Kevin, thank you for your excellent input and inspired questions on this =opic!

> The broad idea is that we'll need to build slack into systems of =biquitous computing. That there's a paradox in that in order to have a =ohesive identity, certain aspects of our lives require omission (or =.g., deception).

There are two sides to this: first of all, many of our interaction =artners may have difficulties to accept (or even comprehend) the =nteractions and social norms that we maintain in other contexts (think: =iving in a small town in the midwest vs visiting Burning Man; religious =ommunity vs. less usual sexual interests; family life vs. work life; =rganizational role vs. friendships). As a result, we compartmentalize =ur social expression. In a culturally inhomogeneous society, this kind =f deception (in the sense of hiding parts of my personality depending =n the context) is a prerequisite of meaningful freedom.

But on a deeper level: while we may maintain the illusion of a coherent =elf, we do not possess a single social persona. Our social identity =merges not only over our personality, but also over the individual =elationships in which it manifests. We become who we are through the =eflection of others.

> The ethnographer Tricia Wang coined "The Elastic Self" after spending = lot of time with Chinese and American youth using various forms of =ocial software (...)

The notion of the "Elastic Self" might capture both aspects. On one =and, we may explore different possible ways of self-actualization by =eeping social contexts isolated from each other, on the other, we =sually maintain more than one persona.

> How would you build a system that provides a patient with the ability =o continue acting deceptively -- in order to maintain a cohesive =dentity -- while providing the doctor with the ability to find -- and =ct on -- perfect information?

The simplest setup: the patient is a BDI (belief, desire, intention) =gent, and has accurate knowledge about himself. He also has beliefs =hat part about his beliefs, desires and intentions are acceptable to =he outside world (which here is a homogenous hospital context and does =ot need further differentiation), and which ones need to be adapted to =it the actual intentions. For perfect information, the doctor gets =irect access to both layers.

The BDI model of agency (i.e. the idea of describing an agent using a =et of beliefs, desires and intentions) is a somewhat crude =implification. We may well hold different, contradictory sets of =eliefs and goals at different levels, and the one that becomes relevant =epends on the context, and the state the agent is in. Also, many =eliefs and intentions are not directly represented, but generated when =eeded, and their content and form may be highly dependent on the =nteraction. In reality, there is often no perfect information for the =octor to act upon, e.g., because some of the information will be =enerated during and depending on the actions of the doctor.

We might want to skip that kind of accuracy if we just want to get an =dea of the benefits of deception for the organization. If we treat the =atients (as well as doctors, nurses, ...) as straightforward BDI =gents, the "perfect information" would be the set of beliefs and =esires that the patient functionally acts upon. If we want to include =elf-deception, we might simply add another layer on top of that: the =et of beliefs that the agent has about his own beliefs,

desires and =ntentions at any given time. For functionally accurate deception of =thers, the patient needs to represent beliefs about the actual beliefs =f the doctor, and actionable desired beliefs of the doctor about the =eliefs, desires and intentions of the patient himself. (A perfectly =lairvoyant doctor would have access to all belief layers of the =atient, and the relationships between them.) Only if we want to assess =he benefits of deception to the agent himself do we need to implement a =ore detailed cognitive model.

Cheers,

Joscha

```xml
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        <key>gmail-label-ids</key>
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