Imagining a NeoFreudian Mind Interface: A Normative Model of Medical Humanities Research

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ABSTRACT

This thesis argues for a new theory of medical humanities practice and research, known as Mind Interface Theory. It begins with the claim that Sigmund Freud expanded medical metaphysics considerably in "A General Introduction to Psychoanalysis," and that this expansion affords the possibility of thinking of the mind as a user interface. Capitalizing on this affordance, the work then introduces mind interface theory as one possible imagining of Freud's metaphysical system, separate from his well-known theory, psychoanalysis. More specifically, it uses his discussion of dreamwork to reveal reprocessing as the mind interface's mechanism of healing, before utilizing this reprocessing principle to orient the medical humanities' research, providing a theoretical framework for increased collaboration between humanists and physicians and a foundation for two distinct modes of activist scholarship: product-based and process-based.

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GENERAL AUDIENCE ABSTRACT

This thesis participates in medical humanities scholarship by advocating for a specific theory of the field that stems from a reading of Sigmund Freud's *Introduction to Psychoanalysis*, a brief series of lectures which were written down for public consumption. Instead of using psychoanalysis itself to form a theory of the medical humanities, my work abstracts the broader suppositions on which psychoanalytic interpretation is rooted. This broader framework I call Freud's medical metaphysics and define as the assumptions about causation and disease which form the basis for his philosophy of medical treatment. In making this distinction, I can more ably build my own theory of a mind interface on the fact that the basic structure of the metaphysics advocated in the lectures implies a vision of the mind that can be likened to a modern user interface. Through conceiving of the mind in terms of a user interface, I use mind interface theory to frame treatment in such a way as to promote a humanist theory of healing. The purport of the method is that humanists can assist patients through helping them utilize signs, language, and symbols to reprocess their experience. The advocation of this method is then applied to current threads in medical humanities scholarship to suggest that efforts in the field would be best served if they were directed towards studying the artifacts of patient populations for narrative and rhetorical strategies which were effective with coping with a specific illness and fostering an environment where patients are encouraged to produce such artifacts.

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Introduction

The following work is an interpretation of *Freud's General Introduction to Psychoanalysis* which puts forward a normative theory of the medical humanities. It should be evaluated as primarily a work of theory and not an authoritative reading of the lectures. Though Freud's work is considered scientific discourse, it contains an immense amount of polysemy, and for this reason, a useful reading should be preferred to one that espouses any "correct" interpretation. This approach fits in well with my original goal of creating something of use to medical humanists that might assist in illuminating where their efforts would be best applied.

It should be noted that the theory I introduce in my close reading of the lectures—mind interface theory—is distinct from descriptive theories that attempt to give an account of medical humanism because it is not aimed at determining what the field is, but rather, its general orientation. Providing an orienting theory has proven no small task, and to the extent to which it remains imperfect, it is somewhat beyond my power to remedy. I can only hope that through gradual accretion, criticism may compile in which other scholars are generous enough to assist in its debugging.

As a whole, my work consists of three main claims. The first is that, in creating psychoanalysis, Freud had to expand medical metaphysics considerably. This metaphysical model is necessary for psychoanalysis because it allows for the theory to establish a user interface. On an abstract level, the user interface contained within psychoanalysis functions identically to the one installed on a desktop computer or tablet—both serve to enable a user to carry out a task without knowledge of the task's mechanics, or true nature.

Just as an everyday computer user requires no knowledge of computer code to open a document, in psychoanalysis, the clinician is generally ignorant of the physical cause of the

disorder. Still, in both instances, the concept of user interface performs the heavy lifting, such that a function can be accompolished even given a lack of mechanical knowledge. While it might first appear that the possibility of user interface stems from psychoanalysis, Freud's lectures reveal that its source is rather the broader metaphysical framework that psychoanalysis assumes

This is to say, that one can imagine a user interface of the mind without imagining psychoanalysis, but not vice versa. It follows from this fact that psychoanalysis goes far beyond Freud's new medical metaphysics, making assumptions that do not directly follow from, and are sometimes even at odds with it.

After reviewing the ways in which Freud materially expanded metaphysics within the medical sphere, I then turn to the connection of his metaphysics with imagining mind as user interface. In part to demystify the true nature of his contribution, my second aim is to explain his metaphysical claims through the lens of user interface before developing my own alternative theory of how a user interface of the mind might be imagined—what I call mind interface theory. The development of this theory then leads me to my final assertion that mind interface theory can serve as a mode of explanation that links the experience of health, and the sign and symbol use surrounding it, to health as usually operationalized by physicians.

