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EPISTEMOLOGICAL PERSPECTIVES ON INDIVIDUAL AND CULTURAL DELUSIONS

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Abstract

Delusions are often expressed not merely as beliefs but as claims of knowledge about the external or intersubjective world. Traditional epistemological approaches evaluate such claims in terms of epistemic justification and therefore regard delusions as illegitimate. However, this perspective risks unproductive clinical disputes, since common-sense beliefs themselves frequently lack explicit justification and rest on shared but ultimately groundless assumptions. This paper proposes an alternative framework based on Nozick's tracking theory of knowledge. From this externalist perspective, knowledge does not require internal access to justification but depends on whether beliefs are sensitive to relevant counterfactual variations. Delusions can thus be characterized not primarily by their lack of justification, but by their fixity: they remain unchanged across nearby possible worlds in which the relevant facts differ. We argue

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that a tracking theory–based approach shifts clinical attention from epistemic legitimacy to counterfactual sensitivity, facilitating dialogue without directly challenging core delusional beliefs. A clinical case of erotomania illustrates this approach, and its applicability and limits with respect to cultural delusions are briefly discussed.

Key words:

Delusion, Knowledge, Epistemic justification, Tracking theory

1. Introduction

Delusions are expressed as claims about the external or intersubjective world such as "Someone is secretly filming me" or "My mother has been replaced by an impostor." When clinicians respond to such claims with "So that's how it seems to you," patients often reply firmly, "It is a fact." On this point, Karl Jaspers described the following (Jaspers, 1968): “We have to assume some specific alteration in psychic function, not a failure of intelligence, if after some delusional experience an individual, who is fully conscious and—as occasionally happens—quite free from any other morbid symptom, maintains a delusion that everyone else recognizes as such, and if he simply declares: «Well, that is how it is; I have no doubts about it, I know it is so»”.

In this passage, "I know it is so" is "Ich weiß es" in German. Thus, when a patient responds "It is a fact," this can be understood as the assertion "Ich weiß es" - a claim of "knowing" that something is actually the case.

1) Delusions as Knowledge Claims

Manfred Spitzer attempted to characterize delusions by focusing on the claim of “knowing” (Spitzer, 1990). According to Spitzer, patients with delusions rarely say that they believe that such and such; rather, they say that they know it. For the patients themselves, delusions are not merely expressions of belief but take the form of knowledge claims.

Statements about external or intersubjective things may be wrong and can be corrected in dialogue. By contrast, first-person statements such as "I am feeling pain" are uttered with subjective certainty and incorrigibility and cannot reasonably be questioned, since no evidence is stronger than one's own experience of thoughts or feelings. This constitutes an epistemological asymmetry. In delusions, however, this asymmetry is illegitimately extended to intersubjectively accessible facts to which no such epistemic authority should apply.

On this account, Spitzer defines delusions as statements about external reality that are uttered like statements about mental states—that is, with subjective certainty and incorrigibility by others. From Spitzer's account, delusions can be understood as unjustified knowledge claims, since patients with delusions lack the willingness to justify their claims, despite the fact that these claims refer to intersubjective matters. In this respect, delusions are epistemically illegitimate.

2) The Problem of Epistemic Justification

However, if knowledge claims about intersubjective matters require epistemic justification, how should we understand common sense? We hold many common-sense beliefs, such as "The Earth is round," "Everyone around us is alive," and "All living things eventually die." These beliefs refer to the external world and appear absolutely certain. Yet, in many cases, we cannot justify these beliefs - that is, we cannot provide epistemic justification for them - by ourselves. For example, although many textbooks state that the Earth is round, it is difficult for an individual to justify the correctness of their content.

Takashi Ikuta points out that we unconsciously presuppose a great deal of common sense in understanding the world (Ikuta, 2003). Common-sense beliefs ultimately lack foundations; nevertheless, they implicitly constitute the fundamental framework of our cognition and thus escape doubt. We live our daily lives on the basis of such common sense without attempting to justify it. In this respect, delusions and common sense do not differ insofar as both involve claims about intersubjective matters that lack explicit epistemic justification.

