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Once an Addict . . .

Learning the Chronic Relapsing Brain Disease Model in Kampala's Rehabilitation Centers

MAURICE

On a hot dry afternoon in January 2018, George and Sarah met at a taxi stage in central Kampala to walk to meet Maurice, a friend of Sarah's, who was currently staying in the ghetto near the university. Sarah had known Maurice for many years already. She had seen him move in and out of rehabilitation centers four times. Maurice's parents had been well off when he was a child, but his dad was a heavy drinker. When his dad learned he had HIV, his drinking only increased, and he spent most of the family's money on alcohol before he died. His mother died of AIDS four years later. Maurice's paternal uncle in Kampala took him in and raised him. These same relatives had now paid out of pocket for several of his stays in rehab. After his last stay, he had returned home and while looking for a novel found a stack of ten US one-hundred-dollar bills: his uncle's wife was saving for a back operation and had hidden her savings within the pages of the book. He took one of the bills and went out to drink. This was before Sarah started working on this project, but Sarah had been with his family when they took him to Luzira Prison to keep him away from alcohol, at least for a little while. He had now been out of prison for five months, living in the ghetto again and drinking even more than before.

Sloping down from the main road, behind the big bars and pork joints, George and Sarah began to snake through the narrow roads lined with mud and wattle houses and sewage trenches, the road so narrow that the iron sheet roofs of the houses opposite one another nearly touched in the center, making a tunnel. Three women in their early twenties were washing clothes in wide plastic basins. A little further down, other women stood outside of a small grocery shop, cooking

food in enormous saucepans to sell. Music blared from a nearby video rental shop and people shouted to be heard. The air was sharp with the smell of alcohol and stale urine, and George felt nervous as people stared at them critically.

After a while, they found Maurice sitting on a wooden bench on the veranda of a small shop with some other men filling out football betting forms. Seeing Sarah, Maurice jumped up and hugged her. Maurice is in his early thirties, tall and strongly built. He had boils all over his body and wounds on his face, elbow, and leg. As he talked, his words slid together. "Sarah, buy me a drink." Sarah offered instead to buy him some food and left to go find the women with the saucepans.

When Sarah returned, Maurice picked lazily at his plate of *matooke* and fish stew. As he ate, Sarah asked how things were going with his recovery. "I don't have much to tell," he said. "I don't want to stop. Maybe reducing."

"How much are you taking now?" George asked.

"Buy me one so I can show you."

George was beginning to feel that this visit had been a waste.

Maurice went on talking to Sarah, jokingly referring to George as her husband, asking her if George could help him to realize his dream of studying in Russia, asking an old man nearby to buy him a drink. The old man did not respond.

. . .

Maurice had relapsed, and Sarah was trying to bring him back to the AA meetings they had once attended together. This way of thinking about what was happening to Maurice, the meetings and the rehab centers Maurice had attended, and Sarah's hopes that he might attend again, were all part of an emergent assemblage (Ong and Collier 2005) of programs, ideas, and ways of living that defined problem drinking as a chronic relapsing brain disease (CRBD) that is both manageable and yet incurable. Building on earlier work that took place in Europe and America, a passionate group of Ugandan psychiatrists, priests, former drinkers, and others have built a small, but growing, network of inpatient rehabilitation programs and Alcoholics Anonymous (AA) fellowships in Kampala and in other towns around the country. Modeled on European and American addiction treatment programs, these rehabilitation centers have introduced new ways of understanding what problem drinking is, new ways of understanding the self in relation to such problems, and new forms of social connection and support.

In this chapter, we explore the workings of two of Uganda's most prominent rehabilitation centers, one public and one private, and the broader network of AA meetings and recovery organizations that are scattered across Kampala and other towns. Building on previous work in the anthropology of addiction (Garcia 2010; Hansen 2018), we argue that despite the constant exhortations to change, the models of time and the self that define the work of these spaces leave many people feeling trapped in an unchangeable condition. Further, and perhaps most importantly, these models place certain limits on the social relationships that people

in recovery are able to build with one another and with their families. Given the importance of social connections in Uganda and the role that bars play in social life, these limits can have personal and practical consequences. While this way of thinking about addiction and "boundaries" is something many readers might take for granted, in the chapters that follow we explore three other models of problem drinking that provide different answers to these crucial questions of the self and the social.

REHAB

Maurice had passed through inpatient recovery programs many times before George and Sarah met him in 2018, and he would go on to stay in others again over the time that we knew him. Some of the "rehabs" in Uganda are small programs, privately owned and run out of small bungalows or storefronts by other people in recovery, but others are considerably larger. These centers are also linked to a handful of AA meetings that constitute an important part of the recovery landscape. These meetings serve people who have come through inpatient rehabilitation programs and also people who have been brought to the meetings directly by friends who were already attending. In addition to the treatment programs and AA groups, there are also several research and advocacy organizations doing research, policy analysis, and alcohol abuse prevention work with youth.

In this chapter, we focus on the two largest rehabilitation centers: the Alcohol and Drug Unit at Butabika Hospital[1] and Lakeview Recovery Center. While these centers differ from one another in several ways, they are both important points of origin and energy for the growing interest in addiction and recovery in Uganda. They also serve as the most likely points of first contact for families looking to explore what this relatively new mode of addressing drinking problems might have to offer.

