Mental Health

MIKKEL KENNI BRUUN, *King's College London*

When we talk about mental health, we could seem to be talking about some self-evident reality. However, the very notion of mental health can be seen to both assume and require a specific vision of human interiority. The so-called ‘sciences of the soul’—or the ‘psy' disciplines—were particularly formative in defining this perceived interior selfhood through various scientific and therapeutic practices of inspection and introspection, through new constitutions, articulations, and regulations of what it means to be human. Mental health could be seen to be fundamental to our collective and individual ability as humans to think, feel, relate, interact with each other, sustain ourselves, and enjoy life. This entry explores some key theoretical and ethnographic interests, and their alignments and tensions, through which different anthropologies of mental health have taken shape. For example, social studies of mental health have been shaped by various engagements of ‘culture’ as a form of both contextualisation and critique. More recently, scholars have examined the political, ethical, and therapeutic processes by which people come to constitute themselves and others—for instance, through everyday practices of self-care or clinical diagnosis and treatment—as particular subjects of mental health. Anthropologists have described how people’s experiences of mental health and its associated afflictions are constituted relationally, in different ways, and with different social consequences around the world. The entry ends with a brief discussion of some current topics in anthropological studies of mental health, from the proliferation of mental disorders and the prevalence of neurobiological understandings of human distress to the increasing digitalisation of mental health. As these and other efforts imply, mental health is becoming a prominent field of enquiry in contemporary anthropology and one with renewed ethnographic salience for everyone involved.

Introduction: Situating mental health

The concept of mental health has drawn together a range of ideas and practices that have come to define, and intervene on, what it means to be human. In contemporary English-speaking societies, it is a concept which is often used to express a concern for human well-being in psychological terms. However, what counts as ‘mental health’ is a question of varied social significance as we move historically and ethnographically across time and space. Increasingly, mental health figures as a universal feature in conceptualising humans, and, conversely, mental ill-health is understood to affect humans globally, with an estimate of 970 million (or 1 in 8) people around the world considered to be living with a ‘mental disorder’.[1]

Some anthropologists have argued that mental illness is recognised in every culture, even if the ways in which people experience, treat, and make sense of psychological distress might differ considerably (see e.g. Luhrmann and Marrow 2016). Others have been sceptical of the very language of ‘mental health’ and ‘mental illness’, particularly where it has been deployed to pathologise or criminalise incongruent desires and bodies, as in the case of homosexuality for instance (Foucault [1961] 1988a), and to uphold systems of colonialism and racialisation (Fanon 1963). At the same time, the concept of mental health construed as a

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shared human condition of what it means to be psychologically well has been deemed important and needed; indeed, mental health has in recent decades come to be regarded as a 'human right' by the World Health Organisation (WHO).[1] Increasingly across different social worlds, from local healing practices and national health systems to everyday affairs of care and kinship, global health discourses, and beyond, mental health has emerged as something that 'everyone has'. It is something that, for better or worse, warrants attention and action.

This entry provides a brief exploration of some theoretical and ethnographic interests that have been particularly instructive in anthropological studies of mental health. Before turning to anthropology, however, the entry suggests a way of situating mental health. This can only be done in very general terms here. One important point is that, despite its contemporary ubiquity and salience, mental health is a relatively recent concept that emerged in particular historical (and historiographical) circumstances, shaped by new psychological practices and institutions, through which new constitutions, articulations, and regulations of a 'healthy mind' were effected. Modern psychology now generally considers people to have something called mental health located in the putatively subjective interiority of the individual person, a human interiority which has become aligned with particular notions of 'the mind' or 'the brain' (Luhrmann [2021] 2023; Martin 2021; Rose and Abi-Rached 2013).

The concept of mental health reveals a complex historiography of social transformations over the past two hundred years, from the era of the asylums to the psychiatric hospitals and mental health services with which we are familiar today (Foucault [1961] 1988a; Unsworth 1993; Shorter 2007). It is a concept shaped particularly by two world wars and the emergence of welfare states with the monitoring of publics and populations (Fraser 1984; Busfield 1998; Marks 2017). Importantly, ideas of mental illness have also emerged in contexts of colonisation and decolonisation (Reyes-Foster 2018; Calabrese 2013; see also Fanon 1963). The historical precursor to the concept of mental health has been traced back to the efforts of the 'mental hygiene movement' that took shape in Europe and America during the nineteenth and early twentieth centuries (Bertolote 2008; Novella and Campos 2017). The idea of 'mental hygiene' gained traction in the second half of the nineteenth century and is often credited to the work of William Sweetser (1797–1875), who defined it as the science of preserving a healthy mind (Sweetser 1850). The mental hygiene movement sought to establish public health measures and interventions in the prevention and treatment of mental disorders. In the aftermath of the Second World War, however, the term 'mental health' gradually replaced the language of mental hygiene because the latter had become increasingly associated with Nazi eugenics.

