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REVIEW ARTICLE

Unravelling the Dominance: An Exploration of the Relationship Between the Medicalisation of Ordinary Mental Distress, the Primacy of Cognitive Behavioural Therapy, and the Influence of Neoliberal Ideology in the UK Mental Health Economy

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ABSTRACT

This article explores the predominant status of Cognitive Behavioural Therapy within the UK mental health sector, and critiques its alignment with the concept of individual responsibility within neoliberal ideology and the tendency towards the medicalisation of mental distress. Drawing from the field of critical psychology, which historically questions the medicalised approach to mental health within the field of psychiatry, this analysis extends into cognitive psychology's clinical applications and questions the scientific underpinnings and widespread acceptance of cognitive behavioural therapy as the prevailing clinical method. Through a critical literature review and evaluation of existing research, the article reports potential biases and methodological flaws identified by researchers, drawing conclusions that its efficacy has been exaggerated and its scientific credibility might be partly constructed. Furthermore, by reviewing research into the qualitative dimensions of the conceptual framework and discursive practices of cognitive behavioural therapy, the author describes how its dominance could be perpetuating individualistic and pathologizing approaches to mental distress. These approaches contribute to the broader medicalisation trends observed in contemporary mental health practices, which both reflect and reinforce the ideological role of individualism in late modern capitalism.

Keywords: cognitive behavioural therapy (CBT); evidence based therapy (EBT); CBT critiques; medicalisation of mental health; mental distress; scientification of mental health; individualisation of mental health

Introduction

This article will examine the relationship between the significant dominance of Cognitive Behavioural Therapy (CBT) in the modern mental health economy in the UK, the influence of neoliberal ideology within the framework of modern capitalism, and the processes by which ordinary mental distress can become medicalised and pathologised. There is an established tradition in the field of critical psychology which critiques psychiatry for the pathologising of ordinary mental distress. This paper draws on that foundation and expands the critique into the field of cognitive psychology and its clinical practice, to explore the relevance of the dominance of CBT as the predominant treatment modality in the UK. Through a critical literature review and systematic examination of existing research, the article seeks to uncover the underlying assumptions and biases that influence mental health practices, focusing on the scientific validation and widespread adoption of CBT.

Despite substantial evidence supporting CBT's effectiveness, emerging critiques suggest that the research supporting it may be compromised by methodological weaknesses and statistical manipulations that serve more to bolster its scientific image than to provide incontrovertible proof of its efficacy. The article delves into the qualitative aspects of mental health discourses, exploring how the dominance of CBT in the therapeutic landscape aligns with broader political and economic agendas. By unpacking the epistemological and discursive practices of CBT, the discussion will illustrate how these practices contribute to the individualisation, pathologisation, and scientification of mental distress, thereby contributing to the processes of medicalisation.

The rise and rise of CBT: quantitative research and examining the evidence base

As little as fifteen years ago CBT was a little known therapy with a small number of practitioners and a modest reputation. With the rapid roll-out of the Improved Access to Psychological Therapies (IAPT) programme by successive UK governments, CBT has become the 'gold-standard' treatment in the UK for all mild to moderate mental health problems including depression, anxiety, eating disorders, obsessive-compulsive disorders (OCD) and self-esteem issues. Approximately 10 million people have been treated using CBT and it has become the single most-researched therapy in the field of mental health. Research studies consistently evidence its effectiveness in the treatment of anxiety and depression, and the phrase 'evidence-based therapy' has become a signifier for CBT-derived therapy. Nonetheless, this increased access to CBT does not appear to have improved the mental health of the nation. In fact, our mental health appears to be getting steadily worse: prescriptions for antidepressants have doubled in the last twenty years, with 25% of the UK population currently receiving psychiatric medication [1,2].

CBT is the most widely researched of any psychological therapy or psychotherapy modality in the world, and there exists an ever-increasing body of evidence arguing for its efficacy in treating a range of mental health problems including depression, anxiety, eating disorders, panic disorders and post-traumatic stress disorder (PTSD). It is currently the only psychological therapy recommended by the National Institute for Health and Care Excellence (NICE) in the UK for mild to moderate mental health problems. The evidence base for it appears to be scientifically robust, and this remains an important factor in its ascendency since its introduction by the NHS in 2005.

