
Integrating Buddhist Approaches and Cognitive Behavioral Therapy to Address Simulacra-Induced Psychological Issues in Modern Chinese Society

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Abstract

This study examines Simulacra-Induced Psychological Issues (SIPI), a proposed conceptual framework for psychological difficulties associated with prolonged exposure to idealized and algorithmically curated digital representations in contemporary Chinese society. The objectives were to: (1) examine patterns of simulacra exposure and perceived psychological effects; (2) explore functional relationships between selected Buddhist psychological concepts and Cognitive Behavioral Therapy (CBT); and (3) develop a preliminary Buddhist-integrated CBT framework. An exploratory multi-method design combined documentary and scriptural analysis, a descriptive online questionnaire completed by 100 Chinese internet users selected by convenience sampling, and semi-structured interviews with seven experts. Participants commonly reported compulsive checking, anxiety, depressive feelings, emptiness, and cognitive dissonance in relation to digital-media use. Documentary and interview analyses identified three candidate mechanisms: addictive design, idealized settings, and reality replacement.

These findings are descriptive and do not establish prevalence, diagnosis, or causality. Comparative analysis identified possible functional parallels between the Five Aggregates and elements of CBT cognitive processing, and between Yogācāra concepts such as ālayavijñāna and manas and hierarchical belief models; these parallels are heuristic rather than doctrinal or clinical equivalences. The study proposes a Buddhist-integrated CBT model and a 12-session intervention prototype incorporating cognitive restructuring, behavioral experiments, mindfulness, Five Aggregates observation, and optional Buddhist practices. Expert feedback supported further development while identifying concerns regarding complexity, cultural fit, and religious applicability. The model requires instrument validation, pilot safety testing, and controlled outcome research before clinical use.

Keywords: Simulacra; Cognitive behavioral therapy; Buddhist psychology; Five Aggregates; Digital mental health; Chinese society

Introduction

Digital media increasingly shape how individuals encounter images, identities, lifestyles, and social comparison. Baudrillard's concept of simulacra describes representations that may cease to reflect reality and instead help construct a form of "hyperreality," in which distinctions between representation and reality become unstable (Baudrillard, 1995). In contemporary China, the scale of mobile internet and short-video use makes this question especially relevant. According to the China Internet Network Information Center, China had more than 1.1 billion internet users by the end of 2024, and short-video platforms reached a substantial majority of netizens (CNNIC, 2025). These conditions provide an important context for examining how digitally curated representations may influence cognition, emotion, and behavior.

The present study uses the term Simulacra-Induced Psychological Issues (SIPI) as a provisional conceptual framework rather than as a recognized diagnosis. SIPI refers to self-reported patterns such as compulsive checking, appearance-related anxiety, depressive rumination, cognitive dissonance, and difficulty disengaging from idealized digital content. These experiences overlap with established research on problematic short-video use, reward-based learning, social comparison, body-image concerns, and digital well-being (Brewer, 2017; Fardouly et al., 2023; Montag et al., 2022; Potenza, 2014; Zhang & DeAndrea, 2024). The purpose of introducing SIPI is therefore heuristic: to organize potentially related experiences around the perceived replacement or distortion of reality by highly curated digital representations, not to establish a new psychiatric disorder.

Cognitive Behavioral Therapy (CBT) offers an established framework for examining relationships among situations, appraisals, beliefs, emotions, and behavior (Beck, 2011). Buddhist traditions, meanwhile, contain detailed analyses of perception, attachment, suffering, mental conditioning, and the cultivation of mindfulness and wisdom. Concepts such as *māyā*, *pañcakkhandhā*, *paṭiccasamuppāda*, *anattā*, and *Yogācāra* theories of consciousness provide distinctive philosophical and contemplative perspectives on how experience is constructed. The present study does not assume that Buddhist and CBT concepts are theoretically or clinically equivalent. Instead, it examines whether carefully

delimited functional analogies can support a culturally sensitive conceptual model for future research.

Accordingly, this study combines documentary analysis, descriptive questionnaire data, and expert interviews to examine SIPI in contemporary Chinese society, clarify selected Buddhist-CBT correspondences, and develop a preliminary integrative framework. Because the questionnaire was based on a convenience sample and a self-designed instrument, the study does not estimate population prevalence or establish causal mechanisms. Likewise, the proposed 12-session model should be understood as a treatment prototype requiring further validation rather than as an established clinical intervention.

Research Objectives

1. To examine the prevalence and influence of Simulacra-Induced Psychological Issues (SIPI) in modern Chinese society and explore Buddhist perspectives on this phenomenon.
2. To explore the interrelationship between Buddhadhamma and Cognitive Behavioral Therapy.
3. To propose a Buddhist-integrated CBT approach to address SIPI in modern Chinese society.

Literature Review

Baudrillard's concept of simulacra concerns representations that progressively detach from an original referent and participate in the production of hyperreality (Baudrillard, 1995, 1996). In digital environments, algorithmic personalization, visual enhancement, and repeated exposure can intensify the salience of highly curated representations. Contemporary research does not generally use Baudrillard's terminology as a clinical construct, but related studies have examined problematic short-video use, behavioral reinforcement, social-media well-being, social comparison, and body-image effects (Fardouly et al., 2023; Montag et al., 2022; Potenza, 2014; Vogel et al., 2019; Zhang & DeAndrea, 2024). These findings support examining how digital content and platform design may interact with psychological vulnerability, while also cautioning against treating media exposure as a single causal explanation for anxiety or depression.

Buddhist literature provides a different conceptual vocabulary for analyzing perception and attachment. Mahāyāna texts frequently employ imagery

of dreams, bubbles, shadows, or illusory appearances to emphasize the conditioned and unstable character of phenomena (Conze, 1958; Muller, 1999). Theravāda analyses of the Five Aggregates, rūpa, vedanā, saññā, saṅkhāra, and viññāṇa, describe dimensions of psycho-physical experience without positing a permanent self (Bodhi Bhikkhu, 2000; van Gorkom, 2010). Yogācāra traditions further develop the concepts of ālayaviññāṇa and manas to explain continuity, conditioning, and self-grasping ((T 16, no. 672, p. 627a; T 31, no. 1585, p. 9a; Lin, 2016; Waldron, 2003). These frameworks arise from soteriological traditions and should not be reduced to modern clinical categories; however, they may offer useful interpretive resources for examining how perception, habit, and attachment operate in digitally mediated experience.

