Constructing 24/7 Madness. The Pathology Behind Schizophrenia in Western Urban Screen Cultures

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Introduction

This research examines the cognitive processes of people with schizophrenia (PSZ) as a way of studying today's conception of the normal and the pathological in Western urban screen cultures. By taking a medical humanities approach, this research will investigate the cultural construction of what accounts for normal and pathological behaviours through the use of media theory and philosophy. As the symptoms that PSZ are struggling with are used within psychiatry to identify their psychopathology, a cultural threshold appears to be set by people within this area of expertise on what is considered to be different from the norm. This

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D. Nguyen et al. (eds.), *Understanding Media and Society in the Age of Digitalisation*,
https://doi.org/10.1007/978-3-030-38577-4_11

research will examine how these standards for diagnosing schizophrenia invite us to reassess our conception of the pathological in *Western urban screen* cultures: contemporary cultures in urban areas in the West in which the interaction with screens is inevitable for efficient, functional, and fast performance. By examining how the concept of the pathological is structured in such cultures, this research will also investigate how the construction of schizophrenia can help to understand and re-evaluate what is considered as the normal nowadays.

Within this research, schizophrenia is used as a case study for studying the cultural threshold that is set for psychopathological behaviour in Western cultures. This behaviour is often studied through the lens of mental illnesses, which implicates that the behaviour is triggered by a dysfunction within the brain. As a result, a person who exhibits the behaviour is considered to be sick and needs help from experts who work in either hospitals or mental institutions. However, one should keep in mind that what is considered to be a mental disorder is limited to the time and space in which the symptoms of the mental disorder take place. For example, it was not until 1973 that the American Psychiatric Association (APA) decided that homosexuality was not a diagnosis of a mental disorder. As a result, many countries repealed sodomy laws that criminalized homosexuality and enacted laws to protect the human rights of lesbian, gay, bisexual, and transgender people both in society and at the workplace (Drescher 2015, 572). The example of homosexuality thus shows how the diagnosis of what is considered to be pathological depends notably on the time and space in which the mental disorder manifests itself. It is for this reason that this research investigates how schizophrenia is considered to be pathological in today's Western urban screen cultures.

The research will be presented in three stages. First, I will focus on how attention is currently restructured within Western cultures due to the media-density of these cultures. Not catching up to this restructuring of attention by citizens within these cultures will then be linked to a societal exclusion that is taking place on the basis of psychopathology. Second, I will introduce how schizophrenia, as a case study, can be used to identify current notions of what accounts for normal and pathological behaviours. Lastly, the diagnosis of schizophrenia will be analysed through textual analysis and genealogy in accordance with a medical humanities approach. Eventually, an answer will be formulated for the following question: how do the cognitive processes of people with schizophrenia fit into today's conception of the normal and the pathological in Western urban screen cultures?

Remaking Attention

Western societies seem to become increasingly mediatized as digital media have been reforming many of the social, political, and cultural processes within them. In everyday life, media play a foundational role in organizing our lives as they have become the tools to understand and organize relationships with one another and the world (Carah and Louw 2015, 32). As a consequence, our lives are filled with media objects which create daily rhythms through the flow that is facilitated by them: reading or watching the news in the morning, listening to music on our way to work while texting, or perhaps finding a dating match based on our preferences and location. It seems as if we are not living with media, but our lives are lived *in* media (Deuze 2016, 326). Western societies have therefore become rather media-dense with people that have become acquainted to various media rituals in their everyday life.

Through our customization of media rituals, media have become a "stand in" for the world that we live in (Couldry 2003, 4). Through formulas and frames, media are able to draw our attention to things that are important for us to see, without balancing out the socio-political positions that are embedded within them. The professional communicators that create, access, regulate, and use the messages within the media outlets are therefore the ones that get to speak from a privileged encoding position. Within a media-dense society, in which messages are tailor-made for many niche audiences, reality itself is not questioned but fragmented; being in charge of the media outlet brings with it the position of constructing a reality, to however the professional communicator sees fit. Western citizens are therefore consuming their tailor-made reality through their personal media rituals while, on the one hand, they function in a society with people who have another reality on their own and, on the other hand, they also have to deal with a 'physical' reality where they wake up in every day.