Working towards this purpose of developing a humanistic theory of medicinal intervention and collaboration, I use the first chapter to explain Freuds' medical metaphysics, defining it as the assumptions about disease and causation that allow for the possibility of mind interface and psychoanalysis. Throughout this process, I make a careful distinction between the former, which is an edifice of my own design, and Freud's system of psychoanalysis. The idea is that both psychoanalysis and mind interface make different assumptions about how a user

interface of the mind is realized, and it is in these different imaginings, that they are to be regarded as separate theories.

In chapter two, I build on the idea of mind being a user interface and begin to articulate mind interface theory as an alternative to psychoanalytic accounts of the mind. However discrete the two theories may be, the goal is to show mind interface theory as containing many of the same characteristics. Due to this similarity, I am able to derive information about the goal and purpose of my own theory directly from Freud's psychoanalytic assumptions about the dream. Since Freuds' discussion of the dream indicates the mechanism of healing that mind interface utilizes, his discussion of dreamwork proves a revelatory site from which much insight about patient care can be mined. The central conclusion drawn from Freud's dream analysis is that such a discussion presupposes that a user interface of mind heals through facilitating the reprocessing of signs, symbols, and experience.

Having uncovered the means through which an interface of the mind can be supposed to heal, I work to further conceptualize how reprocessing functions and apply it to orienting activity in the medical humanities. In chapter three, I argue that descriptive theories have proved insufficient in their lack of ability to direct activity. Through applying mind interface theory and its principle of reprocessing, I am able to integrate several strands in the broad coalition of concepts and terms that currently comprise the medical humanities to illuminate how my normative theory makes possible two distinct activities which leverage disciplinary strengths and invite meaningful collaboration with physicians.

Given that the road ahead is likely to be abstract, I have included a contextualization of the first chapter which broadly works to situate my discussion of medical metaphysics. It proceeds by giving a history of how metaphysics, as a subfield of academic philsophy, has been

applied in medicine, before proceeding to describe the metaphysical inheritance that Freud

received when he began his practice of psychiatry. Such a preface will hopefully provide any

essential background materials that would be necessary to understand what metaphysics means

in the context of medical practice and to understand Freud's contribution toward the subject.

Metaphysics represents an older field of study, native to philosophy, which has always

centered around determining an inventory of existence and the rules governing its constituent

objects. This can be thought of broadly as determining, very literally, the set of all things that

exist and laws that occasion their appearance and behavior. As applied to body and health,

metaphysical conversations diverged early into two directions. The first of these is articulated by

dualist thinkers who hold that there are two types of things: spiritual and material. In *The*

Phaedo, Plato articulates this position well when he calls that which was severed from the body

at death the soul.[1]

This division between spiritual and material, however, was not maintained by all: by

others, mind was seen as arising only from a material substrate. In large part, these two

perspectives have precipitated most of the metaphysical system building of the past two

millennia. Indeed, the belief in the independent mind, the soul, and the more embodied, material,

mind, both persist in being formative to contemporary legal, ethical, and scientific discourses. .

Given their profound influence, the fact that they should have proved significant in the formation

of modern medicine is of little surprise. After all, one's position towards the categories of

spiritual and material existence have very real implications for treatment. A spiritual paradigm

would logically call for the physician to procure health for the spirit, either by putting it in a

better relation to some deity, or by engaging in a ritualistic practice thought to exert some effect

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[1] Plato, Henricus, and Lorenzo Minio-Paluello. *Phaedo*. Nendeln: Kraus, 1973.

on its condition, whilst a materialist paradigm would move one to the pursuit of determining the principles that the body could be said to obey.

As a practicing physician, Freud adopted medical materialism: a monistic philosophy where mind emerges from brain states which are in turn taken as identical to conscious experience. While much more conducive to promoting health than spiritualism, this view also presents medicine with a set of persistent problems. Since treatment under a medical material paradigm stems from knowledge of the brain and its interactions with other elements of physiology, any gap in the knowledge of these particulars could render a disease untreatable. This was a problem Freud faced with many of his patients, as the scientific community had not isolated the specific patterns of neuronal activity responsible for the lapses in memory, judgement, speech, and vigor that his patients presented.

