

# Understanding, testimony and interpretation in psychiatric diagnosis

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**Abstract** Psychiatric diagnosis depends, centrally, on the transmission of patients' knowledge of their experiences and symptoms to clinicians by testimony. In the case of non-native speakers, the need for linguistic interpretation raises significant practical problems. But determining the best practical approach depends on determining the best underlying model of both testimony and knowledge itself. Internalist models of knowledge have been influential since Descartes. But they cannot account for testimony. Since knowledge by testimony is possible, and forms the basis of psychiatric diagnosis, its very existence is a factor in support of an externalist model of knowledge in general. Internalist and externalist models of knowledge also suggest different ways of responding to the practical challenges of basing psychiatric diagnosis on testimony. Thus the argument in favour of externalism also supports a potentially empirically testable hypothesis about interpretation of non-native speakers for accurate psychiatric diagnosis: interpretation of non-English speakers should be as transparent and unhindered by specialised medical knowledge as possible.

**Keywords** Knowledge · Internalism · Externalism · Descartes · Hume · McDowell

## Introduction

Internalist accounts of knowledge are both intuitive and supported by Descartes' seminal account of empirical

inquiry. Internalists claim that the successful justification of knowledge claims must be wholly under the control of those who frame them. But however intuitive a claim about knowledge that is, it cannot account for a central aspect of psychiatric diagnosis: knowledge of patients' experiences through testimony.

The very idea of transmission of knowledge by testimony suggests the need instead for an externalist model of knowledge. This also has practical significance in that it suggests that interpretation of non-English speakers should be as transparent and unhindered by specialised medical knowledge as possible.

In this paper, we first sketch an internalist account of knowledge but argue that it cannot account for the important role of testimony in psychiatric diagnosis. We then sketch McDowell's contrasting externalist conception of testimony and, in that context, set out some practical problems for the testimonial transmission of knowledge in psychiatry. We then outline two opposing views of how best to cope with the practical problems in the light of competing internalist and externalist accounts of knowledge. According to the externalist approach to knowledge we favour, interpretation of non-English speakers should be as transparent and unhindered by specialised medical knowledge as possible. That is a hypothesis open to further empirical testing.

## Internalist accounts of knowledge

In this section, we set out the distinction between internalist and externalist accounts of knowledge, starting with a traditional justified true belief analysis of it.

On the traditional analysis, arguably dating back to Plato, knowledge is identified with justified true belief. The

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analysis can be supported by the following informal considerations. One cannot know what one does not believe. (Thus on the traditional analysis, one does not know what one intends to buy simply by having, without reading, a shopping list.) One cannot know falsely (though 'know' is sometimes used poetically to express deeply held but false beliefs). Finally, knowledge is not a matter of luck. If one has a belief that just happens to be true, for example, a belief one would also have had even had it been false, then that is not knowledge. Addressing this final point, the traditional model adds that true beliefs need also to be justified to be knowledge.

This traditional analysis of knowledge invites an 'individualist', or 'internalist' as it is more normally called, interpretation. If knowledge requires a justification, the justification should be one that the subject herself can give. The justification provides an argument for the truth of the claim that is known, an argument that the subject can frame. According to epistemic internalism, justification for knowledge claims must be known by those who frame them. This contrasts with epistemic externalism which allows that features that may be beyond the ken of subjects may contribute to their epistemic standing. They may have knowledge, for example, because they have formed their beliefs using reliable processes although this fact (that their processes are reliable) is not known to, or even believed by, them.

Internalism is, however, both intuitively appealing and has also been explicitly supported in the history of philosophical discussions of knowledge. In his investigation of knowledge in the *Meditations*, Descartes adopts an internalist view of knowledge which is implicit in his method of attempting to rebuild knowledge of the empirical world in the face of his own sceptical doubts. The method is to start with introspection to deliver self-knowledge which is immune to doubt and then to work back and outwards to knowledge of the empirical world through a series of justifications that he himself can underwrite. This starting point is manifest in passages such as:

