OPINION ON HOW THE CONCEPT OF SAUSSURE'S 'SIGN' FROM 'SEMIOTICS' MAY AID IN METACOGNITIVE THERAPY OF OCD

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Abstract

One of the most singular kinds of mental disorders, Obsessive Compulsive Disorder (OCD) is a mental illness that causes repetition of unwanted thoughts or sensations (obsessions) or the urge to do something over and over again (compulsions). Obsessions and compulsions, though different when taken at face value, have formed a kind of unhealthy symbiotic relationship in OCD. In case of OCD, a trigger often stimulates an intrusive thought stirring up fears of probability of transgression in the minds of those suffering from the disorder. This leads to individuals procrastinating obsessively over these perceived probable transgressions for extended periods of time and trying to reason out with them in order to come to a sense of security that they won't take fruition by compulsively indulging in some sort of ritualistic behaviour or thought process which, they feel, mitigates the perceived probability. This exercise however proves to be futile. However, when taken rationally, the relationships between the trigger and the intrusive thought as well as the intrusive thought and the perceived transgression are arbitrary by nature. Ferdinand de Saussure's Semiotic theory depicted a 'Sign' as being composed of two parts viz the 'Signifier' and the 'Signified'. However, there is no inherent relationship between these two parts just as an intrusive thought has no intrinsic relationship with a perceived transgression which an individual suffering from OCD associates with it. This article tries to rationally suggest the possibility of utilizing Saussure's theory in aiding the Meta Cognitive Therapy of individuals suffering from OCD.

Keywords: Obsessive Compulsive Disorder, Semiotics, Signifier, Signified, Freud, Saussure, Id, Ego, Superego, Metacognition

1. Introduction:

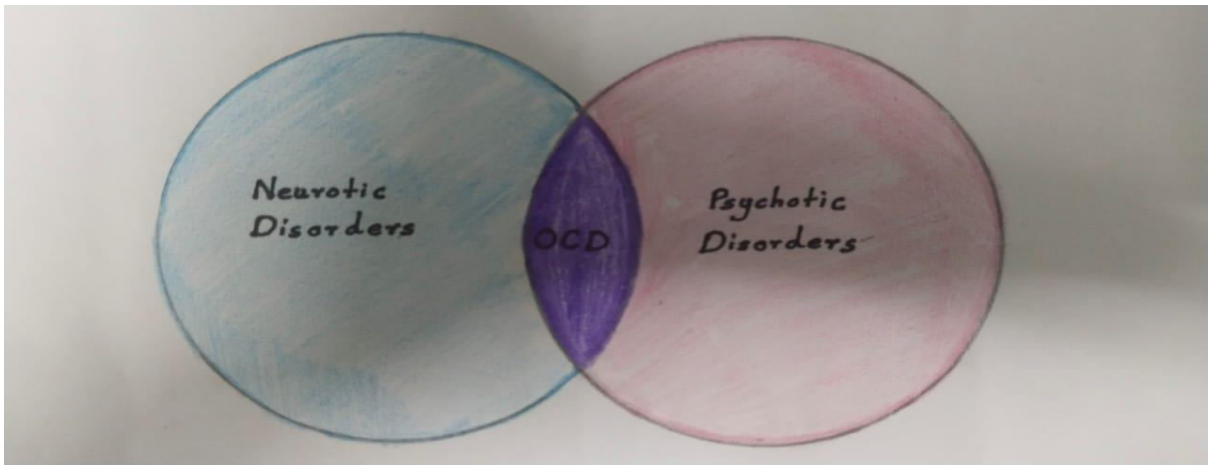
Often regarded as an anxiety disorder, Obsessive Compulsive Disorder (OCD) may be defined as a mental illness that causes repeated unwanted thoughts or sensations (obsessions) or the urge to do something over and over again (compulsions). Obsessions and compulsions, though different when taken at face value, have a kind of unhealthy symbiotic relationship in OCD. Sometimes compulsive behaviours against agonizing intrusive thoughts turn to obsessions when individuals procrastinate over them for extended period s of time. This in turn leads to compulsions turning into obsessions.

