendt (1963) argued that the happiness the Founding Fathers envisioned was not a private or individual notion of happiness that is familiar to us today but rather a sociopolitical, public happiness that involved participation in and engagement with public life and power (see Walker and Kavedžija 2016). Would Americans today recognize this happiness?

We run into similar challenges when invoking normality and the assumptions and imaginings underlying it. Normality is culturally constituted and contextually dependent (Benedict 1934). Vorhölter shows how psy professionals define normality, and she provides a good description of how psy professionals manifest the psy-dispositif and clutch happiness as being vital to normality, therapy, and becoming a middle-class subject. I would use caution, however, when expanding this finding to the middle class themselves. Vorhölter identifies this with a disclaimer, noting how the way “therapists talked about their work and their clients may tell us little about how people in Kampala and northern Uganda actually experience happiness or suffering.” I agree. The next project is to engage how people—in this case, Kampala’s middle class—understand and experience normality, happiness, and so on. Because we do not have this material or a deep engagement with emotions and context, we are limited to staying close to the paper’s main point: psy practitioners in Uganda use psy constructs to interpret their patients’ experiences and to articulate suffering and ambitions to the ethnographer. Vorhölter says that she “developed some insights into people’s struggles and stresses [. . .] From my interviews and numerous conversations with parents, teachers, and friends.” This is exactly the type of material she should foreground to demonstrate and support her findings. I anticipate that she could write another paper with this focus in mind.

Vorhölter notes that the global spread of psy entails much more than just the export of a particular medical or psychological technology. Indeed, I would go further to posit that psy is not the primary agent of change but is one of several palpable indicators, products, or artifacts of larger social and political-economic transformations. Perhaps psy is an emerging language that a segment of the Ugandan people uses to voice these shifts. I also wonder, as noted above, whether these circulating psy constructs are indexing the same thing as their places of origin. This is where the strengths of psychological anthropology rest. To answer this, we need to understand selfhood and the ways that people absorb globalized languages of the self in uneven patterns. Or perhaps we can think about psy languages as an idiom. In this sense, I am more interested in what psy indexes and how it reduces and medicalizes what we would otherwise understand to be moral, relational, economic, spiritual, or existential issues.

With this reframing, the question becomes how can ethnographers access or observe these issues and transformations? This requires not an anthropology that is about a psychology but rather a psychological anthropology. This psychological anthropology calls for person-centered ethnography, for instance, and a cultural psychodynamic framework that attends to individual experiences, and inner worlds—and how sociocultural and political-economic contexts shape them (see Groark 2017). I point to this because I think that Vorhölter is in an ideal position to expand her work in this direction.

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Affect, Social Positionings of Distress, and Localizing Psychotherapies

Against the background of the growing focus on mental health interventions both within and beyond global health settings in
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diverse African contexts (cf. Akyeampong, Hill, and Kleinman 2015), Julia Vorhölter introduces a highly relevant research theme: the establishment of psychotherapeutic interventions, and their corresponding psy-dispositif(s), in two distinct settings in Uganda from the late 2000s onward. As Vorhölter argues, notions of happiness, normality, and well-being have long become desirable life goals in the context of North America and (Western) Europe, as has the idea that unhappiness or mental suffering may require psychomedical intervention in the form of psychotherapy or pharmaceutical treatment. The main argument of her article, however, is that transcontinentally and transnationally traveling forms of psychotherapeutic practice originating in the West—and the “new forms of knowledge, institutions, and practices that embody and represent psychological expertise”—always become emplaced, in particular, in partly intersecting sites within the specific localities or regions in which they arrive. While I find both Vorhölter’s conceptual argument and the ethnographic material she presents intriguing, I think that the article invites further reflection along three analytical and empirical lines.

First, the distinction between the West (where psychotherapy originally developed) and non-Western parts of the world (to which psychotherapy is assumed to travel) is rather intuitive and often quite generalizing across large sections of the article. Recent research has highlighted that there are longstanding histories of psychotherapy and psychoanalysis in Argentina (Epele 2016) and the “Indian Terroir” (Kumar, Dhar, and Mishra 2018), which extend far back to colonial and postcolonial times—to name just two examples from the non-Western world. Thus, given that the mutual entanglements between Western and non-Western ideas and practices of mental health (interventions) have long been established in various parts of the world, one might wonder whether the global and transnational travel of the psy-dispositif to Uganda today could be written in geographically and temporally less linear ways.

The fact alone that the Ugandan government itself seems to harbor strong feelings of distrust regarding the benefits of psychology hints at the possibility that the introduction of psychotherapeutic interventions in the country faces more contestation and counternarratives than the article reveals. Furthermore, the ideas and practices relating to psychotherapy and the psy-dispositif in different places within the country may themselves have more points of geographical and temporal reference than the far-reaching categories of the global and the West suggest. Thus, is it possible that these histories of diverse forms of psychotherapy in Uganda actually comprise more complex trajectories mirroring the multidirectional im/mobilities and dis/connectivities contained in processes of (psycho)medical globalization across colonial and postcolonial settings until today (Dilger and Mattes 2018)?

Second, Vorhölter argues that emerging forms of psychotherapy in Uganda, and the medicalization of unhappiness and suffering that they imply, require that close attention be paid to the ways in which they have become entwined with dynamics of class, age, and gender in distinct historical contexts within the country. In contrast, her research thereby focuses on a rural to semiurban area in northern Uganda that has become a hub for trauma interventions—mostly led by international nongovernmental organizations (NGOs)—for socially deprived people in the wake of a long-standing history of armed conflict in the region. On the other hand, her research explores emerging psychotherapeutic interventions in the private practices of Kampala, where the “(upper) middle classes” with their particular problems turn increasingly to psychological treatments.

Given that Vorhölter’s empirical focus lies on NGO and private practice experts and their professional discourses on psychotherapy in these two settings, it is understandable that her analysis foregrounds their imaginations of their target groups and sites, thus leading to often rather stereotypical representations of African culture or the middle classes as the sites and people they intend to serve. However, if these target groups and locations are understood less as a discursive trope and rather as empirical entities that need to be unpacked ethno graphically, categories such as urban, rural, or semiurban, and also the lower classes and (upper) middle classes, require more theorization. There is a dearth of research on the long-standing ambiguity of kinship relations in the context of rural-to-urban migration in the eastern and southern African regions (Geshiere and Gugler 1998:31), as well as on the pressures that young people experience in the context of various educational settings and in relation to their social positions in society (Dilger 2018:29–30). Equally, recent studies have explored the plurality of middle classes (rather than the one middle class) in various African settings and the ways that they engage in highly diverse dynamics of individual and collective social, economic, and cultural distinction (Scharrer, O’Kane, and Kroeker 2018). Against this background, it would be interesting to unpack more concretely the specific sociocultural circumstances under which some people (and parts of social milieus) in Uganda turn to psychotherapeutic treatments for their distress, while others do not.

Third, as psychological suffering is usually a highly emotional process (Kleinman and Good 1985), the article invites us to think further about the role and formation of different affective experiences and emotional registers in Uganda’s psychotherapeutic settings. It would be interesting to know about the different kinds of affective states that unhappiness implies for patients and their social networks in Kampala and how these are translated into specific emotional codes through a variety of psychotherapeutic approaches (and the specific affective relations and dependencies that diverse treatment constellations imply). While psychological suffering in northern Uganda is experienced as “emotional distress” (Akello, Reis, and Richters 2010), one wonders how trauma interventions in these socially deprived settings produce distinct affective states and emotional interpretations. Such dynamics may also challenge the researcher herself, whose role—in the face of suffering—may at times be similar to that of a psychotherapist (Akello 2007). Taken together, the article lays important groundwork.
for further comparative explorations of the entwinements between the formation (and diversification) of social positionings, affect, and psychological distress and treatment in globalizing and transnational contexts.