The different realities that people have to deal with in their day-to-day lives require a cultural remaking of attention. As Jonathan Crary (2014) argues, our new 24/7 economy requires people to quickly move from one topic and medium (and therefore reality) to the next: our attention needs to be remade into repetitive operations and responses that always overlap with acts of looking or listening (52). Within a culture that is based on 24/7 production and consumption, time becomes, according to Crary (52–53), so valuable that every decision needs to be efficient and functional:

> Any act of viewing is layered with options of simultaneous and interruptive actions, choices, and feedback. The idea of long blocks of time spent exclusively as a spectator is outmoded. This time is far too valuable not to be leveraged with plural sources of solicitation and choices that maximize possibilities of monetization and that allow the continuous accumulation of information about the user.

As Crary indicates, attention now needs to be reconstructed in such a way that it fits the requirements of the system that we are living in: a system that wants us to easily shift from one reality to the next in an efficient, functional, and fast manner, while we also produce and consume at the same time. As Western urban screen cultures demand of their citizens to adapt to this type of attention, those who are able to adapt their behaviour and live according to this model are included within such cultures.

Psychopathology Excluded

People who are often excluded from society are often the ones that are not able to catch up with the cultural demands of it. As Crary has shown, Western urban screen cultures demand of their citizens to get used to a new form of attention, but not everyone is able to reconfigure their attention in such a way. It is tough to be in such a position, since contemporary Western societies demand continuous participation and performance: we have to be efficacious within the culture that we perform in and efficient within the organization that we work for (McKenzie 2001, 18). Therefore, those who are able to perform are included within the culture, while those who cannot are excluded.

The incompatibility to perform, and therefore be productive, is often premediated from a biomedical approach that links the inefficiency to psychopathological behaviour. What is considered to be pathological has been culturally constructed as a non-normative mode of life that is the object of study within scientific medicine, since particular physiology or behaviour does not abide to the usual and normative state of subjects within a society (Canguilhem 1978, 130). However, in the last few decades, the brain has become an important organ that is used to visualize and map pathologies on: discrepancies within the operations of the brain as an organ are used to diagnose mental disorders for pathological behaviour, although this link is sometimes quite implicit (Beijnon 2017, 79). Even though a connection is often made between the brain, behaviour,

and the mind, that connection could be made too precipitative. As António Damásio (1994, 40) states:

> The distinction between diseases of "brain" and "mind," between "neurological" problems and "psychological" or "psychiatric ones," is an unfortunate cultural inheritance that permeates society and medicine. [...] Diseases of the brain are seen as tragedies visited on people who cannot be blamed for their condition, while diseases of the mind, especially those that affect conduct emotion, are seen as social inconveniences for which sufferers have to answer.

Within biomedicine it has become an unconscious convention to study pathological behaviour within a spectrum of mental illnesses that could be caused by physiological discrepancies within the brain.

Biomedicine adapts the diagnoses of mental illnesses to a cultural threshold that is supported by dominant social, economic, and political forces within a society. In his study on madness as a form of pathological behaviour, Michel Foucault (1976, 131) argues that madness is silenced and excluded from daily practices in everyday life within Western societies of the twentieth century. According to Foucault, each culture has its own threshold in the diagnosis of madness and the pathological, which evolves with the configuration of that culture (129). The threshold for the pathological that is set, and therefore the manner in which a diagnosis of mental disorders is made possible, has as an effect that "our culture reads the world in such a way that man himself cannot recognize himself in it" (139). By studying how this threshold is set and therefore how cultures are configurated to a particular conception of, for example, mental disorders, one might get a better understanding of the notions of the pathological within them.

