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CONSPIRACY THEORIES AND DELUSIONS

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Abstract

Conspiracy theories are often compared to clinical delusions and correlations have been found between accepting a conspiracy theory and schizotypal traits. In this paper, we explore some of the similarities and differences between conspiracy theories and persecutory delusions. We compare them in relation to surface features, aetiology, and downstream effects. In relation to surface features and aetiology, we argue that there is some overlap between conspiracy theories and persecutory delusions. In relation to downstream effects, we argue that persecutory delusions are characterized by severe disruption to one's life, whereas conspiracy theories are in general not psychologically harmful to those who accept them. We conclude by commenting on the consequences of comparing conspiracy theories to delusions. Delusions are symptoms of psychiatric disorders and there is a specific kind of stigma often directed at those who suffer from mental illness. The political use of comparing delusions and conspiracy theories—when such comparison is aimed at producing or reinforcing stigmatization and exclusion—is problematic and should be avoided.

1. Introduction

It has become commonplace to compare the acceptance of conspiracy theories, such as COVID-19 denialism, to clinical delusions—that is, unusual beliefs that are symptomatic of psychiatric disorders. An opinion piece on *ABC News* described climate change denial and the belief that the Earth is flat as delusions due to their "unshakeability" (Shearman 2018); in the *Journal of the American Medical Association*, a neurologist also advanced the hypothesis that individuals who accept conspiracy theories have the same deficit as individuals with the Capgras delusion, namely the "faulty monitoring of ideas" (Miller 2020); in a *Guardian* article, an author described Naomi Wolf, a woman spreading vaccine myths on social media and consequently banned by Twitter, as "delusional" (Connett 2021). Psychologists have suggested a correlation between the acceptance of conspiracy theories and schizotypal traits, that is, traits characterized by psychotic symptoms (Douglas et al. 2017).

The implication of this understanding of conspiracy theories is that the phenomenon shares some important features with thoughts and behaviors that are recognized as marks of insanity. This view supports a deficit model of conspiracy theorizing, according to which people accept conspiracy theories due to cognitive biases that drastically—and pathologically—impair reasoning.

Is likening conspiracy theories to delusions warranted? In this paper we address this issue by exploring the similarities and differences between conspiracy theories and clinical delusions. In section 2, we look at common definitions of delusions and conspiracy theories. In sections 3, 4, and 5, we compare surface features, aetiological features, and downstream effects of delusions and conspiracy theories. We conclude, in section 6, by raising some concerns about the sociopolitical consequences of this comparison.

2. Definitions and examples

Let us take a closer look at the definitions of delusions and conspiracy theories to highlight some elements of similarity and dissimilarity.

2.1. Delusions

Delusions are common symptoms in schizophrenia, dementia, amnesia, and delusional disorders; they can also be occasionally experienced as part of depression and obsessive-

compulsive disorder. In the *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association, 'delusion' is defined as follows:

> A false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not ordinarily accepted by other members of the person's culture or subculture (i.e., is not an article of religious faith). When a false belief involves a value judgment, it is regarded as a delusion only when the judgment is so extreme as to defy credibility (DSM-5, 2013, p. 819).

Broader definitions of delusion have also been proposed:

> [A] belief which is implausible in light of general knowledge and/or the weight of evidence to hand (which ought normally to confer doubt), and which is adopted and maintained uncritically as true with unwarranted subjective conviction (Langdon and Bayne 2010, p. 322).

Delusions of persecution, which are the most common type of delusions and those most frequently compared to conspiracy theories, occur when someone believes that a person or a group is hostile to them and intends to cause them harm. Examples include the belief that the postman is spying on one's house on behalf of the government or the belief that one's co-workers are trying to get one fired. Let us offer some further examples in the words of people who have experienced delusions, either directly or from the perspective of a caregiver.