Both of these programs can trace their beginnings to a moment in the early 1980s when several Catholic religious orders began to notice that some of their priests were struggling with problems with alcohol. A priest who had been introduced to AA for help with his own drinking by a group of missionaries and a man who that priest had in turn helped to stop drinking took the initiative to start an AA fellowship in a private home, and small numbers of priests and lay people began to come stay for a few days and attend AA meetings. There was no counseling or other medical support, but the meetings grew in popularity, and by 1992 bishops were formally sending priests to the fellowship for treatment. By 1998, there was a growing realization that the problems of alcohol in Uganda were bigger than this single fellowship could address and that there was a need for something larger and more formal. The four orders involved decided to invite a priest from the United States, running a hostel for people living with substance use disorders in Portland, Oregon, to come and talk about this work in Uganda.

Inspired by this visit, in 2001, a team including Dr. Basangwa, a psychiatrist and the executive director of Butabika Hospital, traveled to the United States for a six-month training program to acquire the expertise necessary to start Uganda's first inpatient treatment centers.

Butabika Hospital

Butabika Hospital was founded in 1955 by the British protectorate government in Uganda (Pringle 2019). Today, its sprawling compound still lies at the edge of the city, at the end of a taxi route that winds its way past houses and suburban trading centers and markets until it reaches a long road overlooking the lake that leads nowhere but here. Past the single roadside chapatti vendor and the security officers staffing the high arched gate is a spotlessly clean, carefully mowed compound of intersecting paths, lawns, and low brick buildings that serve as the wards. Some patients move freely about the paths dressed in loose fitting standard-issue green cotton uniforms: shorts and shirts for the men and dresses for the women. The patients in the acute ward are more restricted, and they shout at passersby from behind the high barbed-wire fence that surrounds their building.

The Alcohol and Drug Unit (ADU) was among the newest additions to the hospital. In 2003, Dr. Basangwa had become increasingly concerned about the prevalence of psychiatric problems related to alcohol and drug abuse on the wards and in Kampala more generally. He had already started a small outpatient clinic to address alcohol and drug addiction, but he also knew that there were patients whose primary problems were related to alcohol and drug use who were being admitted to the general wards and did not feel comfortable there. Having been interested in addressing problems related to addiction for some time, he was finally able to act by taking advantage of a moment of interest in expanding the hospital to propose a new ward that would be dedicated to serving people living with addictions to alcohol and other drugs. In 2006, the buildings were completed, and Sr. Nantambi, who is still the head nurse on the unit, traveled to East London for three months of training in addiction treatment.

Between 2015 and 2018, the ADU could hold twenty-eight men in the public ward and ten men and women in the private wing; women who could not afford to stay in a private room were also occasionally housed in other women's wards in the hospital. Both the public and private wards were nearly always full to capacity, with a lengthy waiting list. Patients staying in the public wing did not pay for treatment, while patients in the private wing paid approximately 80,000 UGX per day and were also sometimes accompanied by a family caretaker who was permitted to stay in their room with them.[2] These patients were all attended to by Sr. Nantambi, who was helped by a team of nurses, all women, dressed either in simple pink uniforms or in white dresses with wide red belts and neatly folded caps pinned to their hair. Also on hand was a psychiatric medical doctor who was primarily responsible for making the diagnoses and treatment plans.

Each of the patients is meant to stay for thirty to ninety days in the small block of sturdy brick buildings that lie behind an unlocked fence at the edge of the hospital. The buildings are set up around a neatly maintained grassy courtyard ringed with immature shrubs. There is also a canteen where patients can pay for meals when they tire of the standard fare.

Their days follow a standard routine which roughly corresponds to the Minnesota Model of addiction treatment common throughout the United States. There is breakfast, medication if needed, and then group educational sessions in the main hall until lunchtime. After lunch, patients have individual meetings with their therapists, watch television, or go out to play football and cricket. During the initial phases of detoxification, diazepam—a benzodiazepine also known as Valium—is used to treat the withdrawal symptoms. Other antipsychotics, antidepressants, and anticonvulsant drugs might also be used, depending on the situation. Patients are given vitamins and undergo blood tests for HIV, syphilis, liver function, and renal function. Former patients also come to lead an AA group on Saturday mornings.[3]

Lakeview Recovery Center

Lakeview is Butabika's private counterpart. Its seven-acre compound is perched on a hill several kilometers outside of Kampala, its multistoried dormitories and spacious administrative buildings overlooking an expansive view of the lush green hills beyond. While these buildings, completed in 2012, can now accommodate up to eighty clients at a time, Lakeview's first incarnation in 2001 could house only five. Demand soon overwhelmed the small space, and so the director looked to rent a bigger house that could accommodate more. First they found one that could accommodate twelve, and then one for eighteen, but there were still long waitlists. In 2009, they approached the Catholic archbishop of Kampala, and he gave them a lease on the land on which the center now stands.