By studying the construction of the pathological, one simultaneously creates an understanding of what is considered to be the normal. As pointed out by Foucault, those who are considered to be mentally ill "[go] back to the earlier phases of evolution, [their illness] eliminates recent acquisitions and rediscovers forms of behaviour that have normally been surpassed" (31). A mental disorder thus shows what sorts of behaviour have been cultivated by society. Any mental disorder is therefore defined in relation to an average or norm, which makes the illness marginal by nature. However, one could also look into a mental disorder from a sympathetic point of view, which shows the cultural logic and syntax that the "normal citizens" are frozen in (Guattari 2009, 78). In applying such an

approach, one will address mental disorders not so much from a pathological perspective but as a societal construction with standardized symptoms that may help to re-examine the cultural notions of the pathological.

Case: Schizophrenia

A mental disorder that is often associated with attention deficiencies is schizophrenia. PSZ show symptoms of hallucinations and delusions and suffer from the inability to focus attention (Olincy and Stevens 2007, 1192). These symptoms seem to be related to being overwhelmed by extraneous stimuli, which impairs the PSZ's ability to think coherently. Within biomedicine, these symptoms are often studied through a medical gaze, which consequentially leads the physician to particular traces of such mental illnesses that can be mapped upon the patients' organs, in this case the brain (Cartwright 1995, xiii). It is for this reason that within psychiatry, the origin of schizophrenia is often studied through the malfunction of bodily organs like the brain (Mattei et al. 2015) or impairments in the hormone regulation (Mueller et al. 2017).

The development of schizophrenia has, however, also been related to the exponential increase of urbanization, on the one hand, and to the contemporary globalized screen culture, on the other. Gruebner et al. (2017) have shown that through growing urbanization, more people tend to get exposed to increased amounts of stress that may increase the risk of the development of schizophrenia. Simultaneously, the present-day screen culture demands of citizens to prioritize efficiency, functionality, and speed. Since the arrival of 24/7 markets and global infrastructures for continuous work in neoliberal societies, citizens have had to adapt to a reshaping of experience and perception that meets the demands of these developments. The neoliberal citizen thus has to become a new sort of neoliberal subject that is created through continuous exposure and interaction with screens within such a society: attention needs to be caught through overabundant information and the citizens' sense of history is translated into images (Pisters 2012, 70). This transition to a dependency on screens and multiple, parallel processes thus asks of Western urban citizens a societal remaking of attention, as attention now needs to be focused on fast repetitive operations and responses. PSZ could in this case be understood as the sort of citizens that are not able to catch up to this restructuring of attention.

In this research, the diagnosis of schizophrenia will be used for analysis to apprehend how and why this mental disorder is considered to be pathological in contemporary Western screen cultures. As schizophrenia is often connected to the modern world and contemporary globalized screen culture (Pisters 2012, 38), this research will focus on this mental disorder to study contemporary notions of the pathological and the normal within biomedicine. There are other disorders that have been categorized on the basis of pathological symptoms that could have been used for this study, like bipolar, depressive, anxiety, and obsessive-compulsive disorder. However, as schizophrenia has often been studied within the academic discourse in relation to its representation within the media (Fuery 2004; Pisters 2012) and through understanding media culture (Guattari 2009; Kanary 2013), it will function as an appropriate case for this research on contemporary Western urban screen cultures.

Method

This research is one of medical humanities research, meaning that it construed "a cross-disciplinary and cross-cultural space for a bidirectional critical interrogation of both biomedicine (simplistic reductions of life to biology) and the humanities (simplistic reductions of sufferings and health injustice to cultural relativism)" (Kristeva et al. 2017, 55). Within the current academic discourse, medical humanities is an upcoming field of study in which people with either a medical or humanities background study the practice of knowledge production within medical care and healthcare. As a main focus of this field, medical humanities studies the boundaries that medicine sets between biology and culture (Viney et al. 2015, 4). Under this umbrella of medical humanities, this research will be conducted with the use of textual analysis and genealogy.