There is something about delusions that leads us to regard them as illegitimate knowledge claims. However, in judging such claims to be delusional, clinicians inevitably presuppose a great deal of common sense. Their common sense is itself inherently groundless. From the patient's perspective, therefore, the clinician's judgment may also appear epistemically unjustified and illegitimate. If delusional claims are rejected on the grounds that they lack justification, the clinician's judgment, in turn, can be seen by the patient as lacking justification as well. This situation risks leading to an unproductive impasse of mutual accusations concerning epistemic legitimacy.

On the other hand, Spitzer's proposal to understand delusions not as beliefs but as knowledge claims successfully captures the standpoint of those who express them. The question, then, is whether there is a way of understanding knowledge itself that can accommodate the distinctive features of delusions as knowledge claims without collapsing into a stalemate of reciprocal charges of epistemic illegitimacy.

2. Epistemic Justification and Tracking Theory

1) Internalism and Externalism

Traditionally, knowledge has been defined as justified true belief. Traditional epistemology requires that when someone makes a knowledge claim, they must have cognitive access to all the factors required for a belief to be justified, and thus these factors are internal to their mind. To say "I know" requires having all the reasons and evidence necessary for epistemic justification at hand, so to speak, and being able to present them as needed. This is the view of internalism about epistemic justification.

In contrast, externalism about epistemic justification suggests that we can have knowledge even if we cannot cognitively access all the elements necessary for justification. For example, in the case of knowledge acquired from textbooks, we do not necessarily have cognitive access to all the reasons that prove their contents are correct. Externalism, when examining whether a belief qualifies as knowledge, focuses not on justification performed by the epistemic subject themselves, but on the connection between belief and fact (Pritchard, 2023). According to externalism, a subject need not be aware of the factors necessary for epistemic justification in order to have knowledge.

This view provides a hint for thinking about delusions, which are considered illegitimate because of lacking justification, without being constrained by that illegitimacy. Robert Nozick's tracking theory develops this line of thought in a radical way (Nozick, 1981).

2) Tracking Theory

Nozick characterizes the relation between belief and the world required for knowledge in counterfactual terms (Nozick, 1981): roughly, if the proposition were not true, the subject would not believe it, and if it were true, the subject would believe it. This counterfactual relation can be understood as follows: when we hypothetically vary whether the state of affairs described by a proposition obtains or not, the subject's belief changes accordingly.

For example, the proposition "It is raining outside" describes a fact about the world if it is assumed that it is indeed raining, but it does not describe a fact if it is assumed that it is not raining. If, tracking this variation, the subject's belief that "it is raining" also varies, then that belief stands in the counterfactual relation to the world required for knowledge. Nozick proposed this relation between belief and the world as a condition of knowledge in place of epistemic justification, and he introduced the term "tracking" to designate this relation.

In tracking theory, one condition for a belief to be knowledge is that the belief tracks the world. This condition is called the tracking condition. That is to say, for your dog to "know" that you are his owner, the dog need not be able to justify this awareness by himself. If the dog barks at people who disguise themselves as you, and does not bark at you even if you pretend to be another person, then we can say the dog "knows" that you are his owner, although the dog cannot articulate reasons or evidence. In general, for a belief to be knowledge, in addition to the condition that the belief is true, it must satisfy the tracking condition. There is no need for the subject to be able to justify that the belief is true.

Strictly speaking, in tracking theory, the idea that a belief "tracks the world" should not be understood as a temporal change within the actual world. Rather, tracking concerns counterfactual sensitivity across nearby possible worlds. A belief tracks the world if, in relevant counterfactual situations across nearby possible worlds, the subject would

believe the proposition when it is true, and would not believe it when it is false. Thus, what is required is not that the content of the belief actually changes over time, but that it would change appropriately under counterfactual variations in the truth of the proposition.

3. Applying Tracking Theory to Delusions

Using tracking theory's perspective changes our understanding of the difference between delusional knowledge claims and other knowledge claims (Ueno & Murai, 2023) . DSM-5 stipulates that "a delusion is a fixed belief that is not amenable to change in light of conflicting evidence" (American Psychiatric Association, 2013). This characteristic can be understood as the tendency for delusions to be asserted unchanged even if the world were to change—that is, even when further conflicting evidence emerges and various events occur. While delusions are claimed as knowledge, they are unlikely to change even if the world changes; they are, so to speak, fixed.