Like Butabika, Lakeview's programming is modeled on American addiction treatment programs. The day is structured around individual meetings with personal counselors and a series of therapeutic activities, many of which take the form of formal classes. Bells ring to mark the time between one activity and the next. As at Butabika, most of these classes focus on teaching clients strategies for avoiding temptation and structuring their time after discharge, but there are also forays into other topics, such as the basics of Freudian psychology, foreign languages, and music. In addition, there are opportunities for exercise and community outreach work and for occupational therapy classes oriented toward teaching the skills necessary to move into new opportunities for microenterprises such as liquid soapmaking, charcoal briquette pressing, and indoor mushroom growing. Family members are invited to monthly "Family Saturdays," so that they can be educated about addiction and how to "manage" their relatives upon discharge. Medical care at Lakeview involves a self-assessment, a family assessment,

a urinalysis drug screening, and a blood test looking at HIV status, Hepatitis B status, and liver and kidney function. The drugs used for detox vary according to the patient's ability to pay for them and often include diazepam, Neurontin, B12, appetite stimulants, and occasionally injections of the long-acting antipsychotic risperidone. Lakeview's executive director often emphasized that every aspect of their program has been carefully designed for maximum therapeutic benefit. This said, more often than not, a majority of the clients could be found playing chess, watching television, or hanging out talking with one another at "the beach," as the area designated for clothes washing was playfully nicknamed.

Lakeview's programs last substantially longer than those at Butabika, with clients staying at least 90 days for alcohol and 180 for other drugs or for multiple substances. Due to the high costs of this extended private program—a 90-day stay cost approximately 5.4M UGX (a little less than 2,000 USD or about as much as a year of university tuition)—their client population was typically about half of their eighty-person capacity.

MAURICE

In late February, George and Sarah returned to the ghetto to find Maurice and his friends sitting on the benches in front of the shop where they had met him before. Some of the men were drinking beer and sipping from plastic tot packs of waragi.

Maurice, to George and Sarah's surprise, wasn't drinking and looked surprisingly clean in his freshly washed striped t-shirt. He mustered the strength to stand, to welcome them and to hug Sarah, but his body trembled as they sat talking, his state of withdrawal showing itself on his body.

"Nothing is moving well. Everything is a mess. I wanted to resume attending AA. I am tired of drinking, and I can see the time running. I don't want to reach the middle of this year when I am still not sober, but I cannot become sober single handedly."

"What do you think is stopping you from doing this?" asked George.

"I stay and sleep here. You have seen these men. It is difficult to stay sober here. They offer me alcohol. I try to refuse, but when I feel stressed, it is hard to say no."

Sarah offered to give Maurice the number of another friend of theirs who coordinates the AA meetings and told him about an open meeting that was scheduled for the next day.

George asked Maurice where he was sleeping and how he manages to get money for food.

"I sleep here, where we are sitting. When it reaches 3:00 a.m., the shop owner allows me to sleep on this veranda. All of these guys do the same. I don't have money for food either, but if I wait until 11 at night the women selling food will give me the leftovers for free."

"Does your family know that you're here?" George asked.

"Yeah, but they don't come to see me here. Last week I went and found my mum at the office. We talked and talked. Before I left, she said, 'I know you want money, but the condition is one and you know it properly; you get sober and everything you want is available for you.' She gave me money for lunch and transport, and I came back here."

Another young man passed by and asked Maurice to share some of the food George and Sarah had bought for him. The man reminded Maurice that they were at university together. Maurice introduced the man to George and Sarah, saying that he is a tailor who comes here to drink whenever he gets money. Minutes later, Maurice asked his friend to leave, sending the rest of his food with him.

"I can't eat much because of the effects of the withdrawals. That's why I'm shivering."

Sarah asked, "How long have you been coming here?"

"Six years," he said.

"When you first came to Butabika, did you come from here?"

"Yes."

"How many times were you in the hospital?" asked George.

"I was at Butabika twice, and also two times in another rehab up country."

"Were your parents taking care to send you there?" George asked.

"My brother especially. Older than me. But when I went to see him two weeks ago, he told me, 'You know the deal, you sober up, we talk.' They can give me everything, a house, a car, but I know that I can't do this on my own. I need support. I have to cut myself off from these guys," he said, his eyes casting about to the men seated drinking nearby. "With them, there is no progress."

"Where do you think you will go?" Sarah asked.

"That's the reason why I don't leave them. I have nowhere to go. I tried going to the AA meeting the other day, but I got lost on the way."

CLASS

Like Maurice, who had once attended Makerere University, the vast majority of patients at both Lakeview and Butabika come from Uganda's English-speaking, university-educated upper and middle classes (Vorhölter 2017) and most had completed at least some university. The training sessions that punctuate the days in the rehabilitation centers replicate the rhythm, regularity, and didactic style of university classes. These classes are invariably held in English, and English is also the language of treatment and conversation among the patients and the families who come for visiting days and family education sessions. As in many contexts in Uganda, this choice to speak English is made in an effort to mark status. While the need to make a point about status makes a lot of sense in a potentially stigmatizing environment where the loss of face is at stake (Goffman 1959; 1986), it is also a linguistic choice that is only available to people who have secondary or

even university-level educations. Patients at Butabika who could not speak fluently in English were marginalized, left out of most activities and conversations, and openly mocked. That said, such situations were relatively rare, for despite Butabika's program being public and requiring no payment, it still attracted a clientele who were exceptionally well-educated.