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Julia Vorhölter’s article makes a welcome and novel contribution to discussions of psychotherapy and the medicalization of mental problems in Uganda.

When colleagues and I started doing research capacity building projects with Gulu University in northern Uganda in 2008, the war had just ended and the sheer number of nongovernmental organizations (NGOs) doing work on psychological trauma seemed overwhelming. Initially, I found the situation resembled what Fassin and Rechtman later coined as “an empire of trauma” (2009) promoting a particular psy-dispositif about the self, and psychological and psycho-pharmaceutical therapy, as described by Vorhölter, in her fascinating article. Yet after more than a decade of doing research on issues related to the postconflict situation, including problems with spirits and trauma, I have come to question the value of the analytical framework of dispositifs and the metaphor of an empire of trauma. Listening to the seriousness and volume of problems related to the violent past that people are still deeply affected by, and for which they often do not find sufficient solutions, made me humble. If not irrelevant, the psy-discourse and empire analysis seemed superficial. Families and individuals who experience continuing problems with spirits and trauma seek help, not only from NGOs offering forms of psychotherapy and clinics giving psycho-pharmaceuticals but also from local diviners doing rituals and from religious institutions offering praying and spiritual support. Similar to the number of psy-professionals, the number of diviners also increased rapidly after the war, as did religious counseling. In short, after the war, various forms of therapy and counseling mushroomed and increased the awareness about how mental problems need attention after violence. Indeed, part of this awareness was promoted by a psy-dispositif headed by NGOs and medical institutions, but the main drive came from families and individuals seeking various forms of help—including from religious institutions and diviners that have long histories in the region.

As anthropologists, we may be quick to spot and term something as medicalization and the spread of Western concepts, such as psy, perhaps because these are forms we recognize. And perhaps also because many anthropologists do their fieldwork through institutions that work with, for example, biomedicine and psychology and interview professionals in offices rather than patients/clients/people in their homes and everyday contexts. The perspective from the office and the home is almost always quite different, and when we foreground the perspective of professionals we get their versions and attend to their dispositifs. Although I would have loved to learn more about the clients and their perspectives and problems in Vorhölter’s important study, I acknowledge there is only so much one anthropologist can do in a study, and Vorhölter made the decision to focus on professionals. Yet given this focus and perspective I am still surprised about Vorhölter’s analysis that psy-dispositifs have been emerging from two different centers in northern Uganda and Kampala since the early 2000s. In 2008 my first Co-Principal Investigator at Gulu University was Professor Emilio Ovuga, who at the time was the only trained psychiatrist to cover the vast region of northern Uganda. Psychiatry and psychology were heavily under-funded and understaffed disciplines, according to Ovuga, and although a few more psychiatrists and psychologists have been trained and work in northern Uganda now, the psy-disciplines are still relatively weak compared with other disciplines. Vorhölter acknowledges that “The refusal by the Ugandan state to promote psy and create more employment opportunities reveals an important difference in Rose’s (1999) analysis of psy as a state-supported modernizing and governing project in Europe” (cf. Vorhölter 2017:574). In northern Uganda, psychotherapy and counseling in various forms have been promoted more by NGOs than by the state, and the NGOs do not represent a permanent apparatus of institutions that consistently promote a psy-dispositif. Many of the NGOs that used to work in northern Uganda and focus on trauma have relocated to other areas and refocused their activities and issues; some of those remaining in the postwar areas have changed their activities according to other emerging—and not least fundable—needs beyond trauma healing, although the need, some would say, is still far from covered.

Vorhölter acknowledges that the struggle in northern Uganda is not about unhappiness; it is rather a struggle to regain everyday sociality (Meinert 2017) and a sense of social harmony (Porter 2017). According to Vorhölter, a new discourse on unhappiness is emerging in Kampala because happiness is becoming the norm and the availability of psychotherapy and medicine pushes this discourse. The way we understand happiness in the West today is tied to neoliberal capitalism, Vorhölter writes. This is probably closely related to a growing happiness industry, and thus I would be curious to know more about the role of commercials, films, and consumption in this emerging business of happiness. Aspects of neoliberal capitalism such as shopping, fashion, music, and communication technology seem to have grown much more rapidly and been adapted much more wholeheartedly in Uganda than the psy-business. Why so?

In Kampala, I am interested to hear about the specific “globalisation” of unhappiness therapy, that is, how a global discourse on happiness is appropriated and takes a local flavor in Kampala, and how psychotherapeutical concepts in both northern Uganda and Kampala are adopted and given form in a specific Ugandan context.
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A Cure for an Unhappy Self: A Response to Julia Vorhölter

“Well, actually, I don’t talk about it with my family much, as lovely as they are, because they don’t really understand depression. They expect a reason, but I don’t have a reason.” The words are Nigerian writer Chimamanda Ngozi’s, told to Lisa MacFarquhar of The New Yorker.16 Her family, she suggests, has a different understanding from hers about this unreasonable feeling of sinking, about which she does not talk to them but mentions to MacFarquhar. She watches hours of films about the Holocaust when depressed. MacFarquhar writes that she “isn’t trying to cure herself — to turn depression into happiness.”

I read the profile on Ngozi at the same time as I was making sense of Julia Vorhölter’s article. Vorhölter contends that psy-dispositifs—discourses and interventions connected to psychology, psychiatry, and psychotherapy—have recently arrived in Uganda. Based on her study on the meanings of (un)happiness and suffering in Gulu and Kampala, she argues that psy has reconstituted, in its medicalizing and psychologizing wake, the notion of suffering into the discourse of psychosocial suffering and unhappiness. She wants to understand who seeks psychotherapy for suffering and unhappiness and why.

The major argument in the article is that new struggles concerning (un)happiness are observable, particularly among Ugandan upper middle classes in Kampala, and that unhappiness and psychosocial suffering are becoming reasons for seeking psychotherapy. At the same time, she asserts, the discourse of an (un)happy self is more evident among the urbanized upper middle classes in Kampala, who can afford private psychotherapy rates, and less so among those of lower class backgrounds in the semiurban and rural setting of Gulu. She states that in her investigation she found that “depression was seemingly becoming a common idiom for expressing feelings of unhappiness and distress.” It’s a suspicious view she seems to hold about depression as an emergent way of speaking about human suffering and unhappiness. Along with the reservation about the language of depression, her article is mainly skeptical of the medicalized norm of happiness.

Reading Vorhölter’s skepticism and Ngozi’s depression side by side, I wondered, not for the first time, when is it appropriate for a person in Uganda, Nigeria, or another African country to speak in public or to her family about her own depression? When is the discourse of depression most reasonable—meaning when is it best placed—to articulate forms about lack of emotional and mental well-being (or suffering), observable in some parts of the world, conscious that such suffering rarely if ever is simply internal or interpersonal but is at one and the same moment imbricated with the structural and symbolic of living? Although the idiom of depression may have arrived in Uganda (or in Nigeria or another African country) with the Western-centric psy-discourses and technologies of self, how sure can one be to claim with certainty that something to which the language responds, and which exhibits signs of unbearable sadness that endure over a period of weeks, had not existed among Africans? Of course, we do appreciate that discourse, which, as Michel Foucault showed, produces the very thing about which it speaks. Nevertheless, inadequate attention is paid to this knotty problematic thing and the forms of its expression and remedy. This is one of a clutch of issues, blind spots, inadequacies, or limitations that I have with the article. Before I outline four more of these, there are two critical interventions Vorhölter makes that I do support.