The following is an extract from a first-person account of schizophrenia in which the author describes the onset of psychotic symptoms after a history of depression and alcoholism:

> The Alien Beings were from outer space, and of all the people in the world, only I was aware of them. The Alien Beings soon took over my body and removed me from it. They took me to a faraway place of beaches and sunlight and placed an Alien in my body to act like me. […] I also saw that the Aliens were starting to take over other people as well, removing them from their bodies and putting Aliens in their place. Of course, the other people were unaware of what was happening; I was the only person in the world who had the power to know it. At this point I determined that the Aliens were involved in a huge conspiracy against the world (Payne 1992, pp. 726-7).[1]

In this other passage, a woman describes her mother's paranoia:

> Although supervisors described her as an excellent employee, she suddenly started accusing co-workers of plotting against her." "She […] avoids answering the phone and uses the answering machine to screen all her calls. She still feels that most people are not benevolent" (Powell 1998, p. 175).

[1] For another first-person account of persecutory delusions involving aliens, see Bayley (1996).

2.2. Conspiracy theories

In the *Encyclopedia Britannica*, a conspiracy theory is defined as:

> [A]n attempt to explain harmful or tragic events as the result of the actions of a small powerful group. Such explanations reject the accepted narrative surrounding those events; indeed, the official version may be seen as further proof of the conspiracy (Scott 2021).

The scholarly literature contains a variety of accounts and examples of conspiracy theories. Here are two examples:

> The epithet 'conspiracy theory' tends to be reserved for conspiracy-based explanations which deal with large scale, dramatic social and political events (such as the AIDS epidemic, the assassination of John F. Kennedy or 9/11); for explanations that do not just describe or explain an alleged conspiracy, but also uncover it and in doing so expose some remarkable and hitherto unknown 'truth' about the world (such as that the Illuminati orchestrated the French Revolution or that the Bush administration had a hand in 9/11); and for accounts that allege the existence of a plot with nefarious and threatening aims (to destroy Christianity, establish the New World Order, take a country to war or eliminate a racial group) (Byford 2011,page 21).

> By "conspiracy theory" we indicate an explanation of a given event that: (1) refers to actual or alleged conspiracies or plots (Conspiracy Criterion); (2) conflicts with the received explanation of the said event, providing an alternative to the "official view" of that event (Conflict Criterion); and (3) offers insufficient evidence in support of the alternative explanation, so that it is not considered as a competitive scientific theory or anything like that (Evidence Criterion). These criteria are meant to be necessary and jointly sufficient for something to count as a conspiracy theory (Ichino and Räikkä 2020, page 3).

One example of a conspiracy theory among those related to the COVID-19 pandemic is COVID-19 denialism, which is the idea that the virus does not exist or that is it not significantly harmful and that figures about the worldwide impact of the virus (in terms of infections, deaths, etc.) are fabricated. According to denialism, this fabrication is the work of powerful individuals or organisations (such as Bill Gates or Big Pharma) who have malicious motives and are looking for financial profits or political power: the want to sell harmful pharmaceutical products, control people's behavior, suppress freedom, etc.

It is worth noting that—just like delusions—conspiracy theories are given *epistemic* definitions; in other words, they are given definitions that refer to notions of evidence, truth, and rationality broadly conceived. Some philosophers have argued that, even though both delusions and conspiracy theories are belief-like in some respects, they should be viewed non-doxastically. According to this view, in at least some cases, people are not committed to

the truth of their delusion or of a conspiracy theory in the same way as they are committed to the truth of their ordinary beliefs.[2] Rather, when reporting a delusion or a conspiracy theory, people might be expressing a *hope*, or an *imagining*, or a hybrid attitude. Thus, people may take themselves to believe a conspiracy theory or to believe a delusion whilst their mental attitude is not actually a full-blown belief, departing in some respects from the common functional profile of beliefs. Our aim here is not to adjudicate the debate between doxastic and non-doxastic accounts of delusions and conspiracy theories, and so throughout this article we will simply talk about "having a delusion" and "accepting a conspiracy theory".