CBT conceptualizes psychological distress through reciprocal relationships among situations, automatic thoughts, intermediate beliefs, core beliefs, emotions, physiological responses, and behavior (Beck, 1979, 2011). Meta-analytic evidence supports CBT for major depression and anxiety disorders, although effectiveness varies by condition, comparison group, and treatment context (Cuijpers et al., 2016). Buddhist-derived practices have also influenced contemporary therapeutic approaches, especially through mindfulness-based methods and research on reward-based learning and attention (Anālayo Bhikkhu, 2006; Brewer et al., 2021). Nevertheless, borrowing Buddhist concepts for psychotherapy requires conceptual caution, cultural sensitivity, and clear differentiation between religious practice and evidence-based clinical procedures.

The research gap lies not in the absence of work on digital-media-related distress or Buddhist-informed psychological practice, but in the lack of an explicit conceptual model connecting Baudrillardian simulacra, selected Buddhist theories of cognition, and CBT in the Chinese digital context. Existing studies have separately examined problematic short-video use, digital well-being, body-image effects, Buddhist psychology, and cognitive-behavioral approaches (Bodhi Bhikkhu, 2000; Fardouly et al., 2023; Montag et al., 2022; van Gorkom, 2010; Zhang & DeAndrea, 2024). The present study therefore develops a heuristic integration while explicitly distinguishing conceptual analogy from doctrinal or clinical equivalence.

Conceptual Framework

The conceptual framework links three research objectives with documentary analysis, descriptive questionnaire data, and expert interviews,

culminating in a preliminary Buddhist-CBT model for understanding and responding to SIPI (Figure 1).

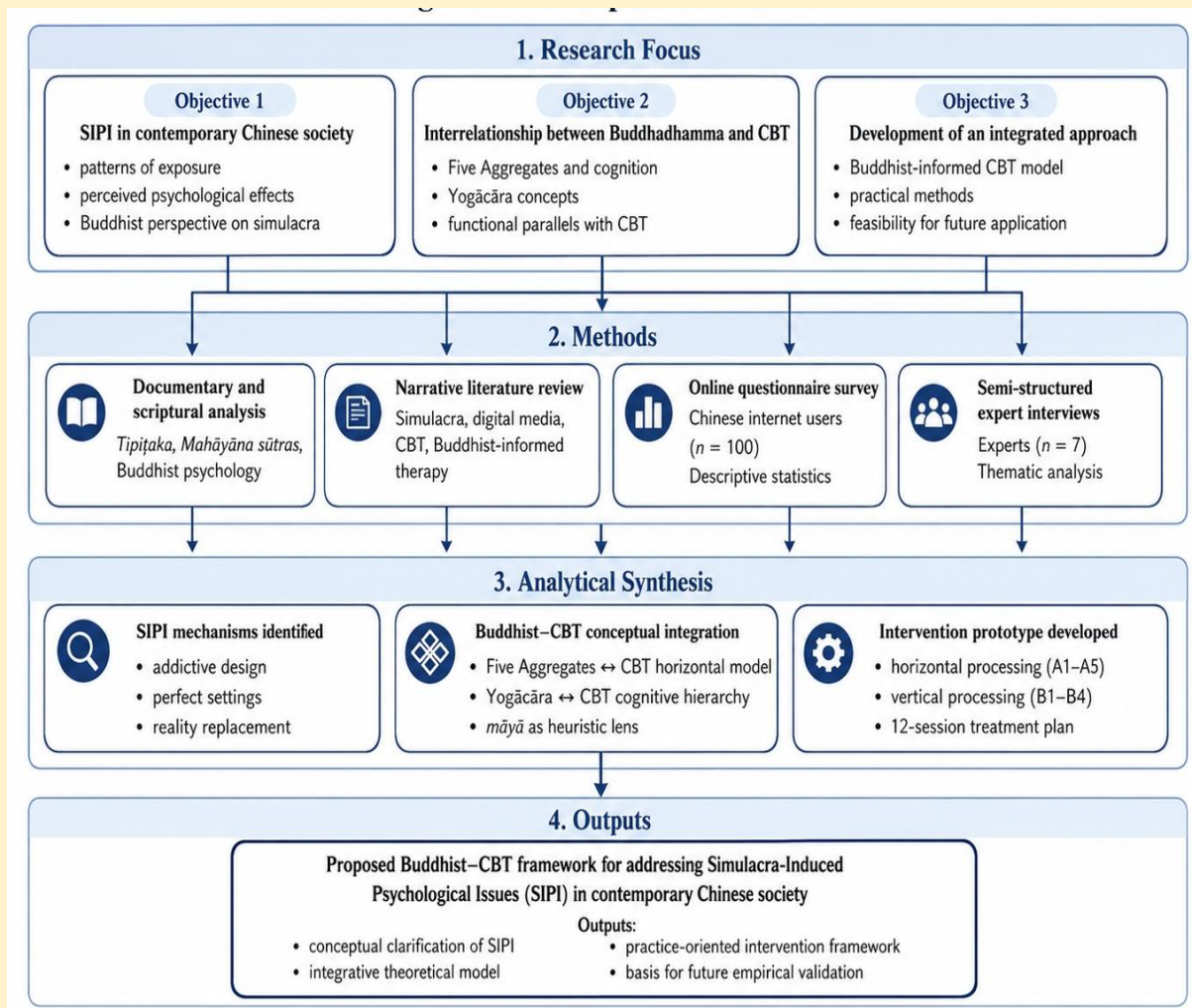


Figure 1: Conceptual Framework

Research Methodology

This study used an exploratory mixed-methods design combining documentary analysis, a descriptive questionnaire survey, and qualitative expert interviews. Documentary analysis examined Buddhist texts, Baudrillard’s theory of simulacra, CBT literature, and relevant scholarship on digital-media-related psychological outcomes. The questionnaire provided descriptive information about a convenience sample of Chinese internet users, while expert interviews evaluated conceptual coherence, cultural relevance, feasibility, and safety considerations. Because SIPI is a proposed construct and the questionnaire was not a validated diagnostic instrument, the study focused on conceptual development rather than prevalence estimation or treatment-efficacy testing.