In the opinion of renowned psychoanalyst Sigmund Freud, the human personality is a complex articulation derived from the constant and unique interaction of conflicting forces that operate at three different arbitrary layers of awareness. These layers are termed as the conscious, the pre-conscious and the unconscious.

The conscious, is akin to human awareness about one's own being and the world around. The pre-conscious, on the other hand, serves as a selective gatekeeper of sorts allowing only certain facets of information to worm their way from the unconscious to the conscious. The unconscious mind serves as a reservoir of feelings, thoughts and memories which are often beyond the conscious awareness. The unconscious contains feelings, thoughts, urges and memories which might be unacceptably unpleasant and may serve to heighten feelings of pain, anxiety or conflict if the contents rise to the surface of the conscious.

The Psychodynamic theory of OCD states that Obsessions and Compulsions are signs of unconscious conflict that an individual may be trying to suppress, resolve or cope with. These conflicts are a result of visualization of unconscious wishes being at odds with socially acceptable behaviour as perceived by an individual. Intrusive thoughts, as a result of external triggers, often make their way into the conscious mind much to the consternation of individuals who are unable to cope up with their surfacing. These individuals end up treating these intrusive thoughts as signs of impending moral transgressions. So, they try to seek assurance from their own minds that they won't ever give in to these transgressions and cause imaginary horrendous outcomes. In this manner, the vicious cycle of obsessions about transgressions and repetitive compulsive ritualistic self-assurances or practices is kicked into motion.

Psychological disorders had hitherto been categorized into two broad spectrums, namely Neurosis and Psychosis. Psychosis is the collective term used to categorize disconnection from reality, whereas Neurosis defines a category of mild mental illnesses which is not caused by organic disease, involving symptoms of stress but not a radical loss of touch with reality. In DSM-5, OCD comes under a separate category with its own sub-categories. Obsessive-Compulsive and related disorders that have a cognitive component have insight on the basis of specifiers ranging from "good or fair insight to "poor insight" to "absent insight/delusional beliefs" with respect to disorder-related beliefs. Based on the aforementioned information, it may be concluded that OCD may not totally fall in the spectrum of either Neurotic or Psychotic disorders, but somewhere between the intersection of the two.



Venn Diagram depicting the existence of OCD at the intersection of the spectrums of 'Neurotic' and 'Psychotic' disorders.

Cognitivism is a learning theory that focusses on how information is received, organized, stored and retrieved by the mind. According to the Cognitive Model of OCD, sufferers of the disease have an inflated sense of responsibility which makes them misinterpret fleeting intrusive thoughts as indicative of desires which may lead to catastrophic outcomes. If the theory of Cognitivism is applied to the context of OCD, then it may be deciphered that individuals suffering from the disorder may be having faulty cognitive filters, rendering the mind inflexible and only capable of sorting the intrusive thoughts into pre-determined areas of apprehension before trying hard to discard them altogether. This, however, may prove to be futile as attempts to sort intrusive thoughts might actually bring these thoughts to the Conscious layer of the mind as opposed to having them washed away by the flow of consciousness if the thoughts were allowed to have a free pass through the cognitive tunnel. In categorizing these thoughts, individuals tend to pay attention to most intricate details of the thoughts, ensuring that they leave an impact on the mind for a long time.

One of the chief traits of OCD is trying to argue or reason with oneself to neutralize the perceived mental threat or apprehended transgression which crops up in response to the intrusive thought. Individuals suffering from this disorder often try to reason with their own fears and confine them in trappings of temporary reassurance. However, their own mental rebuttals against their very own arguments often get the better of them, thus trapping the mind of the individual in a cycle of arguments and counter-arguments where there is no clear winner in view.