Though ignorance of the physical cause of an illness sometimes renders the ailment untreatable, the medical science Freud knew had already done significant work in formulating a classification of cause types. This typology, while it may not have been able to positively identify the particulars of anatomy responsible for the sickness, gave physicians a hint of where to look for answers when the physiological mechanism responsible for the sickness remained indeterminate. Knowing that a particular set of symptoms only arises after the ingestion of a substance, for instance, can go a long way in ruling out ulterior courses of treatment that would likely prove ineffective. In fact, doctors often treat patients without knowing exactly how their recommended treatment regimen is acting on the body. Knowing certain classificatory information about the cause—that it must result from the failure of such and such organ, or lack of fluids—can lead them prescribe a drug that significantly increases one's chance of survival upon its administration, even if the physician has no idea why.

The mode of classification and inference upon which such medical decisions are made constitute medicines' unspoken metaphysics—the corpus of rules determining what type of disease-causing entities there are and how they operate. Treating patients involves understanding a network of causal relation and developing a theory of these relations. Part of developing this important rule set has simply been to adopt assumptions that have proven helpful to treating disease. The integration of materialism is perhaps the best example of this practice. By ruling out spiritual causation, it served to relegate the causes considered in medicine to two main types of physical causation: event-based and somatic. This was the metaphysical inheritance that Freud would receive when he began his practice, in large part simply because making materialist assumptions lead to better patient outcomes and lower patient mortality.

Chapter I. Freudian Metaphysics

Like other psychiatrists, Freud would consider the set of somatic and event-based factors that could cause symptoms and the relationships between these causal categories. In so doing, he builds on traditional medical metaphysics to create his own distinctive formulation which speaks of the mind in a way that parallels contemporary understandings of user interface principles. In order to fully appreciate such a system, as well as how his expansion of metaphysics allowed for its development, an explanation of the metaphysics itself is first warranted. Though a creative endeavor in its own right, Freud's formulation of metaphysics was successful because it built on medical metaphysics as traditionally understood. His lectures appear to extend medicine's metaphysical supposition to a set of natural conclusions, which, in retrospect, would seem unobjectionable to practitioners of medicine because they appear extensions of accepted doctrine.

To fully understand his approach, it is best to overview its basic causal categories before discussing how Freud would employ them in the lectures. The first of the two categories, bodily, or somatic, causes deal with what in the body is responsible for a symptom's onset. They are the most proximate, the mechanism through which all other causes must be actualized.

Event-based causes produce bodily causes, but in their absence, a bodily cause would not result. When put in terms of everyday health concerns, this description begins to make more sense. Thinking about influenza puts this abstract definition into a much more concrete context; someone cannot contract the influenza without first having had exposure. While the virus manipulates certain aspects of one's physiology and produces symptoms in the process, there must first be the environmental cause of coming into contact with the virus. A pure bodily cause

on the, other hand, if even such a hypothetical can be imagined, might be something like organ failure resulting from faulty genetics. It would be something in the body, in and of itself, that was sufficient to cause a malady of the body.

Such examples leave much to be desired, however, especially concerning event-based causes. This deficit is mostly due to the fact that not only are human beings acted upon by causes in their environment; in an important sense, they act on and even produce environmental causes in their own right. This was Freud's major contribution to the metaphysics of medicine. He saw events as not only having the capacity to act on mind and body, but also for the mind to reflect on the inputs of those events and create new causes with them. A memory of going to visit the lake with one's family, for instance, may harbor great pain in its recollection, or might have the potential to ameliorate depression.

Still, there is not only this power of recollection, and the ability to use memories to make meaning, but also the creative ways in which the mind acts on experience to fashion its own products, whether it be novels, poems, diaries, emails, plays, films, or even self. Indeed, it is this conundrum of having such a broad spectrum of event-based causes that made Freud's unpacking of event-based causation so pertinent to the exigence of medicine. In his time, much had already been done to further subdivide bodily causes, but an elaborate system of classification had yet to be developed that painted a clearer picture of how interactions with the world came to both act on the body and emerge from the body.