Data Collection

Documentary sources included selected texts from the Tipiṭaka and Mahāyāna traditions addressing māyā, suññatā, pañcakkhandhā, paṭiccasamuppāda, anattā, and Yogācāra theories of consciousness. Secondary literature covered Baudrillard's theory of simulacra, CBT, Buddhist psychology, problematic digital-media use, and related psychological outcomes. We selected these materials for conceptual relevance to the three research objectives rather than through a systematic-review protocol. References to texts in the Taishō Shinshū Daizōkyō are cited in the conventional form T [volume], no. [text number], p. [page/column].

We administered an online questionnaire in April 2026 using convenience sampling. Eligible participants were Chinese citizens who used mobile internet daily, could use mobile devices independently, voluntarily agreed to participate, and provided informed consent. The self-designed 22-item questionnaire covered four domains: usage patterns, perceived addictive features, self-reported psychological states, and cognitive perceptions. Of 110 responses received, 100 were retained for descriptive analysis. No standardized diagnostic scale was embedded in the instrument; therefore, the results represent self-reported patterns within this sample and should not be interpreted as clinical prevalence estimates.

Seven experts were interviewed online using a semi-structured guide aligned with the three research objectives. Participants represented Buddhist studies, psychology, sociology, and media-related professional experience. Interviews were conducted in Chinese, lasted approximately 30–60 minutes, were audio-recorded with consent, and were transcribed for analysis. Questions addressed the conceptualization of SIPI, the plausibility and limits of Buddhist-CBT integration, and the feasibility and safety of the proposed intervention components.

Data Analysis

Documentary materials were analyzed comparatively to identify conceptual relationships and differences among Baudrillardian simulacra, Buddhist models of cognition, and CBT. Particular attention was paid to avoiding direct equivalence between constructs derived from different philosophical, soteriological, and clinical traditions. The questionnaire data were summarized

using descriptive statistics only. No inferential statistical analysis was undertaken.

Interview transcripts were analyzed thematically through familiarization, initial coding, theme development, review, definition, and reporting. Expert feedback was used to refine the proposed framework and identify implementation concerns, including religious appropriateness, therapist competence, client screening, informed consent, and the need for pilot testing. The expert review was treated as a feasibility assessment rather than evidence of treatment effectiveness.

Research Ethics

Participants received information about the study purpose, voluntary participation, confidentiality, and the right to withdraw. The questionnaire did not intentionally collect direct personal identifiers, and interview participants provided informed consent before recording. The researcher stored research data on a password-protected device. Because the manuscript does not report an institutional ethics-review reference number, add this information before publication if formal ethics approval or exemption was obtained.

Research Results

Objective 1: Self-Reported Patterns Associated with SIPI and Buddhist Interpretation

National internet-use statistics establish the broader digital context rather than the prevalence of SIPI. By December 2024, China had approximately 1.108 billion internet users, an internet penetration rate of 78.6%, and more than 1.04 billion short-video users (CNNIC, 2025). These figures indicate extensive exposure to digitally mediated and algorithmically curated content, but they do not in themselves demonstrate psychological harm or SIPI.

Within the convenience sample of 100 respondents, substantial proportions reported heavy smartphone use, frequent checking, perceived addictive platform features, anxiety, depressive feelings, and dissatisfaction with offline reality. For example, 62% reported compulsive checking and 60% reported unlocking their phones more than 50 times per day. Self-rated anxiety and depressive symptoms were also common. These percentages are descriptive sample findings only: the questionnaire used non-validated response categories and cannot establish diagnosis, severity, national prevalence, or causal attribution to simulacra.

Accordingly, terms such as “addiction symptoms,” “compulsive checking,” and “moderate-to-severe anxiety/depression” should be understood as participants’ self-descriptions rather than clinician-assessed conditions. The findings are best interpreted as signals of potentially problematic digital engagement that warrant further study with validated measures and representative sampling.

Three interrelated mechanisms were identified conceptually: addictive design, idealized representation, and perceived reality replacement. Addictive design refers to platform features such as rapid rewards, metrics, and personalized recommendation systems that may reinforce repeated engagement (Brewer, 2017; Eyal, 2014; Montag et al., 2022). Idealized representation refers to filtered, beautified, or selectively presented content that may intensify social comparison and dissatisfaction. Perceived reality replacement refers to increasing psychological investment in mediated environments at the expense of engagement with offline activities. These mechanisms are theoretical propositions derived from the documentary analysis and participant reports; this study did not test them experimentally.

The proposed mechanisms may help organize experiences such as compulsive checking, appearance-related anxiety, depressive rumination, and cognitive dissonance, but they should not be interpreted as established neurobiological pathways. Existing literature suggests associations between problematic digital-media use, reward learning, body-image concerns, social comparison, and psychological distress (Fardouly et al., 2023; Montag et al., 2022; Potenza, 2014; Vogel et al., 2019). The present study did not measure dopamine, neural activity, or clinical outcomes and therefore cannot demonstrate biological causation.

The documentary analysis also identified a heuristic relationship between simulacra and Buddhist descriptions of illusion. Mahāyāna texts use metaphors such as dreams, bubbles, shadows, “flowers in the sky,” and the “second moon” to emphasize the conditioned and unstable character of appearances (Conze, 1958; Muller, 1999). Digital simulacra can be interpreted through this lens insofar as they are constructed, contingent, and potentially mistaken for a more complete representation of reality. The Mahāprajñāpāramitā Śāstra similarly analyzes material form as lacking fixed independent reality (T 25, no. 1509, p. 349c). This comparison is philosophical and interpretive rather than empirical.