However, it may be noted that while going through the aforementioned exercises in futility, the individuals suffering from OCD are unable to apprehend the fact that there is no rational relationship between the trigger and the intrusive thought, as well as, by extension, the intrusive thought and the perceived impending transgression. In this paper, I have put forward a viewpoint regarding how concept of ‘Sign’ from ‘Semiotics’ may enable one to have a better understanding of OCD and may also aid in the Cognitive treatment of people suffering from OCD. The objectives taken into consideration for formulating the above point of view are as follow:

- To rationalize OCD in ‘Semiotic’ terms.
- To uphold that the relationship between a trigger and an intrusive thought in response to the trigger is akin to that of ‘signifier’ and ‘signified’ and, is therefore, arbitrary along the lines provided by Salkovskis’ cognitive model in which responsibility is considered a critical issue for the onset of obsessions.
- To rationalize that perhaps an insight into the fact that intrusive thoughts do not signify impending transgressions which may aid OCD patients see the flaw in their metacognitive beliefs.
- To suggest the possibility that conditioning individuals suffering from OCD to rationally detach triggers from triggered intrusive thoughts and fears of impending transgressions may eventually render the trigger unable to elicit an intrusive thought as well as eventually nullify underlying metacognitive beliefs regarding the intrusive thoughts.

2. Viewing OCD in terms of Freud’s Iceberg Model:

Perhaps Freud's single most enduring idea was that the human psyche has more than one aspect. The personality theory proposed by Freud in 1923 saw the psyche structured in a tripartite way: the ego, the id, the ego and the superego. According to Freud, the id is the primitive and instinctual part of the mind consisting of the primary drives required for sustaining life. The super-ego represents the moral conscience and serves as the reservoir of societal norms gathered by an individual over his/her lifetime. The ego is the realistic part that balances the pull of the super-ego and the id. According to the depiction via Freud's iceberg model, the id falls solely within the realms of the unconscious whereas the superego and the ego touches all three layers. So, based on a study of the model, it may be concluded that primal instincts, at their most naked forms, lie in the unconscious part of the human mind. The iceberg model, though arbitrary by nature, does offer keen insight into how the human mind processes information.

Anxiety and intrusive thought experts Dr Martin Seif and Dr Sally Winston have an interesting way of describing what they believe, causes unwanted and intrusive thoughts*: "Our brains sometimes create junk thoughts, and these thoughts are just part of the flotsam and jetsam of our stream of consciousness. Junk thoughts are meaningless. If you don't pay attention or get involved with them, they dissipate and get washed away in the flow of consciousness." (2018)*. The overdrive of the super-ego may well serve as the reason why individuals suffering from OCD are often unable to unconsciously disengage with these intrusive thoughts. The superego, while trying to block out the response of the id, often reinforces the id-generated imagery in the surface of the mind by creating its own imagery regarding the outcome of a perceived transgression. This tug-of-war often causes great turmoil in the mind of the individual who will keep engaging in replacing unpleasant thoughts with ritualistic self-imposed and self-perceived positive reinforcement in the form of counter-arguments or ritualistic and repetitive actions instead of consciously refraining from this futile exercise.

Like an autoimmune disorder, OCD too is the autoimmune disorder of the human mind. Akin to autoimmune disorders, where the body senses danger from infection and activates the immunity system without being infected in reality, in OCD an intrusive though is enough to make the mind see a red-flag. Just like people with autoimmune disorders have a heightened immunity system, the minds of those likely to be affected by OCD are, in probability, plagued by an overdrive of super-ego. In the presence of an intrusive-thought stimulating signal, also known as a trigger, which likely hits home with the id, the superego goes into an overdrive to suppress the unpleasant images (thoughts) generated by the id in response to the trigger from surfacing to the conscious part of the mind. It does so by creating images of perceived outcomes to these unpleasant thoughts. Owing to this, the mind is thrown into a tumultuous state as the ego struggles to strike a balance between the superego and id which are at odds with each other.