This class-stratified pattern of participation in inpatient rehabilitation programs is not only an outcome of pricing and referral structures but also reflects how "the addict" has been constructed as a figure of public concern in Uganda. While media attention to problems related to alcohol cuts across class, the form that this attention takes varies: stories about poor drinkers focus on the need to implement legislation to control the supply of alcohol and stories about elite drinkers focus on the need for medicalized intervention (see Netherland and Hansen 2016a). Celebrity testimonials figure prominently in this process of medicalization, allowing some members of the public to identify with unique patients heroically suffering and recovering from medical problems.

This form of publicity generally takes the form of feature-length newspaper and television stories of wealthy or otherwise prominent individuals who have suffered from addictions to alcohol and who are now living in recovery. In these stories, addiction appears as a condition afflicting singular individuals who are rhetorically presented as a possible mirror of the reader or an intimate other in the reader's life. That these stories center celebrities who are seen as successful is especially significant, as it negates the notion that alcohol abuse is the result of laziness, unemployment, or poverty and instead frames addiction as a disease capable of touching anyone. These stories also highlight the specter of squandered potential and the possibility for redemption, themes foundational to the recruitment of the male university students who constitute the majority of the patients presently enrolling in the rehabilitation centers and AA groups that we discuss in this chapter.

The public testimonial offered by Major General Pecos Kutesa in the inaugural episode of the award winning NTV series *Life Stories* is an example of this sort of publicity. Kutesa served as a celebrated field commander during the civil war that brought President Yoweri Museveni to power in 1986. The thirty-minute episode features one-on-one interviews with him and his wife Dora Kutesa in which they alternately recount his years of alcohol abuse, the failure of his liver and kidneys, and Dora's donating 75 percent of her liver to him after he spent four months in a coma in a hospital in New Delhi. Behind them are images of breezy gardens and a waterfall, and as they speak soft flute music plays in the background. During an interview in July 2015, an official in the Ugandan Ministry of Health, who had been chiefly responsible for working on the proposed National Alcohol Policy, cited Kutesa's experience and testimony as the chief cause of the president's increasing attention to alcohol in his speeches. With this in mind, Kutesa's story can be seen both as filling out the image of the redeemed potential of former alcoholics

for a more generalized Ugandan public and as playing a special role in relation to President Museveni's interest in acting to create change around alcohol production because of their long-standing friendship.

The singularity of this particular instance of celebrity biography works alongside other more mundane testimonials offered by successful individuals in recovery from alcoholism and lifestyle and health columns instructing readers how to help alcoholic partners (Kemigisha 2009), explaining the links between alcohol and liver damage (Ssenkaaba 2009), and even works of serial fiction describing one man's experience at a rehabilitation center (Ortega 2012). Whether these articles are found in newspapers or in more focused publications, such as the magazine produced by a peer support organization, all are targeted at the expanding English-speaking middle class and aim to define elite drinkers as potential patients and their family members as potential conduits to treatment.

Articles like "From an Alcoholic to Academic Ace" (Okiror 2009) speak to specific concerns over elite forms of student drinking. While youth access to alcohol has always been an important issue in East Africa (Willis 2002), the current concern that these stories point to differs from those of the colonial and precolonial eras. This is not a question of adults holding onto a threatened monopoly on alcohol as a technique and symbol of power. Instead, we see parents desperately trying to prevent their children from squandering the investments they've made. By the time their children have reached university, parents have poured tremendous resources into their educations, and they expect to recoup these costs through their child's ability to help other members of the family, or at very least to be able to take pride in what their children have made of their lives. When alcohol abuse stands in the way of this achievement, it is not a matter of trying to stop a young person from jumping rank by accessing beer through purchase rather than through the gift of an elder; instead it is an attempt to avoid the tragedy of wasted potential.[4] While the cost of attending Lakeview easily matches university tuition, the expense may seem worth it to families looking to recuperate such a massive potential loss.

The specter of wasted potential is perhaps most poignantly realized in the figure of the student who has "drunk his fees." Over the course of our work on this project, Ugandan friends told us many versions of this story as they affirmed our interest in attending to the importance of addressing problem drinking in Uganda. Within a few days of her first trip, a young priest who was training to be an addiction counselor told China a story of a mother who had looked at the previous week's *New Vision* newspaper, expecting to find the name of her son among the list of students expected to graduate from Makerere University the following week. She looked and looked but could not find his name. The next morning, the mother went to the administrative offices at the campus to find out what had happened. "We stopped seeing your son in the second year," the secretary said. "The first year he came, the second year he came and had some retakes, but then we didn't

even see him. You know, these students start using drugs so they can read and concentrate, but then. . . ." The women eventually confronted her son and learned that instead of paying his fees, he would go straight to the bar with the money and deposit it there to drink with it for the whole term.