I will now shut my eyes, stop my ears, and withdraw all my senses. I will eliminate from my thoughts all images of bodily things, or rather, since this is hardly possible, I will regard all such things as vacuous, false and worthless. I will converse with myself and scrutinize myself more deeply; and in this way I will attempt to achieve, little by little, a more intimate knowledge of myself. I am a thing that thinks: that is, a thing that doubts, affirms, denies, understands a few things, is ignorant of many things, is willing, is unwilling, and also which imagines and has sensory perceptions; for as I have noted before, even though the objects of my sensory experience and imagination

may have no existence outside me, nonetheless the modes of thinking which I refer to as cases of sensory perception and imagination, in so far as they are simply modes of thinking, do exist within me – of that I am certain. (Descartes 1986, p. 24)

But although internalism can seem natural, and receives strong support from Descartes' portrayal of the project of grounding knowledge against error, it fails to fit a widespread form of knowledge and one which is particularly important for psychiatry: testimony.

### Diagnosis, testimony and internalism

This section will argue that individualism or internalism does not fit with an important aspect of psychiatric diagnosis. Because psychiatric diagnosis depends on testimony and because testimony cannot be understood in internalist terms, an important aspect, at least, of diagnosis does not fit this epistemological perspective. The next section outlines one externalist model and the final section will draw some practical consequences for further empirical study.

Diagnosis depends on testimony. Following established use in philosophy, by 'testimony' we mean any form of transmission of knowledge through the reports of others. It thus contrasts with perception, reasoning, whether inductive or deductive, and memory. Testimony plays a role in psychiatry because symptoms are elicited from patients through informal questioning and conversation or more formal structured or semi-structured interviews. In these contexts, clinicians acquire knowledge of their patients' mental states in ways which go beyond their (the clinicians') own direct observations.

This is not to advocate a view of the mind as closed off from the public world and subject only to hypothesis by others. There is logical space between such a view, often called 'Cartesianism', and its polar opposite, behaviourism, according to which mental states lie literally open to view by being logical constructs from behaviour, describable in non-mental terms. Between these extremities lies the more plausible view that while the mental states of others are not literally open to view, their expressions are (McDowell 1982). According to this middle ground, there is something essentially potentially public about mental states though the *behavioural* expression must be described in mental terms if it is to ground the ascription of *mental* states. Nevertheless, even on this third account, testimony is necessary to bridge the gap between having or being in a mental state and reporting or expressing it (whether verbally or by behavioural expression) to others.

In any case, whatever view of the metaphysics of mind one takes, however closely mental states and behaviour are

conceptually tied together, much of what determines diagnosis is not just a matter of patients' occurrent mental states but information about when they began, what prompted them and what their significance and meaning is for the patient.

In psychiatric practice, direct assessment of a patient is often supplemented with collateral history from other informants. This is particularly important in elderly patients who have dementia. Because of their dementia patients may not recall certain crucial symptoms. For example a patient with dementia may develop persecutory delusions at night only and try and leave the house or repeatedly phone the police and be distressed. This may not occur every night so a direct assessment of these symptoms may not be practical. When assessed in the clinic during daytime, however, the patient might have no recollection of these symptoms. Clinical judgement has to rely on a relative's account of events to formulate diagnosis and a treatment plan. To gather this information requires testimony.

Why does testimony not fit the internalist model of justification of the traditional model of knowledge? The problem, in a nutshell, is that an individual cannot do enough to vouch for the status of knowledge transferred. For this to be possible, testimony would have to be justified in terms of, perhaps by being reduced to, processes which do fit an internalist analysis. But this is not possible.

Suppose, for example, that internalist accounts could be given of perception and induction (neither of which seems plausible). An internalist account of testimony would then be possible providing that testimony could be reduced to a combination of perception (of others, of their utterances, etc.) together with inductions from their previous reliability, for example. David Hume attempted to outline just such a defence of testimony in his *Enquiries Concerning Human Understanding* (Hume 1975, pp. 109–116). But as the contemporary philosopher Tony Coady convincingly argues, no such attempt can work (Coady 1992, pp. 79–100). We will mention just two of Coady's criticisms of Hume which suggest the principled difficulty of any such attempt.

