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Symposium

Couldn't Delusion be a Cultural Phenomenon? A Critical History of a DSM 5 Criterion

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Abstract

Background: *According to DSM 5: "The delusional belief is not ordinarily accepted by other members of the person's culture and subculture (e.g., it is not an article of religious faith)". On the other hand, 19th century European psychopathology crested the notion of 'folie à plusieurs' and Cultural psychiatry has been studying mass delusions and pathogenetic effects of specific cultural beliefs for a long time. This contradiction, affecting different diagnostic systems, must be examined in order to shed light on the notion of cultural delusion.*

Aims: *To outline conceptual and historical underpinnings, analyzing the divergent socio-political implications of considering delusions either as an individual phenomenon or a cultural one.*

Methods: Delusion is often seen as a detachment of the individual from the external reality, that ultimately leads to false beliefs. An historical review of the psychiatric literature on them concept of delusion was carried on, with a focus on the interaction between different psychiatric notions of delusion/reality and socio-political changes in western world.

Results: *Enlightenment and positivism saw reality as a universal phenomenon that anyone could recognize. Absorbing this cultural climate, the early psychiatry considered the superstitious beliefs akin to psychotic delusions, considering the "savage" and the psychotic patient equally irrational. During decolonization, and the cultural revolution of the '60 and the '70, anthropology and transcultural psychiatry facilitated the introduction of a cultural-relative concept of reality in Western culture. Mainstream psychiatry eventually followed this revolution and stated the cultural relativity of reality and delusions.*

Discussion: *More than a scientific truth valid now and forever, the DSM-5 principle, stating that delusions cannot be cultural beliefs, appears to be a cultural and historical by-product of the western civilization. Like any other diagnostic instrument, this DSM 5 criterion needs to be considered carefully, otherwise some forms of psychological distress could be left untreated. The concept of cultural delusion could be in this case a useful theoretical tool.*

Keywords: Terrorism, Psychopathology, Culturally shared beliefs, Delusion, History, DSM-5 criteria

Note: *This work was presented at the 5th WACP Congress by dott. Zupin only, according to the congress rules. Here we add two other authors that originally made this research possible.

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Dear colleagues, good morning.

I thank you for being here this morning, and I really want to thank Prof. Fernandez and Chen for organizing the NY congress, Prof. Ascoli e Rovera as well for their presentations and Prof. Bartocci for organizing the symposium.

The title of my presentation is: "Couldn't delusion be a cultural phenomenon? A critical history of a DSM 5 criterion". I tried to focus on the DSM 5 category: according to the DSM there is a whole group of delusion, that includes mainly individual beliefs, like the well-known jealousy delusion. But at the same time the DSM acknowledges the possibility of mass beliefs being delusional, as for example, in the case of the Windshield Pitting Epidemic, that took place in Seattle, in 1954. For a few days, hundreds of people became convinced, that their cars' windshields had been broken by a nuclear fallout, due to a top-secret nuclear test, except that this was proved to be false. On the other hand, DSM 5 denies that culturally shared beliefs can be delusional, no matter how strong, false and incorrigible these beliefs appear to be (APA, 2013). We can call this principle, that defines the delusion mainly as an individual belief, the "individuality of delusion".

Here today we'd like to consider the opposite option. More specifically we'd like to consider the option, that at least in some particular cases, culturally shared beliefs can be pathological. Can we use the category of "cultural delusions" (Murphy, 1967; Prince, 1970; Armando, 2016 e 2017; Daverio, 2015; Bartocci, 2013; Bartocci, 2015; Bartocci & Zupin, 2016; Rapisarda et al, 2016; Zupin, 2016; Rovera, Bartocci, Lerda, 2014; Rovera, 2015, Rovera GG Ascoli M. Rovera GM Bartocci G., in this issue). In which cases can we use this category? Prof. Bartocci already gave us some strong examples in his Special Session, in which supernatural beliefs of the Western culture have shaped our self-awareness, in ways that turned out to be not always healthy. Prof. Rovera examined in depth the links of the Cultural Delusion notion with classical psychopathology. Prof. Ascoli spoke about the flat earth and the anti-vaccination movement.