When we move to present-day contexts of the cognitive sciences, mental health figures as a wide-ranging field of research, with several scientific and clinical definitions currently in circulation. The WHO offers the following:

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> Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.[1]

The WHO states further that 'mental health is more than just the absence of mental disorders'. Conversely, according to this definition, mental ill-health implies that a person lies at a 'negative' end of a health continuum. For instance, mental health professionals might speak of 'caseness', of being 'a clinical case' (see e.g. Susko 1994), which means that a person who reports distress considered as pathologically significant is deemed to be suffering from mental ill-health. We see here that the very conception of mental health hinges on one of the key problems in psychiatry, namely the epistemic resolution of the 'normal' and the 'pathological'—including that distinction itself (Canguilhem [1966] 1989; Foucault [1963] 1973). The various 'psy' sciences (Rose 1985) that emerged over the course of the nineteenth and twentieth centuries established themselves by claiming their ability to deal with a range of mental and behavioural phenomena deemed dysfunctional or abnormal. The concept of mental health was thus historically constructed around notions of pathology and the differentiation between normal and non-normal conduct.

Anthropological trajectories

Contemporary worlds of mental health can be seen to constitute a multitude of sciences, technologies, and professions, as well as involve a wide range of therapeutics and care practices within and beyond clinical settings. In the following sections, we are going to look at some key anthropological trajectories in relation to what has been collectively termed the 'psy disciplines', that is, psychoanalysis, psychiatry, and psychology. Anthropologists have increasingly come to treat mental health as an ethnographic topic of central rather than tangential interest. This entry suggests that we might think of different anthropologies of mental health, some of which have developed within specific subfields of social and cultural anthropology, such as medical anthropology, psychological anthropology, and cross-cultural or transcultural psychiatry. Since the early twentieth century, anthropologists have developed diverse ways of studying issues that we might, for the moment, summarise as concerning 'mental health'. However, this term—and other related terms such as 'well-being'—came generally much later in anthropology.[2]

Anthropological research on mental health has often focused on traversing or reconciling the disciplinary fields of anthropology and psychiatry. One key aim was to render anthropological knowledge applicable to clinical problems. To some, this meant accounting for 'culture' in psychiatry, particularly in terms of 'cultural difference' in the perception and experience of illness, and in the classification, diagnosis, and treatment of people (Kleinman 1980; Littlewood and Lipsedge 1997). Within anthropology, it is largely medical anthropologists who have been at the forefront of dealing with these issues in the context of psychiatry—a discipline that has tended to dominate anthropological studies of mental health both

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ethnographically and analytically (see, e.g., Sapir 1932; Opler 1959; Westermeyer 1976; Kleinman 1988; Luhrmann 2000; Littlewood 2002; Brodwin 2013; Jenkins 2018; Pinto 2020).

Ethnographic fieldwork encourages us to take seriously the experiential realities of those we study. Anthropologists might not always find it appropriate, therefore, to assume a particular definition of mental health but tend instead to be more interested in how the people they study are establishing and enacting their own definitions and self-defining worlds: for example, how people might understand, use, resist, and live 'mental health', and the consequences. As such, rather than taking mental health for granted as pre-given or self-evident, we can think of it as something that emerges relationally. This entry suggests that mental health comes to figure in multiple ethnographic senses: as a presumed universal feature of the human mind; a sense of self; a psychological state that can be intervened upon and taken care of; a measure for populations, groups, or individuals; an object of therapeutic enquiry; a matter of concern for those classified as patients; and so on. We could talk here of different 'definitional realities' of mental health that constitute its meaning (see Ardener 1982; Hastrup 1995; McDonald 2020). For instance, clinical evaluations of mental health are inevitably dependent on the conceptual definitions offered of that reality. Analytically, this means that 'mental health' does not figure as an *a priori* phenomenon anterior to its relations and articulations, but as a *category in action*. Some social scientists might want to talk here about the ontological multiplicity of mental health; for example, how it is enacted and coordinated as a matter of concern—similar to the 'doing' of disease in medical practice (Mol 2002).

The 'social' and the 'psy'

The question of mental health has been shaped by various attempts to either separate or reconcile the social and the psychological. Such attempts were particularly influenced by anthropological studies of the so-called 'primitive mind', the 'personality of culture', and the nature of human cognition. Anthropology addressed mental health as an object of study, in an important sense, via the scientific ambitions of the early psy disciplines, notably late-nineteenth-century and early-twentieth-century psychoanalysis and experimental psychology. Yet mental health was often only implicitly dealt with, eclipsed by prevailing ambitions at the time to ascertain a universal human psychology—'the generalised mind'—inspired in part by the German experimental psychologist William Wundt's (1832–1920) 'introspective' methods, as well as by subsequent anthropological investigations into what was then seen as the 'primitive' or 'savage' mind (Martin 2021, 26–51; see also Rieber 1980; Mandler 2011). Influenced by Darwinian evolutionism and its underbelly of Victorian scientific racism, a widespread theory of human psychology claimed that so-called 'primitive' people lacked higher mental functions while they surpassed 'civilised' people in physical performance, because more energy was seen to remain devoted to their physicality as opposed to their mentality (Martin 2021, 37). This theory was put to test, and eventually challenged, by the 1898 Cambridge Anthropological Expedition to Torres Straits (Haddon 1901; Herle and Rouse 1998; Sullivan 2012), which

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also sought more generally to investigate psychological ‘introspection’, namely the inspection of one’s own internal mental processes. The expedition was influential in shaping both modern anthropology, and in bringing together psychology and anthropology with a common interest in what we might now want to see as an early version of mental health research.