In contrast, knowledge claims that satisfy the conditions for knowledge are required to be sensitive to changes across possible worlds, that is, to track them. When a knowledge claim is expected to track relevant counterfactual variations and its content is true, it satisfies the conditions for knowledge in tracking theory. If it is false, or if it fails to track such variations, it cannot be called knowledge. Nevertheless, if there is an expectation that it would be sensitive to counterfactual changes in the relevant facts, the claim is not fixed and, in this respect, is not delusional.

Note that our common sense is not supported by rigid evidence or reasons. From the internalist view, common sense is not epistemically justified and in this respect is no different from delusional claims. However, from the perspective of tracking theory, even common sense that lacks epistemic justification, if it is expected to be sensitive to counterfactual changes in the world, is not fixed and is thus distinguished from delusional knowledge claims.

This framework has practical and therapeutic implications. When we view patients' delusional claims from the traditional epistemological perspective, their claims lack epistemic justification and are thus illegitimate. In this case, the focus of clinical interaction tends to shift to the epistemic legitimacy of each other's claims, and further

to unproductive debates in which each side accuses the other of inadequate epistemic justification. In contrast, in a tracking theory-based approach, clinicians examine whether patients' beliefs show flexibility in counterfactual scenarios. This shift in focus enables clinicians and patients to sustain a constructive clinical exchange.

4. An example of clinical cpplication

We present an example of a tracking theory-based approach based on a clinical case.

Clinical example: erotomania based on telepathic experiences

Ms. A, a woman in her 40s, came to claim regarding Mr. B, a famous businessperson, that "I am loved by B," "I am going to marry B," and "We communicate through telepathy." One day, after continuously shouting in front of Mr. B's residence and being called the police, Ms. A visited a psychiatric clinic. She told the psychiatrist, "I was only talking with B through telepathy" and "B pulls my body or embraces me through telepathy." The psychiatrist judged these complaints as indicating auditory hallucinations and delusions themed on love, and explained to A that treatment was necessary. However, A did not accept the need for treatment.

The psychiatrist argued, "Telepathy does not exist" and "The fact that Mr. B called the police contradicts your claim of being loved by him," pointing out that A's claims lacked evidential support. However, Ms. A responded that "In the United States, psychometry is used in criminal investigations, and nurses study Reiki. Telepathy also exists" and further elaborated that "Mr. B must have a dual personality. B truly loves me. It was another personality that called the police."

Thus, the dialogue between the two fell into a vicious cycle of mutually accusing each other of defective epistemic justification. The psychiatrist could not continue dialogue with A. While common sense suggests that B does not have a dual personality, there is no decisive way to prove this. The psychiatrist had no choice but to end the dialogue with A and provide treatment based on medical diagnosis—all while vaguely aware that this medical diagnosis was also ultimately based on common sense and contained groundlessness.

1) Applying tracking theory approach

In a tracking theory approach, whether a belief is delusional is assessed in terms of its fixity. Specifically, clinicians consider counterfactual situations that differ from the actual situation but seem to be realistic, and examine whether the belief would be sensitive to such situations.

In the actual situation, B rejected A's visits and called the police. Yet A continues to believe that she is loved by B. We consider the following hypothetical situations. Situation (a): B does not love A and explicitly tells her so face-to-face. Situation (b): B loved A but began to avoid her out of fear that his wife would discover the relationship. Given that Ms. A maintains her belief even after explicit rejection, it is likely that she would continue to believe that she is loved by B in these counterfactual situations as well, for example invoking telepathy. When a belief is judged to be maintained across all hypothetical situations close to reality, it can be regarded as fixed—that is, delusional.

2) Consideration for the patient's perspective

Intervention in delusions based on such understanding does not point out inadequate epistemic justification seen in patients' claims but asks, "If circumstances were different, would your belief differ?" However, to examine the counterfactual situations required by this intervention, it is necessary to set up situations that both therapist and patient acknowledge as realistic.

In this regard, Blankenburg points out, patients with delusions tend to have an impaired ability to put themselves in someone else’s shoes - that is, perspective-taking (Blankenburg, 1991). Therefore, the clinicians must take the patient's perspective and accept the patient's delusion, at least some parts of it, as a starting point. For example, in Ms. A's case, the clinician might ask : "Mr. B may have a dual personality. Setting aside that, if you approach B again, the police might be called again. What would you do then?" This question does not focus on the legitimacy of epistemic justification of A's claims. The intervention is constituted not by attempt to make patients aware of defects in their knowledge claims but by exploring practical implications of beliefs within a range both parties can accept as realistic.