The first objection is that Hume's defence depends on establishing inductive correlations between past instances of testimony and the truth of beliefs successfully communicated. But there is, in fact, much less evidence available to individuals than Hume supposes. Summarising Coady, Peter Lipton puts the point thus:

Hume's discussion systematically hides the fact that our evidential base is far too slender to underwrite in this way even a small fraction of the testimony we rightly accept. Perhaps the main device Hume uses here is to appeal to the correlations we have observed to obtain between various types of testimony and the

facts. This appeal to communal observation closes a vicious circle, since you can only in general know what others have observed on the basis of *their* testimony. The only evidence that you can legitimately appeal to consists of correlations between what you yourself have heard and what you yourself have seen, and this provides far less evidence than would be required to support inductively the wide range and variety of generalisations that would cover all the unchecked testimony you actually accept. (Lipton 1998, p. 15)

A second line of objection is that the observations that an individual might make are not themselves free from past testimony and thus cannot be used to justify it independently. The quickest argument for this is that observations are framed in language and language is taught through testimony. (One might argue that observation *statements* are linguistic and thus depend on the teaching of language by testimony. Equally, one might argue that the *process* or *experience* of observation itself is conceptually structured by a learned language and hence depends on past testimony. For either reason, there seems to be no way that one could frame relevant observations of successful knowledge transfer by testimony without having acquired, also by testimony, a language.)

Thus it seems that there is little hope of offering a non-question-begging justification of testimony, or an account of testimony in internalist terms. Instead, whatever local checks might be carried out, we have to take the general reliability of testimony as a whole on trust. Successfully learning something by testimony is simply hearing in another's utterance that something is the case and taking that at face value. Whilst the ignorance or insincerity of a witness undermines such transmission of knowledge, one does not, and in general cannot, first ensure their knowledge and sincerity in non-question-begging, non-testimony-based terms.

Of course, it is one thing to criticise an internalist account of testimony. It is quite another to articulate a satisfactory externalist account. But a short characterisation of one externalist model will help set the rest of this paper in context.

### Towards an externalist account of testimony

The most popular externalist approach to knowledge is reliabilism (e.g. Goldman 1979). While traditional internalists argue that knowledge is justified true belief, reliabilist externalists argue that it is true belief arrived at by a reliable process. Crucially, the fact that the belief has been so arrived at is not something a knowing subject

needs to know or even believe. One does not need to know that one knows something in order to know it. In this respect it differs from historical internalist accounts. But the new approach has something in common with those in that it aims to shed light on knowledge via its component elements. For that reason it faces the challenge of specifying just how reliable a process has to be for it to deliver knowledge. (If the probability is less than unity, it faces a charge of allowing it to be mere luck that a belief so arrived at is true and thus knowledge. But if the probability is unity, knowledge seems to be practically impossible.)

In the context of testimony, a more promising approach is that of John McDowell. Like traditional internalists and unlike externalist reliabilists, he does think that justifications or reasons have an important role in knowledge. But he thinks that they play a different role in the avoidance of luck in knowledge. Internalists construe justification as something under the complete control of a subject, something they can ensure without any element of good luck. Nevertheless, luck seems to enter the picture because a justified belief, so construed, need not be true. Luck promotes a justified belief to a truth and hence to knowledge. By contrast, McDowell locates the element of luck differently. He rejects the view that:

reason must be credited with a province within which it has absolute control over the acceptability of positions achievable by its exercise, without laying itself open to risk from an unkind world. (McDowell 1998, p. 442)

On his account, even to enjoy a particular justificatory status—a ‘standing in the space of reasons’—requires some luck or that the world has done one a favour. But no further luck is required to transform that degree of justification into knowledge. This proposal is made more natural, and less revisionary, by three further points of emphasis:

1. a comparison with practical reason
2. an anti-intellectual view of knowledge
3. an anti-reductionist view of the kind of philosophical insight needed in epistemology

*Firstly*, McDowell’s proposal about reason and knowledge can be compared with a view of practical reasoning which already seems more natural:

The concept of what one does, understood as applying to one’s interventions in the objective world, cannot mark out a sphere within which one has total control, immune to luck. It is only if we recoil from this into a fantasy of a sphere within which one’s control is total that it can seem to follow that what one genuinely achieves is less than one’s interventions in the objective world. (ibid, p. 406 fn 16)

Although our actions are the result of an interplay between, on the one hand, our beliefs and desires (to adopt, for simplicity, a familiar philosophical slogan) and, on the other, contingent features of the world which shape our abilities for action, this is not taken generally to undermine our responsibility for our actions. (Of course, in particular cases, it can.)