3. Surface features

To offer the most charitable assessment of the view that accepting a conspiracy theory and having a clinical delusion are alike, we focus on the comparison between (a) a conspiracy theory attributing responsibility for an adverse event to agents the individual mistrusts and (b) a delusion of persecution. In this comparison, two key features look immediately relevant. On the one hand, both the conspiracy theory and the delusion appear to involve attributing evil intentions or responsibility for adverse events to an individual or group that the person does not trust—where trust can be withheld either with good reason or for no obvious reason. On the other hand, a conspiracy theory—but not necessarily the delusion—involves a rejection of an official account of the events. The conflict with an authoritative view is not necessarily present when the delusion is formed. Delusions might simply arise to fill an explanatory gap in situations where there are not (or not yet) established official explanations.

A person with a delusion, who has no insight into their illness, has an explanation of their anomalous experience that is incompatible with the one offered by healthcare professionals. However, the "rejection of the official account" differs between the case of having a delusion and the case of accepting a conspiracy theory. For conspiracy theories, the opposition to authority is at the heart of the acceptance of the theory, whereas for persecutory delusions, the individual's take on reality only *happens to* conflict with that of their doctors (and everyone else's). These considerations therefore seem to reveal, beyond a *prima facie* similarity, an important difference between conspiracy theories and delusions. That being

[2] For anti-doxastic accounts, see, e.g., Currie and Ravenscroft (2002), Dub (2016), and Ichino (2020) on delusions, and Ichino and Raikka (2020) and Ichino (forthcoming) on conspiracy theories.

said, there are at least two key surface features that delusions and conspiracy theories have in common: their alleged implausibility and their epistemic irrationality.

3.1. Implausibility

Both conspiracy theories and clinical delusions are regarded as implausible by those who do not share them—although the degree of implausibility can vary from case to case. The COVID-19 denier has a view that conflicts with the mainstream view. We can easily imagine a situation in which the fact that people are ill and many are dying is initially attributed to a health threat that turns out to be illusory. However, COVID-19 denialism is implausible because it clashes with the evidence that has been accumulated by a great number of medical professionals, statisticians, public health officials, etc.

Similarly, although the delusions of persecution described in the quote by Powell involve mundane scenarios such as plotting co-workers or hostile family members, those described by Payne could be the basis for a science-fiction story where aliens are planning to invade the Earth and to make life miserable for those who intend to expose them. This is not just unlikely but highly implausible given that to date there is no evidence of alien intelligent life, let alone of aliens being able to communicate with humans.

Falsity is not a necessary condition for delusions or for conspiracy theories. Typically, conspiracy theories and delusions do not accurately represent events and involve distortions of reality; but in some cases, they can turn out to contain elements of truth. It is also worth saying that both delusions and conspiracy theories can be based on people's previous experiences.

3.2. Epistemic irrationality

Norms of epistemic rationality refer to how well-grounded an attitude is in the light of the evidence that is available and how responsive the attitude is to counterevidence and counterarguments. An attitude can be epistemically irrational because it is *ill-grounded* or because it is *impervious* to counterevidence and counterarguments (Bortolotti 2020, ch.1). Conspiracy theories and clinical delusions have a bad reputation in both these respects and are typically taken to be both ill-grounded and impervious to challenges.

As far as ill-groundedness is concerned, it should be noted that there is considerable variation in the extent to which conspiracy theories and delusions of persecution are supported. Generally, an external observer will find conspiracy theories and delusions ill-grounded. However, there are delusions of persecution that are partially grounded in adverse experiences of abuse in a person's life which may partially explain why the person is suspicious. Also, those who accept a conspiracy theory—or those belonging to their cultural group—might have had experiences that at least partially explain why they mistrust the alleged conspirators.

As far as imperviousness to challenges is concerned, both conspiracy theories and delusions are thought to be *unshakeable*. Individuals who accept one or more conspiracy theories and individuals with delusions do display some degree of *sensitivity* to counterarguments—at least to the extent that challenges to the conspiracy theory or delusion are acknowledged and reasons are offered in response to such challenges. However, typically neither conspiracy theories nor delusions display relevant degrees of actual *responsiveness* to counterarguments—that is, people are not actually open to abandoning or substantially revising their attitudes when challenged. Delusions and conspiracy theories are "self-sealing", meaning that any piece of evidence used against them tends to be reinterpreted as evidence in their favor (Sunstein and Vermeule 2009). As a result, delusions and conspiracy theories may become more entrenched and elaborated when challenged.