It is not only these extreme instances of wasted resources that make families worry. Elite families may also come to recognize that there is a problem when their children have graduated and started working but are failing to contribute to the welfare of other family members. As one of the counselors at Lakeview explained, "Families have spent so much money and so much time investing in these kids and they are expecting them to contribute to the family income or to [be] helping others in the family or at least to [be] helping the family by making progress, showing that their investments in them have paid off. When this doesn't happen, it is a real sign that there is a problem."

The high levels of education and family wealth of those who attended rehabilitation centers during our research presented unique challenges for their recovery efforts. Many struggled with the difficulty of feeling like they hadn't reached where their friends from school had and fearing that they never would. The older clients at Lakeview, who had previously worked in major positions as bankers and lawyers, felt deeply ashamed about the loss of those jobs, their sense of identity still attached to an elite status that now seemed irrecoverable.

The elite backgrounds of the majority of the patients at both Butabika and Lakeview also shaped the culture of the AA groups and other peer support recovery organizations. English was the sole language used in Kampala's AA meetings, and other social gatherings and conversations often involved sophisticated humor and wordplay with references that would have been impossible to follow without an advanced degree. While we delighted in these jokes and the laughter that followed, these language games also made it clear who could and could not participate in this rarefied milieu. The world that people in recovery were building with one another through gathering, meeting, and in-jokes was a precious and jealously guarded space where people could both be honest about their struggles while also enjoying the company of other elites. That said, it could be a difficult space for people like Maurice, who sometimes felt that the ideal of successful recovery was painfully out of reach. If this space felt awkward for people like Maurice, who at least had a foot in the world of people who went to university, held high-paying jobs in the government or formal sector, spoke English with their friends, and spent their leisure time in malls, it was even more unlikely that someone who had never reached university, who worked in the informal sector, and who generally spoke with their friends, family, and coworkers in one of Uganda's many local languages would feel at ease in an AA meeting. This observation was one shared by many people in recovery. They wanted to reach out to people beyond their own circles to share the ideas and practices that had benefited them, and they struggled to think beyond the forms of literacy that were central to AAs "Big Book"—no

matter what language it might be translated into. But finding ways to do this that would also protect the fragile shelter of a recovery community still in the making is something that was yet to be accomplished.

MAURICE

In March 2018, China arrived in Uganda again, and on her first day back we all went to try to find Maurice in the ghetto. Gingerly traversing the muddy back lanes, we arrived at the veranda of the shop only to find that Maurice was gone. The other men on the veranda told us that Maurice had gone off to some church. We realized that they were talking about the African Peace Center (APC), a newly opened day center located in a private house that was donated to the founder by his parents.

After winding through the unmarked roads for what seemed like hours in the suburban neighborhood where the center is located, we eventually arrived at a red metal gate at the end of a small side street. A large commercially printed banner read "African Peace Center–APC." The name gave no indication of the purpose of the center, which both ensured the privacy of those who visit and limited, intentionally or unintentionally, the reach of the center. None of the *boda boda* drivers we asked along the way for directions had any idea what we might be talking about. This was a protected space for people who were already part of a relatively closed community.

We rang the bell on the gate, and after it opened we drove through to find a solid stucco bungalow with a tiled roof and large windows surrounded by a neatly manicured lawn and several large palm trees. We were all tired after what had already been a long day moving around the city, and the cool breeze of this hilltop neighborhood immediately refreshed us.

Inside the glass French doors, there were four new sofas arranged in a rectangle around a large coffee table. There was art on the walls and a bookcase sparsely filled with a few books. A television was conspicuously absent. The intentionality of this absence was quickly pointed out by one of the counselors: "We could have easily afforded one, but the quiet is important." On the sofas, three men sat silently, reading AA books to themselves. One never spoke. The second, wearing high lace-up hiking boots, occasionally addressed us in American-accented English. The third was Maurice.

Maurice spoke to us softly but clearly, his hands shaking lightly as he talked. He looked small and thin in a dark plaid shirt and jeans, his woven belt pulled to the last notch. Despite being in withdrawal, his eyes sparkled, and he seemed happy to talk.

"We first went to the ghetto to find you," said George. "Your friends told us to look for you here."

"Yeah, the last time you saw me, Sarah gave me the number of a friend in AA. I called him and he brought me here. I've been coming every day but Sunday since."

"Do you come here on foot?" George asked.

"Whatever comes first. If I have the money, I board a taxi, but otherwise I walk. I try to stay here all day, so that I am not tempted to drink. I can be here during the day and then at night I go back there, keep to myself, and then in the morning I can come back here. At night in the ghetto, I try to hide in a different bar where people don't know me, where they will be less likely to try to buy me a drink, reading my AA book until it is late. Once it is late, I go back to that bar where you found me to sleep on the veranda. During the day, I can deal with the withdrawal symptoms all right, but at night, I dream. The dreams are the worst part. I dream of snakes wanting to bite me and I wake up. After five minutes I sleep again but see lions chasing me. Those are part of the withdrawal. When it rains, we just open an umbrella under the awning of the veranda to protect ourselves, but it doesn't help much. I will be okay. During the day, I don't get scared to sleep, because there is light. But at night, because we sleep outside, I sometimes think that the snake is for real. I do all right as long as I can come here during the day, but on Sunday, this place is closed, and I don't have anywhere I can go."