Most of the research into the efficacy of CBT uses quantitative research methodologies and is located in a postpositivist or 'science' research paradigm. This paradigm emphasises the importance of observable, measurable, empirical evidence and should produce relatively objective, reliable and verifiable data; it is therefore trusted by both professional bodies and the public to provide the scientific evidence upon which public policy can be based. A critical examination of the evidence base is necessary to ascertain the validity of this assumption, however.

David and Cristea [3] conducted a metareview of CBT research, including several subsets of CBT, comparing it with trials researching interpersonal therapy and psychoanalytic therapy. They conclude that whilst some of the clinical trial-based research is of low-quality, there is enough research of 'high quality' to assure that CBT has been properly represented in the clinical guidelines. However, they delegate explaining what a 'high quality' study is to another reference [4] and fail to summarise their thinking in this paper. Nonetheless, their statistical metareview concludes confidently that CBT is the proven *gold standard* psychological therapy and that patients should be entitled to access only those therapies–namely CBT and its subsets–that are supported by the evidence base (emphasis in the original). Studies like this are compelling and persuasive, not least because of their statistic-led scientific presentation and positioning in the

positivist worldview as 'empirically-proven'.

It is important to dig beneath the surface, however. The most striking aspect of this particular research, which presents a complex-looking statistical picture comparing multiple studies across various axes, is that it does not explain its methodology. So aside from being a 'metareview', there is no description of how the researchers constructed a comparison framework for the multiple research papers they analysed. The obscuring of the methodology continues with a similar obscuring of how the statistics are being represented. For example, 'K' seems to be the number of studies used but this is unclear; 'g' appears to be the most significant factor in that they claim that CBT has a larger 'g' than other methods but they do not explain how 'g' has been calculated or indeed what 'g' represents across the multiple papers they reviewed. This absence of detail, in a paper which boasts a lot of numerical and statistical detail, is somewhat confusing even to the specialist reader.

In a meta-analysis there always exists the problem of heterogeneity across the different studies: are they measuring and studying the same phenomenon in a similar enough way for comparison? Is there sufficient construct validity in the operationalisation of the concept of 'CBT'? This study does not address these issues. So whilst the paper appears to make a compelling statistical and empirical case for the efficacy of CBT, gathering in a large collection of positive studies, one might also contend that the complex representation of multiple variables serves to obscure and obfuscate rather than produce clarity of evidence.

The advanced numeracy required to decipher this research is neither insignificant nor accidental. It is not inconceivable to come to the conclusion that even a practicing psychologist is not intended to understand this style of presentation of quantitative research in this field: I would suggest in fact that being bamboozled by the figures is a part of the picture. In order to take a critical approach to this as a professional academic discourse, we need to move away from psychology and 'science' and consider theories from within the fields of philosophy and sociology–and in particular the sociology of knowledge–to understand how we might be being misled by this so-called scientific approach to the study of CBT.

It is known in sociology as 'scientification': the process of applying data-driven scientific methods and principles to areas of study which do not necessarily have an a priori fundamental truth waiting to be revealed or discovered by the scientific method. Studying the human mind and human behaviour is not equivalent to studying, for example, cell behaviour, or other biological processes. Treating psychological interventions as if they can be isolated and objectively studied in a scientific manner, requires a number of caveats to be openly addressed in the research protocols; caveats which are rarely acknowledged in CBT research. For example, can the complexity of personalised interventions by individual practitioners be sufficiently manualised to be captured statistically? What is the genuine research value of affording a numerical measure to a subjective experience? How can the research protocol account for what is widely considered to be the most significant factor in successful psychological interventions, that of therapeutic relating?

Kazcurkin and Foa [5] do acknowledge the significant difficulties in operationalising CBT for quantitative research purposes. Their research provides another meta-analysis of various empirical research trials. This analysis acknowledges the complexity of construct validity in seeking to measure the specific components which contribute to beneficial outcomes across different studies. For example, factors such as treatment fidelity and therapist effects are extremely difficult to screen out, to the extent that what is being measured in empirical outcome trials can be highly contested. In acknowledging this complexity Kaczurkin and Foa bring a more nuanced approach than the purely statistical one. Whilst acknowledging the difficulties of operationalising CBT, this analysis also concludes that the majority of the research on CBT supports the effectiveness and success of cognitive methods. However, the control groups in the studies included in their review were either waitlist/no treatment or placebo groups. Therefore what this research does not tell us–and this is not insignificant– is how cognitive therapy performs directly in comparison to other psychological therapies.

