Buddhism and Cognitive Therapy

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On June 13, 2005, I will be having a public dialog with the Dalai Lama in Göteborg, Sweden. This occasion has prompted me to share with the readers of Cognitive Therapy Today some of my thoughts regarding the relation of the theory underlying cognitive therapy to Tibetan Buddhism and some of the newer therapeutic approaches such as Attention Training, Mindfulness Based Cognitive Therapy, and the meditation component of Dialectic Behavioral Therapy.

There are (at least) two aspects of Buddhism as elaborated by Matthieu Ricard, a Buddhist monk and scholar, that are relevant to Cognitive Therapy (CT). First, the elimination of the "six main mental afflictions" -- attachment (or "craving"), anger and hostility, pridefulness, ignorance and delusion, afflictive doubt, and afflictive views—and their replacement by serenity, compassion, and peacefulness. Secondly, the application of the technical procedure of meditation aimed at reducing the mental products leading to these afflictions. Implicit in these objectives is the reduction of absorption in the self—the intransigent egocentricity.

We conceive of the self-absorption in terms of three levels. First, what is most apparent in hypochondriasis, panic disorder, and depressive worries and rumination is **the involuntary focus of attention** on bodily sensations or in ideation regarding the individual's self-worth and problems. At another level, we can note **exaggerated self-relevant meanings** that individuals attach to events. Finally, another level deals with people's propensity to place the highest priority—sometimes the exclusive priority—on **their own goals** and desires to the detriment of other people (as well as of themselves). Individuals with psychotic disorders typically demonstrate these levels of intensified self-focus: their attention is fixated on their own internal experiences, they relate irrelevant events to themselves, and they are concerned exclusively with fulfilling their own sets of needs and desires. However, normal individuals often exhibit the same kind of egocentricity but to a lesser extent and in more subtle ways. Both Buddhism and CT attempt to attenuate these characteristics.

The original conceptual framework of Cognitive Therapy was based on observations of patients with psychiatric disorders. The early approach delineated the egocentric patterns of thinking in our patients. We found that they attached exaggerated personalized meanings to events; these meanings involved an exaggerated concern with personal danger, inadequacy, and rejection. Their attention was highly selective and excluded information inconsistent with these meanings. Anxious patients perceived only danger, and depressed patients only loss. Because of their abnormal focus on these mental errors and their lack of objectivity towards them, these individuals had a biased view of their experiences and were prone to anxiety, depression, social phobias, and a variety of other disorders. Somewhat later we found that other patients fixed

their attention on bodily sensations leading to catastrophic misinterpretations typical of panic or hypochondriasis.

A more refined "micro-analysis" of excessive reactions to either external stimuli or internal sensory experiences applicable to normal living as well as psychopathology consists of the following stages:

1. The individual registers an initial evaluation (in milliseconds) of the internal or external situation in terms of "good for me" or "bad for me." This initial evaluation is often so fleeting that the individual is not aware of it.
2. The initial evaluation is rapidly reappraised and attenuated
   OR
3. If the stimulus situation impinges on a sensitive cluster of beliefs about the self, or if the individual's information processing is already in an egocentric mode, then a further elaboration occurs.
4. The second, more elaborate evaluation may be reappraised (or re-framed), and if determined to be wrong or irrelevant it is dismissed or inhibited
   OR
5. If the more elaborated meaning is strongly invested, it progresses into a kind of biased/distorted conclusion such as overgeneralization or "catastrophizing."

The cognitive model also presents formulation for most of the afflictions suggested by Matthieu Ricard:

Anger and Hostility:

1. The initial response to another person's behavior is a fleeting apperception of being threatened or diminished in some way.
2. This initial response is usually eclipsed by the simultaneous attribution of the cause to another person and the inference of "being wronged."
3. The next experience is the feeling of anger and concomitantly the impulse to retaliate.
4. When there is a chronic sense of being wronged by an individual or group, an image of the Enemy is formed.

Pridefulness is generally analyzed in terms of narcissistic attitudes such as "I am a special person and am entitled to special treatment and privileges."

Delusion is conceptualized in terms of the individual's salient beliefs. Certain clusters of these beliefs (enumerated in various inventories) predispose the individual to over-react to situations that are consistent with them. When these beliefs are particularly intense, they may be manifested as psychotic distortions. Their importance is based on their taking over the information processing to the extent that trivial or irrelevant events become important and their significance is magnified.