The nature of his contribution was to shine a light on the ways in which human beings come to mentally represent and manipulate interactions with their environment. This was more substantive, as it highlighted where there was legitimate uncertainty and did not bother to classify the already well understood matter of how environmental agents, like viruses, come to

act on the human body. It was the drive, instead, to provide a causal account of how the world came to be instantiated in the mind, and how the mind came to operate on these pieces of experience, that formed a nascent metaphysics.

His formulation of its tenets arose from reflections upon the work of the neurologist Joseph Breur. Very broadly, the impetus of much of the metaphysics can be traced to Breuer's insight that stored experience can play a causal role in inciting symptoms. Freud extended this observation by differentiating the way in which event-based causation was represented in the mind, whether it be in memories of stored events, or the thoughts that arise as a result of stored experience.

The first of these means can be thought of simply as just the storage of inputs, while the other as an acting causal force composed from the materials of experience. In the lectures, Freud classifies both memories and thoughts as a specific species of event-based causation, known as psychic, or mental causes. This classification allows theorists to use the conceptual relationship between thoughts and memories to think about the mind at a different level of analysis. Here, there is a shift away from thoughts as originating at the level of neuronal firings, and towards examining the functioning of the mind at the level of conscious experience.

Such a study constitutes nothing less than phenomenology, a branch of study defined by the Stanford Encyclopedia of Philosophy as the "the study of structures of consciousness, as experienced from a first-person point of view" (n.p.). Under this careful phenomenology of the mind, Freud allows for forming definitions of memories and thoughts that are not couched in terms of cognitive psychology, or neurobiology. Instead, examining the materials of the mind leads to a cultural and humanistic definition of memories and thoughts, where memories of experience are not only just the inputs, but inputs acted on by the mind to mirror experience.

Furthermore, thoughts are operations on the inputs of perception, signification, and culture (sense data, symbols, signs) to form knew meanings.

When enough of these thoughts and memories aggregate and are affixed to hardware that allows for the intake and storage of experience, their interaction can then be taken to form an agent—a mind. Though it is discussed here in the contexts of hardware and software, Freud's ideas appear to capture common, and even commonsensical, notions of folk psychology. Human beings have appeared to always think of their interlocutors as having separate memories, personhood, and agency than themselves. From a pragmatic perspective, this folk psychology, as it were, probably survived because of its utility in helping human beings cope with the world, but its boons need not stop there; the same utility can be extended even further when coupled with the necessary precision.

As it turns out, it is Freud's meticulous formalization of everyday intuitions about the mind that allows for the possibility of a mind interface—a system of analysis which defines the mind, as it is constituted, by symbols, signs and culture. Such a level of analysis functions to make the unknown and currently unexplainable familiar, allowing for a clever bypass of somatic ignorance. Mind interface is not only a system of analysis, it also serves as a method of treatment and entryway to allow the humanities a fuller participation in the field of medicine. While it may seem strange for a theory to serve as both an edifice which seeks to incite interdisciplinary work and as a discrete method of treatment, this is what I propose. More to the point, however, because mind interface operates with much the same intuition behind the Windows, Macintosh, or IOS user interfaces, there is a beautiful simplicity that should not be overlooked. In getting a sense of what it is exactly that I mean in my interpretation of the lectures as offering medical humanists an interface of the mind, it is necessary to grasp a number of crucial distinctions.

The first is that there is a meaningful difference between mind interface and psychoanalysis. Both use the distinct method of medical metaphysic developed by Freud but make different assumptions as to how that metaphysics is actualized. This means that there are two conceptions of mind that stand in need of exposition: psychoanalysis and mind interface. Instead of listing them separately, I have tried to note the relevant distinctions between my own theory and Freud's by simply describing how both evolved from the same set of metaphysical assumptions. Given that I have undertaken this endeavor, I think it is best to start from the ground up, delineating the series of moves present in the lectures that allow an interface of the mind to be constructed as a viable interpretation.

Chronicling these moves is, in large part, equivalent with an overview of the principles beneath both mind interface and psychoanalysis. In the latter portion of this chapter, I lay out how Freud used two principles—the impossibility of an uncaused event, and the necessity of categorical inference—to create a new metaphysics of medicine. As well as examining how Freud garnered acceptance for this new edifice, I also discuss how it opens up the possibility of thinking of the mind as a user interface.