In accordance with the article titled 'What is PANDAS Syndrome' by Stephanie Langmaid which appears on WebMD.com, OCD may be abruptly caused in children by an autoimmune response to streptococcal infections that triggers strange behavioral changes. Though the exact cause of this remains to be determined, the onus has been put upon the immune system of such individuals which makes it turn on its own healthy cells in response to a trigger. This may be owing to the resemblance which the strep bacteria bears to the normal cells. While fighting the bacteria, the immunity system of the body may also attack the normal cells that

the strep imitates. This subset of disorder is collectively referred to as PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders).

It is worthwhile to note that in the aforementioned case, the immunity system of individuals diagnosed with PANDAS function in the same way in which the super-ego of those plagued with OCD function—by going into an overdrive to keep infection or, in the latter case, uncomfortable mind-generated imagery regarding outcomes at bay.

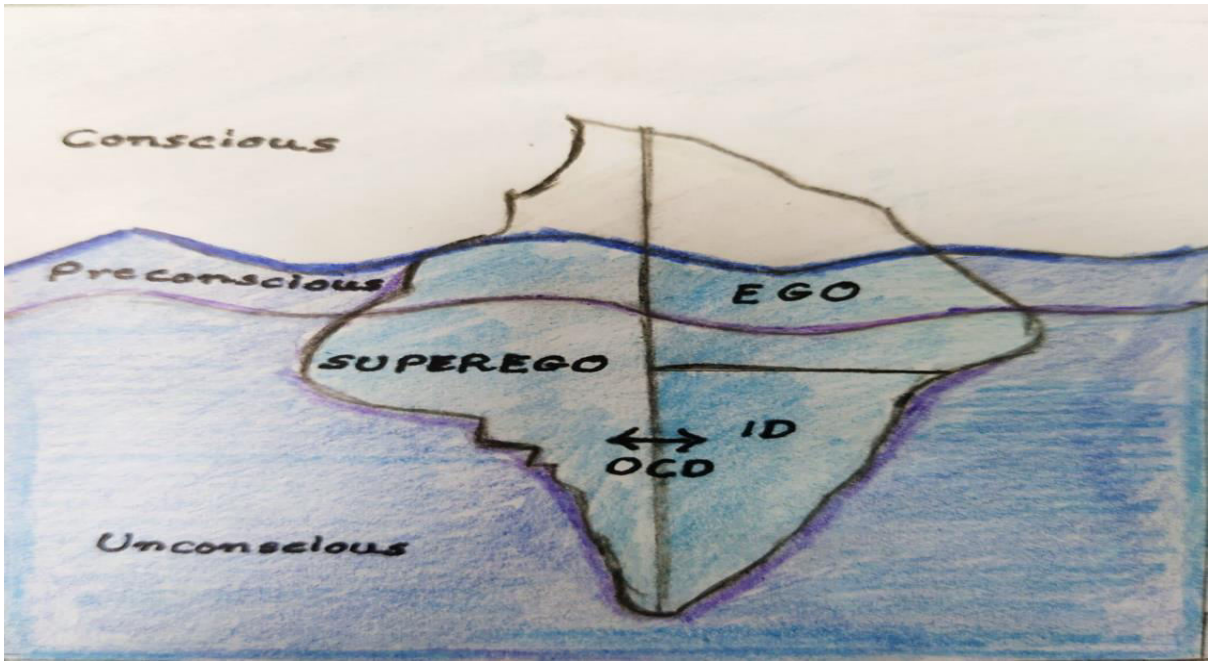


Diagram based on Freud's 'Iceberg Model', depicting the formation of OCD as a result of tension between the Id and the Super-Ego.