If Roberta Payne, who had the delusion about evil aliens, were told that there is no evidence of the presence of aliens, she would have replied that the aliens are skilled at covering their tracks—surely, they do not want to be discovered. Similarly, consider someone—let us call him John—who claims that Bill Gates is using COVID-19 vaccines to insert microchips into people with the secret purpose of controlling their future behavior. One might object that there is no evidence that Bill Gates has either the technology or the power to implement such a plan. To this John might respond that it is in Bill Gates' interest not to let people know what technology he has. This further articulation of the account is often accompanied by a statement or a feeling of epistemic superiority: the individual who accepts the conspiracy theory or has the delusion claims superior knowledge or unique access to the truth. So, John might say: "Bill Gates will not fool me". And, as Roberta writes: "Of course, the other people were unaware of what was happening; I was the only person in the world who had the power to know it".

In relation to being self-sealing, delusions and conspiracy theories are arguably on a continuum with ordinary confabulations.[3] It remains an open question whether the acceptance of conspiracy theories and delusions are more epistemically irrational than other attitudes.

4. Aetiology

Researchers are divided on whether having delusions of persecution and accepting conspiracy theories have similar aetiologies. On some accounts, the similarities in surface features which we discussed in the previous sections do not translate into similar causal histories. Oliver and Wood (2014), for instance, argue that the main predictors of the likelihood of accepting a conspiracy theory are a tendency to believe in unseen or supernatural forces and a preference for narratives in which good and evil are in stark contraposition. These factors do not predict persecutory delusions and do not suggest a disruption in normal functioning.[4]

Other researchers identify significant areas of overlap: both conspiracy theories and delusions of persecution can be explained by predictive processing theories or two-factor models of belief formation. According to predictive-processing theories (Reed et al. 2020; Hohwy 2013), conspiracy theories and delusions of persecution can be both viewed as inferences under uncertainty and, in particular, responses to situations characterized by ambiguity or threat. Belief-updating and learning differences are observed in individuals accepting a conspiracy theory or having delusions of persecution. This includes a higher sensitivity to changes in their environment and a tendency to predict uncertain events inflexibly. On this view, the delusion or the conspiracy theory is the default explanation for mismatches between the existing models of the world and new inputs that are due to the disruption of prediction-error signals.

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[3] "Conspiracy theorists are notoriously difficult to argue with, not only because their beliefs tend to be unfalsifiable, but because their belief schema—the meta-narrative of conspiracy—provides a ready framework for the inference and incorporation of any new facts. Yet this process of interpretation is not, of itself, pathological, but is rather an extension or over-reaction of the everyday confabulation that causes subjects not only to find reasons for preferring one pair of pantyhose over an identical one, for example, but to genuinely believe that they do" (Bergamin 2020, p. 172).

[4] "Although people with unusual levels of anxiety, paranoia, or personal mistrust are also likely to be attracted to conspiracy narratives, believing in unseen forces or liking Manichean narratives is not irregular and would not otherwise impair "normal" functioning in society. Indeed, our supposition is that these predispositions originate in cognitive tendencies that would appear normal or even appropriate in other circumstances, such as knocking on wood for good luck" (Oliver and Wood 2014).

Within two-factor models (McKay et al. 2007a; McKay et al. 2007b; Levy 2019; Pierre 2020; Uscinski et al. 2020), conspiracy theories and delusions are explained by focusing on a first factor that changes from case to case and on a second factor that is shared.