However, the relationship between anthropology and psychology as exemplified by the Cambridge Expedition did not end in a happy marriage. On the contrary, in Britain and elsewhere, the social and cultural were in many ways further delineated in contradistinction to the psychological. During the early twentieth century, new disciplinary identities emerged as practitioners marked out social science (including anthropology) distinct from psychology and natural science. For example, the British anthropologist Edmund Leach treated psychology as a discipline against which social scientists are ranged. He asserted that ‘[the anthropologist] will be well advised to leave psychological matters to psychologists and stick firmly to the public sociological facets of the case’ (1958, 148). This was a disciplinary division of labour according to which the world was also divided into a presumed separation of the public and private, the collective and individual, the external and internal. One of the pioneers of British social anthropology, Bronisław Malinowski (1884–1942) effected his own disciplinary boundary-making by way of critically engaging with psychoanalysis. In *Sex and repression in savage society* (1927), Malinowski famously examined the Freudian ‘Oedipus complex’ in the context of Trobriand kin relations and child development, which led him to dismiss any notion of Oedipal universality claimed by psychoanalysts of the day. While Malinowski remained a critic of psychoanalysis and its ‘exorbitant claims’ throughout his career, he also contended that its ‘open treatment of sex […] is of the greatest value to science’ (Malinowski 1927, vii–viii). Although Malinowski and Leach, and, before them, Émile Durkheim ([1912] 2008), had long moved the ‘social’ away from the ‘psy’, the question of human interiority—for some the seat of cognition, emotion, and subjectivity, complete with an individuated mind or consciousness (indeed, what many today might think of as pertaining to mental health)—never completely disappeared from anthropology.

Influenced by the work of Franz Boas (1858–1942), another famous anthropological pioneer, developments in American cultural anthropology during the first half of the twentieth century offered a rather different engagement of psychological theories. The most prominent development came from the ‘culture and personality’ movement during the 1920s and 30s instigated by the work of Edward Sapir, Ruth Benedict, and Margaret Mead (all former students of Boas) and which subsequently fed into the American-bred field of psychological anthropology (Ingham 1996; LeVine 2010; see also Mead 1928; Sapir 1932; Benedict 1934). Applying their own critical reading of Freudian psychoanalysis, they argued that human behaviour is ‘culturally patterned’, just like speech is patterned by a particular language. The cultural patterns of childhood experience were thus considered to be the cause of adult personality characteristics, which in turn gave rise to culture-specific patterns of mental health and forms of psychopathology. The aim was for some to develop a generalised cultural description of mental health through ethnographic research on

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individual personalities and, by extension, the personality of cultures. For other anthropologists, however, such an ambition simply confirmed what they had previously suspected, that a psychologised version of anthropology was susceptible to reductionism and overgeneralisation (LeVine 2001).

It was only much later with the 'cognitive revolution' of the 1970s, that 'psy' gradually came to occupy another conceptual space among anthropologists as they began to move from the mythic and symbolic universe of structuralism (owed to the work of Claude Lévi-Strauss, and those who read him, see e.g. 1963) to the laboratory of cognitive science. New evolutionary theories equipped anthropologists with novel rethinkings of 'cognition' (e.g. Bateson 1972) that shaped the emerging subfield of cognitive anthropology (Blount 2011). Importantly, some anthropologists challenged what to them appeared to be their discipline's ignorance of a properly scientific study of human mental life. Cognitive anthropology sought to put an end to the Durkheimian separation of the social from the psy that had informed so much of anthropology. However, mental health was still largely a taken-for-granted object in cognitive anthropology, which has tended instead to examine the transmission of cultural representations, Theory of Mind (ToM), innate modularity, and cognate ideas (see Whitehouse 2001; Bloch 2012; Irvine 2018). In all such endeavours, and in those that have come after, the concept of culture looms large.