3. Defining OCD in terms of Semiotics:

The terms 'signifier' and 'signified' are chiefly used in the sphere of semiotics. In semiotics, the terms signified and signifier stand for the two main components of a sign where 'signified' pertains to the "plane of content" and 'signifier' is the "plane of expression". This concept, which was first proposed in the work of Ferdinand De Saussure, one of the two founders of semiotics, if applied to the sphere of Psychodynamic theory of OCD, may very well translate to the trigger being the 'signifier' and the intrusive thoughts, the 'signified'. The 'sign' may very well be something like an apprehension regarding moral transgression and this symptom pertains to one of the classic signs of the disease, specifically of the sub-type Harm OCD.

This interpretation of the disease is largely in line with Salkovskis' five basic assumptions which, he felt, were characteristic of individuals with OCD, viz:

- Thoughts and actions indicate the same.
- Causing harm is similar to preventing harm.
- Despite difficult events, personal liability for harm continues.
- Not engaging in harm related rituals imply intention to cause harm.
- Controlling one's thoughts is a personal obligation.

In all the aforementioned points, it may be seen that 'thoughts' are regarded as being implicative of a desire to cause harm by individuals suffering from OCD. Salkovskis was of the opinion that imagined catastrophic outcomes of obsessions led to heightened sense of responsibility to prevent intrusive thoughts. This, in turn, served to upscale anxiety resulting in an individual resorting to compulsions to exert perceived control over obsessions.

However, it is to be remembered that the relationship between the 'signifier' and the 'signified' is arbitrary by nature as expressed by Saussure. If OCD can be viewed in light of this statement, it may seem that the apprehensive response to an intrusive thought may have no tangibly logical relationship with the thought itself.

It is also to be remembered that the process of signification is a never-ending one as 'signifieds' give rise to new 'signifiers' which, in turn, give rise to new 'signifieds'. Similarly, in OCD, one trigger may give rise to an intrusive thought provoking an imagination about some sort of transgression which may, in turn, become another trigger giving rise to more intrusive thoughts as well as their perceived transgressions and, by extension, ritualistic actions which an individual believes may prevent these perceived transgressions. This gives rise to the panopticon of imaginary thoughts which characterizes OCD. In Salkovskis' opinion, the persistence of obsessions has an unhealthy symbiotic relationship with distorted belief, declining when the latter are enfeebled.

4. Proposed Channelization of Metacognitive Therapy along Semiotic lines:

In light of the above statements, perhaps it may make sense for a psychotherapist attempting to aid a person suffering from OCD to make the latter understand that the relationship between the trigger (signifier) and the intrusive image (signified) as well as the perceived transgression (sign) is in fact arbitrary by nature. This may be cited by breaking down the way in which the concepts of 'signifier' and 'signified' work in real life. For example, in the nomenclature of a human being, the name assigned by one's parents to an individual has no intrinsic relationship with the person in whole.

To lighten up the mood of a patient, the psychotherapist may cite an example of the, oft-regarded as obscenely humorous, thoughts that crop up in an individual's mind when one sees a banana. Here the 'signifier' is the fruit which is being taken as a phallic symbol in jest. The 'signified' may be the human penis and the sign conveyed to the mind may be that the 'banana' is phallic. It may need to be conveyed to the patient that just like the fruit has no relationship with the human phallus, the trigger too has no relation either with the intrusive thought or the perceived moral transgression and by extension, with the inference that one having these intrusive thoughts is not any more likely to become a moral transgressor than one who does not. In the way of positive reinforcement, it may even be implied to those, suffering particularly from Harm OCD, that one who truly fears the outcome predicted by the inference is even less likely to be a transgressor than his/her counterparts.