Baudrillardian simulacra and Buddhist māyā should therefore remain conceptually distinct. Baudrillard analyzes the relation between representation, signs, and hyperreality, whereas Buddhist traditions use māyā and related concepts within broader analyses of impermanence, dependent origination, emptiness, and liberation (Baudrillard, 1995; Bodhi Bhikkhu, 2000; van Gorkom, 2010). The comparison functions as a heuristic for examining attachment to digitally mediated appearances, not as a claim of ontological equivalence.

The study initially considered broader cultural and social explanations for the expansion of simulacra in China. Such explanations should be interpreted cautiously because the present design did not test national cultural traits, educational attainment as a causal factor, or macroeconomic determinants of digital-media use. The most defensible conclusion is that technological availability, algorithmic distribution, social comparison, entertainment demand, and psychosocial stress may interact in shaping digital engagement; establishing their relative contribution requires separate population-level research (CNNIC, 2025).

Therefore, understanding both the external mechanisms and internal psychological processes of simulacra is essential for developing sustainable approaches to mental health and well-being in contemporary Chinese society.

Objective 2: Heuristic Relationships Between Buddhadhamma and CBT

The analysis identified several possible functional parallels between Buddhist descriptions of mental processes and CBT, while also identifying substantial doctrinal differences. Both traditions examine how perception, interpretation, habit, and repeated mental activity shape distress and behavior; however, CBT is a clinical framework oriented toward psychological functioning, whereas Buddhist systems are embedded in ethical and soteriological projects concerned with suffering, non-attachment, and liberation (Beck, 2011; Bodhi Bhikkhu, 2000; van Gorkom, 2010).

The comparison between the CBT horizontal model and the Five Aggregates is therefore presented as heuristic rather than structural equivalence. External situations may be compared with sense objects and material form; feeling (vedanā) with affective tone; perception (saññā) with recognition and meaning-ascription; and volitional formations (saṅkhāra) with tendencies, intentions, and habitual responses. Consciousness (viññāṇa), however, is not equivalent to emotion or behavior, and the Five Aggregates are not a linear information-processing sequence. Table 1 therefore presents functional

similarities together with explicit differences (Beck, 2011; Bodhi Bhikkhu, 2000; van Gorkom, 2010).

Canonical descriptions of the Five Aggregates emphasize impermanence and non-self rather than a fixed psychological sequence (Bodhi Bhikkhu, 2000). Accordingly, any mapping to CBT should be interpreted as a pedagogical device for generating questions about experience, not as a doctrinal translation of the aggregates into contemporary cognitive science.

To clarify this comparison, the following table presents both similarities and important differences between the CBT model and the Five Aggregates framework.

Table 1. Heuristic Similarities and Differences Between the CBT Model and the Five Aggregates

CBT Component	Proposed Buddhist Parallel	Possible Functional Similarity	Important Conceptual Difference
Situation	External rūpa / six sense objects	Both refer to conditions or stimuli encountered by the individual.	A CBT “situation” may include external events, memories, bodily states, or internal experiences, whereas <i>rūpa</i> specifically concerns material form and is only one of the five aggregates.
Initial processing / Process 1	Vedanā (feeling)	Both may involve an early affective response to contact with an experience.	<i>Vedanā</i> refers specifically to the hedonic tone of experience, pleasant, unpleasant, or neutral, and is not equivalent to a general cognitive-processing stage.
Automatic thoughts	Saññā (perception)	Both involve rapid recognition, labeling, and interpretation of experience.	<i>Saññā</i> is a broad perceptual function involved in recognition and designation, whereas automatic thoughts are situation-specific verbal or imaginal cognitions within CBT.
Intermediate processing / Process 2	Saṅkhāra (volitional formations)	Both may involve tendencies, intentions, impulses, and patterns that shape subsequent responses.	<i>Saṅkhāra</i> is a much broader Buddhist category encompassing volitional and conditioned mental formations and cannot be reduced to a single CBT processing stage.
Emotion, behavior, and physiological response	Viññāṇa and kamma-related response	Both concern aspects of conscious experience and subsequent behavioral responding.	<i>Viññāṇa</i> refers to consciousness dependent on sense contact and is not an “outcome” of the preceding aggregates. <i>Kamma</i> concerns intentional action and has a doctrinal scope substantially broader than behavioral response in CBT.

This comparison is heuristic rather than doctrinal. The Five Aggregates are not simply a linear cognitive model but a comprehensive classification of all psycho-physical phenomena, emphasizing their impermanent and non-self nature (Bodhi Bhikkhu, 2000; van Gorkom, 2010). *Rūpa*, *vedanā*, *saññā*, *saṅkhāra*, and *viññāṇa* each have broader doctrinal meanings than their assigned CBT counterparts. This comparison aims to identify functional parallels for therapeutic application, not to equate the two systems ontologically.

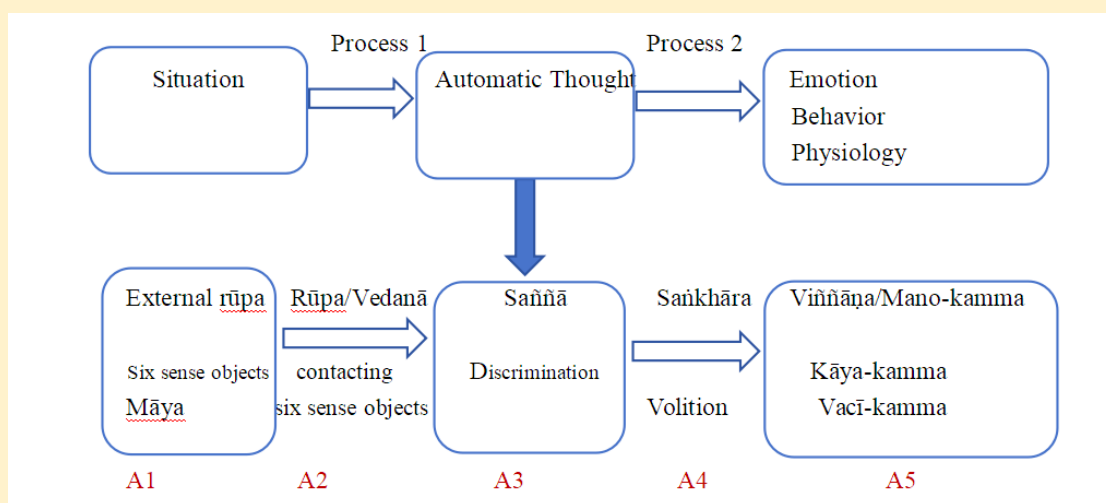


Figure 2. Heuristic Transformation from the CBT Horizontal Model to a Buddhist-Informed Model