Culture and mental health

Anthropological studies of mental health in the second half of the twentieth century have been driven by efforts to account for 'culture' and 'cultural differences' that came out of interdisciplinary borderlands between psychiatry and anthropology, sometimes referred to as 'cross-cultural' and 'transcultural' studies (cf. Opler 1959; Westermeyer 1976). Culture was also taken up as a language of anthropological critique. For example, the psychiatrist-cum-anthropologist Roland Littlewood has argued that the concept of culture remains ambiguous for psychiatry as it has tended to perceive it as secondary to a biomedical reality. He argued that psychopathology is inherently 'local', and that the discipline of psychiatry has its own tacit 'culture' (Littlewood 1996). Earlier work had already introduced the idea of 'the cultural construction of clinical reality' and encouraged 'a clinical social science capable of translating concepts from cultural anthropology into clinical language for practical application' (Kleinman, Eisenberg and Goods 1978, 140). Its authors urged a distinction between 'disease' and 'illness', as well as the concept of 'explanatory models' that sought to include and elicit the 'patient's experience' of disease and treatment: how do people understand and live with mental illness? How is disease perceived in cultural terms? What or who caused it, and how? This work seemed in many ways novel and important, but it still took for granted many of the old dichotomies of medicine. For instance, Kleinman and his colleagues presented a scenario of doctors with scientific 'knowledge' and patients with culturally determined 'beliefs'; with 'disease' (medical reality) on the one hand, and 'illness' (cultural experience) on the other.

The disease versus illness distinction has informed much research in the intersecting fields of anthropology

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and psychiatry, as well as beyond: it is now a common component of clinical education programmes where it features as a way of reinserting 'the cultural context' where such is deemed lacking or to acknowledge 'the patient perspective'. Yet this conceptual binary can also imply a problematic separation of the physical versus the mental whereby the former is seen as underlying (biological) causation and the latter as mere (cultural) representation. This has tended to presuppose that neurobiology—as a seemingly culture-free reality—is the ontological foundation of mental health upon which perceptions and experiences of it are culturally or socially constructed. We can trace many contemporary versions of this type of social and cultural constructionism in anthropologies of mental health and related fields.[3]

The earlier work of Kleinman (1980; 1988) along with the anti-psychiatry movement of the 1970s (e.g. Szasz 1974) nevertheless had a significant impact in confronting psychiatry with 'culture', although their reasons for doing so differed greatly: anthropologists generally sought to improve psychiatry rather than dismantle it. Even so, anthropologists now seemed equipped to take apart the cultural preconceptions built into psychiatric diagnoses and treatments in a manner that exposed psychiatric conceptions of mental disorder as inherently ethnocentric, revealing underpinning cultural biases and assumptions (Littlewood and Lipsedge 1997). Anthropologies of mental health and illness have since been routinely embedded in constructs of 'cultural difference' or 'different cultures' (e.g. Littlewood and Dein 2000; Luhrmann et al. 2015; Onchev 2019). The language of culture has also been considered a worthwhile mode of contextualisation in a field of research that still tends to be dominated by biological determinism (e.g. Sargent and Larchanché 2009). Some anthropologists have found it compelling to talk of 'the culture' of the mental health clinic (Luhrmann 2000, 119–57); of differences in professional and therapeutic cultures, with diagnosis, treatment, and patients recontextualised. More recently, new interdisciplinary engagements between anthropology and psychology have described how different cultures 'invite' people to relate to their mind in particular ways, which in turn affects the kinds of mental experiences people have and how they make sense of them (Luhrmann 2020; Weisman et al. 2021). Understanding mental health here means grasping shifting cultural models of mind.

Historically, anthropologists have thus been largely responsible for introducing the concept of culture to the study of mental health (cf. Mead 1953; Opler 1959; Westermeyer 1976), although it did not always bring about the anthropological insights that occasioned it. For example, 'cultural competency' now regularly features as an important educational component of many mental health training programmes and services (e.g. Carpenter-Song, Schwallie and Longhofer 2007). But cultural competency efforts, despite their best intentions, can appear to treat culture simply as a variable to be accounted for. Different differences—what might be seen as pertaining to nationality, gender, ethnicity, race, and sexuality—are often brought together under a single denominator of the 'cultural', thereby eliding a range of experiences altogether.[4]

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The concept of culture has in many ways effected its own problems. Introducing 'culture' in studies of mental health, as suggested above, meant introducing 'context' and then 'meaning'. Yet, in these instances, culture is easily reified in ways that some anthropologists might find rather problematic (Strathern 1995; Fox and King 2002; McDonald 2012). For example, speaking about different cultures of mental health might imply an unhelpful normativity that requires further anthropological validation, and evoking culture as a mode of contextualisation and critique does not always differ significantly from people's own self-understanding. Whitney Duncan (2017) explores this latter point in her ethnography of psychoeducation (*psicoeducación*) in Oaxaca, Mexico. Working with psychologists and patients in and around a psychiatric hospital, she describes how mental health practitioners come to understand culture as a barrier to mental healthcare. They strive to further 'psy-globalisation'—the transnational flow of ideologies and practices around mental health. Practitioners see themselves as involved in a global and modernising movement to promote mental health but express frustration about how difficult this project is in Oaxaca, where 'local culture' prevents their efforts (Duncan 2017, 37). Mental health practice thus emerges as a project of what she terms 'psychological modernisation', a movement that is defined against its own perception of local culture (consisting of 'traditional medicine', 'beliefs', and 'magical thinking'). It considers local culture to be incommensurable with global notions of mental health and a source of resistance to mental healthcare and its de-stigmatisation. Not only does psychoeducation in Oaxaca provide a means of self-understanding among professionals and patients alike in the context *of* modernity, Duncan argues, but it also actively seeks to produce the psychological conditions *for* modernity.