In the case of delusions, the first factor varies across types of delusions and arguably accounts for the delusional *theme*. For monothematic and circumscribed delusions—those with one theme and that do not tend to take the form of elaborated narratives—the first factor is an *anomalous experience*, often due to brain damage from trauma or degenerative disease. In the Capgras delusion, where the theme is that a loved one has been replaced by an impostor, the anomalous experience is due to a problem with the affective route of the face recognition system. It is not easy to identify the first factor contributing to delusions of persecution, where the theme is that a third party is hostile and threatening. It has been shown that people with delusions of persecution tend to interpret ambiguous stimuli (such as a stranger glancing at them from a distance) as a sign of hostility (Freeman and Garety 2004), suggesting that they have a somewhat distorted perception of social exchanges. Another factor in persecutory delusions is mood instability: disturbances of mood are often a mediating factor between trauma (such as bullying) and paranoia, leading people to experience the world as unpredictable and unsafe (Broome and Bortolotti 2018).

In the case of conspiracy theories, the first factor is commonly described as *epistemic mistrust* and the general theme is the presence of a secret plot (Pierre 2020). The mistrust in question is generally shared by well-defined social groups and often directed at institutions—such as the press, the experts, etc. It does not play a significant role in theories of delusion formation, where paranoia is typically idiosyncratic.

For both delusions and conspiracy theories, the second factor is thought to be predominantly cognitive. Most commonly, it is described in terms of reasoning deficits and biases (McKay et al. 2007a; Pierre 2020). On these accounts, such deficits and biases explain the *form* of delusions and conspiracy theories—that is, surface features such as implausibility and imperviousness to counterevidence.

For Coltheart et al. (2010), the second factor in delusion maintenance is a cognitive deficit inhibiting the rejection of an endorsed belief even in the presence of strong counterevidence, making the belief virtually impossible to revise. For McKay (2012), the second factor in delusion formation is a cognitive bias towards explanatory adequacy which leads people to

accept hypotheses that seemingly explain their experiences even when such hypotheses have low prior probability and conflict with existing beliefs.

In the case of conspiracy theories, for some authors, the second factor consists in a variety of cognitive biases, such as the so-called 'intentionality', 'proportionality', and 'confirmation' biases, as well as various forms of motivated reasoning. These biases underlie the ways in which people seek to fill the "epistemic vacuum" created by the rejection of the official account (Pierre 2020; Douglas et al. 2019). Although such biases may be accentuated in people prone to having delusions and accepting conspiracy theories, this does not seem to indicate a distinctive dysfunction. The cognitive tendencies attributed to them by predictive-processing accounts and two-factor accounts are not exclusive to these groups. They include: seeking a causal explanation for threatening or unusual events; wanting to restore a sense of control or give meaning to distressing circumstances; being willing to modify previously held beliefs for the sake of providing a satisfactory explanation of new and salient events; and to defy apparent counterargument in order to hold on to a seemingly satisfactory explanation (Bortolotti and Ichino 2020; Ichino and Bortolotti forthcoming).

Both for delusions and for conspiracy theories, there may also be motivational elements, such as a need for control and attributional biases (Pierre 2020; McKay et al. 2007b). In delusions of persecution, poor life outcomes can be attributed to the hostility of others as a response to low self-esteem (Bentall 2003). For conspiracy theories but not for delusions, group-marking and in-group positivity also play a role, given the way conspiracy theories are shared within political communities (Douglas et al. 2019).

5. Downstream effects

A key difference between conspiracy theories and delusions concerns the roles they play in an individual's social life and relationships: conspiracy theories are shared with relatively large social groups and tend to strengthen group belonging and affiliation, whereas delusions are typically idiosyncratic and deeply isolating. McKay and Ross (2020) suggest that "what distinguishes […] beliefs in conspiracy theories from delusions may be partly a matter of whether or not the belief strengthens community bonds. If sustaining a belief impairs your daily functioning and disrupts your social relationships, then your belief is more likely to count as a delusion".

