Actas

14º Congreso Mundial de Semiótica: Trayectorias

Buenos Aires

Septiembre 2019

International Association for Semiotic Studies (IASS/AIS)

Tomo 2

Alteridades, Identidades

Coordinadores

Marita Soto y Federico Baeza

Proceedings of the 14th World Congress of the International Association for Semiotic Studies (IASS/AIS)

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Imagen utilizada para la tapa: *Sin pan y sin trabajo*, Ernesto de la Cárcova, 1894.

ÍNDICE

Presentación.
Marita Soto y Federico Baeza 13

I. ALTERIDAD, IDENTIDADES

a. Las voces del archivo

No es lo que parece. Eduarda Mansilla, voces femeninas desde la frontera interior. *Laura Sacchetti* 17

La mirada semiótica al discurso sufragista en México (1916-1923). *Olga Nelly Estrada y Griselda Zárate* 27

Los amorales y las "buenas costumbres": memoria discursiva y clasificación de la disidencia sexual en la DIPPBA. *Paulina Bettendorff y Laura Bonilla* 37

b. Identidades y territorio

Encyclopedic anthroponym as the sign of culture. *Svetlana Bogdanova y Elena Ignatieva* 51

The corset and the hijab: alternations of absence and presence in the 19th and 20th-century fashion system *Marilia Jardim* 59

Entre orillas. Trayectorias discursivas de la identidad gallega en la Argentina. *Claudia López* 71

Los varrios de San Diego California. Resistencia chicana-conchera. *José Luis Valencia González* 81

II. CUERPOS RECUPERADOS

a. Cuerpos recuperados en la metodología

La pregunta por el cuerpo en la semiótica contemporánea: performatividad, vinculación y memoria. *Susana Temperley* 97

Intersubjetividad, multimodalidad y adquisición del lenguaje. *Fernando Gabriel Rodríguez* 109

Trajectories of possibilities. Semiotics of the unpredictable future. *Katarzyna Machtyl* 121

Between semeiotics and semiotics: the body as a signifying text. *Simona Stano* 133

La praxis enunciativa y lo real: articulaciones interdisciplinarias para un modelo de análisis del discurso. *Marcos Javier Mondoñedo Murillo* 141

Libidinal intelligence: cinema and literature. *Roseli Gimenes* 149

b. Cuerpos y mediaciones

Semiotic strategies to create heritage: luxury fashion brands in the age of social networks. *Daria Arkhipova* 161

La escenografía del cuerpo en el diseño del desfile de moda. *Mihaela Radulescu de Barrio de Mendoza* 167

Trayectorias discursivas: la alimentación entre *ciencia y comunicación. Simona Stano* 179

A cidade como espaço de comunicação mercadológica: o potencial de produção de sentido das marcas a partir de intervenções publicitárias no contexto urbano *Sergio Marilson Kulak y Rui Torres* 189

III. DISIDENCIAS

a. Disidencias y acciones

#Yosoydiverso, más que un hashtag, un llamado a la tolerancia desde la perspectiva del pluralismo cultural en la virtualidad. *Norberto Fabián Díaz Duarte y Antonia María Moreno Cano* 205

Barrios en foco: el discurso audiovisual entre lo translinguistico y lo transdisciplinar. *Valeria Car, Alfredo Isasmendiz - Preti y Cinthia Naranjo* 215

b. Representaciones y disidencias

Discursos, piquetes y orden democrático. *Liliana Pazo* 229

Análisis semiótico de la representación de género en la película Persépolis. *Lucía Leticia Anaya Avilés* 239

La persistencia del amor romántico: análisis de su representación e influencia en los roles de género tradicionales en *Ruby Sparks* y *La La Land* desde las figuras de Eros y Psique. *Itzel Mayelli Flores Urzua y José Honorio Cárdenas Vidaurri* 251