The material that will be studied through textual analysis and genealogy is the latest version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM functions as the guidebook for mental health professionals to ensure global uniformity of diagnoses such as schizophrenia. Approximately every decade, an updated version of the DSM is published. The first official version was published by the APA in 1952 and contained around 60 mental diagnoses. By the fourth version in 1994, around 365 diagnoses were listed. In the latest version, DSM-V, which was released in 2012, these diagnoses are studied under 22 different categories of diagnostic criteria and codes. As the DSM has been translated

into more than twenty languages, and is referred to by physicians, researchers, policy-makers, and criminal courts, the manual has become hegemonic in its status as *the* reference for the assessment and categorization of mental disorders in many Western and Eastern parts of the world (Kawa and Giordano 2012, 1). The DSM-V might therefore be a well-established guideline for the current governmentality in these cultures: an artefact that embodies "how we think about governing others and ourselves in a wide variety of contexts" (Ouellette and Hay 2008, 9). By using both textual analysis and genealogy, the DSM-V will be critically dissected to get a better understanding of how a dominant Western conception of the normal and the pathological is being created when it comes to the mental disorder of schizophrenia.

Textual analysis will be used to first distinguish the ideological formation behind the DSM-V. As Ron Becker (2018) describes, texts are able to communicate a dominant ideology: "a way of thinking about the world that emerges from and reinforces a specific social order" (11). Through textual analysis, one can critically dissect the myths that are reproduced through a register of ideology, which cultivates particular meanings for a hegemonic group (Eagleton 1994, 189). This would mean that through the use of texts within the medical discourse, physicians are able to manage systemic tensions within the language, while they can also establish narrowed-down frames that confirm their ideology. This research will use textual analysis to critically examine how texts within the medical discourse shape the dominant ideology that is encoded by physicians, while it also verifies a specific world view and organization of power. Since dominant codes are able to constitute a dominant cultural order so that preferred meanings are taken for granted, it is important to examine how these codes are encoded and decoded (Hall 2007, 483). Through a textual analysis, this research will break down the dominant hegemonic codes that are suggested to be decoded dominantly by the reader: it will closely examine how particular texts are legitimizing the claims that are made regarding the reasons why some behaviour can be considered pathological.

The second method within this research is that of genealogy. Genealogy focuses on how discourse practices and power function to explain why some discourses prevail over others (Anderson and Grinberg 1998, 340). As a method, genealogy invites the researcher to view the production of

disciplinary practices as strategic elements within relations of power. The conception of the normal, and therefore normative behaviour, can through genealogy be studied through a critical and questioning disposition. This research shall use genealogy to dissect the discursive practices that create the discourse of the normal and the pathological for schizophrenia. The main focus in the genealogy will be on the medical discourse in relation to the cognitive processes that are involved in the construction and experience of an environment, and not so much to physiological malfunctions or hormonal regulations since this research is interested in behaviour instead of anatomy.

Approach

The analysis is structured through the various diagnoses that are set for schizophrenia. Within the DSM-V, schizophrenia is studied from what has been coined as the "schizophrenia spectrum" (APA 2013, 87). This means that schizophrenia cannot be studied on its own, without taking into consideration that symptoms might indicate that someone might lean to a particular side of the spectrum. Within the schizophrenia spectrum, there are twelve different diagnoses, including three diagnoses related to catatonia. For the scope of this research, the analysis will limit itself to the diagnoses that are (1) specified, (2) not medication induced, (3) not due to another medical condition or in combination with another mental disorder, like catatonia or bipolar disorder. This narrows down the diagnoses to the following four types of disorders of which three[1] will be studied within this research on the schizophrenia spectrum:

- Delusional disorder
- Brief psychotic disorder
- Schizophrenia

For every disorder, this research shall go through the diagnostic criteria that are set in the DSM-V. The steps that lead to the diagnosis of the particular disorder shall be studied through critically examining the text and

[1] Schizophreniform disorder shall not be studied as it fits the same diagnostic criteria as brief psychotic disorder but for the occurrence of a maximum of six months instead of one.

the genealogical discursive practices that are operated throughout it. This means that the specification of types or the associated features supporting the diagnosis shall be studied with the two proposed methods to understand how each symptom is creating an understanding of what is considered to be pathological. For every symptom that is found to be pathological, a conception of what is implicitly assumed as the normal shall be formulated.