*Secondly*, McDowell combines his view that having an epistemological standing depends at least in part on a lucky relation to the world with an anti-intellectualist view of knowledge. It can be brought out by considering his attitude to a contrast between what he terms ‘mediated’ and ‘unmediated epistemic standings’.

An unmediated standing would be one which was foundational, or an ‘absolute starting point’ (ibid, p. 431). A mediated standing is one that, by contrast, stands in rational relations to other positions. McDowell argues that unmediated standings are the stuff of epistemological foundationalism and an instance of the Myth of the Given. Following Sellars, he rejects any such approach to epistemology (Sellars 1997). Even *perception* is a mediated standing. This leads to the question if all epistemic states are mediated, what is the nature of the relation between one mediated state and another?

On one approach a mediated standing in the space of reasons is one for which an *argument* can be given, by the knower, from premises which do not beg any epistemic questions about the status of the position in question. The argument might thus move from premises about how things look to a conclusion to the effect that the subject can see that things are thus and so. Such arguments articulate the kind of rational relations that make up the space of reasons in general.

McDowell does not deny that there are *some* arguments relevant to one’s epistemological status. If a subject sees (or has seen; or hears; or has heard) that something is the case, then it must be the case. That argument is a simple consequence of the ‘factiveness’ of the locution ‘sees that’ (or ‘hears that’). What follows the *‘that’* must be a fact. Furthermore, to be a subject capable of knowledge, the subject must be sensitive to the rational relations that make up the space of reasons. This is a necessary background condition for being capable of knowledge at all. But McDowell does reject the idea that the epistemic position of seeing that something is the case can be *reduced to* or *constructed out of* something more basic via an argument that the subject of the position could provide.

What I am proposing is a different conception of what it is for a standing in the space of reasons to be mediated. A standing in the space of reasons can be mediated by the rational force of surrounding considerations, in that the concept of that standing cannot

be applied to a subject who is not responsive to that rational force. But that is not to say that the epistemic satisfactoriness of the standing *consists in* that rational force. (ibid, p. 430)

In the case of testimony, it is particularly clear that a hearer would not in general be in a position to rule out possible sources of error in what the speaker says or other factors that would imply that the speaker does not *know* what he or she affirms. Thus, in general, a hearer cannot provide an argument from what he or she hears said to its truth.

Pre-philosophically, however, it seems clear that testimony can indeed provide knowledge. McDowell's response to this tension is to suggest that the attempt to give a reductionist account of epistemic good standing is mistaken.

The idea is, then, that one's epistemic standing with respect to what one comes to know by testimony consists in one's, say, having heard from one's informant that that is how things are; not in the compellingness of an argument to the conclusion that that is how things are from the content of a lesser informational state. (ibid, p. 436)

So—and this is the *third* point flagged above—the tenor of the analysis runs in the opposite direction to what is normal. Rather than attempting to decompose the concept of knowledge into constituent elements which form its epistemological base or foundation, McDowell suggests that *it* is the most basic concept in play. Justification is thus explicated from the starting point of a standing in the space of reasons.

The previous quotation continues:

Not that the subject does not [also] enjoy a lesser informational state. It cannot be true that he heard from so-and-so that things are thus and so unless it is true that he heard so-and-so say that things are that way – a truth that leaves it entirely open whether things are that way. (ibid, p. 436)

But McDowell suggests that the very idea of having heard that things are thus and so should not be analysed using this lesser state as a starting point. Similarly, seeing that things are thus and so implies that it seems or appears to the subject that things are thus and so, a truth that leaves it entirely open whether things are that way. And similarly that should not be the starting point of an analysis of 'seeing that...'.<sup>1</sup>

The net effect of this reorientation is not to offer a philosophical checklist for when testimony amounts to knowledge but rather to stop commitment to a fallacious view of knowledge undermining the surely correct claim

that: 'if a knowledgeable speaker gives intelligible expression to his knowledge, it may become available at second hand to those who understand what he says' (ibid, p. 417).