Índice general de las Actas 263

Between semeiotics and semiotics: the body as a signifying text

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1. Introduction

From the Greek σημεῖον, *sēmeion*, "sign, mark", the term *semiotics* shares its etymology with the word *semeiotics*, which refers to the branch of medicine dealing with the interpretation of symptoms. In fact, according to various scholars, semeiotics may be considered a semiotic approach through and through — and possibly the first one ever[1]. As Eugen Baer (1988) recalls, "the art of healing, in Greek antiquity, was called *techne semeiotike*, a craft having to do with signs. This gives medicine its shortest and most inclusive definition: the art of seeing the connection between signs and remedies" (1). The expression stood in fact for the process that professional physicians followed in evaluating signs of bodily disorders (in Hippocratic terms, the *praesentium inspectio*, today called "diagnosis", which makes reference to the present of illness), understanding their cause (the *praeteritorum cognitio*, or "anamnesis", which points to the past), suggesting therapy where beneficial, and foreseeing the patient's future (*futurorum providentia*, or "prognosis") (cf. Cobley 2009: 264). This points out the threefold characterisation and temporal orientation of "medical signs".

Drawing on these premises, this paper intends to retrace the theoretical reflection on the relation between semeiotics and semiotics, particularly focusing on the the analysis of the symptom as a sign, and relating to recent research on corporeality.

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[1] According to Giovanni Manetti, for instance, one can see in semeiotics "not only the integral presence of semiosic processes but also the first real theoretical constructs around the sign and inference. Later, when semiotic theorizing passed directly into the field of philosophy and rhetoric, many traces of its medical origins remained" (2010: 15).

2. The symptom as a sign

In “Sémiologie et Médicine” (1972), Roland Barthes describes symptoms as brute facts emerging from the body — that is to say, purely phenomenal sensations that are not necessarily linked to any act of interpretation, and so do not constitute semiotic entities as such. Nonetheless, he also supports that they turn into signs once they are “put into discourse”, that is, when they are “modelled” (in Lotman’s (1977) terms) through language. Such an opposition is partially overcome by Thomas Sebeok (1976), who pushes further the association between signs and symptoms, conceiving the latter as “compulsive, automatic, non-arbitrary sign[s], such that the signifier coupled with the signified in the manner of a *natural* link” (46; cf. Sebeok 2001). In his view, symptoms can be seen as a marked category (*species*) of an unmarked one (*genus*, that is, the sign), thus acquiring a semiotic status *per se*. For the American semiotician, in fact, the symptom represents a specific type of sign, together with the signal, the icon, the index, the symbol, and the name. By adopting such a model, he openly associates the science of signs with medical semeiotics (as developed by Hippocrates and Galen). Furthermore, he counterpoises the “minor tradition” of Saussurian semiology with what he considers — due to its temporal amplitude and thematic extension — the “major tradition” of semiotics, which is mainly represented by authors such as John Locke, Charles William Morris and Charles Senders Peirce.

This last is particularly important to understand the conception of the symptom, both in Sebeok’s analysis and beyond it. Peirce, in fact, does not pay much attention to the so-called medical semiotics, but there are various points in his reflections that are worth considering here. It is interesting, first of all, to note that he refers precisely to symptoms to illustrate his idea of indexes. In his famous letters to Lady Welby, for instance, he writes: “I define an Index as a sign determined by its Dynamic object by virtue of being in a real relation to it. … such is the occurrence of a symptom of a disease” (Peirce 1958 [1904]: 391). According to the American philosopher’s triadic model, therefore, symptoms are not a distinct species of sign, as it is for Sebeok, but a mere subspecies, namely of indexes, since the relation between the sign of disease (i.e. the symptom) and its object (the disease) is one of direct contiguity, or cause-effect. As such, as Paul Cobley (2009) claims, they “are typically considered to be semiotic phenomena, but have been of lesser interest to most semioticians because they are not thought to be culturally constructed and symbolic” (264), which might explain why Peirce did not focus on the study of symptoms.

In contrast with this model, Thomas Sebeok (1976) points out that “it is a peculiarity of symptoms that their *denotata* are generally different for the addresser (the patient – “subjective symptoms”) and for the addressee (the physician – “objective symptoms”), thus partially recognising their symbolic

character, and differentiating them from indexes. However, his definition of symptoms, as mentioned above, still adheres to the idea of a direct, non-arbitrary, somehow "natural" link between a certain condition of the body and the appearance of some material or immaterial signs.

