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IS RACISM A CULTURAL DELUSION?

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Abstract

The current definition of delusion in psychopathology implies an inherent culturalist approach: a delusion is a fixed belief which is not in keeping with the world view shared by the patient's sociocultural group of reference. This essential characteristic, however, doesn't help the clinician when it comes to making a judgement on the sanity or the insanity of a seemingly delusional belief held by a person, which is entirely in keeping with the beliefs of the majority of the people within the same society, or at least a considerable number of them. The concept of cultural delusion can be helpful in such scenarios. Cultural delusions are defined as notions, views, convictions or even “knowledge” (pseudo-knowledge) held by a sociocultural group and, as a result, they are perceived as “normal”, “true”, “valid” and self-evident realities. Just like

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in individual delusions, the morbidity of cultural delusions lies within the resulting altered relationship with the rest of the world and reality, rather than on their factually erroneous content. Cultural delusions are based on a shared world view, therefore they are not private or idiosyncratic beliefs held by a visibly dysfunctional individual. In this sense, they defy the commonly held notion that a delusional reality necessarily locks the person in a private world, the validity of which he/she is the only one to acknowledge. By the same token, the potential for harm of cultural delusions is incomparably higher than that of individual delusions. Racism is a good example of such delusional beliefs, and conceptualising racism as a cultural delusion can be a useful approach to unveil its dysfunctional nature from a psychopathological perspective. This article intends to offer a preliminary and tentative interpretation of racism as a cultural delusion and a clinical vignette will be presented, illustrating one of the many forms in which racism reveals its cultural delusional nature in psychotherapeutic work.

Key words:

Racism, Delusion, Migration, Cultural delusions

Introduction

The term “delusion” comes from Latin, “de lira ire”, which means “to cross the boundary”. The etymology suggests an image where in a field, a plough cuts a furrow in the ground, delimitating an area or a field, and being delusional implies “crossing over”, “going beyond the furrow”, therefore locating oneself outside the field. Therefore, the very etymology of the word implies an existential position of the delusional patient located outside of the “shared territory” (inside the furrow) where the diverse notions of reality and the world held by each individual within the sociocultural group of reference can interact with each other (agreeing, clashing, complementing or contradicting one another). In other words, the world views inside the furrow can still relate to each other, no matter their differences, as each individual holder can put themselves in a relativistic perspective and recognise that the belief is their own, whereas the delusional person located outside this territory, which we call reality, has lost this chance. In fact, numerous clinical observations and psychopathological descriptions will confirm that the delusional person is not at all disturbed by the fact that

nobody, in his shared sociocultural group, peer group, family, etc, agrees with his/her belief and considers it valid, nor is the person concerned about the clash between the new “knowledge” and any other belief that he/she might have held before the onset of the delusional belief. Even more notable is the phenomenon, well known to any psychiatrist, whereby on a ward, individual patients with the same typology of delusion (for example, being Jesus, or a prophet, or the chosen one by God), hardly ever interact with each other, despite the shared beliefs. There are, however, notable exceptions to this rule. The existence of “folie à deux”, for example, testifies the “contagiousness” of the delusional belief in enmeshed relationships between two or more individuals (spouses, twins, parent and child, etc), usually mostly isolated from the rest of the world, where the delusional reality is shared as long as the persons involved stay together, persisting in the primary case and subsiding in the secondary case after separation. The possibility of being delusional, but not alone, challenges the classic notion that a delusion must necessarily be a private reality. Psychopathology has not set a quantitative limit on the number of people who must “cross the boundaries” of the shared reality of a sociocultural group, before they cease to be delusional and constitute a sect, a subculture, or even another culture. In fact, religions and religious sects are a good example of how such a blurred boundary makes the definition of which beliefs can be considered delusional and which cannot, extremely difficult. There are over 1.4 billion Catholics in the world, some of them gynecologists, firmly believing that Mary, the mother of Jesus, remained a virgin before, during and after the delivery of her baby. The Peoples Temple, a religious sect established and led by Jim Jones, led to a mass murder-suicide of 909 of its members in Guyana, on the 18th of November 1978. To those who would object that the morbid nature of the beliefs held by the sect is self-evident in its tragic epilogue, as compared to billions of peaceful and highly functioning Catholics, I would reply that the number of victims of Christianity and Catholicism (including the Crusades, witch-hunts, the Inquisition, forced expulsions and conversions, pogroms, and countless religious wars) exceeds by far the number of victims of the Peoples Temple. So, where do we go from here?

Cultural Delusions

The concept of cultural delusions is new, in Psychopathology. Cultural delusions can be defined as:

- Fixed beliefs widely shared by a cultural group that are unverifiable, held despite very poor adherence to, or total dissociation from, reality (Rovera et al, 2020)
- Cultural structures encouraging the radicalisation of extreme forms of detachment from reality that can be followed by delusions in the strict sense (Bartocci and Zupin, 2016)
- Collective ideational abnormalities that are an integral part of a culture (Rovera et al., 2020), the morbidity of which lies in the resulting morbid relationship with reality.