A more recent study by Cuijpers et al [6] takes a more circumspect approach to the conclusive nature of the evidence. This is a large study, including 409 trials incorporating 52,702 patients. They conclude that the quality of CBT research has improved over time. This is evidenced by the increasing number of trials with low risk of bias, the decrease in the use of waitlist control groups, and the increase in sample sizes of included studies. This enhancement in study quality helps to reinforce the validity of findings related to the effectiveness of CBT. However, despite these improvements, the study also notes that some analyses indicate large variations in results across the different studies, and some

degree of publication bias. Although the meta-analysis revealed that CBT is generally more effective than other psychotherapies, the difference is nonetheless small and in many sensitivity analyses became non-significant. The study finally concludes that CBT's efficacy appears to be well documented, but importantly the superiority of CBT over other psychotherapies for depression is not clearly established by this meta-analysis.

Notwithstanding methodological issues, it is important to take seriously what appears to be at face value a body of evidence in favour of CBT, produced by quantitative methodologies. However, it is critical to recognise that the claims of 'hard evidence' provided by these empirical studies are contested and this will be further examined in the next section of this paper.

Evaluating the evidence for CBT: a systematic review

There is a growing body of research challenging the hegemony of CBT through a systematic, critical review of the scientific quality of the quantitative research base [7-14]. This is important to consider in order to deepen an understanding of the primacy of CBT and the dominant position it currently holds in the treatment of mental distress. I cite Shedler [12] as an example of such critique, as he offers a systematic review of a body of CBT research. This review is located within a constructionist and transformational research paradigm [15] and is thus transparent about its values in interpreting evidence in terms of their political understanding of the hidden power dynamics and political context in which CBT research is funded and conducted. Shedler's acknowledgement of his subjectivity should not be conflated with bias, however. Contemporary research paradigms in the social sciences do not seek to entirely erase subjectivity, which is considered something of a fool's errand, but rather bring them out into the light for consideration by the reader, who is then in the unique position to decide if the obscured subjectivity of the scientification process is more or less concerning than the named subjectivity of the constructionist researcher.

Shedler identified four concerns with research protocols:-

First, *most patients are never counted* [12(p52)]. He argues that the inclusion and exclusion criteria mean that those patients who meet a DSM criteria for more than one diagnosis, those who have traits of personality 'disorder', those who might be suicidal, or those who are considered 'unstable', get excluded from the studies. As Shedler notes, 'the two-thirds that get excluded are the patients we treat in real-world practice' [12(p52)]. This does not effectively meet the ecological validity requirement of psychological research.

Second, *control groups are shams* [12(p53)]. Schedler argues that evidence-based therapies are rarely compared to a legitimate alternative therapy practiced by an experienced professional in a control group. For example, he cites evidence where the control group 'psychodynamic psychotherapy' was delivered by graduate students with only two days of training. That is just 2 days of training, compared to the more usual 2 to 4 years of training in the UK. Most studies do not even use proper control groups, and are comparing to 'waitlists' or 'no treatment' . As Dalal notes:

> ..it has been empirically demonstrated that patients who think that they are receiving something, anything, do better than those that know that they are not receiving anything (Kirsch, 2011). Both are true of CBT research: it habitually tests its treatments against doing nothing; and because those being tested know that they are in treatment, more of them will say that they feel better than those who know that they received nothing. That's a scientific fact. [8(p587)]

Third, *the superiority of evidence-based therapy is a myth* [12(p54)]. Shedler cites Wampold et al[16] who examined 149 studies claiming to compare evidence-based therapy to another valid therapy. On examination of these alternative therapies, only 14 of the original 149 studies had a control group that were receiving what would be considered a valid 'true-life' alternative psychological therapy. Of these 14, there was no evidence that the manualised therapy performed any better than the control group alternative. Shedler concludes, in agreement with the more recent meta-analysis by Cuijpers et al [6], that the claims to superiority are significantly overblown.

Finally, *data are being suppressed* [15(p55)]. Shedler identifies a strong publication bias, arguing that only the studies that demonstrate the outcome desired by the researcher get published. This inevitably brings a skewed picture of the actual research findings. If 'negative findings' are shelved, the research picture is not accurately representative of the field. This is not valid scientific procedure and does not meet the criteria for scientific objectivity, implied by the positivist worldview within which this research purports to sit. Shedler's findings in this regard are also supported by Dalal[7] and Davies [17].