Analysis

The order in which the disorders will be examined is structured by the duration of the symptoms. Delusional disorders shall be dealt with first, since the persistence of delusions plays a crucial role in the other diagnoses on the schizophrenia spectrum. The other two disorders are organized based on the duration of the episodes: brief psychotic disorder with a maximum of one month and schizophrenia, which is only diagnosed after six months.

Delusional Disorder

The first category on the schizophrenia spectrum that is dealt with in the DSM-V is that of delusional disorder. The DSM describes delusions as "fixed beliefs that are not amenable to change in light of conflicting evidence" (87). People that deal with delusions are therefore very persistent in the description of their own worldview and find it tough to modify it. In its description of delusions, the DSM makes a strong claim of what can be considered as pathological: not being able to revise one's perception of the world for more than one month (90). However, as in Western cultures various media representations operate for different niche audiences, it is often considered as a given that people are able to consume the media contents that fit them. Our media rituals then help us to confirm our worldview so that a dominant meaning keeps on being decoded by the subject. People who struggle with delusions are not capable of dealing with another worldview, that is they find it hard to comprehend that individuals have their own tailor-made worldview. The DSM therefore suggests that it is normal that people in Western cultures recognize that others have a different worldview. As a hegemonic artefact, the DSM therefore confirms an ideological conception of individualism, while it also acknowledges a sense of solidarity.

One of the diagnostic criteria that the DSM foregrounds in the diagnosis of delusional disorder is that the daily functioning and behaviour of the subject is not profoundly damaged: "Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired, and behaviour is not obviously bizarre or odd" (90). To better describe the conception of bizarre behaviour, the DSM provides the following explanation: "Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences" (91). The words 'bizarre' and 'odd', as a diagnostic criterion, are used to specify a difference with what accounts for the normal. It therefore appears that this type of functioning and behaviour is considered to be different, but it is not explicitly clarified what accounts for the normal. One can therefore implicitly assume that normal behaviour is something that is based on thoughts that are deemed to be plausible, understandable, and based on ordinary life experiences. Delusions are then excluded on the basis of their relation to everyday life and to the extent the thoughts differ from the occurrences that might happen in that life, while normal thoughts are included on the same relation but more on the plausibility of it: what is considered to be plausible can be included, what is deemed to be impossible is excluded. The DSM is therefore granting psychiatrists the right to decide over what is plausible or not.

To categorize these bizarre thoughts, the DSM provides five different types of delusional themes with which subjects can deal with. Every type has a predominated theme, but a subject can also deal with multiple types at the same time, which is then categorized as either *mixed* or *unspecified*. In the *erotomanic type*, the subject believes that another person is in love with the individual. This person is usually "of higher status (e.g., a famous individual or a superior at work) but can be a complete stranger" (91). The DSM therefore implies that it is pathological to have the belief that someone who has more power than the subject might be in love with them. This diagnosis then confirms a societal organization which is based on economic and social status, which is an ideological model that corroborates old capitalist beliefs of the organization of power (Carah and Louw 2015, 62–63). Although we currently live in Western neoliberal cultures that have abolished the belief in feudalism, the DSM substantiates a world order in which it is normal that individuals can be ranked in classes and find affection within them.

Another subtype is the *grandiose type*, which has as its central theme the belief of "having some great talent or insight or of having made some

important discovery" (91). The DSM does not offer any examples for this theme, but it does claim that these delusions may have a religious content (91). This diagnosis constructs the pathological behaviour on the basis of someone's capabilities. It confirms the conception that individuals must act according to the laws of power within their class. People are not able to have greater talent than the people in the class that they are already a part of, otherwise they would already have been in a different one. In a highly mediatized and urban culture, people who consider themselves to be special, based on their talent or personal insights, will be considered as pathological. It therefore appears to be normal to not be too different and too critical. At the same time, the DSM offers a bias for the occurrence of pathological behaviour within religious cultures, as it claims that thoughts based on religious content should already be considered as a flag for delusions (93). This type of delusion therefore confirms a normal that is constituted by atheistic people that do not believe to be special and therefore do not question the societal class structure.