Attachment or Craving is analyzed in terms of the stimulus → appraisal → physiological reaction. The sequence is:

1. The individual experiences a particular feeling (sadness or elation) or is exposed to a particular external situation (e.g., somebody smoking pot or acquiring a new television set).
2. This stimulates a craving to moderate the feeling (binge on food, take a "hit," or go shopping).
3. In an addiction, the individual then gives permission to consummate the craving even though he/she knows it is a bad idea.

Strategies of Cognitive Therapy

The cognitive therapy approach to these problems consists first of three related processes: distancing, reframing, and decentering. By learning to identify their problematic "automatic thoughts" (the first or second stage of evaluation), the individuals can evaluate whether they represent reasonable interpretations of events (through looking at the evidence, considering alternative explanations, and examining the logic of the conclusions). We frequently refer to this process as **distancing**. Having determined that the interpretations are unreasonable, the individuals can then focus on the most reasonable or logical explanation for the observed data (**reframing**). The end result of this procedure is the ability to make less personalized and more objective impersonal interpretations. ("He was not ignoring me—he was preoccupied with his wife's illness.") An end result of deemphasizing personal meanings is **decentering**: the reorientation of patterns of thinking. As the grip of exaggerated self-referent thoughts is loosened, the patients are enabled to experience understanding, empathy, and compassion for others rather than unreasonable anger, worry, and self-debasement. In theory, as their attentional resources are freed from their binding to self-focused processes, the resources are made available for more social and task-oriented behavior.

A further technical innovation has been added to cognitive therapy in recent years by British investigators including David M. Clark and Anke Ehlers as well as Adrian Wells. This consists of effortful, intentional focus on other individuals and other environmental stimuli in the Clark-Ehlers work with social phobia and a more formal procedure of Attentional Training by auditory focusing in Wells' work with panic and also the ruminations of chronic depression.

These newer approaches are reasonably conceived within the cognitive model, since they are based on the theory of overinvestment in unhelpful (dysfunctional) ideas and use a specialized cognitive technique to attenuate them. Conceptually, the techniques enhance executive functioning so that attentional resources can be redeployed from evaluation of the self and bodily sensations to other entities or activities (again, decentering). The procedure of effortful focusing is comparable to a form of Buddhist meditation known as "one-point concentration" but differs from other forms such as transcendental meditation and mindfulness, which are

more passive. In all forms of mindfulness, the individual is instructed simply to recognize the thoughts in the stream of consciousness but not to attempt to evaluate their validity. The process, as in CT, appears to involve distancing from thoughts, recognizing them as mental products but not necessarily representations of reality. In Attentional Training, furthermore, the thoughts are simply regarded as noise and are disattended. The proponents of the mindfulness strategies as utilized in Mindfulness-Based CT, Dialectic Behavior Therapy, and Acceptance and Commitment Therapy explicitly differentiate their approach from CT and its emphasis on cognitive restructuring of dysfunctional cognitions.

Another area in which Buddhism and CT share a common interest is in the relief of suffering. CT has already been shown to be effective in reducing psychological pain in a wide variety of psychological disorders. More recently, Tom Sensky and his colleagues in London have conducted systematic research on patients with chronic disabling medical disorders associated with considerable pain and distress. The investigators came up with two lines of evidence that indicate that the attitude towards their illness as well as the capacity to reflect on it objectively were relevant to the degree of pain they experienced. Specifically, the ability to make sense of the experience of illness and find positive aspects of illness were correlated negatively with distress. Patients who accepted their illness and were determined to get on with their lives and perceived positive values such as increased appreciation of family and friends and deepened empathy for others suffered less than those who did not have these values.

Cognitive therapy, thus, aims to achieve the Buddhist objectives of reducing hostility, addictions, and pridefulness by addressing three levels: first, recognizing and reframing the biased self-referent meanings that lead to anxiety, anger, and sadness; secondly, reducing the patients' attentional fixation on their feelings, cravings, and thinking; and finally, by evaluating and modifying unhelpful attitudes. CT attempts to accomplish this through a combination of techniques involving increasing executive control of attention, reframing, and assuming more constructive attitudes. As with Buddhism, the mental processes involve both distancing and decentering. The final objective is a decrease in distress, an increase in freedom, and an increased capacity to relate to others with understanding, empathy, and compassion.

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