Shedler paints a picture of a CBT research community with poor adherence to proper research protocols and the manipulation in bad-faith of the often dense and complex statistical evidence. Even more importantly, he argues that the success rates of the outcome studies, once the figures are deconstructed, hover around 25-30% and have not changed in a decade. In other words, 70-75% of patients who receive evidence-based therapies (CBT and its subsets) either do not improve or relapse quickly.

Dalal [8] is similarly scathing about the endemic nature of the corrupt research protocols within CBT research. He cites an example of what he terms 'statistical spin' published in the prestigious medical journal, The Lancet [18]. I quote Dalal at length, as he describes a rather impressive example of statistical spin:

> The abstract states 46% of those who received CBT had improved, reporting at least a 50% reduction in symptoms of depression, compared to 22% [in the control group]. (p. 375) The first thing to notice is the unusual way that the numbers are mentioned – one number for the treatment group and another for the control group – rather than the statistical amalgam of the two that is the norm. This is to cover up the fact that the treatment was found to be helpful to just 23% of those tested (46 minus 22). And notice, the treatment does not cure; all it manages is to reduce symptoms by 50%. Further, the use of the number 50% makes it seem that the measure is objective. But it is not. All that is taking place is that people are being asked is to answer questions like: on a scale of 1 to 5 how depressed are you feeling? Despite the answer being delivered as a number, it is clear that it is subjective. The answer 5 is no less subjective than the answer "very very depressed." It is in this way – the presence of numbers – that it is made to appear that subjective human experiences are being objectively measured. We are witnessing hyper rationality at work. When all this is taken into account, the "results" of this study actually ought to be announced in this way: About two out of ten people came to feel somewhat better because of having received CBT; however, although feeling better, they are still depressed, only less depressed. By the way, eight out of ten people receiving this treatment will not be helped. [8pp587-588]

Dalal goes on to describe his astonishment that such poor pieces of research are routinely published by high status peer-reviewed journals. He wonders if 'the only way to explain it is to say that this sort of chicanery is commonplace and has become part of the acceptable norm.' [8p588]

It is important to acknowledge the context in which Shedler and Dalal are conducting this critical analysis of the research into evidence-based practice. Shedler is a practicing psychoanalytic therapist and Dalal a practicing group analyst; as such they may have a personal investment in challenging the current hegemony of CBT. However, their research is clear about the values in which it is situated and from a transformational worldview is openly critical of the hegemony of CBT and the lack of genuine choice for people who are suffering in distress. And their analysis of the corrupt misuse of statistics is, ironically, as statistically justifiable as the research they critique.

The primacy of CBT and the politicisation of research: an inductive narrative analysis

In the interest of real world validity, it is important to locate this topic within the political context within which CBT has achieved its current hegemony. Because CBT remains the only therapy that receives high levels of public funding in the UK, it is legitimate to ask the question *what task might it perform on behalf of government*? This is a question that has to some extent shaped the research of those who seek to critically analyse the primacy of CBT.

Davies [9] identifies the links between the rise of CBT and what he refers to as the 'new capitalism': a capitalism which emphasises individual responsibility, a reduced role of the state and a significant step away from social democratic capitalism and its commitment to collective responsibilities for state welfare. This ideology is also known as 'neoliberalism'.

CBT was first introduced in the UK as a 'back-to-work' therapy, initiated by Lord Layard–who had been researching the economic burden of unemployment–and David Clark, a cognitive psychologist. Davies argues that the reason the government of the time, and successive governments since, were willing to invest enormous sums of money in promoting, researching and implementing CBT is because it synchronised with the values of new capitalism. That is to say, it emphasises individual

responsibility; it decontextualises and depoliticises distress from any social conditions or determinants; and it reframes distress as a 'medical' problem through the active cooperation with outcome measures which significantly lowered the bar for diagnosis of depression and anxiety, and appear to numerically measure experiences that can then be clustered as 'symptoms'.

CBT is also highly adapted to the culture of managerialism: the use of outcome measures, performance metrics and the tendency to quantification. In a critical discourse analysis of the context in which CBT has thrived, Dalal [8] argues that the scientification of the discourse has led to 'fetishised measurement 'which has obscured what he describes as the 'corrupt science' at play in large parts of the CBT research community [8p580].