The *jealous type* is described as the belief that the spouse or lover of the subject is unfaithful. According to the DSM, "this belief is arrived at without due cause and is based on incorrect inferences supported by small bits of 'evidence'" (91). With this specific category, the DSM confirms the belief that relationships should be monogamous: one should not have more than one significant other and should not cheat on him or her. It appears to be pathological to have more than one lover, and that jealousy is a pathological trait. The belief that someone might be unfaithful is therefore considered as odd, since the standard that is coined confirms the idea that lovers are faithful. This is then endorsed by ascertaining the cause of this jealousy as coming from out of nowhere: when someone has suspicions regarding the faithfulness of their lover, they can have feelings of jealousy. The DSM therefore supports a belief that monogamy and faithfulness are the norm, and that jealousy is an emotion that can only be shown when grounded on evidence.

The most common theme for delusions is embodied in the *persecutory type* (92). The DSM describes that this type of delusion "involves the individual's belief of being conspired against, cheated, spied on, followed, poisoned, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals" (91–92). As subjects within the persecutory type are often paranoid towards forms of authority, they make attempts to take legal or legislative actions against the forces that work against them (92). This theme is considered as pathological because of the belief that

someone might be harmed or deceived by authorities. The DSM thus suggests with this category that the normal status is that institutions and authorities are not managing their power in such a way that it deceives individuals: people are not spied upon, not cheated, not followed, and so on. However, current Western screen cultures have endorsed surveillance capitalism, and with that a digital enclosure, which highly depends on unconsciously produced user-generated data (Andrejevic 2007, 297). Authorities are therefore often involved in the data collection of individuals' behaviours on- and offline. The DSM is, however, suggesting that these paranoid thoughts are delusional and should therefore be considered as pathological. With such a category, the DSM is establishing a normal that does not question the data spying by authorities but explains such forms of data collection as being untrue. It is therefore normal to trust authorities and not question if they are misleading or spying on you.

The last theme, the *somatic type*, applies when the central theme of the delusion involves bodily functions or sensations. Within this type, the body can be involved in several ways. The most common belief is that "the individual emits a foul odor; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are misshapen or ugly; or that parts of the body are not functioning" (92). With this category the DSM supports the conception that the world in which our bodies live is a shared space and time through which we have created ideas that can be considered as objective due to the shared physiological state of our body and culturally embedded agreements (Beijnon 2018, 146). The DSM therefore implicitly claims that people can be deemed as pathological when their physiological state is not conforming to the objectivity within the society that one lives in. It is therefore considered to be normal to have a body conform to the shared physiological state in a culture, where beliefs regarding its state are not questioned.

Brief Psychotic Disorder

The second disorder that is mentioned within the DSM on the schizophrenia spectrum is brief psychotic disorder. According to the DSM, people with such a disorder experience at least one or more of the following three symptoms: delusions, hallucination, and disorganized speech (94). One could also show symptoms of grossly disorganized behaviour, but this symptom must not necessarily be met for the diagnosis. Delusions, which have been explained in the section on delusional disorder, could

therefore be one of the steppingstones in the diagnosis of brief psychotic disorder. Just like for the delusional disorder, it is important in the diagnosis that the duration of an episode is at least a day but less than one month (94). What makes this disorder different from the delusional disorder is mostly the experience of emotional turmoil and rapid shifts from intense affect to another (95).

What is considered to be pathological in this disorder is predominantly the level of "disturbance" (95). According to the DSM this pathology can be seen in the disorganization in the behaviour and speech, which therefore implies a sort of standard to which people with a brief psychotic disorder cannot live up to. This standard justifies that "supervision may be required to ensure that nutritional and hygienic needs are met and that the individual is protected from the consequences of poor judgement, cognitive impairment, or acting on the basis of delusions" (95). Although it is clear that human needs must be met in the form of nutrition and hygiene, it is unclear as to what sort of cultural and social threats the subject must be protected from. This diagnosis therefore implies a standard in the decision-making of the subject that is not met since it is steered by delusions. As has become clear from the earlier section, delusions appear to be categorizable. This would mean that the internal thoughts of the subject are considered to be pathological, since they are not living up to the normal standard that is set by the DSM. By explaining disturbance as a way of making judgements, the DSM grants psychiatrists the power to decide over the plausibility of one's thoughts and whether the way that subjects act upon it seems right.