Cultural delusions have many formal characteristics in common with the formal characteristics of individual delusions, described by classic psychopathology, as follows:

- They are cultural beliefs influencing the life of a wide group in their relationships with themselves, other groups and the outside world.
- They are culturally specific realities: cultural delusions do not correspond to the reality that other cultural groups can deduce from their perception or experience of the world.
- They are rigid and valid “beliefs” about a group’s own reality of life.
- They are held by a sociocultural group as self-evident realities.
- They are held with a certainty that does not need any proof.
- They are a “knowing”, rather than a “believing”.
- They are impossible to place in a relativistic perspective, also based on the phenomenon of group confirmation.
- They determine the lives of those who adhere to the delusional beliefs, and at times the lives of those who don’t.
- They are fixed, rigid, inflexible, and held with absolute certainty.

- They are often self-centred: their contents have often something to do with the group of reference (for example, being under attack or threat by other “powers”, being superior to other groups, etc).
- They are refractory to logical arguing or evidence of the opposite.
- They are not based on evidence or logic. On the contrary, pseudo-evidence is gathered and logical fallacies are used to support the pre-existing belief.
- They are usually, although not always, impossible to share with other sociocultural groups.

However, some formal characteristics distinguish cultural delusions from individual delusions, namely: cultural delusions are in line with the beliefs held by the majority of people, hence the “culturally deluded” is, by definition, “inside the boundary”; there is mostly an absence of subjective suffering, and the “culturally deluded” can not only maintain adequate levels of functioning, but even thrive, because a “positive selection” of the belief is possible in certain historical conditions – Hitler and Nazism are an excellent example of this; They are untreatable with available conventional interventions (psychotropic medications, psychotherapy, etc); Cultural delusions have the potential to cause disastrous consequences on a scale that is simply unfathomable for the individually deluded patient.

Group delusions exist in various forms in Western cultures: conspiracy theories (birds are not real, the Earth is flat, Australia does not exist, chemtrails, vaccines and 5G, the Covid virus and pandemic do not exist, lunar expeditions are fake, etc.) and small religious sects are examples of such “limited” phenomena. However, cultural delusions exist as large scale group delusions, as in the notable cases of racism.

Racism as a cultural delusion

Western racism, defined as the conviction of the superiority of the white race (and Western culture) over all others, has underpinned every field of the Western culture for the past 300 years, and despite cultural changes, globalization, socio-economic and scientific progress, and legislative efforts towards its eradication, it continues to exist and to determine intolerable inequalities in modern ethnically and culturally diverse societies. Racism shares several of the characteristics of cultural delusions: it’s a fixed

belief, an ideational abnormality detached from reality encouraging radicalization towards hatred and leading to discriminatory or violent action; the self-evident pseudo-notion of the superiority of the white race experienced by the racist does not correspond to the reality that other groups of people on the planet can deduce from their perception or experience of the world (with the notable exception of internalised racism, which we could compare to the mechanism of the *a folie à deux*). Racism is refractory to logical arguing or any possible evidence of the opposite; it is a self-centred, self-evident belief about one's race's superiority over all others. Racism sought confirmation, in the form of pseudo-evidence and pseudo-logical arguments (pseudo-scientific theories such as craniometry, physiognomics, etc) supposedly proving its validity but actually formalised mostly at the end of the 19th century and the beginning of the 20th century, when racist ideas were already very well established in European culture. Last, there's very little to elaborate on the scale of dangerousness of racism, as testified by its well-known historical consequences (colonialism, the slave trade, the Holocaust and countless other racially motivated genocides, just to name a few).

Experiences with migration and cultural delusions in clinical work

What happens to cultural delusions, such as racism, when the culturally deluded individual leaves their original sociocultural group, for example through migration, and finds himself/herself the beholder of a suddenly idiosyncratic fixed belief that is not shared by others in the host country? Is there an onset of subjective suffering? Could this result in an inability to maintain adequate levels of functioning? Is acculturative adjustment distress based solely on obvious cultural differences, or also on the clash between the cultural delusions of the immigrant and the reality of the host country? Do cultural delusions become treatable during the acculturation process? Are they still as dangerous as when they are shared by large numbers of people?

I am an Italian who has been living in the UK for the past 22 years, and I recently spent four years living and working in China, in Beijing, as a psychiatrist and psychotherapist at an international hospital, mainly treating the mental health problems of a transient population of wealthy Western immigrants living in Beijing. Like any population, this group of immigrants presented with pre-existing, pre-diagnosed, known mental health problems, as well as adjustment issues from various sources (acculturative stress,

demanding jobs, etc.) and mental health problems of new onset. In some cases, however, racist cultural delusions, disguised as adjustment disorders, are the cause of the stress that brings the patients to therapy. In this subgroup, the specific request for a Western psychiatrist or psychotherapist can be a genuine cultural need of the neo-minority group, for a variety of reasons. In some cases, the word “western” used by the patient actually means “white”, and the stated motivation of “ensuring cultural competence” in the therapeutic process reveals engrained racist attitudes towards the Chinese majority.