Dalal and Davies agree that the reason that unscientific research protocols are overlooked is because of the huge investment that successive UK governments have made in the roll out of CBT through the Improved Access to Psychological Therapies (IAPT) programme. They argue that the research in favour of evidence-based therapies has become politicised by successive governments: because the principles and practice of CBT invest actively in the decontextualisaion of human distress, this allows governments to appear to be investing positively in mental health whilst ignoring the significant body of evidence asserting that the social determinants of mental distress are the most significant [18-21].

To illustrate the issue of individualisation and depoliticisation, Davies undertook an inductive narrative analysis of labour therapeutics in the workplace: 'the application of therapeutic ideas and interventions to the understanding and management of employee distress' [22p1]. All of the therapeutic interventions identified in his narrative analysis of five institutions were CBT based. Davies concluded two propositions: first, that high rates of work stress and dissatisfaction are likely to be reframed as mental ill health located in individual lack of resilience, or in the micro-arrangements of the workplace; second, that either of these narratives are likely to be responded to with individual therapeutic interventions (CBT) that require the individual to resolve the issue at a personal psychological level.

It is important to acknowledge that qualitative research methods such as critical discourse analysis and inductive narrative analysis are deeply subjective. In an inductive narrative analysis the researcher is central to the meaning that is made and not the data itself, which comprises narrative concepts and discourses. The interpretations themselves are always subjective and prone to different nuances according to one's personal ontological and epistemological positions. In a critical discourse analysis this is even more so, as the analysis extends beyond the narrative data itself and into the context in which the phenomena is produced, and by whom, for whom, and who benefits. This is all deeply subjective; however, subjectivity is not sufficient grounds for dismissal. One could equally argue that the reflexive requirements of the qualitative researcher, because of their active engagement with the issue of an ongoing subjectivity, make for a more rigorous research process than one which seeks to cover its epistemological tracks, as happens in the misuse of quantitative methodologies in a framework of scientism.

This article shall now consider the processes and concepts which contribute to the medicalisation of emotional distress.

The process of medicalisation: using interpretive repertoires to examine themes and practices

The concept of 'medicalisation' will be examined using a number of qualitative studies which move overtly into a social constructionist worldview.

Drawing upon Elias's process sociology, Doblyté conducted 21 semi-structured interviews and applied a thematic reflexive analysis to examine the processes in society that may lead to 'unpleasant emotions in everyday life being managed through medical solutions' [23p363]. This research is social constructionist in nature, with a strong leaning into the transformational worldview: the transformational worldview holds as central the idea that research and knowledge should account for structural power differences, and that knowledge should not be constructed as objective or 'neutral' but should have an overtly emancipatory function to account for the fact that structural inequalities are an endemic part of our social world.

She concluded that the medicalisation of human emotion happens at an institutional level as a form of collective action, and also at individual level in terms of the discursive concepts used to describe one's experience. This can be linked to Elias's process sociology [24].

Elias's major influence is on the understanding of the 'civilising process', that is an analysis of how social

norms and behaviours evolve in an interplay between individuals and institutions. In this process the institutionalised social-constraints ultimately become internalised and operationalised as self-constraints: Doblyté notes how the patients in the study came to use medicalised language and constructs to formulate their individual experiences of distress within a health system which was already highly medicalised. She identifies two distinct discursive components: the language of *individualisation* and the language of *scientification*, that is to say the tendency to apply scientific principles in order to understand an issue.

Doblyté does not argue that the discourses of individualisation and scientification necessarily lead directly to the medicalisation of human distress, in a simple cause and effect process, but that they produce what Abend describes as the 'conditions of possibility' [25] that make it possible. They become, effectively, a necessary part of the self-constraint process that arises from the collective need for social-constraints.

The conclusions are informative, but as with most quantitative approaches the resource-intensive method–in this case semi-structured interviews–means that sample sizes are small and therefore difficult to generalise from. Additionally, the interviewees in this research self-volunteered for the project, and it is likely that the politicised nature of the topic of study may generate self selection bias. The researcher's own subjective positioning, which is overtly named in this kind of transformational worldview, also needs to be considered as part of the process of evaluating the validity of the research claims. While this research does not provide 'hard' evidence, the hypothesising that 'scientification' and 'individualisation' are key factors in the medicalising process is a theory that appears regularly across the critical literature, and Doblyté's research in this area is compelling [23,21,27].