From governmentality to self-cultivation

Michel Foucault (1926–1984) has arguably been one of the most influential scholars in social studies of mental health and illness. It was the earlier body of his work on the history of madness and the birth of the clinic (Foucault [1961] 1988a; [1963] 1973) which initially inspired critical examinations of the psy disciplines—speaking of a 'great confinement' of the mad into asylums and new scientific ambitions that effected the authority of a 'medical gaze' (e.g. Hacking 1998; Rose 1989; Danziger 1998). These accounts have traced how, over the course of the twentieth century, psychological knowledge regimes have effected new forms of self-governance—what Foucault called 'governmentality'—and political relations. The insight that whole populations and 'life itself' have become problematised as objects of management and regulation gave rise to the terms 'biopower' and 'biopolitics' (Foucault et al. 1991; Rose 2006).[2] In the formation of (neo)liberal democracy, Nikolas Rose (1996) has shown that diverse psychological knowledge practices require that we 'invent our selves' or constitute ourselves *as if we were selves*. The crux of the arguments that run through much of this and related Foucauldian scholarship is the contention that, in the name of expertise and well-being, the psy disciplines—their institutions, professions, technologies, and interventions—conceal and instil specific moral and political ideologies that shape the ways we come to

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know, relate to, and act upon ourselves and others. Constituted through discourses of individual autonomy, people are rendered responsible for their mental health—for instance, in everyday articulations and requirements 'to take care of yourself'—in the name of their own freedom.

Anthropologists of mental health have also drawn from Foucault's work on 'subjectification' (*assujettissement*) in examining the different modes and processes by which human beings are made into subjects. Subjectification refers not only to a mode of having power and control exercised over oneself ('political subjection') but also to modes of acting upon oneself and others that constitute one as a particular kind of subject (Foucault 1997). When applying this analytical lens to mental health, it can elucidate, for instance, the effects of people subjected to practices of diagnosis and treatment by which they are classified as distinct clinical cases (e.g. 'a patient with anxiety disorder'), at the same time as they are required to take up particular subject positions (see Hacking 1985, on 'making up people'). Consider as example the construction of 'post-traumatic stress disorder' (PTSD). Based on Vietnam War veterans' reports of war-related trauma, PTSD was officially accepted in 1980 as a universal disorder, when it was included in the third edition of the American Psychiatric Association's *Diagnostic and statistical manual of mental disorders (DSM*-III*)*. This followed a political struggle by psychiatric workers on behalf of the large number of veterans who were seen to suffer from the psychological effects of traumatic memory (Young 1995). Contrary to the depiction of the disorder in psychiatric classification practices, PTSD may thus not be timeless, nor does it possess an intrinsic unity:

> Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilised these efforts and resources' (1995, 5).

Young shows how clinicians in the US applied the diagnostic criteria to include people that they felt ought to be seen as mentally ill and shows the way patients in turn began to present themselves in such a way as to fit into the diagnostic categories of PTSD.

Moreover, some scholars have argued that psychiatry's capacity to define the 'mentally ill' has been achieved partly through the making and remaking of the *DSM* (American Psychiatric Association 2013)[3] and through historical processes of institutional colonialism, market capitalism, and a medicalisation of human suffering (see e.g. Healy 1997; Kirk and Kutchins 1997; Borch-Jacobsen 2012; J. Davies 2021). This literature targets modern psychiatry and pharmaceutical industries in particular, and has echoes of earlier critiques that came out of the anti-psychiatry movement of the 1960s and 70s (e.g. Fanon 1963; Szasz 1974). This was a movement influenced by Foucault's genealogy of madness, which appeared to expose psychiatry in many ways as a structural oppressor. Foucault's scholarship thus had a significant impact on intellectual anti-psychiatry critics, many of whom held academic positions in psychiatry, although he often distanced himself from the direction in which they took his work.

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Since the 1980s and 90s, then, social scientists have been ready to contextualise and deconstruct mental health within an analytical frame of 'politics'. Neoliberalism—with its associated ideals of autonomy and individual responsibility (Ganti 2014)—has often been evoked as one such political frame within which to locate and critique mental health. Social scientists have pointed to the impact of neoliberal attitudes on social and economic stressors such as unemployment in relation to the rapid increase in 'mental health problems'. Neoliberalism especially shapes depression (Ecks and Kitanaka [2021] 2023) and the growing 'happiness' industry (W. Davies 2015). At the same time, even putatively 'neoliberal' mental health initiatives might be seen to move beyond political agendas and logics with unexpected consequences. For example, some anthropologists argue that the self-governing practices of individuals required to 'work on' their mental health—and any process of subjectification this might entail—are not always sustaining any straightforward or self-explanatory neoliberalism (Cook 2016; Bell and Green 2016). It has also been common in social science studies of mental healthcare for 'politics' (neoliberalism or capitalism, for instance) to be seen and cited as a domain that gets in the way. By the same token, one common way of criticising care has thus been to situate it in the service of politics.