A second heuristic comparison concerns the CBT hierarchy of automatic thoughts, intermediate beliefs, and core beliefs and Yogācāra accounts of the first six consciousnesses, manas, and ālayaviññāṇa. Both frameworks address different levels of psychological patterning and continuity, but they arise from different theoretical purposes. CBT core beliefs are clinically formulated propositions about the self, others, and the world; ālayaviññāṇa is a Buddhist philosophical construct concerning karmic continuity and latent tendencies. Likewise, manas refers to a form of self-referential appropriation rather than a direct equivalent of intermediate beliefs (Beck, 2011; Lin, 2016; Waldron, 2003).

Yogācāra texts describe ālayaviññāṇa as a basis for the continuity of latent seeds (bīja) and manas as persistently appropriating this stream in relation to selfhood (T 16, no. 672, p. 627a; T 31, no. 1585, p. 9a; Lin, 2016; Waldron, 2003). These concepts may provide a comparative vocabulary for discussing deeply conditioned cognitive patterns, but the analogy should not imply that

Buddhist consciousness theory anticipated or validates CBT. The clinically relevant question is whether the comparison helps clients or practitioners understand patterns in a culturally meaningful and ethically appropriate way.

Accordingly, the proposed correspondence is explicitly heuristic. Yogācāra concepts belong to a soteriological framework concerned with saṃsāra and liberation, whereas CBT constructs are designed for case formulation and psychological intervention. Functional parallels may support conceptual dialogue, but ontological, mechanistic, and clinical equivalence cannot be inferred (Beck, 2011; Lin, 2016; Waldron, 2003).

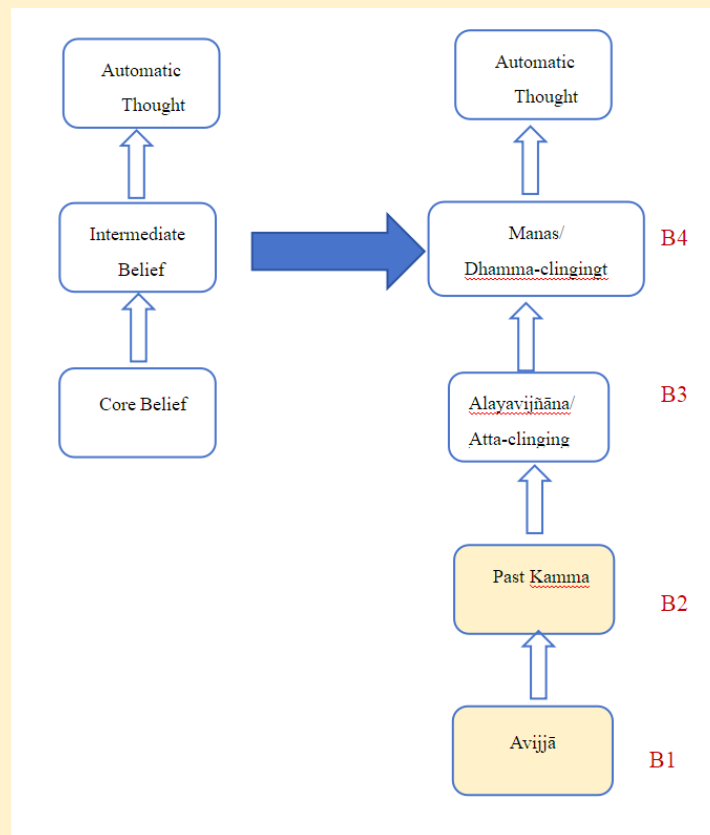


Figure 3. Heuristic Comparison of the CBT Vertical Model and a Buddhist-Informed Model

Dependent Origination (paṭiccasamuppāda), ignorance (avijjā), and kamma were also introduced as Buddhist interpretive dimensions that extend beyond standard CBT formulation. These concepts should not be described as missing causal mechanisms that make CBT “incomplete.” Rather, they represent additional ethical and soteriological perspectives on conditioning, habit, and suffering that may be relevant in explicitly Buddhist contexts. Their inclusion in a therapeutic framework requires careful translation and cannot be assumed to

improve clinical outcomes without empirical testing (Bodhi Bhikkhu, 2000, 2012; van Gorkom, 2010).

On this basis, the study proposes two complementary heuristic pathways: a horizontal pathway using the Five Aggregates to support moment-to-moment observation of experience, and a vertical pathway using selected Buddhist concepts to reflect on deeper patterns of attachment and conditioning. These pathways are intended as conceptual scaffolds for future pilot work, not replacements for established CBT case formulation.