Freud begins the lectures with a discussion of everyday mishaps—little slips of the tongue, bouts of forgetfulness, mis-readings, all together "certain phenomena which are very frequent, very familiar and very little heeded.[2]" He thought that these errors, such as slips of the tongue, lapses in memory, and motor execution etc., must have satisfying explanations that would render a picture of what exactly was responsible for their development. The problem, as it presented itself to him, was that the circumstantial explanations for these everyday mistakes were easily

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[2] Sigmund Freud, *A General Introduction to Psychoanalysis*, 7.

dismissed and, altogether, unsatisfactory. For Freud, everyday mishaps constituted cases where the traditional assumptions of medical metaphysics could be extended, since there was no satisfying explanation otherwise. The way he derives the unconscious intention that caused a slip of the tongue, for instance, is the same means of derivation used in ordinary medicine, but strengthened so as to presume that a previously unadmitted type of cause can be appealed to if there was ever an event with no other satisfying explanation.

What this means practically is that if no commonly accepted cause type can account for an event—in this case a slip of the tongue—then an unrecognized category must be presumed to be responsible for the event. This means of abductive reasoning takes determinism to its ultimate manifestation—a world where there is nothing that is self-propelled into action and a new cause type can be supposed if the admitted cause types fail as explanations. It is only against this austere and mechanistic background that Freud can begin to develop his extension of metaphysics, as it is the metaphysical supposition that when extended provides the design tools necessary for its second major move. In providing grounds to believe that there must be a satisfying explanation of every phenomena, Freud then lays the groundwork for supposing that new cause types can be deduced from empirical evidence and the application of reasoning.

Though novel, the type of cause that Freud would postulate stayed within the bounds of conventional materialism. When he derived mishaps as psychic causes, psychic causes fell into the existing category of event-based causation. The fact that psychic causes were compatible with the existing framework made them seem, in no small part, derived from it. Below I present an expanded version of the history of psychic causes which illustrates how the second principle of categorical inference was applied to place psychic causes within the existing framework of medical metaphysics.

Freud enmeshed psychic causes within the extant model of medical metaphysics by a

categorical inference. Since, broadly, all causes must be either bodily, or event-based, if one of

the types is ruled out, it allows for the others to be inferred. While it may be difficult to

understand by itself, the well-known case of Anna O. illustrates the application of categorical

inference perfectly, while also historically situating the development of psychoanalysis and mind

interface.[3]

Though Ms. O. was not a patient of Freuds', a great deal can be surmised from his remarks

about the situation surrounding her treatment. In his cowritten essays on hysteria with the

neurologist, Joseph Breuer, it is noted that she presented a complex of diverse symptoms which

could be traced to no physical cause.[4] At times she was immobilized and bedridden, at others,

profoundly impaired in speech and other faculties. In addition, her hallucinations were frequent

and there were even momentary schisms where there seemed to be a divergence of herself into a

good and bad personality.[5] As there was no known bodily cause responsible for any of these

symptoms, Breur inferred that the causes in question must be event-based, and that it resulted,

particularly, from her stored memories of certain events.

Corroborating this hypothesis was the fact that Anna healed miraculously simply by

recounting unpleasant events, usually from adolescence and late childhood. For Freud, this

landmark case was an important moment that pushed traditional boundaries of inference. Prior to

Breuer, it would have been accepted that interaction with the environment could cause some

bodily change which then affected health. What was altogether different was that Breuer

believed in an event-based cause without the presence of any bodily injury resulting from an

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[3] Sigmund Freud and Joseph S. Breuer, *Study-on-hysteria.pdf*, PDF, SigmundFreud.net
[4] Sigmund Freud and Joseph Breuer, *Hysteria*, 11-26.
[5] Sigmund Freud and Joseph Breuer, Hysteria, 12-23.

interaction with the world. In acting on this belief, he made a reasonable leap of faith that relied on an expanded sense of event-based causes which included stored mental content. The basic structure of his categorical inference was as follows: either type A or type B, not type B, so type A. Freud would come to, consciously or not, employ this same mode of reasoning to phenomenologically define parts of the mind, their materials, and the behavior that they could be said to exhibit.

Acting on the belief that there were no uncaused events, he took Breuer's inference of stored mental experience being a potential cause of symptomology in psychotic patients as a belief that needed theoretical grounding. Categorical inference could be extended much further so as to postulate novel cause types which fell under the umbrella of event-based causation if the current understandings of causation were found lacking. These cause types were not just born from their own utility, however, but from an extension of prior notions of cause and empirical support taken from clinical cases.