First of all, there is of course no medical cure to an unhappy self—surely not a permanent one, not a historically and culturally universal one, and not one that accounts for addressing all types of unhappiness (like gender-based violence). Medicalized psychotherapeutic interventions can never on their own turn all suffering—and certainly not abductions, rapes, brutal killings, displacement, or destitution, such as that caused by the war between the Lord Resistance Army and Ugandan state in northern Uganda—into happiness.

Second, notions of psychological normalcy and psychopathology in psychotherapy, or well-being and its absence implicit in psychology, like the very psy-disciplines themselves, are soaked with culture. Criticisms regarding the cultural inappropriateness of prevalent imported forms of psychotherapy that Vorhölter observed in all of her interviews are not unfounded and cannot be overemphasized.

Regarding problems, the first weakness of Vorhölter’s is that while the article notes the distinctions between different types of happiness—hedonic versus eudaimonic—her own understanding of happiness is unclear. The most we are made to understand is that happiness is the absence of suffering, the “other” of unhappiness. But she does also state that “while experiences of suffering or happiness are always, to some extent, individual and subjective, they are shaped by contexts and authoritative voices.” That said, it ought to be noted in much of the literature on happiness that the concept is used interchangeably with concepts such as life satisfaction, quality of life, subjective well-being, and flourishing. If, then, happiness is implicitly understood as well-being by the psy-professionals she interviewed, does that change our misgivings against the happiness discourse, even while we must continually question its medicalization?

Second, Vorhölter maintains that the desire for happiness and relief of suffering is class and context bound. The need to

be happy, it is said, is a historically contingent Western fixation of late tied to a neoliberal capitalist regime. Positing that a phenomenon is class and context bound is not uncommon in critical and constructionist inspired social science and is often enough accurate. But here, as elsewhere, there is no scrupulous evidence to support such a position. The argument against the West and neoliberalism is also too casual. It is best to show, not simply tell. Among several possible meanings, I take happiness to mean to feel psychically—in the soul—good. In this regard, there is no meticulous body of African-centered research to support the conclusion that Africans have no original desire to feel psychologically good.

Third, Vorhölter betrays a certain depressing view of her subjects when she conflates her sites of inquiry, two unrepresentative sites in Uganda, with all of Uganda itself, and worse, with Africa as whole: “To date, this phenomenon of private psychotherapy in Africa has not been much studied, certainly not in Uganda, although I believe it represents a larger trend across the continent.” This is simply wrong. Historical record shows that psy-disciplines can be traced to the first half of the twentieth century in certain parts of Africa, such as South Africa, when in 1917 psychology as an independent discipline from philosophy was formally inaugurated by the establishment of a department at the University of Stellenbosch. False too is the claim that private psychotherapy in Africa has not been much studied. It would serve the author better if she were to be more circumspect in how she formulates these points.

Finally, it may be costly to a culture and individuals to buy into the markets of (un)happiness about the idea of unhappiness as pathological. Yet any proposition that happiness or relief from suffering is not something people in Uganda, Nigeria, or other parts of Africa have not always expected from life is ludicrous and potentially harmful. Nothing is natural about the suffering of Ugandans. This does mean ignoring the fact that the discourse of (un)happiness has increasingly been colonized by psy experts, not forgetting the economists. But we might want to begin by trying to understand what, for instance, is a Nigerian woman who watches hours of Holocaust films trying to find? She is trying to understand herself, I think. The films convey a discourse, a perspective, a way of making sense. Often, that is all we need: more languages to make sense of our interiors, our suffering, and our desire for a satisfying life.

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Circulation, Appropriation, and Enacting

I have long wondered why there has not been more attention devoted to the emergence and uptake of globally circulating psychotherapeutic discourses in African societies. Julia Vorhölter’s article on the emergence of a psy-dispositif in Uganda tackles exactly the spread of these discourses through two case studies. In her discussion about emergence, she gives us not only a grounded empirical discussion but also contributes to discussions about globalization as cultural mélange (Nederveen-Pieterse 2015). She reminds us of the need to be attentive to the ways the global circulation of ideas, goods, and people blend in various ways. Vorhölter gives us two insightful but contrasting cases of the way psychotherapy is taken up in postwar northern Uganda and in the capital Kampala. In their difference, they help us to distinguish between and specify the role of local historical trajectories and different forms of hegemony (neoliberalism, biomedical discourse, etc.) and hence the different ways circulating matters are appropriated. The article hinges on two circulating matters. First, psy-dispositif enters Uganda in very distinct ways. In northern Uganda an international assemblage of aid in the form of trauma interventions has taken root, while in Kampala a small number professional psychotherapists are setting up practice. Second, the circulation of the idea of happiness dovetails with both developments but points to a distinct cultural formation mainly in urban areas. The pursuit of happiness seems to be less of a question for people in the North, whose situations Vorhölter describes as a syndemic form of suffering, while for the (upper) middle classes in Kampala, it seems to be an important goal in life. Both cases merit more in-depth investigation, as they open up new avenues for the study of the globalization of mental health discourses and their vehicles. Globalization needs to be unpacked in distinct junctures: circulation is not an even process; therefore, appropriation follows in different ways depending on needs or desires, and hence the enactment of a (psycho)therapeutic discourse occurs in various ways.

As Vorhölter’s cases show, the circulation of global mental health discourses follows different routes. Whereas in Uganda (psycho)therapy entered the country in two distinct ways, in a study on the emergence of the diagnoses of attention deficit hyperactivity disorder (ADHD) in Ghana, we found another introduction of the globalizing mental health care discourse (Bröer, Kraak, and Spronk 2017). In 2013, the World Health Organization (WHO) set up a Mental Health Gap Action Programme, as part of the global Mental Health Action Plan 2013–2020 that seeks to improve access in low-income countries by scaling up mental health services and treatment, promoting human rights, ending social exclusion, and developing mental health laws. Ghana was selected as one of the beneficiaries. Although it was also an international intervention similar to the one in northern Uganda, the scale of the program is a far cry from the intervention Vorhölter describes. In Ghana, the intervention focuses on transference of knowledge for setting up an infrastructure for a national mental health program. At the same moment the WHO program was introduced, seemingly unrelated, individual (psycho)therapists and psychiatrists responded to the need among mainly the middle classes for new forms of therapy with regard to ADHD but also marital conflict, sexual questions, and depression. So in both Ghana...
and Uganda, global mental health care practices emerge via different routes and in response to a variety of needs.

The appropriation of global mental health care practices also happens in diverse ways. Indeed, a portion of the populations in the global South—those that might be described as middle class (Donner 2017)—face challenges pertaining to their urban and cosmopolitan lifestyles. They embody societal transformations, and their lives testify to these societal reconfigurations of gender, domesticity, and kinship. The shifts in the social fabric create new situations and experiences and generate its particular ambiguities, tensions, and anxieties. How, exactly, the cultivation of middle-class personhood relates to older ways of worldmaking while creating new forms of experience is a question that needs more investigation. For instance, whereas in Uganda an elaborate infrastructure of voluntary counseling and testing (VCT), as a response to the HIV/AIDS epidemic, may have paved the way for other forms of (psycho)therapy, in Ghana this is absolutely not the case. Yet in Ghana I have also come across people who opted for psychotherapy rather than the counseling provided by their churches. Another interesting case in Kenya, for example, is the Amani Counselling Centre and Training Institute founded in 1979. For decades, it published a weekly column in which a therapist addressed problems posed by letter writers from all over the country (Spronk 2009). As such, the merits of mental care and seeking help were widely known throughout the country even before counseling became widely accessible through VCT. Moreover, the self-help and wellness discourses that Vorhölter describes occur across the continent and have occurred for many years, (see Mutongi 2007; Newell 2008, for instance), and what may look deceptively uniform is likely to differ in the appropriation and enactment. These examples point to the variety of trajectories that new practices meet new needs in the process of globalization.