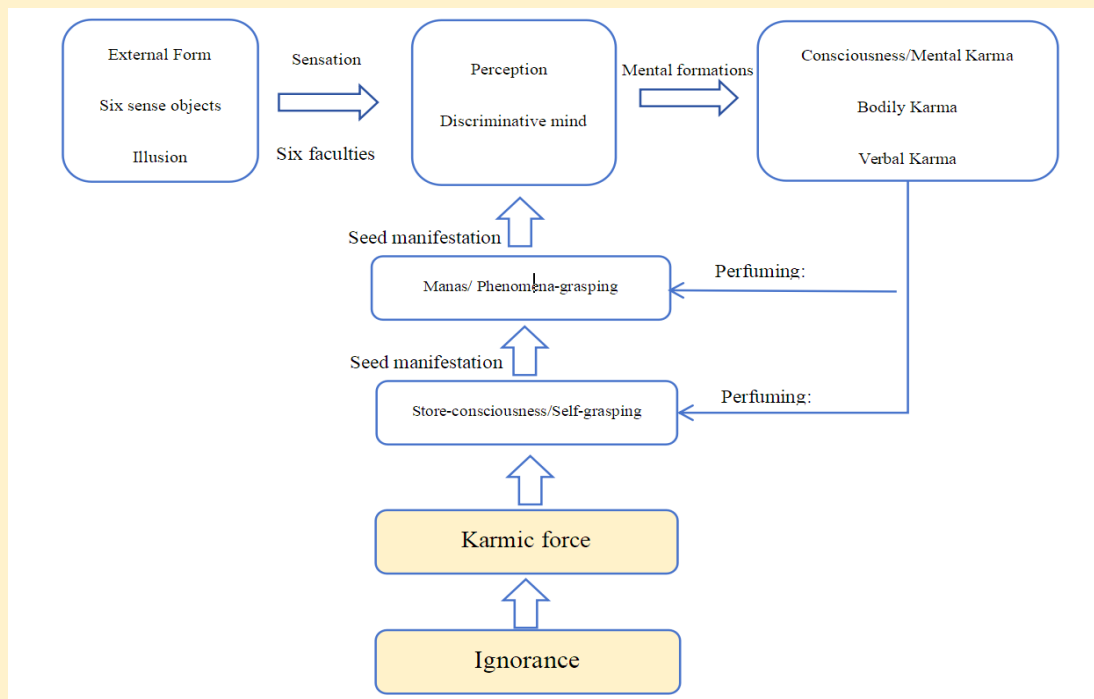


Figure 4. Proposed Buddhist-Informed Reinterpretation of Aaron T. Beck's Cognitive Hierarchy Model (based on Buddhaddhamma)

Objective 3: Proposed Buddhist-Integrated CBT Framework

The third objective generated a preliminary intervention framework that combines standard CBT procedures with selected Buddhist-informed practices. The model includes a horizontal component focused on moment-to-moment observation and a vertical component focused on beliefs, attachment, and conditioning. Because no clients received the full protocol in this study, all intervention components should be regarded as hypotheses for feasibility and safety testing rather than established treatments.

Proposed Practice Components: Safety and Implementation Considerations

Any future clinical testing of the proposed procedures should require appropriately trained mental-health professionals, participant screening, informed consent, standardized outcome monitoring, predefined stopping criteria, and independent ethical oversight. Buddhist-origin practices should be optional and should not be presented as clinically superior to secular alternatives. The proposed 12-session sequence is therefore a research prototype, not a treatment recommendation for routine clinical use.

Practitioners involved in future pilot research should have formal CBT competence and sufficient familiarity with the Buddhist concepts used in the protocol to avoid doctrinal misrepresentation. Components involving explicitly religious practices would additionally require cultural competence and clear procedures for obtaining participant preference and consent.

Future pilot studies should establish eligibility and exclusion criteria prospectively and use validated measures for depression, anxiety, problematic digital-media use, and adverse events. Participants with acute suicidality, psychosis, severe substance-use problems, or other conditions requiring higher-level care should be referred for established clinical services. Because SIPI has not been validated as a clinical construct, eligibility should be based on operationalized research criteria rather than on the assumption of a new diagnosis.

Distress should be monitored throughout any future intervention study, with predefined stopping and referral procedures. The current manuscript proposes possible thresholds and monitoring practices, but these require review by qualified clinicians and an ethics committee before implementation. No efficacy or safety conclusions can be drawn from the present expert-feasibility assessment alone.

Horizontal Processing Methods (A1-A5):

For A1 (External Rūpa / Situation), the framework proposes awareness-oriented exercises that examine discrepancies between perceived and actual screen time, temporarily reduce selected digital inputs, and critically analyze how simulacra are produced. These procedures are intended to increase metacognitive awareness of media-use patterns and the constructed nature of digital representations. References to guarding the sense doors (*indriyasamvara*), emptiness (*suññatā*), and impermanence (*anicca*) may be included for participants who knowingly choose a Buddhist interpretive framework (Baudrillard, 1995; Conze, 1958; Eyal, 2014; Muller, 1999). Claims involving physics or “string

theory” have been removed because they are not necessary to the psychological rationale and could create conceptual confusion.

For A2 (Vedanā / Process 1), the proposed exercise involves repeatedly observing emotional responses to a brief digital stimulus. The intended purpose is not to induce habituation as a guaranteed therapeutic mechanism but to help participants notice changes in affective response over time. The exercise draws conceptually on contemplation of feeling and on behavioral observation, but it requires pilot testing, standardized monitoring, and clear stopping criteria before clinical use (Anālayo Bhikkhu, 2006).

For A3 (Saññā / Automatic Thoughts), contrasting digital stimuli can help participants identify rapid judgments, labels, and interpretations. The proposed procedure may be paired with standard CBT thought monitoring and cognitive reappraisal. Buddhist language concerning perception and conceptual proliferation should be presented as an optional interpretive aid rather than as a substitute for evidence-based cognitive formulation.

For A4 (Saṅkhāra / Process 2), the framework proposes observing urges and action tendencies that arise in response to salient stimuli. The aim is to improve discrimination between an external cue, affective response, interpretation, urge, and subsequent action. This functional analysis is compatible with CBT and behaviorally oriented approaches, while the Buddhist terminology provides an additional contemplative vocabulary for participants who find it meaningful.

For A5, the proposed Five Aggregates observation form integrates external stimulus, feeling, perception, volitional response, consciousness, and reflective attention. The form is best understood as a self-monitoring tool for future feasibility research. Claims that repeated use will necessarily “remove discrimination” or improve emotional outcomes have been avoided because these effects have not yet been tested (Anālayo Bhikkhu, 2006; Bodhi Bhikkhu, 2012; van Gorkom, 2010).