Another example is the Breivik case. In 2011 he killed 77 people in Norway, protesting against multicultural European Union. He strongly believed that European governments were plotting to replace the resident population with Muslim immigrants. He believed he carried the heritage of the Middle Age Knight Templars, and that his mission was to defend Christianity (Breivik, 2011).

The 1st psychiatric assessment on Breivik found his beliefs to be fitting all the criteria of delusion…except that of individuality! This is because his beliefs, at that time, were shared by a small part of the European culture. But there is something even more interesting, the psychiatric experts felt embarrassed, not diagnosing him as delusional for the absence of the individuality principle. They wrote: "He challenges the current classification and understanding of models, (...) Thus, also challenged the boundaries between law and psychiatry. The experts will not hide on that this represents a general uncertainty at the forensic psychiatric assessment" (Tørrissen, Aspaas 2012). Unfortunately today the part of the European public opinion sharing Breivik beliefs is growing bigger and bigger. Can we suppose that "Cultural delusion" is a valid concept in this case? According to DSM we cannot, of course. But are we so sure?

Let us try a change of scenario and consider this issue in a post-colonial studies context. We may end up investigating the DSM criterion of the individuality of delusion, considering it like a belief, a psychiatrists' belief. We can try to view psychiatry as a sub-culture to be studied (Kirmayer, 2007; Littlewood, 2002). To do so, I felt it is important to know in which historical and cultural background, the individuality of delusion is embedded.

I reviewed several psychiatry handbooks, from an historical perspective. As you can see from the middle of the nineteenth century to the seventies of the twentieth century, for most of the authors the answer was: "yes", delusion can be culturally-shared (Tab. 1) (Kraepelin, 1907 [1887]; Le Maléfan, Evrard & Alvarado, 2013; Tanzi, 1905; Bleuler, 1934 [1911]; Freud, 2003 [1919]; Jaspers, 1920; Jaspers 1997 [1959]; APA, 1952; APA, 1968). The exact opposite of today. The first relevant exception is Jaspers, that introduces the individuality of delusion just in the 7th edition of his General Psychopathology (1997 [1959]), while that principle was absent in the former edition (Jaspers, 1920).

After the seventies, the situation changed radically (Tab. 2). Now most of the authors' opinion is "No, delusion cannot be culturally-shared, at all" (Griesinger 1882 [1861]; Scharfetter, 1992 [1979]; APA, 1994; APA, 2013; Sadock&Sadock, 2000; Campbell, 2009). DSM III introduces the principle of the individuality of delusion (APA, 1980), and as you all well know today most of the psychiatry handbooks take DSM-based nosography for granted. Relevant exception are Henry Ey (1989), and some cultural psychiatry handbooks, like Tseng (2001).

Let us see it on a timeline perspective. Now, we can widen our question a bit, by adding to the first question - could delusion and reality be culturally shared? - a second one: Is there an objective reality to be used as a touchstone for assessing delusions?

It is important to keep in mind that delusion is always considered a deviation from reality (Jaspers, 1997 [1959]; Sadock&Sadock, 2000; Oyebode, 2015). So, delusion and reality are related concepts

On the basis of the previously said timeline, we can find that at first the answer to our question was "Yes, there is an objective reality and yes, delusion can be culturally shared". The concept of reality was that of a strong form of universalism. For example: we know the earth is round, and if you think earth is flat, and you feel like that you're absolutely right, not only you're wrong…but maybe even delusional. Of course, we do agree to that, but we also believe this way of thinking implied, at that time, colonialist underpinnings. Indigenous people were thought to have false beliefs, like animism, and for that reason to be akin to psychotic patients, and children (Griesinger, 1882 [1861]; Kraepelin, 1907 [1887]; Tanzi, 1905). What kind of social or political forces contributed to this worldview? It is well-acknowledged in the history of psychiatry, for example by Berrios (2008), the part played in this by the heritage of the Illuminism, and the ongoing positivism. At that time some anthropology matters were in fact misunderstood. Levy-Bruhl wrote: "How native think". But the original title in French sounds like this: "The psychological functioning of the inferior society" (1910). It is easy to grasp that some people took this like: "Ok, we're superior because we've science and we're Christians; they're inferior because they're savages, and animists ". Colonialism and colonial psychiatry were one thing; probably you all remember the example of Carothers, a colonial psychiatrist who said that the Africans were like "lobotomized Europeans", implying that they had a constitutional lack of the reality test (Carothers, 1954). And there were some evolutionists too that thought the same, according to Ellenberger (1994 [1970]).