### Testimony and interpretation: some empirical issues

The picture presented so far is one according to which a key aspect of psychiatric diagnosis rests on matters that are not within the direct control of the clinician. This is not to say that he or she can make no further tests on the reliability of evidence presented to him or her second hand. But even the clinician's best epistemic position is one in which some factors lie outside his or her control. He or she may, for example, test the reliability of one witness against another but there is no prospect of justifying the use of testimony in independent terms which an individual can ensure non-question-beggingly.

The picture set out above also suggests that acquiring knowledge through testimony is much less of an intellectual matter than one might be tempted to suppose. One can acquire knowledge simply by taking someone else's utterance at face value, providing that one understands it.

Given the attraction of the internalist approach to knowledge, partly due to Descartes' influence, one response to the implausibility of an internalist account of testimony is to deny that testimony really can or does underpin knowledge. To take a non-medical example, one might claim that it is not possible, for example, to gain knowledge of the location of a station in a foreign city simply by asking someone. Although one may gain a true belief about where the station is, it cannot amount to knowledge, according to this view, because it depends on an element of luck in avoiding a practical joker who would have misled one. Proper knowledge, according to this modification of the natural view, is limited to first-person perception, memory or reasoning.

This will not do, however, because, as mentioned above, even first person observations are framed using linguistic concepts that are indebted to testimony. To give up on testimony as a source of knowledge is, in fact, to give up on most claims to knowledge both second and first hand. If an internalist account of knowledge by testimony is impossible, so much the worse for internalism. Testimony as we all know—not least because we have been told this!—*can* provide us with knowledge.

On the non-intellectual description supported by discussion of McDowell, knowledge can rub off on other people, who have ears to hear it. It can, however, be impeded. One blockage which is relevant to psychiatric diagnosis is if a speaker and hearer do not speak the same language. This can be the case in psychiatric diagnosis if,

for example, a patient does not speak the same language as the clinician.

A successful diagnostic assessment is contingent upon good communication between the clinician, the patient and the carer (Bhalla and Blakemore 1981; Shah 1992; Jones and Gill 1998; Shah 1999). Good communication between the clinician and the patient will depend upon the clinician's fluency in the patient's language, the patient's fluency in English for example, the accuracy of interpretation services and the availability of appropriate vocabulary in the patient's language for signs and symptoms of mental illness described in western diagnostic classifications.

Consider the case of many ethnic minority elders who do not speak English (Barker 1984; Manthorpe and Hettiaratchy 1993; Lindesay et al. 1997a, b). It is plausible to think that, ideally, such patients should be assessed by a clinician who is able to speak the patient's language and belongs to the patient's culture. But this is often not possible. The use of bilingual health workers to facilitate such assessments has been advocated, but they are uncommon (Phelan and Parkman 1995). Either of these approaches might seem to promise the transparent communication of signs and symptoms of mental illness. But this may nevertheless fail because transparent transmission by testimony is blocked.

It may be, for example, that there is a lack of matching vocabulary for signs and symptoms of psychiatric illness in the patient's language. Interpretation will thus fail to be fluid and even a bilingual clinician will struggle to ask questions on symptoms based on western diagnostic classifications. There is, for example, no matching vocabulary for depression in some languages, such as Gujarati (Shah 1999).

Disorders which of their nature undermine interpretation can block transmission by testimony. Formal thought disorder in languages with significantly different grammar from English, such as Gujarati, are difficult to elicit (Shah 1999). Similarly, testing for cognitive impairment in the context of dementia can also be difficult in patients without fluency in English because many of the existing screening and diagnostic tests depend upon fluency in English.

In cases where direct communication in a shared language is not possible, relatives, non-clinical staff, clinical staff and professional translators (with and without special training in mental health) have been used (Phelan and Parkman 1995; Shah 1997a, b).

To take another example: a 65-year-old woman who had been deaf and dumb all her life was referred by her GP for a psychiatric assessment of depression. The patient could only communicate by sign language. She was, therefore, seen with a sign language interpreter. Other than non-verbal communication, all the communication was through

the sign language interpreter. The psychiatrist had no alternative but to rely on an interpreter. It would not have been practical to find a psychiatrist with such sign language skills and the psychiatrist could not learn them.