Together, these warrants, along with clinical data, allowed Freud to expand his metaphysical system much further and clearly define a picture of how exactly mental contents can causally determine symptoms. An important aspect of his methodology was that it was consistent with the contemporary metaphysical model of medicine at the time, even appearing to draw out its implications. This allowed him to build on Breuer's work in the lectures by simply arguing that he had so much faith in the basic metaphysical principles of clinical science that he believed they could be extended apodictically in combination with clinical cases. That is, he could apply the metaphysical principles to analyzing cases and then extract larger truths about treating patients from their synthesis.

One of the first instances of this is a major extension of categorical inference that works to delimit the province of mind quite considerably. While the case to which I am about to refer was never identified as formally functioning in this way, it, nevertheless worked to help him start to organize an inventory of materials of the mind. In the lectures, Freud tells us relatively little biographical info concerning this patient, only that she is nineteen years of age and noticeably precocious. She came to Freud hoping that he would be able to stop the compulsive evening rituals that attended, and often prevented, her sleep. Unlike the absence of biographical data, however, the details of the ritual and her subsequent compulsions are covered in excruciating detail: the silencing of the clocks, the cautious reorganization of breakable items, the compulsion to reposition pillows and comforter.

When trying to discern the cause of such symptomology, Freud's question became whether these behaviors were to be thought of as purposeless, or purposeful. There was also the documented query of whether the fears being acted out in the behavior had anything to do with the patient's conscious rationale, and how a justification could be obtained for positing another meaning than what his patient suggested? As is in most cases, when considering Freud's thought, the ramifications which he believes can be extrapolated from the facts of the matter seem both brilliant and commensurately absurd.

The idea of the nineteen-year-old woman fearing her parents' procreative capacity, that she is unknowingly obsessing over the potential birth of a rival sibling; her acting out of the archetypal carnal lust of the daughter for the father, along with the accompanying resentment of the mother; her fear of not bleeding after her future marriage ceremony and failing to signify virginity; all seem absolutely shameful and dubious suggestions. The only thing stranger than this prognosis, however, was the result that its acceptance produced in the afflicted patient. My

claim is that this empirical support not only serves to substantiate claims pivotal for Freud's

metaphysics, but also links it to the empirical endeavor of medicine. In this respect, his

metaphysics is not created from scratch. It was instead the result of a laborious study of the

output produced by patients in response to certain varieties and permutations of inputs by the

physician. In the case of the patient suffering from ritualistic behavior, Freud relates that:

> In the working out of the interpretations I had to hint and suggest to the girl and was met
> on her part either by positive denial or mocking doubt. This first reaction of denial,
> however, was followed by a time when she occupied herself of her own accord with the
> possibilities that had been suggested, noted the associations they called out, produced
> reminiscences, and established connections, until through her own efforts she had
> reached and accepted all interpretations. In so far as she did this, she desisted as well
> from the performance of her compulsive rules, and even before the treatment had ended,
> she had given up the entire ritual.[6]

Clearly, these results are at odds with what one would expect; after all, the acceptance of an

incestuous desire for one's own father seems at least mildly traumatizing. Upon closer

inspection, it even seems that fantasies of fatherly incest and potential sibling rivalry are not

strictly necessary—that they could even be a form of mild gaslighting which, although it seemed

to produce salubrious consequences in the moment, could actually prove deleterious later in life.

This is just one of many examples of where Freud's lecture makes a much better argument for

the inchoate structure that he needs to undergird psychoanalysis than for psychoanalysis itself.

This is where it is very important to begin to differentiate psychoanalysis from the

underlying medical metaphysics that it presupposes. For example, when looking at this particular

clinical case, Freud made a more reasonable list of assumptions concerning the situation

completely separate from the psychoanalytic interpretation he proffered. The assumptions doing

the work are likely to be the metaphysics, not the bizarre psychoanalytic explanation.

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[6] Sigmund Freud, *An Introduction to Psychoanalysis*, 156.

There is, in fact, little doubt as to the role of the two components of experience which he would have relied upon to best explain the performance of the compulsions. As Breuer pointed out, in the absence of an event-based cause which produces bodily symptoms, the physician should look to stored mental experience as a tertiary type of causal explanation. Freud treats this mode of categorical inference as obvious by offering an explanation of the compulsion which makes use of the patient's life history, but he extends it much further. By reading into the rituals a symbolic meaning, he tacitly presumes that the patient has actively reflected on this experience, and therefore presumed a psychic cause, or a complex of such causes.