In another study employing semi-structured interviews, Jones and Edwards [28] sought to explicitly research the unconscious ontological and epistemological commitments of trainee counsellors using Flyvbjerg's concept of 'rich' or 'thick' qualitative data [29]. The data were analysed using deductive and inductive thematic analysis using Haslam's folk psychology model [30]. Their research found a significant amount of medicalising language used to interpret the mental distress of their client base: the language of disorders and pathology; a positive orientation towards the use of medication; and assumptions that mental distress is caused by biochemical imbalances or neurological malfunctioning.

A difficulty in appraising this evidence is that the researchers did not specify which modality the trainees were training in. Although they describe it as an 'evidence-based therapy' it is not made clear that this is CBT which makes the evidence difficult to evaluate in specific relation to CBT. Also, the sample size is extremely small and so difficult to generalise from. What is notable, however, is that there is not a single counselling modality which openly locates itself within a medical model: all modalities fall under the broad umbrellas of humanistic, psychodynamic or cognitive-behavioural. This research appears to suggest that medicalised discourses operate outside of critical awareness, to some extent, of the overtly identified epistemological frameworks of humanistic, psychodynamic or cognitive-behavioural.

The conceptual framework of CBT: a Critical Discourse Analysis

It is not possible to examine the links between CBT and medicalisation without analysing the conceptual framework CBT is situated in and its epistemological foundations. Quantitative measurements of CBT's efficacy do not inform the reader about its concepts, values, and epistemology. For that, we need research which pays attention to the epistemological and discursive constructs which produce particular kinds of meanings and practices in order to establish whether or not CBT can be considered to contribute to a 'medical model'. This requires the use of research methods which can dig deeper into the more obscured aspects of how CBT is constructed, utilised and leveraged in the mental health economy.

Ratnayake [31] employs a critical discourse analysis (CDA) to critique the conceptual and theoretical framework of CBT. Using an abductive logic of inquiry, he begins from a given, stated assumption that the medicalisation of ordinary human distress is a feature of modern mental health services. His research critically analyses the epistemology, the context, and the texts and practices of CBT, to investigate how CBT may contribute to the issue of medicalisation.

This research looks for two different strands to the discourse: first, the tendency to pathologise ordinary distress and second, the tendency to medicalise by presenting symptoms as requiring specialist psychiatric, therapeutic, or medical interventions. Ratnayake begins with the key constructs of CBT.

The key theoretical construct in CBT therapy is the notion that human distress is caused by 'distorted

thoughts': it is not the material conditions of a given situation that causes unhappiness, depression, anxiety or low self-esteem, but rather the 'cognitive distortions' that prevent the individual from being able to cope with it. These cognitive distortions are of two types: *validity,* relating to the 'inaccuracies' of the thought; and *utility,* relating to the 'usefulness' of the thought. The cornerstone of CBT therapy is in confronting these distortions, described variously as 'faulty', 'inaccurate', 'maladaptive' 'unhelpful' and 'irrational'. But the core issues for Ratnayake is that of 'typicality'.

His systematic analysis of the conceptual framework of CBT illustrate that the CBT practitioner has to hold as central a set of tenets about what is a 'typical' or 'rational' thought, and establish to what extent the patient is expressing distortions from that typicality. Ratnayake argues that the premise of the therapy, therefore, is to assume that the patient in front of you is engaging in irrational, cognitive distortions which produce their inability to cope with their material circumstances. He makes the case that what might be an entirely normal response to a romantic break up, for example–"I will never love anyone like that again!"–in this conceptual framework is constructed as maladaptive pathology. Assigning these thoughts as 'atypical', as a deviation from the norm, he argues is a 'prima facie' case for believing that CBT pathologises and medicalises individuals having ordinary, 'irrational', emotional experiences.

Ratnayake wants to expand this interpretation to the whole of psychotherapy; using CBT as a test case in this paper his claims are that they can be applied across the board to psychotherapy as a discipline. Conflating the cognitive approach with humanist and psychodynamic approaches is highly contested territory, and this to some extent undermines the credibility of the paper. Nonetheless, the central argument that the fundamental premise of CBT is one which pathologises very small deviations from the norm, from typicality, is an important one.