Another important issue is how the DSM distinguishes brief psychotic disorder from culturally sanctioned response patterns. As an example, the DSM provides the following: "in some religious ceremonies, an individual may report hearing voices, but these do not generally persist and are not perceived as abnormal by most members of the individual's community" (95). It is for this reason that the DSM suggests that someone's cultural and religious background should be taken into account when considering whether thoughts are delusional. With this issue, the DSM proposes that thoughts can be considered as normal when they are recognized by a majority of a community. As religious and cultural backgrounds are put in relation to this issue, the DSM attempts to standardize particular delusions: although thoughts might appear to be delusional outside the context in which they are usually experienced, one must acknowledge the normality of the delusion due to the collective experience. The DSM

therefore implies that diagnoses of delusional thoughts can only take place on an individual level, which can be experienced when one is on his or her own. It therefore appears that in a mediatized culture, where attention is given to one's personal media rituals, it is important to base one's thoughts still on something that is shared by a collective to go by as normal. Thoughts become pathological when people believe them to be 'different' from the others' media rituals of which the subject is a part of.

Schizophrenia

Within the DSM schizophrenia is diagnosed on the persistent occurrence of delusions, hallucination, and disorganized speech. Also, the impairment of both social and occupational functioning is significant for schizophrenia (104). It is for this reason that the DSM formulates as its second diagnostic criteria for schizophrenia that "the level of functioning in one of more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset […] or there is failure to achieve expected level of interpersonal, academic, or occupational functioning"(99). The DSM therefore implies that areas such as work and social relationships are cornerstones in the functioning of everyday life. It then implies a normality, or 'expected level', in those environments and relations which appears to be related to the productivity that the subject shows: he or she does not act efficaciously or efficiently. As examples, the DSM provides the display of inappropriate affect, having a dysphoric mood, a disturbed sleep pattern, and a lack of interest in eating (101). One thus acts pathological when they are not capable of living up to the expectations of these 'major areas' in their lives, which they often have to share with others. People can be normal when they perform efficiently and find ways to relate and communicate with others; being antisocial and inefficient is pathological, while the opposite accounts for the normal.

In its diagnosis of schizophrenia, the DSM sets a norm for what personality, the perception of reality, and the physiology of one's body should be. One of the associated features that support the diagnosis of schizophrenia is that "depersonalization, derealization, and somatic concerns may occur" (101). This would mean that these subjects are unsure about the experiences that they have over their body, which therefore may affect the way they perceive their world and their subjectivity in it, while the subject is unaware of the abnormality of this perception (101). As Shaun Gallagher (2005) has argued, the conception of the body can be considered from

two positions: a *body image*, which consists of a system of perceptions, attitudes, and beliefs pertaining to one's own body, and a *body schema*, a system of sensory-motor capacities that function without awareness or the necessity of perceptual monitoring (24). One could thus argue that these subjects experience the plasticity of the body schema and a decrease in the ownership of their body schema. The experience of subjectivity for these subjects is therefore directly related to the experience of ownership of the body. However, as the body schema shows that this experience can go beyond the physical properties of the body, these subjects have difficulty in constructing a sense of ownership of their body in the reality that they perceive. It is therefore considered to be pathological to have a disownership of one's body which then creates a derealization of the environment that one is in What accounts for the normal is then the conception that one has ownership of one's body and believes the reality that one experiences through it to be true.