We thought for a while together about where else he could go at night. "Maybe there is a church that would allow you to sleep on the grounds," Sarah suggested.

"There are, but they are very far from here," Maurice replied.

Despairing, Maurice blamed himself for his drinking. "No one poured liquor down my throat," he said, flipping through his AA Big Book to find the story where this quote comes from. "There is no one else to blame for my drinking and the problems it has caused in my life. I need to work hard in recovery now to put my life back together."

As we got ready to leave, China wanted to find a way to give him 5,000 UGX for taxi fare and a meal, but Sarah worried that giving him that much money might also trigger a relapse. After much discussion we decided to give the money to the counselor, so that he could give it to Maurice slowly to facilitate his travel to and from Rubaga Cathedral, where he hoped he might find a place to sleep.

PARTNERS IN CRIME

The daily training sessions at Butabika constituted one of the most important aspects of the program, and we were encouraged to participate in these sessions as often as possible. The content of these sessions varied a bit, but typically focused on explaining the physical dangers of alcohol and cigarettes and helping patients learn strategies for avoiding temptation and negotiating sobriety. Many of these strategies focused on meeting the need to reorganize one's relationships and, crucially, to avoid spending time with the people with whom one used to drink.

As Sarah, then a volunteer trainer at Butabika, told a group of patients one Tuesday morning, "Your partners in crime will be aggressive, they will want to pull you back. Your partners will try to pull you back. They will always want you to be

at their same level. They will be saying, 'How can she move away from us? We want her to be the same.' They will even try mixing it into some of your drinks. You must try to reconsider and find other ways of dealing with it." Over and over again, the patients were advised to change their friends, what they did with their time, their way of dressing, even their routes for reaching home so that they would not pass by their old drinking spots.

This way of talking and thinking about the need for a person in recovery to change their "people and places" might sound so familiar that you scarcely give it a thought. But the challenge of doing this when social connection is the foundation upon which everything else is built is rarely acknowledged by the people leading these discussions. As we saw in the last chapter, those "partners in crime" may have also been the people with whom one has lived and worked and who one has relied on for meeting most basic needs. In Uganda, being together, being part of one another (Eisenstein 2021), constitutes the necessary condition for experiencing a sense of well-being and for securing basic necessities. With regard to the latter point, the limits of Uganda's governmental and nongovernmental social safety nets result in a situation where there are no shelters, no halfway houses, no soup kitchens, no unemployment offices. Anyone who needs to find a place to stay, food to eat, and eventually a job, will have to depend on friends and family.

With friends redefined as "partners in crime," people in recovery often turn to family. While we saw families provide housing, food, and connections to jobs over and over again, these relations were also shadowed by feelings of mutual resentment and suspicion on both sides, and these feelings of mistrust could be amplified by a disease model that posited addiction as a more or less permanent condition.

These relations were further strained by the fact that some people were taken to the treatment programs at both Lakeview and Butabika by force. Prospective patients were sometimes tricked into coming, told that they were being taken to buy land, to go out to eat, or to go to the beach, and then were surprised when they arrived at the center. In one instance, a university student admitted to Lakeview was left holding his mother's handbag. She told him that she would be back for it in a minute, but she never returned, and when he opened the bag, he realized it was empty. Another man, a middle-aged business lawyer, was left at Lakeview and not told who was paying to keep him there. In other cases, the parents of prospective clients told them where they were going, but that they would only need to stay for a week or two, not the ninety days the Lakeview program would really require.

These moments of force were not, of course, the only points of tension between people in recovery and their families. Experiences of injury and betrayal usually preceded the drinking problem, and they followed after treatment too. People who had moved through the recovery programs at Butabika and Lakeview often found themselves living with family members who they felt were watching their every movement, constraining their actions, and waiting for them to fail.

At the end of one of the morning training sessions at Lakeview, George crossed the compound to go and visit with the clients who were drinking tea and washing their silverware at the outdoor sinks commonly called "the beach." Over the talk of the others, George spotted Peter sitting alone and taking a cup of tea with a banana. He was surprised to see him, having ridden along with Peter to Kampala just a few weeks before when he was being discharged. One of the other men who was admitted just after Peter joked that Peter used to be his senior, but now he is Peter's senior. George pulled up a chair and sat down to talk.

"What happened?" George asked. "You had gone to your sister's house, right?"

"Yeah, I drank. I had become annoyed. My sister was following me, nearly looking under my bed to see if there were tot packs there. They were all over the place, but they belonged to the caretakers of the house. She was trying to turn my after-rehab into a rehab, monitoring all of my movements. I am a responsible adult! I have children at university! Yet, my sister wanted to manage every minute of my day. She wanted me to jog during the evening and I wanted to jog in the morning. I don't like the afternoon heat; I like it in the morning when it is cool. Can you believe that she even wanted to audit the time I go out jogging?"

"She doesn't work?" George asked, wondering how this woman had so much time on her hands.