Thus, it may be inferred that Saussure's concept of 'sign' may be utilized for a clearer understanding of multiple mental issues that plague the human race. Many mental disorders like OCD and Schizophrenia stem from a distorted perception of reality. If this

‘distorted perception of reality’ is viewed in the light of Semiotics, it may just be referred to as the ‘sign’, the trigger as the ‘signifier’ and the intrusive thought as the ‘signified’. The intrusive thought might be provoking unvalidatable thoughts and fears which lead to people having distorted perceptions of their own mental conditions or the mind in general. If a psychotherapist is able to impress upon the patient that the relationship between the trigger and the intrusive thought as well as the fear of moral transgression is just as arbitrary as the one between the ‘signifier’ and ‘signified’ and by extension, the ‘sign’, it may help serve as a catalyst to an epiphany where the patient may realize the innocuousness of the intrusive thought and may be able to break through the treacherous panopticon of obsessing over intrusive thoughts and their perceived outcomes.

Metacognition is defined as ‘cognition about cognition’, or ‘thinking about thinking’. It largely banks on an individual being able to recognize his/her thinking patterns. Often these thinking patterns are largely influenced by beliefs which an individual may harbour about himself/herself. Beliefs come under a couple of sub-categories: Those which can be verbally expressed (explicit) and those which cannot be verbally expressed (implicit). The chief aim of Metacognitive Therapy is removing the involvement of the Cognitive Assessment System (CAS) in response to negative thoughts by raising awareness about this process and improving selective control over it, thus enabling a person to come to terms with intrusive thoughts by challenging the underlying metacognitive beliefs.

If, instead of merely allowing an intrusive thought, in response to a trigger, to have a free run through the mind of a patient in order to condition the patient to its presence, the patient is conditioned to detach the trigger from the associated intrusive thought, rationalizing the relationship between them as arbitrary, as soon as it crops up, then, eventually the patient may be conditioned to believe in the harmlessness of the trigger and, by extension, the futility of the belief in response to a particular intrusive thought. This may be proved along the lines of Pavlov’s Theory of Classical Conditioning, which states that learning process is governed by an association between an environmental stimulus and another stimulus which occurs naturally. In accordance with this theory, if an individual suffering from OCD is conditioned to detach the intrusive thought from the trigger as soon as it arises, then he/she may habitually imbibe this practice within his/her own cognitivism. In doing so, the trigger may be rendered inactive in due course of time and the belief in the intrusive thought nullified.

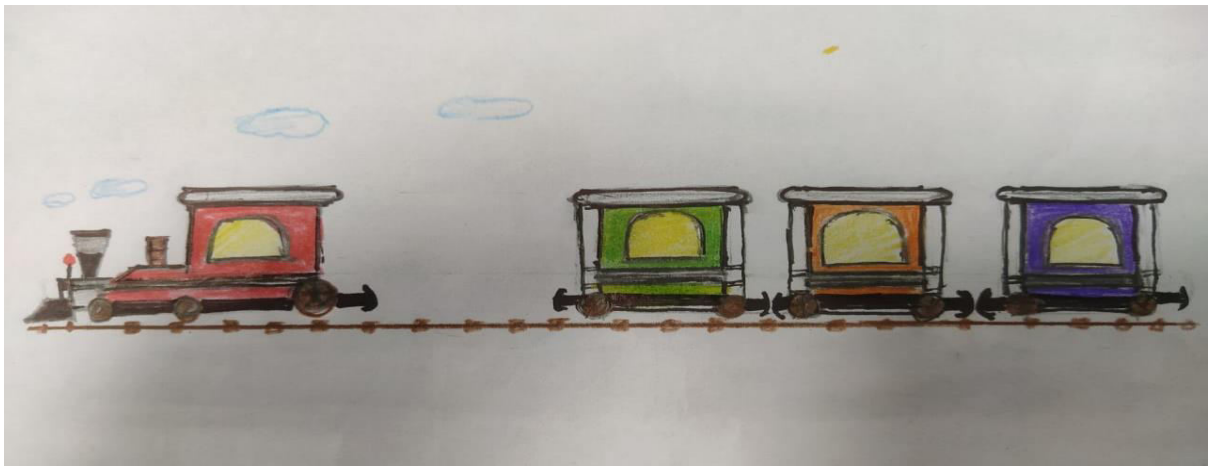


Diagram projecting uncoupling of the carriages of a train from the engine. Just as the relationship between the carriages and the engine is arbitrary, so is the relationship between the trigger in OCD and the intrusive thoughts associated with it, as well as the fear of the transgression. If an individual with OCD is conditioned to think along the aforementioned lines, he/she may succeed in bringing intrusive thoughts to a halt by detaching them from the trigger each time they arise, thus, eventually, rendering the trigger inactive.