The difference in downstream effects between delusions and conspiracy theories is a point on which there is much agreement in the literature (Brotherton 2015; Uscinsky 2019; Douglas et al. 2019; Pierre 2020). This has important implications for how these phenomena impact on a person's wellbeing. It is indeed partly because of isolation and social withdrawal that delusions of persecution are usually accompanied by anxiety and stress, which may be caused either directly by the distressing content of the delusion or indirectly by the reactions of the people in the surrounding social environment to the person reporting such content. Delusions of persecution can be extremely distressing, as it emerges from first-person accounts, and can heavily disrupt a person's life. Payne moved cities, gave up her studies and her job, and stopped contacting family and friends as a result of her fear of what the Alien Beings might do to her or her loved ones. The acceptance of a conspiracy theory, in contrast, is generally comforting and soothes uncertainty by providing a story that fits with the person's existing beliefs and other attitudes and is generally shared by one's immediate social circle.

One might object that this line of argument overplays the positive effects of accepting a conspiracy theory, whilst not paying enough attention to the negative effects. Indeed, psychologists warn us that although it is true that conspiracy theories are accepted to satisfy some psychological need for comfort and reassurance, the question whether they do *actually* manage to satisfy such needs, thereby improving a person's wellbeing, remains open (Douglas et al. 2017; 2019). Moreover, even if conspiracy theories have no immediately perceived negative effect on a person's wellbeing, they might lead to anti-social behavior that could result in individual and collective harm (Jolley and Douglas 2013; 2014; Douglas et al. 2019, pp. 17–21).

Moreover, not all clinical delusions are harmful or disruptive; some people find their delusions rewarding and empowering (Jackson and Fulford 1997). This also applies to persecutory delusions (Ritunnano et al. 2021). In the many delusions with distressing content that are associated with harm, the delusions themselves might not be the actual cause of harm but might be thought of as imperfect responses to situations that were already critical for the person's mental health (Gunn and Bortolotti 2018; Bortolotti 2020, pp. 175–176).

These considerations suggest that the difference between delusions and conspiracy theories with respect to downstream effects are less neat than they initially appear to be.

6. Conclusions

We have shown that there are both similarities and differences between having a clinical delusion and accepting a conspiracy theory. In particular, we have shown that: (a) in both cases, the person claims something implausible and is not typically open to abandoning the claim even in the light of powerful challenges; (b) although some factors responsible for the adoption of a delusion and a conspiracy theory may be different and depend on the person's life history and past or present experiences, some of the underlying cognitive mechanisms significantly overlap in the two cases; and (c) having a delusion often brings harm and disruption to a person's life (and this is what typically justifies medical intervention), whereas accepting a conspiracy theory may be neutral or even psychologically and socially beneficial for an individual—this difference likely being due to the fact that delusions typically isolate people whereas conspiracy theories unite them.

It is difficult to draw general conclusions from the comparison between delusions and conspiracy theories. However, one thing worth discussing is that stressing the similarities between the two phenomena might lead one to consider the acceptance of conspiracy theories as a symptom of a disordered mind, which might in turn lead to the stigmatization of those who accept (one or more) conspiracy theories. It is commonplace to depict those who accept conspiracy theories as irrational. Likening conspiracy theories to delusions brings support to this move, pushing it even further through the suggestion that those who accept conspiracy theories are not just irrational in an everyday sense, but are also mentally ill.

The stigma that is commonly associated with having a mental illness is harmful and ethically objectionable in its own right.[5] When this kind of stigma is directed at those who accept conspiracy theories, it functions as a tool for excluding them from the arena of public debate and for impairing their participation in collective discussion and deliberation.

Stigmatizing one's political opponents without addressing their concerns and motivations is, in general, politically undesirable. It is certainly useful to explore the similarities and differences between delusions and conspiracy theories, just like it is useful to explore the similarities and differences between delusions and ordinary beliefs or attitudes. However, the political use of the comparison between delusions and conspiracy theories—especially when

[5] The assumption on which stigmatizing attitudes are based, e.g., that those diagnosed with psychiatric disorders are irrational in a way that is different in kind from people who are not, lacks justification (Bortolotti and Puddifoot 2019).

it is aimed at producing or reinforcing stigmatization and exclusion—is problematic and should be avoided.

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