"She's retired. Even to go and greet my mother, she said 'It is not necessary.' These counselors at Lakeview poisoned her mind, telling her things about me that weren't true, directing her to be strict with me.

"Even at church, as they were collecting the offertory, she pulled out money and gave it to me. I said, 'No, I have my own money.' When she saw the money she asked, 'Where did you get that money?' How can she ask me that? I have a bank card from Stanbic Bank and Bank of Africa. I have a pension. How do you ask me where I got the money from? She treats me like I'm a street kid on Kampala Road asking for a coin. I thought about packing up my bags. I was so annoyed."

"So, you went to a bar?" George asked.

"No," he said. "I went to an old friend. An old family friend who has sons who drink."

While relatives paid for expensive stays at Lakeview and provided critical resources of food and housing following discharge, many, like Peter, felt that these resources came at the cost of constant surveillance and judgment. People like Peter chafed against the control and the infantilization that came with it: "I have a pension and a child in university. And you ask me where I got money from?"

Another possible solution to this problem of isolation and the need to establish new networks of trust and social support were the Alcoholics Anonymous fellowships themselves. Yet, while some people managed to find friends through these meetings, many others mentioned the limited nature of this community of support. People come to meetings but leave immediately after. Those with cars drive away, while those without are left to find their own way home, often walking long

distances due to lack of money for transport. Support is focused on working the steps and avoiding relapse, with little opportunity for making more practical sorts of connections.

This is not accidental. AA makes a firm distinction between social support and material support. Members of AA fellowships can, and should, support one another emotionally, both within and outside of the meetings. People frequently called one another by phone, checked up on one another by text, spent time together socially outside of fellowship meetings, and occasionally went out of their way to go and visit someone in person when they were in an acute state of crisis. But more material forms of support are strictly prohibited, justified with appeals to AA's explicit valuation of self-sufficiency.

Readers familiar with Uganda and many other parts of sub-Saharan Africa will likely be struck immediately by the incongruences of this firm line between the social and the material and the forms of friendship that define everyday life. In Uganda, sharing with one's friends, neighbors, and relatives is a moral imperative. This does not mean that society is egalitarian—far from it—or that one needs to give to the point of impoverishing oneself, but to withhold resources from a friend in need is considered to be immoral, even cruel (Scherz 2014). While prohibitions on material support might allow people in different economic situations to come together without wealthier members needing to worry about the fiscal implications of the relationships that might emerge, the refusals, both explicit and implicit, can also feel cruel to those in acute need.

As you will remember, Maurice was left to walk from the ghetto to the APC on a daily basis on an empty stomach. Even when others were eating at APC, no one offered to share their food with him. And certainly, no offers of housing were made. There were many nights when the prohibitions on material support left him in both physical and emotional pain and left him materially reliant on precisely those same "partners in crime" that he had been instructed to avoid.

MAURICE

In April 2018, Sarah went out to find Maurice again. She hadn't seen him at the APC in a while and suspected that she might be able to find him at J's shop in the ghetto. It had been raining and the place was soaked, the trenches that line the paths filled to the top with dirty water. After sitting with the men at the shop for a few minutes, she felt a tap on her shoulder and turned around to find Maurice, dressed in a dirty red t-shirt and denim shorts, hiding behind a shop door. As he came to sit on the bench next to her, he started to cry, holding her tightly, smelling strongly of alcohol.

"Maurice, what happened?"

"Sarah, I walk up to APC every day on an empty stomach, keep there the whole day on an empty stomach, walk back here at night, do the same the next day, and

over and over again. Truly, what do you expect? I got someone's phone and called my brother to at least buy me some *posho* (cornmeal), beans, groundnuts, and charcoal and put them at APC. There's a charcoal stove. I can cook for myself, get something to eat and then come back here at night. I don't need much. But my brother just kept quiet on me."

They walked together for a while, trying to reach his brother by phone, but he wasn't picking up the calls. Maurice asked Sarah for some money, but Sarah, having just seen Maurice try to bargain with a food seller to give him alcohol later instead of the full lunch Sarah was trying to buy for him, refused, saying that the little money she had with her was for her transport home. Before he left her, he promised to go back to the APC, and then disappeared into the rush of speeding cars.

ONCE AN ADDICT, ALWAYS AN ADDICT . . .

One of the defining features of the programming at the rehab centers and AA meetings in Uganda is the tension between efforts to teach people in recovery skills that will enable them to resist relapse and the sense that the temptation toward relapse will always exist for them because their addictions have permanently altered their biology. Given that the leadership at both centers was trained and mentored by US-based addiction specialists, it is unsurprising that the programming at both Butabika and Lakeview revolved around this understanding of addiction as a CRBD.