Vertical Processing Methods (B1-B4):

For B4 (Intermediate Beliefs / Manas), the model combines standard CBT techniques such as the downward-arrow method and behavioral experiments with an optional Buddhist analysis of attachment to concepts. The functional aim is to identify rigid assumptions and rules that maintain distress. The Buddhist

comparison should remain exploratory and should not imply that manas is clinically equivalent to intermediate beliefs (Beck, 2011; Lin, 2016).

For B3 (Core Beliefs / Ālayaviññāṇa), standard CBT procedures for identifying and evaluating core beliefs may be supplemented, for consenting Buddhist participants, by reflection on anattā and the Five Aggregates. Such reflection should be used carefully because Buddhist teachings on not-self are doctrinal and contemplative concepts, not established methods for restructuring negative core beliefs. The proposed integration therefore requires therapist competence, cultural sensitivity, and empirical evaluation (Beck, 1979, 2011; Bodhi Bhikkhu, 2000).

For B2 (Kamma), the Four Powers of Confession are retained only as an optional religious practice for participants who explicitly request or accept a Buddhist framework. The practice should not be framed as a treatment for psychopathology or as a method for “purifying” clinically defined symptoms. Its possible role is limited to structured reflection, regret, reparative intention, and commitment to changed behavior within an appropriate Buddhist context (Pabongka Rinpoche, 1991).

For B1 (Avijjā), the model recognizes ignorance as a Buddhist soteriological concept rather than a clinical target. Future interventions should not claim to eliminate avijjā through psychotherapy. For participants seeking Buddhist study outside therapy, optional educational resources may be suggested, such as Zhao (2018), Jiang (2009), and Nan (2022), provided that such recommendations are clearly separated from clinical treatment and respect participant preference.

Adaptation for Non-Buddhist Clients:

For non-Buddhist participants, religious language should be replaced with established secular therapeutic processes rather than translated mechanically. Reflection on past patterns can be framed as nonjudgmental functional analysis; “remedy” as constructive behavioral change; “abstention” as relapse-prevention planning; and “support” as therapeutic alliance and social support. These adaptations should be evaluated empirically rather than assumed to reproduce the meaning or effects of the original Buddhist practice.

Secular Alternative to the Four Powers of Confession:

A fully secular version can rely on standard CBT processes: identifying recurring behavioral and cognitive patterns, evaluating automatic thoughts and

assumptions, testing beliefs through behavioral experiments, and using behavioral activation where indicated (Beck, 2011; Martell et al., 2010). This option matters because an integrative model should not require religious assent to provide psychological care.

Precautions Against Guilt or Imposition:

When explicitly Buddhist practices are used, therapists should emphasize compassionate self-understanding rather than moral condemnation, distinguish constructive accountability from excessive guilt or shame, monitor emotional responses, and remind participants that religious components are optional. If religious anxiety, shame, or distress increases, the practice should be discontinued and a secular evidence-based alternative used (Beck, 2011; Martell et al., 2010; Pabongka Rinpoche, 1991).

Treatment Plan and Feasibility

The study developed a 12-session prototype organized around assessment, digital-use awareness, Five Aggregates observation, cognitive formulation, belief-focused work, and long-term planning. Seven experts judged the framework conceptually coherent and potentially relevant, while also raising concerns about religious applicability and practitioner knowledge. This feedback supports further model refinement but should not be interpreted as evidence of effectiveness, client acceptability, or clinical safety. All components require manual development and staged pilot testing before any controlled efficacy study.

Table 2. Proposed 12-Session Prototype for Future Feasibility Testing

Session	Theme	Model Node	Core Methods
1	Initial Assessment & Relationship Building	Assessment Baseline	Simulacra Time Experiment (Time1-4), Scale Assessment
2	Abstinence Experiment & Guarding Sense Doors	A1 Element Processing	App Organization·24-hr Abstinence·Teaching Guarding Sense Doors
3	Simulacra Production Experiment	A1 Deepening	Production Experiment·Initial Emptiness Probe·Introduction to Dependent Origination & Emptiness
4	Five <i>Khandhas</i> Education & <i>Vedanā</i> Training	A2 Element Processing	Teach Five <i>Khandhas</i> Model·Single simulacra Contact·Contemplate <i>Vedanā</i> as <i>Dukkha</i>

Session	Theme	Model Node	Core Methods
5	<i>Saññā</i> Observation & Identifying Discrimination (<i>Vikalpa</i>)	A3 Element Processing	<i>Saññā</i> Observation·Identify Discrimination·Ordinary/Noble Attention
6	<i>Saṅkhāra</i> Identification & Urge Awareness	A4 Element Processing	Physiological Reaction <i>Saṅkhāra</i> Experiment·Urge Intensity Recording
7	Initiate Five <i>Khandhas</i> Comprehensive Training	A5 Integration	Six-Column Five <i>Khandhas</i> Training Form·7-Day Progressive Training Plan
8	Downward Arrow Technique & Vertical Model Introduction	B4-B3 Exploration	Downward Arrow·Excavating Intermediate/Core Beliefs
9	Intermediate Belief Restructuring & <i>Dhamma</i> -clinging Analysis	B4 Deepening	Behavioral Experiments·Innate/Discriminative <i>Dhamma</i> -clinging Deconstruction
10	Core Belief Restructuring & <i>Anattā</i>	B3 Deepening	Emptiness of Five <i>Khandhas</i> · <i>Anattā</i> Concept·Loosening <i>Atta</i> -clinging
11	Four Powers of Confession & <i>Kamma</i> Purification	B2 Processing	Complete Four Powers Confession Practice
12	Integration Summary & Long-term Planning	Full Model + B1	Summary Assessment·Introduce <i>Avijjā</i> ·Long-term Practice Plan

Discussion

The findings should be interpreted as an exploratory integration of digital-media research, Buddhist psychology, and CBT rather than as validation of a new diagnosis or treatment. Three points are particularly important: SIPI's status as a provisional construct, the limits of Buddhist-CBT comparison, and the distinction between conceptual feasibility and clinical efficacy.