In the second section of our timeline, the approach changed in "No, there is no standard reality, because reality is culturally constructed in any social group by the insiders", and "No! delusion cannot be culturally shared". Here relativism became a validated worldview. You can believe you go to paradise in the afterlife, (and that can be right), you can believe you go through the reincarnation process, (and that can be right), and you can otherwise believe your body and soul will rot (and that can be right too). All beliefs are thought to be the same, an expression of their culture. Of course, the concept of relativism already existed before the seventies, but what happened in the fifties and the sixties, in order to make it a more validated worldview? The anti-colonial wars. Some liberation movements held also anti-psychiatric positions, like that of Franz Fanon (1967 [1964]; (1991) [1961]). Antipsychiatry had strong supporters as Michel Foucault (2006 [1972]) in France and Franco Basaglia in Italy (2014a [1975]; 2014b [1971]). Our discipline too, cultural psychiatry, had a role in de-pathologizing indigenous worldviews. And finally, but not less important, there was Woodstock and the '68 movement. All these movements were questioning the Western political and scientific authority in defining the norms, and hence the deviation from the norm. All these movements were

demanding the oppressed people and indigenous worldviews to be considered. So, if before the 70's there was a specific idea of what is reality and wich reality is ‘true’, after the 70’s reality is a relative concept, and delusion too. This change of perspective was the outcome of a complex interplay between scientific, philosophical and political forces.

For this reason I would propose that, maybe, the principle of individuality of delusion isn’t a scientific truth, discovered, valid now and forever. Rather it could be considered as a by-product of the historical, political, philosophical changes in our society, and that psychiatry simply followed these changes. Considered this we should handle with care the principle of the individuality of delusion. After a heated debate between relativism and universalism in cultural psychiatry, Jilek (2014) pointed out that today, there is a consensus in using a balanced mix of the two. I think we should use this balanced mix of universalism and relativism for the diagnosis of delusion as well. It is not that we should come back to the old-fashioned psychiatry, and pathologize indigenous people, of course. But in cases like Breivik’s, at least we must consider the possibility of the cultural delusion. I am not stating with absolute certainty that he is mentally disordered, but at least we should consider the possibility of diagnosing him delusional; and not be trapped in a strict interpretation of the individuality of delusion.

So, if we cannot rely solely on individuality, which criteria are to be taken in consideration for delusions? Of course, the classical criterion from Jaspers: the belief is false. Prince (1970) reframed the criterion of falsity: (the beliefs is) highly implausible, improbable, and not verifiable. Then, the belief is hold with extraordinary conviction, and it is incorrigible. Also: pervasiveness of content within the field of consciousness, influence on behaviour, overall impact on the patient’s level of functioning, preceded or not by *wahnstimmung* (delusional mood), stability of delusion over time. I must confess that before cultural psychiatry, my first love was phenomenological psychiatry (Binswanger, Minkowski, Blankenburg and so on), meaning tons of books on delusion. And at the end of the day, everybody agrees that there is not a satisfactory definition of delusion, but all criteria should be taken into account, balancing their relative weight. Finally about our proposal of using the category of “Cultural delusion”, I suggest that in the diagnosis of delusion every criterion should be relative... even relativity.

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Tab. 1. Can delusion be culturally shared? Psychiatric literature: 1850-1970 ca

	Yes	?	No
Esquirol, 1845		?	
Griesinger, 1861		?	
Kraepelin, 1907	yes		
French psychopathologists 1850-1930	yes		
Tanzi, 1905	yes		
Stoddard, 1908			No
Bleuler, 1911	yes		
Freud 1919	yes		
Jaspers, 1920	yes		
DSM I, 1952		?	
Jaspers, 1959			No
DSM II, 1968		?	

Tab. 2. Can delusion be culturally shared? Psychiatric literature: 1970-2018 ca

	No	?	Yes
Scharfetter,1979			Yes
DSM III, 1980			Yes
Ey , 1989	No		
DSM IV, 1994			Yes
Kaplan, 2000			Yes
Tseng, 2001	No		
Campbell, 2009			Yes
DSM 5			Yes
Sims, 2015			Yes