Discussion

The exploration of the medicalisation of mental distress is warranted for both pragmatic and existential reasons. Pragmatically, A mental health diagnosis may affect insurance access, employment opportunities, the right to adopt or foster children, or take up particular kinds of public office, and a diagnosis can be stigmatising and life-limiting. But there are also more existential reasons: Medicalising individual experiences strips mental distress of its social context, its psychological and existential meaning, and locates it squarely within the realm of individual self-deficit. Emotional responses to the vicissitudes of life cease to be understood as the effects of life-diminishing social and structural inequalities, or individual adverse life events, but become firmly located as self-deficits to be resolved purely at an individual level. It is a reductionist understanding which demands a wholly individual resolution.

Central to the discussion are four discursive strands that characterise the medicalisation process: biomedical explanations, the pathologisation of experience, the individualisation of experience, and the scientification of concepts, treatment and research.

Regarding the biomedical model, It is important to note that despite billions having been spent on research in the past half century, no such biological substrate has yet been found for any mental illness, challenging the assumptions of a biological substrate to mental ill health [1,21,32,]. Despite this, it remains a prevailing part of mental health discourse even outside of medical disciplines. In terms of the question under discussion here, It is true that the foundational assumptions of CBT are not overtly situated in a biomedical framework; CBT is positioned conceptually as a cognitive, not a medical model. Nevertheless, what this article seeks to demonstrate is that the dominance of CBT plays a role in producing the conditions of possibility for the medicalisation of ordinary distress in its tendency towards pathologisation, individualisation and scientification.

The evidence provided regarding the epistemic framework and the discursive practices of CBT can be seen as actively reinforcing the pathologising processes. Its foundational epistemology produces individualised understandings, stripping mental distress of its social and political context and locating both cause and solution firmly within the psychology of the individual. This is not a 'neutral' or scientific position, but a sociopolitical one. CBT sits at the heart of the new mental health economy, a cornerstone of the neoliberal individualisation of social troubles. It aligns with medical interpretations that treat experiences such as 'anxiety' and 'depression' as empirical categories and not conceptual ones. It may not overtly use biomedical terminology, but it occupies a pivotal place in the modern discourse about mental health: a key part of the decontextualisation and depoliticisation of the concept of 'mental health' in late stage capitalism.

Importantly, this does not in any meaningful way reflect the understanding of the vast majority of researchers and professionals in the field, who

agree that the causes of mental health difficulties are multi-factorial: psychological factors relating to adverse childhood experiences; social determinants related to social and structural inequalities and poverty; dysfunctional cognitive constructions; and finally, the possibility of genetic factors which *may* predispose individuals towards particular psychiatric 'illnesses'. This final factor nonetheless remains contested. The issue at hand is that whilst the vast majority of experts in the field–including medical experts–agree that the causes of mental distress are complex and multi-factorial, public health responses in the UK are comprised solely of cognitive therapies (primarily CBT) and medication regimes, and neglect the sociopolitical aspects of mental health.

Moreover, the scientification of the quantitative research base and tendency towards a culture where opaque measurement techniques are 'fetishised' [7] in a culture of hyper-rationality, in Dalal's words, all serve to contribute to an illusion of 'science' that is more beguiling than it is reliable. This reflects a broader, problematic trend in mental health care where scientific research and practice are politicised, often at the expense of a more holistic understanding of mental health.

Conclusion

This article has critically examined the complex interplay between the dominance of CBT, the medicalisation of mental distress, and the sociopolitical context of late modern capitalism in the UK mental health economy. A literature review has found that whilst there appears to be a significant body of scientific evidence for the efficacy of CBT, further systematic review of this evidence highlights a research culture with weak research protocols and an unscientific manipulation of statistical evidence. Qualitative research suggests that the primacy of CBT needs to be understood within a political context: it is the only psychological therapy that receives high levels of both public funding and private funding from pharmaceutical companies, and so one can legitimately ask the question as to whose interests are being served by the ongoing 'success' of this research? Additionally, the epistemological practices of CBT can be seen to play an active part in the processes of individualisation, pathologisation, and scientification, all of which serve to contribute to the medicalising process.

This critique underscores a pivotal concern: the manner in which contemporary capitalism, with its inherent structural inequalities and emphasis on individual responsibility, not only shapes the mental health crisis but also influences the therapeutic modalities deployed to address it. Notably, the analysis presented by Davies [1], Dalal[7,8] and Moncrieff [19] reveals a nuanced critique of how economic and political power dynamics pervade the mental health system, urging a reconsideration of how publicly funded clinical resources can better respond to the complex and multifactorial causes of mental distress.

Conflict of interest statement

The author declares no conflict of interest and has not received any funding towards this research.

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