First, the descriptive survey suggests that heavy digital engagement, compulsive checking, anxiety, depressive feelings, and dissatisfaction with offline reality can co-occur within the study sample. This is broadly consistent with literature linking problematic digital-media engagement with reward processes, social comparison, body-image concerns, and well-being outcomes (Fardouly et al., 2023; Montag et al., 2022; Potenza, 2014; Vogel et al., 2019; Zhang & DeAndrea, 2024). However, the present study used convenience sampling and a self-designed questionnaire, so it cannot establish the prevalence,

diagnostic validity, or causal structure of SIPI. A more defensible contribution is identifying three candidate mechanisms, addictive design, idealized representation, and perceived reality replacement, that can be operationalized and tested in future research.

Second, Buddhist concepts provide a rich interpretive vocabulary for examining attachment, perception, conditioning, and the instability of experience, but their relationship with CBT should remain heuristic. The Five Aggregates are not a linear cognitive-processing model, and *ālayaviññāṇa* or *manas* are not historical precursors of core and intermediate beliefs. The value of comparison lies instead in generating culturally meaningful questions about how stimuli are perceived, interpreted, appropriated as self-relevant, and transformed into habitual responses (Beck, 2011; Bodhi Bhikkhu, 2000; Lin, 2016; van Gorkom, 2010; Waldron, 2003). This distinction protects both Buddhist doctrinal integrity and psychological scientific validity.

Third, the proposed Buddhist-integrated CBT model should be regarded as a research prototype. Expert endorsement indicates perceived conceptual feasibility but does not demonstrate efficacy. Several components, including media abstinence, repeated exposure to digital stimuli, not-self reflection, and the Four Powers of Confession, could have different effects across participants and therefore require explicit clinical rationale, cultural consent, adverse-event monitoring, and comparison with standard CBT procedures. A staged research program should begin with construct validation and manual development, proceed to small feasibility and safety studies, and only then examine comparative effectiveness.

New Knowledge from the Research

The principal new contribution of this study is proposing SIPI as a hypothesis-generating framework linking digitally curated simulacra with three candidate mechanisms: addictive design, idealized representation, and perceived reality replacement. Rather than defining a new disorder, the framework organizes a cluster of self-reported cognitive, emotional, and behavioral difficulties that future studies can examine using validated measures.

A second contribution is a two-level Buddhist-CBT comparative model. At the horizontal level, the Five Aggregates serve as a contemplative scaffold for

observing moment-to-moment experience; at the vertical level, selected Buddhist concepts concerning attachment, conditioning, and self-grasping generate reflective questions about deeper belief patterns. The innovation lies in using these comparisons as explicit heuristic bridges while acknowledging that Buddhist and CBT concepts differ in purpose, ontology, and clinical status.

The resulting framework can be summarized as:

digital simulacra exposure → candidate psychological mechanisms → moment-to-moment observation → cognitive-behavioral formulation → optional Buddhist-informed reflection → adaptive behavioral response.

Its contribution is conceptual rather than therapeutic: it identifies testable constructs, clarifies where Buddhist concepts may enrich culturally sensitive formulation, and provides a prototype for future intervention research without claiming that the proposed model has established clinical efficacy.

Several limitations constrain the findings. SIPI has not been psychometrically validated; the questionnaire used a convenience sample of 100 internet users and a self-designed instrument; expert interviews involved only seven participants; the proposed causal mechanisms were not experimentally tested; and the 12-session prototype was not delivered to clients. The Buddhist-CBT correspondences are functional analogies rather than doctrinal or mechanistic equivalences. Future research should therefore prioritize construct definition, scale development, representative sampling, qualitative validation with intended users, therapist-manual development, adverse-event procedures, and controlled feasibility studies before making treatment claims.

Conclusion

This study explored how digitally curated simulacra may be associated with psychological difficulties in contemporary Chinese society and developed a preliminary Buddhist-CBT framework for future research. Descriptive findings from the convenience sample suggest that heavy digital engagement can coexist with compulsive checking, anxiety, depressive feelings, cognitive dissonance, and dissatisfaction with offline reality. These findings should not be interpreted as population prevalence estimates or evidence that simulacra directly cause psychiatric disorders.

The comparative analysis indicates that Buddhist teachings can contribute interpretive perspectives on perception, attachment, conditioning, and self-related cognition, while CBT provides established methods for case formulation, cognitive restructuring, behavioral experiments, and behavioral change. The Five Aggregates, dependent origination, and Yogācāra concepts may therefore support culturally meaningful reflection, but they should not be treated as equivalents of CBT constructs or as independently validated clinical mechanisms.

The major contribution of the research is a testable conceptual framework and 12-session prototype rather than a validated treatment. Its future value depends on rigorous operationalization of SIPI, use of validated psychological measures, clearer intervention manuals, ethical and cultural safeguards, pilot safety studies, and controlled outcome research. Until such evidence is available, the model should be presented as a preliminary interdisciplinary contribution at the intersection of Buddhist psychology, digital-media studies, and cognitive behavioral therapy.

Recommendations

At the policy and educational levels, the findings support continued attention to digital-literacy education, transparent platform design, age-appropriate safeguards, and public awareness of algorithmic curation and idealized online representations. Buddhist organizations and educational institutions may contribute mindfulness, ethical reflection, and media-awareness programs, but mental-health interventions should remain within professional scope and should distinguish spiritual education from clinical treatment.

Future research should first validate the SIPI construct using qualitative work and standardized psychometric development, then test its associations with established measures of problematic internet use, anxiety, depression, body image, loneliness, and functional impairment. Subsequent pilot studies may evaluate the acceptability and safety of selected Buddhist-CBT components using pre/post measures such as the PHQ-9 and GAD-7, along with digital-use and adverse-event measures. Comparative studies should examine whether the integrative model adds value beyond standard CBT or mindfulness-based interventions and whether adaptations differ for Buddhist and non-Buddhist participants.

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