While carrying forward aspects of a research program that took off in the middle of the twentieth century, the CRBD model did not fully coalesce in America until the 1990s.[5] In his seminal 1997 paper "Addiction Is a Brain Disease, and It Matters" Alan Leshner, who was at that time the director of the National Institute on Drug Abuse in the United States, defined the CRBD model and argued for the urgency of its acceptance by policymakers and the general public, for whom the idea that addiction is "a chronic, relapsing disease of the brain is a totally new concept" (1997, 46). Leshner argued that two decades of neuroscientific and behavioral research had shown that "prolonged drug use causes pervasive changes in brain function that persist long after the individual stops taking the drug," making the addicted brain "distinctly different from the non-addicted brain" (46). As opposed to earlier models, which Leshner saw as stigmatizing drug users or focusing on the need to help people through the period of acute withdrawal, the CRBD model sought to reframe addiction as a chronic illness that could be managed, but rarely cured. Given the long-lasting effects of drug use on "brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues," Leshner argued that successful drug treatment could result in "a significant decrease in drug use and long periods of abstinence, with only occasional relapses," but that a permanent cessation of compulsive drug-seeking was an unrealistic goal.

Since this time, the CRBD model has been the guiding force in most NIDA-funded addiction research in the United States and has been the model at the center of many landmark articles and special issues. While not as uncontested as NIDA claims (Courtwright 2010), NIDA's call for broad public acceptance of the CRBD model in the United States has spread beyond the pages of scientific journals, with talk of hijacked brains and fluorescent images of fMRI scans flashing across American television screens and informing the curricula on addiction in American classrooms (Campbell 2007, 2010). While we do not aim to contest the neuroscience that informs this approach, we do follow the lead of researchers who have explored the harms this model can inflict upon those who have been diagnosed (Garcia 2010; Hammer et al. 2013), harms that are now spreading beyond the United States as this model gains international acceptance.

Patients and their families at Lakeview and Butabika were consistently instructed that addiction was a chronic disease, likened to diabetes, cancer, and HIV. They were constantly reminded that "a recovered alcoholic is not a cured alcoholic." "There is no cure," they said. "You are always an alcoholic." At Family Saturdays at Lakeview, parents were told that alcohol had permanently changed their children's brains and that these changes could never be reversed. Clients in Lakeview classrooms were encouraged to "get used to the disease," to remain consistent in their efforts to avoid relapse and to be constantly vigilant. "An addict can never truly be relaxed," the counselors said. Closing a session for new patients at Butabika, Sr. Nantambi reminded them of the importance of the closing lines of the AA Serenity Prayer, "Help me to accept the things that I cannot change." "It is a journey; remember. Once an addict you remain an addict, even when you are sober," she said. At times, the mark that was being put upon their characters extended beyond their propensity to relapse. One patient remembered one of the therapists they had met during their time in a rehab center telling them that alcoholics were liars. "You addicts will do anything. You'll lie, cheat, steal, just for a drink." While people, and not only people recovering from addiction, do indeed lie, these words reverberate in the social space of the recovery community, where accusations of lying and despair can add to the difficulty of regaining trust, shaping many social interactions.

While Maurice's parents and the friends he had made through AA hoped that one more stay at rehab might be enough to set him right, at least for a while, the cycle of relapse and return that shaped Maurice's life is also part of the story of addiction as a chronic condition without end (Garcia 2010). In other therapeutic pathways, failure may be diagnostic, pragmatically indicating that the next step on the quest for therapy for this particular illness lies elsewhere (Whyte 1997; Janzen 1982). By contrast, the CRBD model is unfalsifiable. When someone relapses again and again, it is, at least in part, a verification of the diagnosis. Maurice and those around him hoped that he might be able to change, but this hope was tempered by the forms of vigilance fostered by the recovery programs themselves and a

corresponding reluctance to fully embrace the possibility of change and to fully enter into materially substantial forms of friendship.

As with the question of class discussed above, this problem of social connection was one that some members of Kampala's recovery community acknowledged themselves. Greg, whose recovery was supported both by AA and by his active involvement in a Pentecostal church, wondered with us about the possibility of an African AA, one that would speak to the ethics of interdependence at odds with the strangely individualistic form of fellowship being proffered in the globalization of American twelve-step programs.

While reminders about the dangers of relapse can indeed prove to be crucial barriers against efforts to "test" the cure, or to return to "social drinking" after discharge, many of those who succeed in their vigilance also find themselves completely defined by their identity as addicts and alcoholics. While some found minimally compensated or voluntary work as counselors or AA group leaders in small rehabilitation centers or other spaces related to recovery, their lives revolved around efforts to find a way forward for themselves in ways that were almost completely defined by their past. Called by others in the recovery community to appear in radio, television, and newspaper stories about addiction, they were granted public recognition, but in a form that required the confirmation of their continued identification with addiction. This is not to say that these opportunities for work, community, and media attention were not appreciated; they were. But these opportunities also required an incessant reaffirmation of the person's status as an incurable addict, even as they celebrated the person's processual state of "being in recovery."

Readers in Europe, North America, and elsewhere have lived with the CRBD model as their primary framework for understanding drinking problems for many years now. Having come to accept this model, they may find it hard to suspend the naturalness of the idea of addiction as an incurable disease. Likewise, they might take for granted the need to maintain good "boundaries" not only with those in recovery, but really with anyone. With these assumptions in mind, the chapters that follow demonstrate that this is not the only framework that exists and argue that these other ways of thinking, which place an emphasis on the possibility of transformation and release, have the capacity to orient people toward time and social connection in very different ways.