The merit of the aforementioned viewpoint however needs to be ascertained via proper scientific trial.

5. Conclusion:

According to the Diagnostic and Statistical Manual of Mental Disorders- V (DSM-V), being able to name disorders is essential for being able to study them. In this manner, treatments which may be effective can be best identified. For treatment to be considered effective, a tangible reduction in symptoms which make up the disorder needs to be validated. As per the definition of DSM-V, once the symptoms and other factors undergo fundamental changes or get reduced, the disorder ceases to exist.

However, in case of OCD, existing Cognitive Behavioral Therapies (CBT) with an emphasis on Exposure and Response Prevention (ERP), has not succeeded in totally producing desirable outcomes. According to 'Beyond OCD', the disease often remains underdiagnosed and undertreated. The article titled 'What's Broken with Cognitive Behaviour Therapy Treatment of Obsessive Compulsive Disorder and How to Fix It' by Avigdor Bonchek, published in the American Journal of Psychotherapy highlights the following causative points for CBT missing its mark:

- Inability of patients to comply to the vigorous regimes for Exposure and Response Prevention treatment, resulting in dropouts.
- Requirement of physical presence of a therapist in all the sessions, which is not always feasible.

According to M.E. Franklin and E.B. Foa in their chapter titled 'Cognitive behavioral treatments for obsessive-compulsive disorder', 25% of patients with OCD refuse Exposure and Response Prevention therapy owing to the increased exposure to anxiety, which is an integral part of the treatment.

The above points, coupled with the inability of some people with OCD to afford the proper therapy often owing to mental health problems not being covered by health insurance policies as well as low level or lack of motivation result in the therapies for OCD often missing their mark.

In view of this, it has been stated that people might need long-term ongoing or more intensive treatment, a part of which may be handled by patients on their own, especially in view of the second opinion by Bonchek.

Prolonged exposure to the trigger (causative agent for anxiety) without providing a meaningful insight, expecting the patient to acclimatize himself/herself to the trigger may prove to be largely inefficient and might even severely magnify the disorder. This might lead to an undesirable actuality of taking the disorder out from the intersection of the treacherous

barrier of the Neurotic and Psychotic realms totally into the realms of the Psychotic where the patient might believe that the perceived transgressions to be real. Instead, exposure with meaningful insight may eventually neutralize the trigger and render it valueless. Instead of attacking the intrusive thought associated with the trigger, the suggested therapy may serve to nullify the trigger itself and eradicate the belief regarding intrusive thoughts in the minds of patients. If cognitive therapy be regarded as a positive communicative reinforcement, then the suggested therapy might actually provide a patient with both Clarity regarding OCD, as well as Content regarding how to deal with it. This in turn may help boost the Confidence of the individual as people suffering from OCD are oft victims having low self-esteem and confidence.

Clarity + Content = Confidence

According to Arthur Jones, founder of Nautilus, physical exercise of any form, in order to be efficient, has to be brief, infrequent and intense. He suggested that enough time between workouts should be allowed to elapse for optimum recovery of the body from the energy inroads created by physical exercise. If therapy be regarded as an exercise of the mind, then vigorous number of sessions may make deep inroads into the limited recovery ability of the mind, leading to a deeper level of mental exhaustion which may prove to be detrimental for the patient. So, along these lines, one insightful supervised session must be followed by enough time for the mind to acclimatize to the insight acquired. Then when the patient has recovered from the inroad, it should be followed by another session. This may be proved along the lines of Jones' High Intensity Training Theory. Gradually as the patient gets more acclimatized, the number of sessions may be reduced further in order to enable the patient to adapt to disarming the trigger alone. Thus, the solution might prove to be not only cost-effective but also bereft of the need to have a therapist in each and every session as some intermediate sessions can be conducted on their own. This might be useful to rational minded sufferers of OCD if they can eventually get conditioned to it.