How people enact globalization (psycho)therapeutic discourses remains less researched. Vorhölter closely follows the reasons her interlocutors provide for the stress they experience: the high demands in the lives of pupils who must not fail, university students who must consolidate their higher education, and couples who must validate and further bolster their middle-class lifestyles. Yet people have always experienced stress, so what makes them turn to (psycho)therapy at this particular moment? The local trajectories of existing mental health practices (such as prayer meetings, possession rituals, weekly columns), the circulation of a psychotherapeutic discourse, and a careful analysis of peoples all need to be studied further. What people refer to as desirable and how and when they turn to (psycho)therapy remains an empirical question, as practices of care continue to shift with the reconfigurations of the social fabric. The newness of therapy must not be overstated, and its practices must be related to existing and ongoing practices and ideas of care—in other words, happiness and suffering must be understood and acted upon across time and within groups. The practice of mental health has never been equally distributed, as what is considered a mental question has always shifted over time. In pointing this out, Vorhölter brings an important question to our attention.

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For those of us who research mental health and illness in the global South, many of the ethnographic details of Vorhölter’s analysis of an emerging psy-dispositif in Uganda will likely ring familiar: the inextricability of mental illness from poverty and violence in rural areas, the growing cottage industries of self-help and psychotherapy in urban ones, and the influx of well-meaning foreign and foreign-trained mental health professionals. In this respect, the article mirrors many of the prevailing trends in the anthropology of mental health and illness in recent years. However, the theoretical insights Vorhölter draws from the ethnographic material gives not only medical anthropologists but also cultural anthropologists in general a great deal to contemplate.

Much of the foundational work in the cross-cultural study of mental health and illness examined the political-economic basis and embodied experience of social suffering and psychiatric distress and deconstructed professional diagnostic categories to highlight the cultural conflicts between biomedical psychiatry and what anthropologists termed ethnopsychiatry. Central to this work were critiques of the cultural incompatibility of biomedical psychiatry as it is practiced in and often imposed onto non-Western contexts and, consequently, calls for more culturally competent forms of mental health care. Although certainly aware of the problematic hegemony of the Western psy-disciplines, Vorhölter, however, withholds judgment about the psy-discipline’s ultimate benefits and drawbacks for individuals and seems open to the possibility that some of them may benefit from psychotherapy. Indeed, talk therapy’s lack of cultural concordance may be largely what bestows therapeutic value, as it offers people different vantage points of their own circumstances that their backgrounds obstruct. However, the therapeutic project in Uganda is no easy feat: patients must tap into an upwardly mobile structure of feeling in order to transform themselves into people who believe they can and should be happy.

The shift from suffering to unhappiness that Vorhölter outlines is critical because it asks what constitutes mental health instead of focusing on the lack thereof. Positing unhappiness as a form of illness has ironically normalized the expectation of happiness. This process, however, has unfolded in very different ways throughout Uganda. While the possibility of happiness for Kampala’s rising middle class compels many to ruminate on the gap between what they have and what they want, the poor in northern Uganda are portrayed by experts in the psy-disciplines as condemned to suffer. The normalization
of happiness frames mental health as a basic human right. This has the potential to restore wellness and dignity for the country’s elite, but it dehumanizes those targets of humanitarian aid who suffer without hope of an emotionally normal life.

The global monoculture of happiness has long-standing associations with the neoliberal construction of an inwardly focused and politically anodyne self (Kirmayer 2002). However, the therapy culture that Furedi (2004) and Illouz (2008) theorized has evolved in recent years. For example, psychotherapy has become a rallying cry for mental health as a civil right in the United States. (Just think of the ways that the student activists at Marjory Stoneman Douglas High School advocated for mental health care during their 2018 protests against gun violence.) Moreover, it is clear that the project of happiness has important political implications in Uganda as well, and how the psy-dispositif that Vorhölter describes might be taken up by laypersons would be a welcome next step in this research. How does the internalization of the therapeutic self rework existing notions of affect, morality, and madness? Does the psy-dispositif also prompt the development of an accompanying psy-sociality that encourages new ways of interpreting and managing suffering with others (Duncan 2017b)? Furthermore, the way that the psy-dispositif is deployed in the two field sites seems worlds apart, but I would be interested to learn what connects them in a national context.

If cultural anthropology is no longer bound by the suffering slot (Robbins 2013), then how does the study of psychic distress remain relevant to the discipline? As the boundaries between mental health and mental illness become increasingly difficult to determine, the specter of mental disorders has moved from the margins to the center. This maddening trend is aided not only by biomedical psychiatry but also by the neoliberal construction of a middle- and upper-class identity marked by so much utter destitution, poverty, and misery that the introduction of a psy-therapy that appears to be geared toward producing uplifting rhetorics in counseling sessions becomes immediately disqualified by the local population as being irrelevant. In the context of Kampala, in contrast, a small and elite section of the population appears increasingly fascinated by a psy-practice that aims to promote particular forms of lifestyling, such that states of unhappiness become addressed, diminished, and serviced by psy-speech aimed at fostering happiness. Here, psychology is rendered in the service of the reproduction of particular class positions by the help of a North Atlantic frame of reference concerning mindsets and lifestyling notions.

In this sense, the article creates binaries of worlds apart; the rural versus the urban, the poor and destitute versus the rich and affluent, the place of suffering versus the bubble of enjoyment, the place of disconnection versus the place of North Atlantic engagements. Why is it that this type of psychology seems involved in this production of worlds apart? Of worlds that do not seem to have anything in common and that nowhere engage each other meaningfully? In fact, the psy-therapy as described by Vorhölter appears to resist a level of reflexivity vis-à-vis fundamental questions of inclusiveness and Africanization of psychological epistemologies and its practices.

While the article emphasizes that unhappiness is increasingly seen as a deviation of the norm (an unhealthy state) on the basis of North Atlantic paradigms and as a reason to seek psychotherapy for the elites in Kampala (hence the medicalization of unhappiness), in northern Uganda the absence of (individual) happiness is not necessarily seen as abnormal or as a reason to visit a psychotherapist. While psy-practices in the northern region of Uganda claim to be aimed at reducing suffering, the local population appears hardly interested in pursuing therapy in this regard, as it does not in any way solve more pregnant issues. Hence—as if ships passing in the mist—Vorhölter frames the “absence of happiness” as abnormal in Kampala versus ordinary unhappiness in northern Uganda.

While there is a danger in using these types of dichotomies, there are other reasons why there are more local, emic notions of the irrelevance of a psy-dispositif based on happiness-as-norm, especially in the northern region. While Vorhölter emphasizes the existence of “a system of diagnostics that explains suffering in medical or psychological terms rather than religious, spiritual or other, and attributes the cause of suffering to the individual rather than to some broader collective phenomenon or outside force,” the documentation of illness narratives from different (including nonbiomedical) healers, help-seekers, their families, and significant others could have created more insight into the different meanings given to (un)happiness,

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Worlds Apart? Exploring the Problematic Irrelevance of a Psy-Therapy Promoting Happiness-as-Norm in an African Context

In her article, Julia Vorhölter seeks to establish an understanding of the emergence of a psy-dispositif in two settings in Uganda; one that relates to the introduction of psy-therapy in the northern region of the country, and one that studies new forms of psy-therapy in what can be described as a cosmopolitan, elite bubble in the capital, Kampala. In both contexts, she concludes that in neither case can the emergence of psy-therapy be considered highly relevant to major sections of the population. She demonstrates that in the northern region the actual circumstances of major sections of the population are marked by so much utter destitution, poverty, and misery that the introduction of a psy-therapy that appears to be geared toward producing uplifting rhetorics in counseling sessions becomes immediately disqualified by the local population as being irrelevant. In the context of Kampala, in contrast, a small and elite section of the population appears increasingly fascinated by a psy-practice that aims to promote particular forms of lifestyling, such that states of unhappiness become addressed, diminished, and serviced by psy-speech aimed at fostering happiness. Here, psychology is rendered in the service of the reproduction of particular class positions by the help of a North Atlantic frame of reference concerning mindsets and lifestyling notions.