It is only a few years later, with Kathryn Vance Staiano's essay "Medical semiotics: Redefining an ancient craft" (1982), that the symbolic dimension of symptoms is fully recognised:

> The signs of illness or disease are, no matter what our personal response, the indication of a very reasonable process. Our interpretation of ourselves as "sick" and the diagnostician's interpretation of us as "diseased" are interpretations based on signs that are very often produced by the body in response to the perception of the presence of a pathogen. These signs, therefore, are not produced directly by a disease organism but represent the body's attempt at self-regulation (Staiano 1982: 336).

In this sense, the semiotic analysis of the disease emerges as crucial, as it allows identifying the interpretative pathways through which the concepts of sickness or health establish themselves. This further undermines a conception of illness as a simply dyadic relation between a cause and an effect, rather envisaging the disease as an arbitrary sign in which there are many elements (which, recalling Peirce, could be called "interpretants") that define and determine its development.

3. Beyond Peirce, reading symptoms in light of Peirce's theory

While Peirce does not pay much attention to symptoms, his general theory of signs is useful to further describe their semiotic character. To this purpose, Eugen Baer (1982) suggests reconsidering his ideas of Firstness, Secondness, and Thirdness. According to Peirce, after the "the germinal nothing, in which the whole universe is involved and foreshadowed [, and which, a]s such, … is absolutely undefined and unlimited possibility — boundless possibility [or] freedom" (*CP* 6.217), there is Firstness, a sort of pre-verbal, immediate, initiative, original, spontaneous, but yet vivid and conscious category, that precedes all synthesis and differentiation, and so has no unity nor parts (*CP* 1.357). Such a differentiation is precisely what, in Baer's view, marks the passage from the symptom considered before its genesis, which is "without meaning, without causal connections, without content — [that is, an absolute nothing with] no purpose, no cause, no quality" (Baer 1982: 22) to the symptom as first, which involves the awareness of its existence, but "*is never really present as an object*. It is … an all-pervasive mood which is not graspable. … [It] is … an absolute primary feeling, pre-rational, pre-reflexive, pre-objective, pre-representational" (Staiano 1982: 24).

The passage from the sphere of potentiality to that of existence and experience takes place with Secondness, where articulated thought comes into play: here everything is opposed, in conflict, clashing, irrupting, “for the real is that which insists upon forcing its way to recognition as something *other* than the mind’s creation” (*CP* 1.326). Such a realm of alterity is the universe of the index. Here the symptom appears as an irrational and brute force, an external or internal aggressor, based on a dyadic relation — that is to say, a conflict, a struggle, a collision between one’s own and a form of alterity, without a third (Baer 1982: 24).

Finally, Thirdness is the dimension in which the incompatibility and heterogeneity of Secondness are brought into a relation of mutual containment: “circularity, reversibility, and chiasmus of the differentiated units are the main properties of this category” (Baer 1982: 22). This is the universe of representation, which relies on symbolic relations. By making reference to such a category, Baer (1982; 1988) uses Peirce’s theory to overcome his classification of symptoms as indexes, coming to describe the symptom as the result of an interpretative process that can be in turn subdivided into three sub-dimensions or levels:

- At the *psychological level*, it is the person who feels and experiences the symptom that confers meaning on it, by representing it. However, as it is well known (and Baer himself recognises), individual frames of meaning cannot be detached from the socio-cultural dimension, since they are inevitably influenced by it. This dimension cannot therefore exist *per se*, but only in relation to the other levels identified by the Swiss scholar.
- At the *biological-natural level*, the disease is conceived as a set of physical and molecular processes that, as such, are studied through the tools offered by natural sciences. Although representing the dimension of symptoms that really matters for many physicians and patients, this model too, taken in isolation, is evidently deficient, since it “does not account for the meaning contexts of sickness” and neglects the basic cultural assumptions from which it proceeds (Kleinman 1981: 18);
- Finally, at the *sociological level* — that is, the socio-cultural context —, the symptom gains its full sense and meaning, and is perceived as a cultural product. Here, then, is where illness fully emerges as a cultural event or experience, which is inseparable from social and political realities (Staiano 1979: 108; cf. Eisenberg (1977), Fabrega (1972, 1974), Foucault (1961, 1963), Illich (1976), Kleinman (1973), Kleinman, Eisenberg and Good (1978), Sedgwick (1973), Sontag (1978), Szasz (1970, 1973, 1974 [1976]).