Through pathologizing reductions in attentions and (social) cognitive processes, the DSM creates a standard of how the body should be capable of functioning within contemporary societies. According to the DSM, subjects experience "[a]bnormalities in sensory processing and inhibitory capacity, as well as reductions in attention" (101). It is therefore pathological to have a different sensory experience of what is known as reality and a devaluation of attention. However, within contemporary Western urban screen cultures, it has become more complicated to distinguish what accounts for reality through the perception of the body schema in multiple realities. The DSM already points out that "the incidence of schizophrenia and related disorders is higher for children growing up in an urban environment" (103). As the body schema in these environments now needs to interact with many processes, different screens, and virtual environments that have been tailor-made for the media rituals of one person, it has become more challenging for the body to determine its role within the realities of such an environment. As our attention needs to be focused on parallel processes through multiple screens (Crary 2014, 52), it appears to be normal to be able to recognize one's position and subjectivity between these multiple realities in which the body needs to function. The DSM therefore emphasizes that being unable to have such a sensory experience and perception of reality can be considered as pathological. What is expected to be normal is then a body that can sensorially experience its position and subjectivity through the distribution of attention over multiple realities.

Lastly, it is important to address that for the diagnosis of schizophrenia, the DSM elaborates on culture-related diagnostic issues that might arise from particular cultural and socioeconomic factors. The DSM states that ideas that might seem delusional in one culture may be commonly held in another (103). As an example, the DSM provides again the visual or auditory hallucinations that one might get within a religious content as one is part of a collective religious experience. In addition, the DSM explains that the assessment of disorganized speech may be difficult because of the linguistic variation in narrative styles across cultures (103). The factor of distress is also dropped as a matter that can take the form of hallucinations, but these must be considered as "pseudo-hallucinations and overvalued ideas that may present clinically similar to true psychosis but are normative to the patient's culture" (103). Again, the DSM thus uses the collective and cultural experience as the driver of labelling thoughts and behaviours as pathological. Some thoughts might appear from a clinical gaze as delusional when they are taken out of their context, but through collective experience these pathological traits become normal. This would mean that the collective experience of 'different' thoughts and beliefs surpasses the clinical diagnosis of the pathological, which makes pathological traits become normal within their context.

Conclusion

This research started with the question how the cognitive processes of PSZ fit into today's conception of the normal and the pathological in Western urban screen cultures. Through a medical humanities approach, which combined textual analysis with genealogy, this research critically examined the DSM-V. The analysis showed that schizophrenia cannot be studied on its own without taking into account the other diagnoses that are in the spectrum. For this reason, the research investigated three diagnoses on the spectrum to examine what accounted for pathological and normal behaviour: delusional disorder, brief psychotic disorder, and schizophrenia.

One can conclude from the analysis that it is not so much the individuals who *have* pathological behaviour that they want to perform but that Western urban screen cultures may have pathological demands for the subjects that live within them that trigger this behaviour. As such cultures are currently built on the success of efficiency, parallel process, the division of classes, unconscious data collection, and both personal and collective

experiences, these cultures seem to demand a type of behaviour that is conform to this success. As a current form of governmentality, these cultures include the cognitive processes that fit to this success, like being efficient in the 'major areas' of life, having a sense of ownership of the body, being able to handle judgement on the basis of plausible thoughts, and not questioning the data collection by authorities. The type of behaviour that does not fit this governmentality is therefore excluded and institutionalized. Through pathologizing the behaviour that does not lead to a productive participation, and therefore success for the culture itself, this behaviour is placed as abnormal, odd, and sick. It is for this reason that people that fit these a-typical behavioural traits are diagnosed with a disorder, which gives authorities and institutions the right to exclude these people from the culture that they live in.

Disorders on the schizophrenia spectrum therefore do not fit in today's conception of what accounts for normal in today's society. This research has, however, shown that through analysing these diagnoses from the perspective of the pathology, we can learn more about the current expectations and sort of behaviour that we have in such mediatized cultures. By using media theory and philosophy through textual analysis and genealogy to study these biomedical discursive practices, this research has attempted to show how examining the medical disciplinary construction of schizophrenia can help to understand and re-evaluate what is considered as the normal in Western urban screen cultures. As this research was not able to study all the different diagnoses on the schizophrenia spectrum, future research with a focus on the other diagnoses might provide deeper insight on what the spectrum can tell us about current discursive practices of the construction of normal behaviour by pathologizing others.

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D. Nguyen et al. (eds.), *Understanding Media and Society in the Age of Digitalisation*,
https://doi.org/10.1007/978-3-030-38577-4