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While there is a danger in using these types of dichotomies, there are other reasons why there are more local, emic notions of the irrelevance of a psy-dispositif based on happiness-as-norm, especially in the northern region. While Vorhölter emphasizes the existence of “a system of diagnostics that explains suffering in medical or psychological terms rather than religious, spiritual or other, and attributes the cause of suffering to the individual rather than to some broader collective phenomenon or outside force,” the documentation of illness narratives from different (including nonbiomedical) healers, help-seekers, their families, and significant others could have created more insight into the different meanings given to (un)happiness,
(mental) health and suffering. In northern Uganda, for example, ajwaki (spiritual mediums), ancestral spirits, and cen (vengeful spirits) certainly play a role in the meanings of and dealings with suffering/poor health/disaster/unhappiness. One should not forget that many Ugandans have greater access to traditional health care than to psy-therapy. Nonbiomedical healers are also appreciated as sources of knowledge on health and of interpersonal problems that are causing distress. The markets of well-being go beyond the biomedical domain and are not necessarily as pro bono /noncommercial as Vorhölter argues. Hence, there is again the question of the irrelevance of psy-therapy if the discipline and the practitioners remain fully North Atlantic oriented, fail to become more inclusive vis-à-vis the recognition of these locally based (healing) traditions, resist a decolonization of its episteme, and thereby reify the overarching notion of a psychology placed in maintaining a worlds-apart type of perspective.

The author could have problematized this local perception of the irrelevance and of the noninclusiveness of this particular form of psy-therapy along these lines; there is a politics of knowledge at stake in both contexts that the author has not identified or questioned. Offering an analysis of how the therapy is framed by psy-professionals, more attention could have been given to why and how different actors in the different settings construct a story on the meaning of ps. It appears that the article privileges how the psy-professionals perceive how their clients “talk about and frame the absences and presences of happiness or suffering.” This is, however, again creating a sense of a world apart in view of the questions Vorhölter raises in the introduction on the meanings of (un)happiness and suffering, and the kinds of strategies and therapies that people from different (class, age, gender) backgrounds seek. These questions imply a broader discussion of these strategies and the relative significance of psy-therapy as compared with other means of intervention and social engineering of people’s personal realities.

There are interesting topics in this regard: Do psy-therapists construct ideas on help-seeking behavior and therapy expectations that may indeed coincide with ideas of clients? Do clients think about concepts of (un)happiness and suffering as motivating a quest for therapy (and, if so, in what way)? How do expectations and needs of help-seekers overlap with the narratives that psy-professionals have about them? And what role do other actors play in determining what is considered to be ’appropriate care’?

All in all, the article would have provided a good opportunity to pay attention to debates on the understanding of psy as a Western construct and to question the cross-cultural applicability of mental health relevance of psy-therapy from the level of an emic understanding and contestation of this. As an anthropologist, the author could have provided an analysis of the critical power issues involved if elites embrace psychology as a noninclusive form of enhancing their class positions, while the destitute and marginalized contest psychology on the basis of its irrelevance when the absence of happiness is medicalized.

Problematizing the noninclusive workings of Western concepts of practices of psy-therapy would have been highly welcomed.

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Julia Vorhölter’s article makes a useful contribution to an emerging literature on the increasing deployment of a range of psychotherapeutic techniques (or the psy sciences, as Rose calls them) in parts of contemporary Africa. She frames her study in terms of the changing meanings of happiness and suffering in two very different Ugandan contexts: postconflict northern Uganda and middle-class Kampala. Her conclusion is that a medicalization of unhappiness is underway, evidenced by the increasing use of the idiom of depression. Vorhölter begins her discussion of the globalization of psy with a rather sweeping generalization about the nature of suffering. In the West, she argues, this is focused on the individual; in “other parts of the world,” she contends, it is seen as a social and intersubjective experience. Although many of us would recognize an element of truth in this statement, we might want to question whether this bald and ahistorical categorization is a useful starting point. As Vorhölter herself shows, it does not hold up well for one country. Although much social anthropological work on sub-Saharan Africa has, indeed, stressed the social and intersubjective expression of suffering and ill health, there is also an extensive literature on the concept of the self in African societies. The same can of course be said of many other parts of the world not usually categorized as Western.

Vorhölter usefully uncovers the rather different genealogies of the psy-dispositif as it emerged in northern Uganda and Kampala. Clearly the appeal of these techniques (which are not closely described) is somewhat different in these two locations, as a result of both the specific professional agents at work and the local histories of the communities. She dates the emergence of psychotherapy in Uganda to the early 2000s, although she acknowledges that there were forerunners, including the counseling practices that accompanied the HIV/AIDS epidemic from the late 1980s. She distinguishes four regimes of expertise in Uganda that deal with psychosocial suffering: traditional healing, faith-based healing, psychiatry, and psychology, the latter being the focus of her study. My own reading of the development of psy practices in eastern Africa would push this chronology backward and also emphasize the interpenetration of faith-based healing and its psy-science counterparts. The long history of Christianity in this region has had a profound influence on both conceptions of the self and conceptions of suffering. Christian counseling goes back many decades. Many African professionals practice a psychotherapy that consciously combines secular theories imported from the West.
with powerful religious beliefs. Some also consciously "Africanize" their practice, incorporating what they feel to be useful and appropriate aspects of traditional local culture. This is not to deny the newness and the appeal of novelty of some aspects of psychotherapy, but to assume that psychology is necessarily distinct from spiritual healing seems to me to be a misreading.

Finally, Vorhölter argues that unhappiness is being medicalized in Uganda in the form of depression. It is hard to know whether medicalization is the best term for the processes she is describing without a better sense of the ways that the concept of depression is being translated and mobilized by therapists and clients and the ways that it is incorporated into preexisting categories and discourses. It is surely correct to take a critical perspective, as Vorhölter does, on what is sometimes seen as the expanding "empire of depression" and the promotion of an industry of unhappiness, particularly in its pharmaceutical manifestation. However, in eastern Africa there is a colonial history lurking here that must be brought into consideration. A powerful colonial psychological discourse held that Africans were childlike in their psychology, that their individualization was incomplete, and that their spiritual beliefs were paramount. It followed that they were unable to take individual responsibility for their actions and were highly prone to projection and therefore rarely experienced guilt. This surprisingly long-lived theory was employed to account for the allegedly low levels of depressive illness and suicide on the continent, as well as for myriad other things, including anticolonial political activism. Although, as Vorhölter points out, psychiatry professionals may not always see eye to eye with those promoting psychotherapy techniques in Africa (particularly given the chronic underfunding of state-run mental health services), and many psychiatrists practicing in the region would want to argue that the incidence of what they see as severe depressive conditions has been routinely underestimated—partly as a result of the legacy of colonial thinking—and that there is an urgent need to address them.

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Treating Psychosocial Insecurity in Uganda

Julia Vorhölter adroitly illuminates a development in Africa that seems fairly widespread but has not yet attracted much scholarly attention: the growing use of psychotherapy in the form of counseling. She sets humanitarian therapy for the stresses of modern middle-class life in Kampala. This brings out contrasts between rural and urban and between deprivation and prosperity. She sees the growth of "psy" therapies as part of the development of a whole apparatus or dispositif. Importantly, this urges us to a historical perspective on different positions in a political economy and diverse international articulations.