T.M. Luhrmann's (2000) ethnography of American psychiatrists can be read as an objection to the kind of critical studies of the psy disciplines discussed above. Luhrmann refrained from situating her study of American psychiatry in terms of Foucauldian governmentality, deeming such social science perspectives a naive romanticism that does little justice to the suffering subjects:

> Foucault did presume that madness had always existed, but he romanticised it in a way that, despite all his insights, did a terrible disservice to its pain. […] Madness is real, and it is an act of moral cowardice to treat it as a romantic freedom. (2000, 11–2).

Instead, Luhrmann identified two competing paradigms in psychiatry: the psychotherapeutic model (informed by psychoanalysis and psychotherapy) and the biomedical model (informed by neuroscience and pharmacology). Her ethnography provides a remarkable account of the epistemological conflicts between 'talk therapy' and 'drug therapy', and the medico-moral consequences of losing the former to the latter.

More recently, it is Foucault's later writings on ethics and care (see e.g. [1978] 1988b; 1997) that have inspired anthropological perspectives on mental health. People who undergo mental healthcare, for example, can be understood as participating in active processes of self-cultivation through an ethical practice of 'reflective thought' (Laidlaw 2018). Here, one's mental health is constituted as an object of reflection in order to change it, or one's relation to it. Practitioners of 'mindfulness-based cognitive therapy' develop a particular 'distanced perspective' as they are learning to cultivate a detached relation to thoughts and feelings: 'I have thoughts, but I am not my thoughts' (Cook 2015, 223–9). This seeming capacity for introspection, to take one's 'self' as an object of inspection and reflection, is at once assumed and required in psychological therapies as practised in the UK and elsewhere (Bruun 2023). In the face of

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the promise of postsocialist democracy, the work of post-Soviet Russia's psychotherapists can be understood as an ethical practice of freedom, but one that ultimately hinges on 'an ongoing struggle between different assumptions about freedom […] that plays out through precarious care' (Matza 2018, 241). The freedoms sought in post-Soviet Russia are less individualised and based instead on collective forms of 'self-work'. Psychotherapists seek to cultivate mental health for themselves and their clients but are caught between psychology's ambiguous care for the lives of two distinct groups of people—those who accumulated wealth and those who did not—following the collapse of the Soviet Union. There is no easy way out of biopolitics here, but the logics of psychotherapeutic care also enable new ethical orientations, new modes of caring for self and others.

Foucauldian notions of both governmentality and self-cultivation have encouraged anthropologists and mental health practitioners alike: not only have they provided important conceptual frameworks within which anthropologists might contextualise and critique psychological realities, but they have also informed mental health practitioners' own critical assessments of their professional worlds.

Psyches, minds, bodies, and brains

Within the historiographical context of the sciences, mental health emerged in mutual distinction and self-definition: physiology dealt with 'the body'; psychology with 'the mind' or 'psyche'. The so-called 'sciences of the soul' were particularly formative in defining a perceived human interiority through different practices of inspection and introspection (Coon 1993; Danziger 1998; Vidal 2011). The modern disciplines of the clinic thus helped divide the human into the mental and the physical, the psychological and the physiological. We have largely inherited this and other dichotomies from the eighteenth and nineteenth centuries where also 'subjectivity' and 'objectivity' emerged in contradistinction (Daston and Galison 2007). New psycho-technologies and scientific methods of introspection helped constitute 'the human mind' as an object of both scientific observation and intervention (Rieber 1980; Green 2010; Martin 2021). Reified as empirical objects, 'the mind' and 'the body' established in turn universalising ideals about 'mental' and 'physical' health, including their demarcation and distinct disciplinary subdivisions and specialisms.

With the rise of neuroscience in the twenty-first century, some feel that mental health has finally been anchored in the physical reality of the brain (Rose and Abi-Rached 2013). Consequently, a biologically orientated psychiatry now tends to see the distressed mind as a result of a biologically dysfunctional brain. Focusing on the persuasive power of brain images as experienced by people suffering from mental ill-health, Joseph Dumit's (2003) ethnography shows how neuronal connectivities and chemistries, such as neurotransmitters, come to be seen as the aetiology of distress. Through encounters with neuroscientific causation models where brain images (such as PET scans) play a key role, people come to understand themselves as having chemical imbalances in their brain that cause mental illness such as depression. Neuroscientific facts cast the afflicted person as a dysfunctional brain by which they acquire a sense that

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they *are* their brain. The persuasive idea here is that 'the mind is what the brain does'. But this understanding of mental health, in which the person experiences distress because of their brain, also comes to sit in tension with people's sense of an agentive self and a capacity for self-determination: 'is it me or my brain?' (Dumit 2003).