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Disclaimer: *The views projected in the article are solely those of the author and not necessarily of the institution where he serves.*

References

Ackerman, C. A.: (2018, July 10) *What are intrusive thoughts in OCD & how to get rid of them*. Positive Psychology. https://positivepsychology.com/intrusive-thoughts/

Arnold, P. D., Richter, M. A.: *Is Obsessive-Compulsive disorder an autoimmune disease? Canadian Medical Association Journal (CMAJ).* https://www.cmaj.ca/content/165/10/1353

Cherry, K.: *The Role of the Conscious Mind*. Very Well Mind. https://www.verywellmind.com/what-is-the-conscious-mind-2794984

Cherry, K.: *The Preconscious, Conscious and Unconscious Minds*. Very Well Mind. https://www.verywellmind.com/the-conscious-and-unconscious-mind-2795946

Deibler, M.: *The fear of losing control with OCD.* Very Well Mind. https://www.verywellmind.com/fear-of-losing-control-in-ocd-2510667

Hershfield, J.: MFT *How Having No Cure for OCD Is the Cure*. Shepphard Pratt. https://www.shepphardpratt.org/news-views/story/how-having-no-cure-for-ocd-is-the-cure/

Kelly, O.: *The Three Main Theories of Obsessive Compulsive Disorder*. Very Well Mind. https://www.verywellmind.com/causes-of-ocd-2510476

Langmaid, S.: *What is PANDAS Syndrome*. Retrieved 13th December, 2022.

Foa, E.B.: *Cognitive behavioral therapy of obsessive-compulsive disorder.* Dialogues in Clinical Neuroscience. Taylor & Francis. https://www.ncbi.nih.gov/pmc/articles/PMC3181959/

Pittenger, C., King, R. A. (ed.) *Psychodynamic Perspectives on OCD* in Pittenger, C. (ed.) *Obsessive-compulsive Disorder: Phenomenology, Pathiphysiology and Treatment* (New York, 2017; online edn, Oxford Academic, 2017, October 1)

Bonchek, A.: *What's Broken with Cognitive Behaviour Therapy Treatment of Obsessive Compulsive Disorder and How to Fix It*. American Journal of Psychotherapy 63(1): 69-86.

Storch, E., Abramowitz, J., McKay, D.: *Ineffective and Potentially Harmful Psychological Interventions for Obsessive-Compulsive Disorder.* https://iocdf.org/expert-opinions/ineffective-and-potentially-harmful-psychological-interventions-for-obsessive-compulsive-disorder/

Treatment Challenges. Beyond OCD.org. https://iocdf.org/information-for-individuals/treatment-challenges#:-:text=Ineffective%20or%20inappropriate%20teatment%3A%20Some,not%20effective%20treatments%20for%20OCD

Franklin, M.E., Foa, E.B.: *Cognitive behavioral treatments for obsessive-compulsive disorder*. A guide to treatments that work. 339-357. Oxford University Press. New York (1998)

Maltby, N., Toilin, D.F.: *A Brief Motivational Intervention for Treatment-Refusing OCD Patients*. Cognitive Behaviour Therapy. 34(3). 176-184. (2005)

Diagnostic and Statistical Manual of Mental Disorders and OCD. OCD UK. https://www.ocduk.org/ocd/clinical-classification-of-ocd/dsm-and-ocd/#:~:text=DSM%2D5%20Categorisation,Hoarding%20Disorder

Darden, E.: *The Why of Less.* Inside Outside Medical Spa. http://www.insideoutsidespa.com/the-why-of-less-darden-inside-outside.php