Vorhölter invites us to consider the ways that conceptualizations of mental well-being and distress relate to the means of dealing with them and to changing life conditions. In the Foucauldian tradition, she relates professional therapeutic practice to knowledge and assumptions about subjectivity. Invoking Nikolas Rose for her discussion on struggles to be happy in Kampala, and Fassin and Rechtman for trauma treatment in postconflict northern Uganda, Vorhölter shows how each version of psy therapy interpellates subjects. There is a kind of tel- eology at play, where the solution shapes and attracts the problem, although Vorhölter is careful to show that therapies do not always work as solutions and that even professionals sometimes doubt their adequacy for their clients' real problems and dissatisfactions.

Vorhölter’s work uses newer approaches to address contemporary phenomena, yet it belongs with a long-standing concern of scholars working in Africa. To take just one example, Field’s Search for Security (1960) linked the growth of new shrines in rural Ghana to the growing psychosocial insecurity consequent on the expansion of cocoa production. She cites a new (in the 1950s) proverb, “Cocoa has not shown us the good man,” to emphasize the envy, strife, and unease that brought people to the new shrines. The shrine priests supported conceptions of witchcraft that included women’s convictions that they themselves were witches, a self-understanding that Field analyzed as depression. Like the psy therapists of Kampala, the Ashanti priests drew clients troubled by the stresses of modern life; both kinds of healers shaped and strengthened a particular subjectivity. But the Ugandan psychologists provide therapy appropriated from Euro-America and modified to local conditions, while the Ashanti priests seem to have reworked older indigenous traditions.

The rapid expansion of counseling in Uganda can be traced to the AIDS response, as Vorhölter notes. In fact, one might add HIV counseling to the genealogy of psy therapy in the country. The Kampala psychologists in private practice were at pains to distance themselves from the didactic approach of HIV counselors. But when the AIDS Support Organization introduced counseling in the 1980s, it was presented as client centered, which was a revolutionary concept at the time. The ideal of dialogue is fundamental (Whyte et al. 2018), although it is difficult to realize as more and more people are tested and treated within a clearly asymmetrical patron-client relationship. Vorhölter writes that there is no market for psy where therapy is pro bono, as in northern Uganda, and as it is in HIV care. But there was certainly a kind of futures market for training in counseling in the first two decades of the epidemic. Health workers and others were extremely keen to obtain credentials, which were deemed necessary for getting a better job with donor-funded HIV programs. During this time, the number of counseling courses expanded enormously. In many ways, the response to the AIDS epidemic laid the foundation for the dispositif she is examining. It is comparable to the humanitar-
ian use of psychotherapy in northern Uganda but more far-reaching and more integrated into health care in the entire country.

It is difficult to write about these matters without trying to work out a set of distinctions, or at least to set terms in relationship within a semantic field. Vorhölter implies that unhappiness and suffering differ, suffering being the stronger term—more appropriate to the conditions of people in northern Uganda dealing with war, internment, poverty, HIV, alcoholism, and gender conflicts. The absence of happiness (however that is understood) implies discomfort, unease, and dissatisfaction but not necessarily affliction in the sense of disastrous misfortune. Yet, as she shows, once terms are popularized, they bleed into one another. Thus, unhappiness may be called depression, even though it does not meet the criteria of the Hopkins Symptom Checklist. And posttraumatic stress disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders becomes trauma in vernacular speech, a term that can describe desolation owing to many kinds of distressing experience and that overlaps with depression.

The difficulty in maintaining distinctions is evident in two other aspects of the field Vorhölter is cultivating. One is the contrast between medicinal treatment for mental problems and talk therapy. The emergence of depression as a popular figure of illness worldwide is often linked to the spread of anti-depressants and the “pharmaceutical imaginary” that shapes the self (Jenkins 2009:6). Ecks (2014), for example, has shown how Indian pharmaceutical companies target medical practitioners and the public to raise awareness about depression. Vorhölter wants to focus on psychotherapy rather than medicine, but as she herself writes, psychopharmaceuticals are appreciated and easily available. Treatment is not either/or. With the exception of VIVO, most of the trauma programs in northern Uganda combine psychotherapy and medication. The emergence of the psychotherapeutic ethos is pushed by both psychology and pharmaceuticals.

The other distinction that must be problematized is that between individual and social causes and treatments of distress. Vorhölter writes that a precondition for the emergence of the psy ethos is “a system of diagnostics that . . . attributes the cause of suffering to the individual rather than to some broader collective phenomenon or outside force.” Yet in both northern Uganda and Kampala, conditions of life are seen as sources of suffering and unhappiness. Psychotherapy aims to better equip individuals to deal with collective phenomena, but there is certainly recognition that social circumstances need to be changed as well.

Reply

I thank all the commentators for their critical and in many ways stimulating thoughts and feedback, not all of which I can adequately respond to here. The article comes out of an ongoing research project and therefore many of the comments are inspiring and helpful, not just because they point out the strengths and limitations of this particular article but because they help me to think in new ways about the project as a whole and suggest lines of inquiry for future study.

Grace Akello’s comment raises an important point: namely, that international mental health policies and interventions are often too generalized, developed by policy makers who do not have sufficient knowledge of specific countries or regions, and thus appear, as Akello puts it, “context-free [and] dissociated from local social, political and economic circumstances in developing countries.” This is particularly true for interventions in sub-Saharan Africa, one of the reasons being, I suspect, that Africa—in policy-oriented research but also in academic studies—is still commonly portrayed as a place that lacks modern biomedical, psychiatric, and psychological services and knowledge (often referred to as the treatment gap) and instead relies on so-called traditional healing (cf. Cooper 2016b, 2016a).

While such observations may not be completely false, they fail to capture the diversity and growing disparities in (mental) health care between and within African countries and societies—which are increasingly class based (although class often intersects with other social categories like region, ethnicity, gender, or religion)—and they produce distinct class-based health subjectivities (cf. Vorhölter 2017). As Cooper (2016b) has pointed out, there are two dominant types of studies on mental health in Africa. First, there are those that see the existing mental health care landscape as deficient, backward, and inhumane and advocate for large-scale external intervention to provide new forms of therapy and treatment based on a biomedical or psychological paradigm—this type is common in a lot of the recent global mental health literature. Second, there are those that condemn psychological and biomedical interventions and celebrate and romanticize traditional healing as a sufficient and equally valid alternative. The question Cooper asks is whether we can “find other ways of understanding help-seeking for mental distress in Africa based on alternative kinds of systems of classification . . . [and whether this] could transform the ways in which we understand how people seek support for mental illness in Africa?” (708).

Like Akello and Cooper, I aspire in my work to confront oversimplifications of mental health care in Africa—which is admittedly easier said than done. By focusing on class, socioeconomic, and political conditions, I want to draw attention to the vastly different circumstances that people live in and that affect mental health and mental health care requirements within one country, as well as to the similarities in help-seeking behavior among people of a particular class strata across the globe who are struggling with the competitive, high-paced, and individualized lifestyle that seems to have become so normal for many under neoliberal capitalism. Making nuanced arguments about how one particular form of therapy, in my case psychotherapy, may be welcomed and seen as very suitable in one context (i.e., for upper-middle-class Kampalans struggling...
with lifestyle-related stresses) and may be less or differently relevant in others (i.e., northern Uganda, where people targeted by psychosocial interventions face structural violence for which therapy does not offer an easy solution) may be one step toward overcoming generalizations about mental health in Africa—generalizations that often reiterate simplistic and culturalist dichotomies between Africa and the West.