Neurobiological theories that envisage the brain as a chemical laboratory of mental health have, for a long time now, equipped mental healthcare systems with scientific rationales for the use of psychopharmaceuticals in the treatment and management of people who experience distress (Petryna, Lakoff and Kleinman 2006; Jenkins 2010; Oldani 2014). Biomedical models of mental health can thus appear to locate responsibility and agency elsewhere, namely in the biochemical constitution of brains. Conversely, anthropologists have also described how psychotherapists have tended to locate moral responsibility on the part of the afflicted person (Kirsner 1998; J. Davies 2009). Littlewood (2002) has construed this tension as 'naturalistic' versus 'personalistic' explanations of mental ill-health. For the biomedically-trained psychiatrist, however, mental illness was no longer anyone's fault: people were instead suffering from discrete 'disorders' that could be detected neurologically and treated with drugs (Luhrmann 2012). By the 1980s, neuro- and cognitive scientists were throwing out the psyche and Freud had become a footnote in psychology textbooks as psychoanalytic theories and methods were largely discredited. Psychological scientists have since strived hard to situate mental health research in the scientific principles and measures of 'real science' on an equal footing with biomedicine, contending that their discipline could otherwise be lost to 'pseudoscience' (cf. Lilienfeld, Lynn and Lohr 2004).

Notions of the biochemical and genetic brain remain instructive in contemporary understandings of mental ill-health and its treatments (Rose and Abi-Rached 2013). It is partly through the persuasive notion of a universal human physiology that the concept of mental health has acquired its own universality. But it has also brought with it a biological understanding of minds and maladies. For some anthropologists, this entails a problematic reductionism which has caused a 'psychiatric drug epidemic' by way of pathologising human distress (J. Davies 2017). Over the past forty years, numbers of mental disorders have grown exponentially in the publications of international diagnostic manuals, resulting in a proliferation of psychopathologies and market-driven pharmaceutical treatments (Petryna, Lakoff and Kleinman 2006). In an age of psychopharmacology, the 'pharmaceutical self' (Jenkins 2010) continues to shape experiences of mental health with vast social, ethical, and economic effects.

Anthropology encourages us to treat the division of health into the 'mental' and 'physical' as a matter of ethnographic interest. It is, in other words, worthy of study to anthropologists that some people conceptualise health in terms of 'mind' and 'body', and that these divisions in turn mark out different realities deemed 'psychological' and 'physiological'. More recently, the 'biopsychosocial' model, invented by the American psychiatrist George L. Engel (1977), has been an attempt to bring together different disciplines (biology, psychology, social science) alongside their associated realities (body, mind, society).

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Rather than treating these as separate phenomena, this model claims to further a more holistic and scientifically rigorous understanding of humans as biopsychosocial beings. In the context of mental healthcare, such an understanding has in turn encouraged a perspective on treatment in which it is no longer sufficient for interventions to consider only biological or psychological factors. Instead, treatment must include 'the social' in the sense of environment, context, and culture (see e.g. Álvarez, Pagani and Meucci 2012; Gask 2018). According to this model, mental health is not only a case of a biological body (a case of 'brain chemistry', for instance) existing anterior to its psyche, social relations, or environment, but of a whole body-mind-subject—biologically, psychologically, and socially constituted—in a particular cultural world. However, the anthropologist might wonder at the separations and connections that are sought here. We might ask, for example, if the tripartite differentiation put forward in the 'biopsychosocial' is still suggestive of a problem rather than offering a novel reconciliation.

The proliferation of mental health

Following the Covid-19 outbreak in 2020, an upsurge in mental ill-health around the world and its associated medical, social, and economic impacts, including an exacerbation of existing health inequalities, have been widely reported on in scientific journals (e.g. Moreno et al. 2020; Wu et al. 2021). The Covid-19 pandemic has reinvigorated mental health as a matter of concern, from local and national levels of concern—pertaining to 'individuals' and 'populations'—onto a cosmopolitan scale as part of 'global mental health' efforts (Yates-Doerr and Maes [2019] 2023). Mental health perceived as a global phenomenon, which might require equally global intervention, seems now a well-established reality that has received further experiential confirmation by reports of a worldwide mental health crisis of depression and anxiety disorders caused by the pandemic (e.g. Santomauro et al. 2021). Anthropological investigations of mental healthcare in times of 'crisis' seem therefore both pertinent and needed (see e.g. Wright 2022).

An important trajectory of anthropological research in the field of mental health has focused on the production of neuroscientific facts (Cohn 2008, 2010; Dumit 2004), the effects of pharmaceuticals (Dumit 2012; Jenkins 2010; Petryna, Lakoff and Kleinman 2006), and the construction of 'disorders', such as bipolar disorder (Martin 2007), autism (Belek [2019] 2023), depression (Kitanaka 2012), and schizophrenia (Luhrmann and Marrow 2016). Furthermore, the expansion of 'evidence-based psychological therapies', especially cognitive behavioural therapy and mindfulness, and a proliferation of mental health initiatives and psy professions around the world have been a recent focus of ethnography by which new accountabilities, healing modalities, and configurations of care and politics have been examined (Brenman 2021; Bruun 2023; Cook and Cassaniti 2022; Duncan 2018; Huang 2018; Long 2018; Matza 2018; Pickersgill 2019b; Vogel 2017; Vorhölter 2021; Zhang 2020). These studies deal diversely with issues of precarity and access to mental healthcare, the transformation of therapeutic practices within and beyond their particular cultural or clinical environments, and the social and ethical consequences of particular

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scientific, economic, and political framings of mental health.