4. The symptom, the world, and the body

As the above-discussed aspects clearly show, there is not a fixed reality of symptoms, nor any natural connection between them and the body. Talking

of the symptom always implies considering at least three factors: “the patient, the doctor, and the doctrine of medicine concerned. For each of these partners, this problem presents itself … in a different way” (Uexküll 1982: 210). However, as lamented by Staiano (2012), such a fact is still disregarded among biomedical practitioners, who tend to stick to the differentiation between what they consider “clinical signs” — i.e. the findings produced by “scientific” methods (such as, for instance, x-ray images) — and symptoms or “subjective signs” — i.e. the complaints presented by the sick person (pain, dizziness, weakness, inability to eat), which are considered less reliable because the physician can neither immediately visualize them nor experience them directly. Biomedical technologies are in fact designed to try to turn many of the subjectively produced symptoms into clinical signs, thus establishing a clear imbalance among the levels identified by Baer. Conversely, the psychological level is very important in terms of signification processes, mainly because of its unavoidable tie to the socio-cultural dimension: any symptom is “a communicative act, an attempt to channel and express subjectively perceived states in culturally approved modalities” (Staiano 1979: 111).

Even before this type of communication, moreover, another one takes place. It involves the very body of the sick person, which points out the importance of adopting a biosemiotic approach. In a biosemiotic perspective, in fact, the body does not simply consist of material isolated parts, but of constantly communicating cells and organs engaged in an exchange of messages within the organism itself, as well as with the physical and social environment in which the body exists. This is crucial to a comprehensive analysis of symptoms, since it recognises that even supposedly objective signs may be altered within the body in its relationship with its internal and external environments: “organs, cells and DNA transmit messages which may not be consistently interpreted and which appear in some respects to act with intention” (Cobley 2009: 264).

Therefore, even though the system of internal codification by which sensory inputs are organized and made meaningful is not available for examination, a codifying system certainly exists. This system is the one that reduces, summarizes, and organizes sensory impressions. Referring to the Peircean model, Yoshimi Kawade supports that “the molecule as a sign has the chemically defined structure as its sign or representamen, the biological function as its object, and, as its interpretant, the cell or its part or any other ‘whole’, a higher order structure, that endows the molecule with biological meaning” (1996: 200). What is more, such processes are inevitably mediated by the self, which is “a product of the social and cultural milieu” (Staiano 1979: 114-115), and therefore cannot but be influenced by such a milieu.

Whichever perspective one takes, in other words, it is undeniable that corporeality plays a crucial role in the processes of signification charactering the trajectory analysed in this paper: the body is not only the place where

symptoms become visible, as a result of internal and yet externally influenced communication processes, but also the entity experiencing them (on the perceptual level) and making them intelligible (on the cognitive level). Such processes imply crucial theoretical issues such as the semiotic analysis of the senses and aesthesis as ways to access meaning, and so the related problem of the passage from the sensory or perceptual level to the axiological dimension (cf. Stano 2019). All these issues are still matter of debate within the science of signification, and certainly need a deeper consideration not only within the specific trajectory traced in these pages, but also at a more general level.

Furthermore, it should not be forgotten that our body is part of the world in which it exists and incessantly interacts with such a world, thus necessarily being a "social body", that cannot but communicate with other bodies. Consequently, symptoms, making themselves visible on and through the bodily dimension, cannot but be always put into a discourse. This clearly points out the need, in the desirable extension and development of the trajectory between semiotics and semeiotics traced here, to adopt a sociosemiotic perspective. A perspective able to overcome any distinction between a presumed pre-semiotic world and the semiotic sphere, hence recognising precisely in corporeality the instance of translation between these regimes. In fact, it is because of such a translation that the body emerges as the threshold of semiosis *par excellence*, since — as the study of symptoms clearly shows us — it is able to produce, interpret and at the same time communicate sense.

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