This point also speaks to Aaron Denham’s comment. While I certainly agree that the article would have hugely benefited from more data and information on local notions and conceptualizations of the self, of emotions generally, and of happiness in particular, I do not think that the only role of psychological anthropology is to focus on ethnotheories or ethnopsychologies. In fact, I find those terms to be problematic because they suggest stasis and homogeneity and are therefore less useful in capturing the dynamics and growing individualization of experiences and the multiple local, national, and global influences that shape people’s beliefs. Psychological anthropology’s main focus has long been—and still is—on ethnopsychologies and, for lack of a better term, traditional healing. Much of this work is extremely valuable; however, it tends to privilege the cultural and concentrates mainly on cultural incompatibilities between different healing systems (as Allen Tran notes in his comment) and thus, perhaps unintentionally, reiterates images of Africa as essentially different. In my opinion, this kind of psy anthropology would hugely benefit from a complementary anthropology of psy, which is comparative, which can capture broader trends and dynamics at the meso and macro levels, and which focuses on socioeconomic disparities within, and similarities between, societies rather than primarily on cultural differences.

In this spirit then, the main aim of the article was to provide an overview and comparison of recent developments in the field of mental health in Uganda that have not yet been systematically assessed. As Denham suggests, the article can be seen as a starting point for researching psy and the ways it is emerging in manifold forms rather than an in-depth study of a single case, place, or institution. The point of the article is precisely to show that psy is becoming appropriated in very different—ethnic, linguistic, socioeconomic—contexts and that one of the big struggles psychotherapists face is to adapt their knowledge, approaches, and practices, which largely derive from Western textbooks, to vastly different types of clients. Whereas in northern Uganda, the majority of clients did have a common linguistic, cultural, and ethnic background (they identified as Acholi and sessions were usually held in Acholi language, sometimes with the help of a translator), and one could possibly identify something like a local Acholi ethnopsycho-psychology (based on, for instance, beliefs in vengeful spirits, con, and spirit mediums like ajwaki—although these beliefs were widely contested and clashed with other local belief systems, especially those promoted by the churches), this would be much harder to do for the clients seeking psychotherapy in Kampala. Sessions in Kampalan private practices were usually held in English, which is the official national language in Uganda. However, most Kampala-based therapists, if necessary and possible, occasionally also counseled people in vernacular languages. They described to me how much this prolonged and complicated the therapy process due to the difficulty of finding adequate translations for psychological concepts or terms for emotions. However, they also stated that the therapy could still be and often was successful. In summary, challenges of translation—not only in Kampala but also in northern Uganda—differed depending on a client’s level of education, international exposure, language capacities, religious convictions, gender, age, and many other factors and were not simply reducible to culture or ethnicity.

In this regard, then, I agree with Denham and with Rachel Sprock and Hansjörg Dilger, who all stress the need for more refined and ethnographically robust analyses of how psy concepts and practices circulate and become appropriated and enacted in different localities and by different actors, and how what they signify may shift. For this purpose, the distinctions I use in the article (between urban and rural, rich and poor, West and non-West, etc.) are certainly too generalizing. While such dichotomies are commonly evoked in Ugandan discourses and are, as such, indeed meaningful (cf. Vorhölter 2012), I agree that they need to be further theorized and that one needs to carefully unpack the complex intersections and dynamics between factors such as class, gender, age, level of education, place of living, religion, and ethnicity that shape engagements with, and contestations of, psy and health subjectivities more broadly.

Likewise, the history and global travel of psy “could be written in geographically and temporally less linear ways”—as Dilger, Vaughan, Whyte, and other commentators suggest. There are indeed several psy-genealogies and various historical and contemporary influences—colonial psychiatry, the Mental Health Gap Action Programme by the World Health Organization, HIV/AIDS counseling, Christianity—that I do not mention or only mention in passing in the article and that are relevant to understanding recent developments of psychotherapy in Uganda and elsewhere. Nevertheless, I do think that there is something new about psy’s current expansion that is worth paying attention to and further reflecting on. One relevant feature, I think, is the shifting focus from mental illness and pathology to mental health and normality. In its emerging form, psy no longer targets just the sick and “crazy” but everyone. One could think of it as a worldview or a language that, as Denham suggests, offers a broader framework for interpreting not only the self but life more generally. Psy responds to shifts in the social fabric, to new tensions and anxieties, and it introduces new ways of sense-making and new emotional repertoires and moralities. Further researching these affective dimensions and dynamics—as called for by Dilger, Sprock, and Tran—is certainly an important field for future research. Nevertheless, it is important not to overstate the role and

17. For complex political reasons, none of the more than 40 indigenous languages has the status of official language.
current importance of psy in Uganda. At this point, psy, as one of my interlocutors aptly put it, "is still a baby in Uganda and it needs nurturing." I am sure, however, that it will continue to grow in the years to come.

I am grateful for Lotte Meinert’s and Megan Vaughan’s comments, and, although less charitable, also for Kopano Ratele’s, as they give me the chance to clarify and elaborate aspects of the article that might be misunderstood. I think it is very important to take seriously the very real, painful, and disturbing experiences of suffering and the desperation that leads people, both in northern Uganda and Kampala, to seek psychosocial support and that seem to get lost in all-too-detached and critical analyses of dispositifs, medicalization, and the like. Listening to some of the stories therapists recounted about clients, but sometimes also their own life experiences, that motivated them to become therapists (personal struggles with depression or addiction, family members’ mental health problems, concerns about their communities and fellow citizens) did indeed make me humble. I remember, for instance, how drastically the atmosphere and context of an interview with an addiction counselor changed when, during our conversation, her own son—who was suffering, possibly dying from a severe addiction-related illness—entered the room. From every therapist I interviewed, I got a sense of their very sincere desires to help the people who came to see them—even if they knew the limits and sometimes the futility of their efforts. Thus, while I certainly think there are problematic aspects that come with the global spread of psy, particularly the marketing of psychopharmaceuticals that Whyte refers to in her comment, I am not trying to make a moral argument against psychotherapy in Uganda. I am also not trying to suggest—as van Dijk and van Bemmel infer—that it is necessarily irrelevant in places like northern Uganda. In fact, the comments and publications by Meinert and Whyte (2017, forthcoming) demonstrate that psy-services (both in the form of drugs and talk therapy) have become integrated into local help-seeking strategies in northern Uganda and that people turn to psy, and sometimes find relief, when other healing attempts (by ajwaki or faith-based healers) have failed.

It was not my aim in the article to question the reality of Ugandans’ suffering or, even worse, to naturalize it, as Ratele suggests. It is also not true that I hold an a priori suspicious view of depression. And I certainly do not question that depression as a clinical condition exists in Africa. Plenty of studies by psychiatrists and other experts, including anthropologists, demonstrate that something like what the Diagnostic and Statistical Manual of Mental Disorders refers to as depression has long existed and been recognized in Africa (cf., for instance, the early studies by Field 1960 in Ghana that Whyte mentions or a more recent study by Okello 2006 in Uganda). Vaughan rightly points to the harmful legacy of colonial myths about the nonexistence of depression among Africans and the continuing importance of debunking those. Being more clear on this point would have certainly benefited the article.

However, and to reiterate, the article simply does not pose the question of whether depression in Uganda is real. As Ian Hacking (1995:8ff.) has pointed out, this is generally not a fruitful approach to the analysis of mental illness. The point I make in the article is that depression has only recently emerged as a frame and popular concept for making sense of suffering among laypeople and that this potentially reconfigures how they understand, deal with, and talk about suffering. The question is not whether it is appropriate for someone in Africa (or elsewhere) to use the language of depression. The question is why that increasingly seems to be the case in Uganda and what potential consequences may result from it. Hacking’s (1995) concept of the “looping effect” is helpful here, that is, the idea that changing (self) classifications of people, for instance, as depressed or traumatized, has profound effects on the people classified who start to perceive themselves in those terms and act accordingly, which in turn reflects back on and changes the classifications. Thus, over time, new forms of knowledge—like those provided by a psy-framework—and the way they come to act on people not only relabel people but actually create new scripts and, more fundamentally, entirely new ways of being.