This approach has three advantages. First, it does not require patients to immediately abandon core delusional beliefs. Second, it focuses on behavioral consequences rather than epistemic justification. Third, it may assist their recovery by rehabilitate their ability of perspective-taking. Thereby, it contributes to continuing mutual dialogue while avoiding pointing out each other's inadequate epistemic justification in trying to make the other admit errors.

5. Application to cultural delusions

On the basis of the tracking theory approach described above, we consider how this framework can be applied to cultural delusions, which constitute the theme of this symposium.

Delusions are typically characterized as unprovable, unverifiable, and unchangeable beliefs, even though they are inconsistent with or dissociated from reality. The term “cultural delusions” designates cultural structures that encourage radicalized forms of detachment from reality, which may subsequently give rise to delusions in the strict clinical sense (Rovera et al., 2020). In this sense, cultural delusions refer not to individual pathological beliefs themselves, but to the cultural background that promotes or sustains individual delusions.

For example, when a person belonging to a group that shares conspiracy theories develops delusions involving an extreme intensification of those theories, the conspiracy theories themselves may constitute cultural delusions. Similarly, when a person belonging to a religious group that believes in the afterlife and resurrection comes to claim, after their spouse’s death, that the spouse has “come back to life,” refuses burial, and continues to live with the corpse, the religious beliefs concerning resurrection may function as cultural delusions.

Cultural delusions have an important characteristic. Beliefs constituting cultural delusions are regarded as normal and meaningful within specific cultural contexts, yet are considered invalid or irrational by outsiders who do not share those beliefs. This feature can be regarded as a shared epistemological character between cultural delusions and individual delusions.

1) Traditional epistemological approach and its limitations

When focusing on presence or absence of epistemic justification regarding individual delusions, clinicians would examine whether those delusional beliefs are epistemically justified. For example, they inquire into the reasoning or evidence for those beliefs. However, this approach can provoke difficulties in clinical practices. Patients often elaborate some evidence or reasoning to defend their delusional beliefs. For example, Ms. A brought up telepathic experiences as evidence of being loved. And she tried to justify that telepathy exists by citing psychometry investigations and nurses studying Reiki. As a result, the psychiatrist and A are trapped into unproductive debate.

Whether individual delusions promoted by cultural delusions or cultural delusions themselves, when asked about grounds or reasoning, the person who has the "delusion" will propose a kind of grounds or reasons. What results is mutual accusation over inadequate epistemic justification. Even if clinicians try to dismiss supernatural beliefs by appeal to the natural scientific worldview, they may be met with the objection that so-called natural scientific worldview itself is an artificial construct produced in laboratories and therefore fails to capture reality.

2) Possibilities of a tracking theory approach

Next, we consider what happens when a tracking theory-based approach is applied to cultural delusions. Within groups that hold cultural delusions, those "delusions" function as an underlying framework for understanding the world. For groups that accept the existence of souls as self-evident, a situation in which souls do not exist cannot be regarded as a realistic possibility. Just as we, however thoroughly educated with a materialistic worldview, cannot envision as realistic a situation in which we have no minds. For individuals who hold cultural delusions, situations in which cultural delusions themselves are false cannot be imagined as possible and thus fall outside the scope of counterfactual examination. For this reason, such situations cannot be employed in a tracking theory-based approach. In this sense, tracking theory cannot directly address cultural delusions themselves.

Nevertheless, a tracking theory-based approach can be applied to individual delusions that develop on the basis of such cultural delusions. Consider an individual belonging

to a community that shares cultural beliefs such as fox possession or rebirth, who comes to hold beliefs such as “my son is possessed by a fox” or “my husband has come back to life after death.” When such beliefs are asserted as knowledge claims within the cultural framework, clinicians can examine, from a tracking theory perspective, whether these beliefs are sensitive to counterfactual changes in the world.

