

## The Meta-Gavagai Problem and its Implication to a Psychiatric Diagnosis

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### Introduction

The Gavagai problem is a famous and well thought out construct which aims at establishing a fundamental indeterminacy in translation, the comprehension and analysis of implication of a given foreign linguistic construct. While the Gavagai problem remains at the realm of language an extension in this spirit is possible for emotional and cognitive communications in a specific language itself much in the spirit of existential constructs of reality communicated in that language. In this context language it becomes an approximation of an experience in the Gavagai sense thus a Meta-Gavagai problem. This Meta-Gavagai has a deep and relevant significance in the manner in which a DSM based psychiatric diagnosis gains validity as the DSM itself is suggestive of a disorder and based on verbal cues and thus opens to interpretation. Further in this spirit the entire German repertoire of the original literature in psychoanalysis is subject to a Meta-Gavagai in terms of the "experience of a disorder"/ "description of the disorder for diagnosis" divides at the first level. At the second level the subjective nature of the therapist and his learning of the field "tints" a diagnosis which does not possess an absolute objectivity as in a deterministic medical framework like heart subject to the same Meta-Gavagai consideration. At the third level the Meta-Gavagai gains relevance in a clinical setting in which a patient can in principle never communicate the actual existential nature of his problem but only verbal cues subject to the same indeterminacy as the original problem construct and the choice of language and the manner of language used by the patient determines the entire nature of the diagnosis which may not reflect the underlying reality or the existence of a condition. A step further would be to say that the entire existence of a condition in the DSM is only at the level of language and its self consistency rather than to reflect an objective reality. These trivially place the conditions as a Meta-Gavagai construct [1-3].

### Two examples of Meta-Gavagai derived from the original linguistic Gavagai

A child learning a language would be an ideal example in the Meta Gavagai setting as he/she tries to communicate an experience but only ends up approximating expressions which is subject to (the same Gavagai) confusion by the elder interpreting it though speaking the same language. Thus the child due to a lack of vocabulary or syntax ends up communicating the same "Gavagai" as the tribal in the problem in a Meta sense and though they may speak the same language they are not on the same terms in terms of communication. This is contrasted with the original problem in which the tribal speaks a different language and thus there is a fundamental indeterminacy in translation itself.

Another example would be a rare person who has an original insight into a subject while in the process of learning it and because of the high level of technicality is unable to communicate the insight in the language of the field and thus gets into a Meta-Gavagai situation.

It is thus posited that such a Meta-Gavagai problem exists in psychiatric practice more so than in other fields giving rise to a fundamental inconsistency in diagnosis, psychometrics and prescription.

### Meta-Gavagai in a psychiatric diagnosis

The case for a Meta-Gavagai at the basic level of the construct is

trivial to observe in clinical practice and in social setting. The very idea of a group in psychiatry underlines this relativity in condition diagnosis which is very different than that of groups diagnosing heart or lung disease. This accepted difference exists at the level of disease perception. Further in psychiatry the existence of different schools of thought and their approach to the same disease diagnosed is worth consideration. As a gedanken consideration, if based on the approach to disease the schools change the name of the disease it would lead to interesting consequences for the pharmaceutical industries and as the approach to the disease is more real than the disease diagnosed from a set of verbal cue correspondences.

However the Meta-Gavagai makes a case for a Gavagai contradiction in the very existence of the disease itself. As a gedanken experiment I would like to bring to attention the consideration that the DSM is available in only mainly European languages and the idiosyncrasies of the individual languages distort the manner of presentation of each disease. Further cross cultural considerations complicate the identification and diagnosis of a specific complaint. Thus the Meta-Gavagai consideration is three fold –one at the level of correspondence of the linguistic DSM to an objective reality of a condition questioning the true validity of the condition itself, second the correspondence between the therapists' cognition of the disease from the linguistic cues from the DSM to the diagnosis of a patient and third the gap that exists between communication of a "diseased" experience, the relation between manner of communication and the objective reality of the existence of the condition if at all the objective existence is accepted as an absolute (which is debated from the first condition) which is the communication a gap between the therapist and patient and complications therefore. These considerations invoke complications and host of considerations that the Meta-Gavagai becomes active at various levels in itself (interchangeable levels in their presentation) [5-7].

As a final example consider the widely empathized condition of depression as it is the most associable and common to imagine. Firstly since depression is "emphatizable" it is easy to transcend the DSM definition in clinical practice for a "holistic" diagnosis but if we take it as a case and go strictly by the DSM it is immediately seen that guideline definition of DSM is too narrow and does not take into account the different manifestation of the same. This narrowness is compounded by the subtypes and further classification and the markers for a wrong classification of a specific case is absent without even invoking the Meta-Gavagai. In this spirit, if one goes into non associable conditions in which the empathy of depression is lost we find that the road that

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mislead and cause confusion are numerous creating “a hazy cloud of overlapping conditions which transcend names” like a Meta- Gavagai which has a deep relevance to medication and the pharmaceutical aspect. This exists at the level of a priori existence of a disease definition itself making the case for a first level Meta-Gavagai. Compound this to the subjective nature of the therapist himself and his subjective comprehension of these and compound this with the medication correlation, it is obviously clear that “lost in translation” is the most probable outcome at the second level of Meta- Gavagai. Thirdly the diagnosis of a condition in a patient (overlooking the objections of first and second level contradictions) in a clinical setting in which the patient approximates his existential experiences in the form of linguistic cues in order to be diagnosed by a framework whose a priori existence is a Meta- Gavagai contradiction of the third kind.

### Conclusion

Thus in this communication the Gavagai problem in linguistics and its extension to a Meta-Gavagai highlighted with its reference to psychiatric diagnosis at three main levels is expounded. This

communication if explored to its full potential and extension would make a case for a rethinking of DSM based psychiatric practice and thus I hope is of relevance.

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