The argument in the article is not a moral one against psy-categories and forms of practice. Rather, my research tries to say something about larger societal changes in Uganda that both cause new reasons for suffering and affect how people understand and deal with it. Hereby, I take inspiration from Mullings’s (1984) monograph in which she assesses the interrelationship between multiple and changing therapeutic regimes and shifting social and moral orders and power relations. Mullings’s basic argument is that the ability to manipulate healing can be used to reinforce selected social relations, class distinctions, and ideologies. Based on ethnographic research among different mental healers in Accra in the 1970s, she demonstrates how therapies are created within given socioeconomic orders but also how they reproduce and change those orders.

This brings me to Allen Tran’s and Rijk van Dijk’s and Karin van Bemmel’s important question about the political implications of an emerging psy-regime in Uganda, which, I unfortunately can only address very briefly. Uganda is seen by many Ugandans as a country of binaries—north versus central, urban versus rural, Kampala versus upcountry—that reflect real and perceived inequalities and long-standing political and economic divides. It is also experienced as country that, under the Museveni regime, has undergone rapid political and economic changes (Wiegratz, Martiniello, and Greco 2018), which have affected people across the country in different ways. Psychotherapy can be seen as a response to these transformations and resultant problems, but it is indeed also somehow involved in (re)producing divisions and inequalities (cf. Vorhölter 2017). Many of the therapists I talked with had worked or considered working in the North because that was where most jobs funded by nongovernmental organizations (NGOs) were, but many did not want to live upcountry permanently or were deterred by the prospects of working with...
trauma victims. In the absence of government-funded jobs, they were thus dependent on creating a market for private psychotherapy in Kampala where more people could pay for therapy, even if they were perhaps not the ones who needed it most. Apart from a few expats, most counselors in northern Uganda came from the region and had undergone short-term courses provided by NGOs, although there were also some with university degrees. Susan Whyte’s point about the futures market is interesting here and reminds me of Abramowitz’s (2014) study of trauma counseling in Liberia. However, while there seems to be a growing interest in and expansion of trauma counseling trainings in northern Uganda, it has not reached the dimensions Abramowitz describes—and it is certainly not comparable to HIV/AIDS counseling. Since there is hardly any government support, and NGOs are withdrawing, at this stage the prospects for a non-HIV-focused counseling futures market are fairly limited.

Health care is only one of many fields in which the logic of neoliberalism produces and reproduces class-based inequalities. As the Ugandan state is largely absent in providing good and affordable mental health care (even more than in other fields of health), mental health care becomes a matter of choice, self-care, and ability to pay rather than a civic or human right. Poorer people—in the North and in Kampala—could and would only access services (most notably the psychiatric hospital) if they were suffering from severe mental illnesses. In the overcrowded and understaffed hospital, they would be medicated rather than talked to. Financially better-off people could choose when and where they would seek what kind of treatment. Perhaps they could also frame and subjectively perceive their problems as mental health issues in a way that poor people could not.

While the rise of psy is clearly interlinked with capitalist and neoliberal modes of economic, political, and moral governance that promote individualism and self-responsibilization, the relationship between psy and capitalism is a dialectical and ambivalent one. Psychotherapy was originally conceived as a revolutionary doctrine and can, at least in theory, also challenge and question capitalist logics and social orders. It has the potential to reveal or conceal structural inequalities, empower or disempower those who seek it, and awaken or silence resistance (Tweedie 2016). In Uganda, the therapists were certainly not simply dupes of neoliberalism but were committed to the idea of providing meaningful care—which involved both making people accept structural conditions but also empowering them to question taken-for-granted assumptions, authorities, and ways of life.

Last, I will try to clarify what I mean when I speak of Western conceptions of happiness and elaborate in a bit more detail the historical emergence of happiness in the West. In the article, I mainly draw on Bruckner (2011). In his book, Perpetual euphoria: on the duty to be happy, he shows how since the second half of the twentieth century happiness has become an ideology and how the desire to be happy has become an imperative and even a burden in Western society. Bruckner traces the historical emergence of current notions and ideologies of happiness to the French and American revolutions and the period of the Enlightenment, which popularized the idea that happiness was deserved and could be achieved, at least potentially, by everyone, in the here and now, and that, as a consequence, suffering and human inequality should be alleviated. In Bruckner’s words: “The hope of happiness triumphed as ideas of salvation and grandeur waned, in a double rejection of religion and feudal heroism” (29). Such thinking marked a decisive break with former notions, closely tied to Christian thought, that human existence was characterized by suffering and that only those who led good and virtuous lives would be rewarded in heaven. With the declining influence of religious doctrines, which had hitherto rendered suffering explainable and thus perhaps more bearable, and the parallel rise of science, came the idea and in fact the imperative to improve life and rid humanity of suffering in this world rather than wait for a promised beyond. Suffering came to be seen as something not only undesirable but abnormal and to be avoided at any cost.

Over time, however, it became increasingly uncertain what exactly constituted suffering, leading to a loss of a sense of proportion of what suffering is/is not and a rapid expansion of all sorts of ways—therapy, medication, consumption—to fix it or escape from it. According to Bruckner, “today we suffer from not wanting to suffer just as one can make oneself ill by trying to be perfectly healthy” (4). In short, whereas in former times—and as Bruckner, superficially, claims in “other cultures” (65)—suffering and pain were considered normal aspects of human existence, the West has come to see happiness as the norm and based on this idea has created a new moral order (cf. Rubin 2013) that obliges everyone to strive for happiness. “[T]oday, it is being unhappy that is immoral” (49), or as Mathews and Izquierdo (2009) claim for US society: “It is almost as if one is required to be happy, or at least to be able to describe how one is earnestly pursuing such a state, in order to be fully and normally American” (7).

I found Bruckner’s analysis inspiring to think about changing understandings of well-being (to use a more encompassing term) and suffering across the globe, and in Uganda specifically, and how these relate to the global expansion of psy. I certainly agree that the paragraph on this subject in the article is a “rather sweeping generalization”—as Vaughan rightfully points out—and would require much more nuance and a less dichotomous framing.

I also agree with many commentators that I do not engage enough with local conceptualizations of happiness in Uganda. Maybe in the end it is not happiness per se that I am talking about but a certain lifestyle—one revolving around consumption and a particular kind of social life and one that requires keeping up appearances and at least pretending to be happy (cf. Livingston 2009)—that, at least in Kampala, is leading to new ways of evaluating and dealing with suffering and that itself causes new forms of stress. A less leading way of formulating the research question would then be to ask: What do different people in Uganda strive for in life—status, salvation, survival, happiness? How do these goals shape what they per-
ceive as suffering? When and where do they seek help when these life projects seem to fail?

The way people talk about and frame the absences and presences of well-being may reveal what, in particular places and times, is considered to be desirable, normal, or achievable in life. However, in the end, concepts like happiness or suffering are never self-evident; they are dynamic and to some extent envisioned and experienced differently by each and every person. Michael Jackson (2011:196–197) beautifully captures this idea when he writes:

In fact, it may be as impossible to ameliorate the conditions under which we live as it is to arrive at a single formula for what makes life worth living or what might change it for the better. . . . [F]or those who fulfill their ambitions and achieve their goals, new dissatisfactions invariably arise, new objects of desire. This is not to pour scorn on human aspirations for a better life, or argue against helping others achieve their goals to the extent that one’s own resources allow. Rather, it is to remind oneself that the imagination typically gets ahead of itself, producing a cognitive surplus to survival needs and fostering the illusion that we can transcend our circumstances, re-born into a world where losses are made good, injustices redressed, prayers answered, patience rewarded, and knowledge achieved.

—Julia Vorhölter

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