In addition to the problems already mentioned, there may be everyday difficulties in this process that render it less than transparent and thus undermine the direct transmission of knowledge about signs and symptoms. Interpreters may inaccurately translate the content of the questions or answers. They may translate their opinions rather than facts, and they may be emotionally biased. Patients may be too cautious to reveal signs and symptoms of mental illness because of doubts about confidentiality.

In the context of the discussion of testimony as a general method of inheriting another's knowledge, one kind of bias or breakdown is particularly relevant. An interpreter may not accurately translate questions to the patient or accurately translate the patient's response back to the clinician because of the interpreter's beliefs about the patient's illness (Shah 1997a, b).

This has been observed in clinical settings by one of the authors of this paper (AS) who understands Hindi, Punjabi and Urdu, but not sufficiently fluently to conduct a psychiatric interview without an interpreter. The clinician's questions were frequently badly translated and leading questions were introduced by the interpreter, a practice frowned upon in psychiatric interview technique. In some cases, patients' answers were translated only after interpreters had added their own diagnostic interpretations of their responses. In other cases, there was an absence of matching vocabulary in the patients' languages for the symptoms enquired about. Since in Gujarati, for example, there is no specific word for 'depressed mood' interpreters, faced with this difficulty, often attempt to get around it by asking about other related but distinct symptoms or states such as a lack of happiness but rarely tell the psychiatrist that they cannot translate the symptoms as asked.

Given these problems, two strategies present themselves depending on one's underlying approach to epistemology: internalist or externalist. According to an internalist-influenced strategy, interpreters should be medically trained. The thinking behind this is as follows. If a clinician is to gain knowledge from a patient via an intermediary, then the intermediary had better have knowledge to give. But if that is the case and if knowledge has to be analysed in internalist terms then the intermediary has to be able to justify his or her own claims to know. Thus it would seem that he or she needs to have a full medically informed understanding of the significance of all terms employed by the patient. Only so will the interpreter be able fully to justify his or her account of the patient.

The alternative view is influenced by the externalist description of testimony set out in this brief paper and is

suggested as a response to the experiences described above. On this view, gaining knowledge by testimony depends on a transparent transmission. Providing nothing impedes it, it is possible simply to inherit another's knowledge, including a patient's knowledge of her symptoms and their duration. On this second view, testimony is most reliable when it is least transformed in transmission.

This is not to say that clinicians can simply ignore factors that might impede such transmission. To be in a position to have knowledge, to have a standing in the space of reasons as McDowell puts it, they must be rationally responsive to such factors where they might practically exist. But they do not need to be able to provide an argument to the truth of their beliefs from risk-free descriptions of appearances in order to gain knowledge by testimony. That they should be able to do so is merely an unrealistic philosophical prejudice.

On this second view, the best interpreters are those who most transparently pass on the meaning of the words of patients. This suggests that their knowledge of medical theory should be as close as possible to, but no more than, that of the patient. The risk, otherwise, is that the theoretical apparatus of the interpreter can intervene between patient and clinician. It becomes an opaque screen, rather than a transparent medium, for the transmission of knowledge. Of course, if interpreters are fully medically trained, they can simply make diagnoses themselves. That is possible in the case of bilingual doctors. But on the assumption that an interpreter is not so fully qualified, it is better, according to this model, for them not to exceed the theoretical knowledge of the patient.

This is, of course, a claim with empirical consequences. It would be interesting to test the validity of diagnosis based on interpreters with these two kinds of skill. But the discussion has at least suggested that a prior unreflective commitment to the internalist view of knowledge should not blind one to this possibility and purely conceptual arguments would favour the second approach.

## Conclusions

Internalist accounts of knowledge are reflected in lay thinking and historically by the assumptions that shaped Descartes' influential defence of knowledge against scepticism. Internalism, however, cannot account for the transmission of knowledge by testimony, which plays a key role in psychiatric diagnosis. Thus one important result of recent reflection on the status of testimony is that it, and thus diagnosis as a whole, cannot be fitted within the influential internalist framework.

A second feature flows from the inapplicability of internalism to testimony. The model of knowledge by testimony implies that knowledge can be passed via an interpreter even though the interpreter himself or herself is not medically trained. Indeed, there is a reason to believe that medical training might introduce a barrier for the transparent communication of symptoms.

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