Clinical vignette: a disastrous first consultation

M. is a 43-year-old female from Western Europe, who spent most of her life in Australia and who migrated to Beijing to work as an international schoolteacher. She recently joined her partner, who has been my psychotherapy patient for about a year. At the point of booking her first consultation with me, she is told by the receptionist that psychotherapy with me won't be possible, both because I am her partner's therapist, and because I will be leaving Beijing very soon. However, she insists on seeing me and I agree. She presents with mild depressive symptoms. M. came to Beijing from a town by the seaside in Australia, she finds living in Beijing difficult and states: “as you know, there's nothing to do in Beijing and nothing is within walking distance”. She complains that she is used to goint to the beach during her lunch break, but there's no beach in Beijing. She goes on saying that she is appalled by the incivility and rudeness of Chinese people (“you know how they spit, they burp, they fart, they shout, they don't queue, they touch you without consent”) and that nothing prepared her for this. When asked why she insisted on seeing me, despite being told that therapy with me won't be possible, she mentions concerns about the training received by the Chinese therapists in my department. When I point to her attention that all our therapists have been trained abroad (in the US, the UK, Australia and Brazil), she insists on the possibility of “cultural misunderstandings”. When I reply that in the Mental Health Department of my international hospital all my colleagues are very experienced in treating patients from a variety of cultural backgrounds, M argues that the problem is confidentiality, insisting that it's common knowledge that “they are all government spies”, “the Chinese Government has access to their clinical records” and “the consultation rooms might be bugged”. I challenge all these claims: anybody could be a spy or a double agent, including me. I will write my clinical records on the same electronic system used by my

Chinese colleagues, and the logic of her reasoning would dictate that my office should be the first to be bugged by the government. At this point, M becomes angry, gets up uttering profanities and leaves slamming the door, refusing to pay for the consultation.

Discussion

This case illustrates various aspects of racism as a cultural delusion. First, while we can conceptualise M's clinical presentation in various terms (depressive episode, acculturative stress, adjustment disorder, perhaps paranoid personality disorder, or paranoid reaction, etc) the patient's main cause of suffering and impediment to progress is that she holds fixed, impermeable beliefs (racist cultural delusions) diffused to the whole of her current surroundings. These views are determining her life and creating a morbid relationship with the reality in which she now lives. M lives her life in enemy's territory, surrounded by hostility and danger. For this reason, I find it difficult to consider her views as simple prejudices. Rather than being reassured by my counterarguing, which might open up different possibilities for her, M reacts with extreme anger and doesn't accept to be challenged. Rather than wanting reassurance, she is seeking for, and expecting, a confirmation of her views, because they are fundamentally about her identity. M's immediate transference reaction is based on the assumption that I share her same (racist) views about Chinese people (as testified by the continuous use of expressions such as "as you know", "We.... They"). M assumes that I agree with her and probably that I must have faced similar adjustment problems and crisis upon my arrival, therefore I will naturally understand her complaints and unhappiness in full, guaranteeing "cultural understanding". I call this, the "white face" transference. Based on race, M assumes a correspondence of personal biographies, identities, opinions, values, worldviews, etc, strengthened by our common condition of being western, English-speaking immigrants in China. In this context, astonishingly, M feels free to utter a series of openly racist remarks against the Chinese people that would nowadays be extremely rare to hear, in this explicit and outspoken form, in many modern western countries, where legislation to curb the open expression of racial hatred has long been in place. My consulting room has become a white island in the Chinese sea. M, who does not know anything about me, except my country of origin, doesn't contemplate any alternative possibility, other than our total identity: for example, I might have been in China for a long time, I might speak Chinese, I might love China,

be married to a Chinese person, or have mixed race children. M's racist belief locks her existence in a semi-paranoid state: her lived experience as an immigrant is that she is being surrounded and outnumbered by a herd of uncivilized people, enemies and spies. Somehow, the whiteness of my skin is for M a guarantee that I am not one of them, that my office is not bugged with recording devices, and that my existential situation in the host country and my world views are identical to hers. My rejection of her racist narrative with logical arguing triggers intense anger (uttering profanities on her way out) and immediate devaluation (refusing to pay for the consultation): if I'm not one of "us" (her/my kind) then who am I? I could have temporarily accepted this transference attitude, and not challenge the patient's racist ideas, with the purpose of establishing a therapeutic relationship that might then allow some work on the M's cultural delusions. The risk of this approach, however, is an anti-therapeutic collusion with the core cause of M's suffering, that might have unhelpfully entrenched her in her racism even deeper and longer. The alternative solution, which I adopted, to challenge her racist prejudice wasn't very successful either.

Conclusions

Cultural delusions are pathological beliefs, with formal characteristics in common with individual delusions, held by large groups of people in society, and dangerous due to their compatibility with high levels of functioning, the potential of spreading by positive selection and their capacity to motivate people to action. Cultural delusions are located at the intersection between psychopathology, sociology and politics. Understanding racism as a cultural delusion can be a useful conceptual framework to describe its pathological nature. Although the treatability of cultural delusions through psychotherapy is questionable and unlikely, the therapist's consulting room is a privileged space where the adverse consequences of racist cultural delusions on the life of the individual in particular circumstances, such as migration, can be revealed.

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