Another recent direction of research explores the digitalisation of mental health. The proliferation of digital monitoring technologies and AI-assisted interfaces—such as computerised therapeutics, online clinical platforms, smartphone apps, and wearable self-tracking devices—has constituted new fields of digitised mental healthcare (see e.g. Birk and Samuel 2020; Brandt and Stark 2018; Fullagar et al. 2017; Minozzo 2022; Pickersgill 2019a; Trnka 2022). Self-monitoring of 'mental well-being' is now part of many people's daily health regimen as everyday activities of eating, sleeping, work, and recreation have become digitalised objects of observation shaped by ambitions to 'encode wellness' and promote personalised forms of health surveillance (Cearns forthcoming; Bruun forthcoming). This move towards 'digital psy' presents us with 'disparate subjects, practices, places and temporalities of sensing, predicting, diagnosing, or treating mental health' (Bemme, Brenman and Semel 2020). New therapeutic socialities and relationalities have unfolded.

Conclusion

The anthropology of mental health has come a long way. This entry has shown how 'mental health' can figure both as an analytical category in anthropology and an object of ethnography. Ethnographies of mental health can help us grasp not only the structural features of healthcare systems but also the modalities of healing and care in and beyond the clinic (e.g. Meyers 2013; Patton 2010), the medical and moral complexity of psychological distress (e.g. Luhrmann 2000; Zhang 2020), and the experiential realities that take shape around these issues. Where issues of authority and mental illness come together, anthropologists have demonstrated how people might resist, reinvent, or transform the therapeutic worlds in which they live (e.g. Brodwin 2013; Calabrese 2013; Myers 2015). Ethnography also teaches us that people's experiences of mental health are situated in their own and others' classifications and understandings of it (Bruun and Hutten forthcoming). Mental health thus entails particular kinds of theories that people have about themselves and others and the world in which they live. Anthropology can help us better understand why and how people experience mental distress but also what well-being and happiness might mean and look like.

Mental health might be seen to have acquired a hard-won universality. While some find this universality compelling and needed, others are critical of the ubiquity of mental health as an organising concept with the capacity to both normalise and pathologise. Kleinman, among others, contends that the expansion of the category of mental health 'seems to simultaneously trivialize the most serious medical conditions and to medicalize social problems' (2012, 118). He suggests that 'fifty years from now this category will have been abandoned' (Kleinman 2012, 118). Meanwhile, the realities of people's experiences of mental health are unlikely to go away any time soon. In many parts of the world, mental health is now something that 'everyone has'. To have mental health everywhere brings home its ethnographic salience.

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Note on contributor

Mikkel Kenni Bruun is a Research Associate at King’s College London, where he currently works on the ERC SAMCOM project (https://samcom.uk). He also teaches anthropology at Cambridge University and is co-editing a volume on the anthropology of psychology. He holds a PhD in Social Anthropology from Pembroke College, Cambridge.

Dr Mikkel Kenni Bruun, Department of Digital Humanities, King’s College London, Strand, London WC2R 2LS, United Kingdom. kenni.bruun@kcl.ac.uk

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[2] World Health Organization. 2022. “Mental health.” June 17. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response. Accessed 1 October 2022.

[3] World Health Organization. “Health and well-being.” https://www.who.int/data/gho/data/major-themes/health-and-well-being.

[4] Some early anthropological work that sought to study mental health explicitly is collected in the volume *Culture and mental health*, edited by Marvin Opler (1959). Many of its contributors were also professional psychiatrists.

[5] For a critique of cognitivist and cultural models in anthropology and psychology, see Toren 2012.

[6] A related issue concerns ‘structural competency’ efforts in the training of healthcare practitioners (Hansen and Metzl 2019). The ‘structural’ refers here to an analytical shift away from the level of the individual to examine institutional structures (clinical, educational, judicial, etc.) that underlie social determinants of health problems and access to care.

[7] It is important to note that Foucault was dealing mostly with the historiography of the ‘western’ subject. There are other histories and formations, of course. Recent anthropological writing on the relationship between the emergence of the psy

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sciences and colonialism has considered how we might think about presenting this history (Reyes-Foster 2018; see also Fanon 1963, on the 'psycho-affective' effects of colonisation). I am grateful to the anonymous reviewer for drawing my attention to this work.

[8] The *DSM* is currently in its fifth edition (*DSM*-5), published in 2013. It replaced the *DSM*-IV which appeared in 1994. For a critical review of the *DSM*-5, see Hacking (2013).

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