For example, if the son were not possessed by a fox, would the individual still make the same claim? Or, if fox possession were in fact present, would the individual be able to make appropriate judgments about it? Similarly, if a person claims that her husband has come back to life after death, how would she respond if others in her community denied the resurrection? If the determination of resurrection depends on a religious ritual and the result of that ritual contradicts her claim, would she continue to maintain her belief?

Thus, although cultural delusions themselves lie outside the direct scope of tracking theory, it remains possible—by accepting them as shared premises—to address individual delusions held by persons within that cultural context.

6. Discussion: clinical utility and limitations

A tracking theory–based approach has several advantages in clinical practice. First, it focuses on the fixity of beliefs, which is a central feature of delusions, without directly disapproving patients’ claims as lacking epistemic justification. Second, it does not require patients to immediately abandon their core delusional beliefs, but instead encourages reflection on how those beliefs would respond to changes in circumstances. Third, by emphasizing behavioral and practical consequences rather than epistemic validity, this approach may help rehabilitate patients’ capacity for perspective-taking and thereby facilitate continued clinical dialogue.

However, this approach also has important limitations. First, fixity of belief may not be unique to delusions; other psychiatric symptoms, such as obsessive ideas, may also exhibit similar rigidity. This raises difficulties in distinguishing delusional knowledge claims from other strongly held beliefs solely on the basis of fixity, though the fixity of delusions and that of obsessions probably differ in their relation to the epistemic closure and nearby possible worlds. Second, examining whether a belief would vary across counterfactual scenarios inevitably relies on clinical speculation, as such situations

cannot be directly observed. Moreover, applying a tracking theory–based approach requires clinicians to remain sensitive to differences in cultural background and shared assumptions about reality. Without such sensitivity, clinicians may arbitrarily determine which counterfactual situations count as "realistic," thereby reproducing the same impasses encountered in approaches that focus on epistemic justification alone.

These difficulties are particularly salient in contemporary society, where individuals increasingly cross boundaries between heterogeneous and unfamiliar cultural contexts. As a result, clinicians may struggle to grasp the cultural background that informs a patient's beliefs, making it difficult to apply a tracking theory approach that accepts cultural premises while examining individual delusions.

This issue is not merely epistemic but also ethical. Consider the case of Anders Breivik, who killed 77 people in Norway in 2011. Breivik held extreme beliefs about Muslim immigrants, including conspiracy theories about demographic replacement, and viewed himself as a successor to the Knights Templar charged with defending Christianity. Such beliefs have been discussed as examples of "cultural delusions" rooted in broader ideological structures (Zupin et al., 2020). In cases like this, applying a tracking theory-based approach faces serious ethical challenges, as accepting such beliefs even provisionally as premises for dialogue risks legitimizing discriminatory or violent ideologies. This highlights the need to carefully consider the scope and limits of clinical intervention.

Despite these difficulties, merely labeling beliefs as "prejudice" or "delusion" and criticizing their epistemic inadequacy is unlikely to resolve conflicts or promote therapeutic engagement. In contrast, a tracking theory–based approach offers a practical strategy for identifying aspects of reality that patients and clinicians can share, and for exploring how beliefs guide action under counterfactual conditions. In this sense, the approach encourages a shift from mutual accusations of epistemic error toward collaborative dialogue focused on practical understanding and clinical progress.

7. Conclusion

Examining delusions through tracking theory provides an alternative to traditional epistemological approaches. This framework allows us to acknowledge that patients'

delusional assertions take the form of knowledge claims, while shifting the focus from epistemic justification to the relation between belief and the world.

From a theoretical perspective, this shift introduces fixity as a criterion for distinguishing delusional beliefs from ordinary knowledge. Clinically, it offers a practical approach in which clinicians examine whether a belief is sensitive to counterfactual variations across nearby possible worlds, rather than dismissing it outright as an illegitimate form of knowledge. Through this change in perspective, clinicians and patients can avoid unproductive disputes over the adequacy or legitimacy of each other's epistemic grounds and instead engage in more constructive dialogue.

Tracking theory-based approaches may thus be useful as clinical interventions for individual delusions. However, in contemporary society, the boundary between cultural and individual delusions has become increasingly complex. This situation calls for further inquiry into the epistemology of delusions, in particular, in terms of nearby possible worlds and sensitivity to counterfactual situations, and in relation to the distinction between epistemological judgment and ethical evaluation.

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