This presumption works in concert with stored mental content to produce a picture of the mind that is defined on the level of experience, rather than physiology. Since it is defined on a functional level, and not an anatomical one, Freud can proceed like a programmer in defining a variable of interest and then building upon that denotation a system which, in many cases, obviates the need for knowledge of other cause types.

The variable definition built is a conjunctive one, comprised of two parts, where any mind can be seen as the products of its stored experience and the thoughts which make use of that experience. In the clinical case, it need not be reckoned that Freud's interpretation accurately captured the reality of the matter, only that the patient's malady was in fact the result of thoughts and memories. Breaking the case down further, the patient had thoughts and memories which acted on her stored experience of the world, and these thoughts were processed in a way which made them act in a harmful capacity.

Contrasting this with the case of Anna O., where simple retrieval of mental content proved sufficient to restore her functioning, in the 19-year-old patient, it was largely the reprocessing of the information which resulted in the elimination of symptoms. In order to terminate the ritual, a

narrative was required that would promote the reprocessing of the content so that the symptoms subsided. On its own, however, the definition just provided of minds seems to tell little about how a physician could ever hope to remediate symptoms without knowledge of physical causation.

Even if limited, these cases illustrate an active link between the physicality of the body and the products wrought of the mind. If further particulars of the mind's composition could be obtained, the causal linkage could be exploited in favor of promoting desirable health outcomes. Through assuming a defintion of mind which is defined by its content—the psychic causes of thoughts and memories, Freud's metaphysics moves physicians closer to being able to treat conditions without knowledge of etiology. In a sense, this basic picture of the mind presupposes that it functions like a user interface. In the next chapter, I will build on this affordance of conceptualizing mind as a user interface and use it to develop mind interface theory.

As I hope to demonstrate, an interface reading of Freud's argumentation allows one to build on the previous metaphysical principles of no uncaused event and categorical inference to derive a denotation of mind much more conducive to humanistic treatment. Throughout my elaboration of the interface, I shall try to be diligent to differentiate those propositions which I think necessarily follow from the Freudian metaphysics espoused in the lectures and those which are adjunctive aspects of the mind interface theory outlined in these pages.

Chapter II. Imagining an Interface of The Mind: The Birth of *MIT*

To begin, the metaphysics espoused in the lectures seem to necessitate that the mind be defined phenomenologically—that it will operate in the domain of not the particular content of thought itself, but the materials of which thought is composed, and the experience of having a first-hand account of consiousness. While individuals may be highly unalike in the content of their thoughts, Freud takes for granted a certain universality in the experience of thinking. Also taken for granted is the deterministic structure for how this experience of thought gets enacted in minds. The mechanics of his phenomenological definition of mind, however, remain woefully inchoate. In constructing mind interface, I have put together one particular imagining of how Freud's deterministic metaphysics might materialize in a way of thinking about the mind.

In general, I have thought of the mind as being limited in the material on which it acts. As such it can be thought of as simply an aggregate of the types of materials which it receives as inputs from the world and the outputs it produces from the inputs. Its thoughts are perceptual, semiotic, and cultural productions which arise from specific inputs types held in common amongst members of the species. As everything must have a cause, thought itself emerges from the physical structure of brain, but to be about anything whatsoever, it must also have recourse to percepts, or sense data.

From this point, what developed was contingent. With sense data, humanity developed language and other semiotic system by which it could communicate meaning and, from language and action, culture. By application of categorical inference, if the only inputs are percepts, signs symbols, and culture; and somatic inputs, such as emotions, then a phenomenological definition of the mind could not consist of anything ulterior to the sources of inputs and the force which is

productive with these raw materials. This is to say that under mind interface, thoughts and memories are nothing but arrangements of input and stored experience, nothing but an archive of inputs obtained either from the body, or from interactions with the world. This leads to the raw materials inference of mind interface theory, where categorical inference is applied, to provide an inventory. Under this view any mind is simply a collection of different types of sense data, signs, symbols, and the rules that govern their usage in making meaning. Each of these materials is supposed to be held by humanity in common, with exceptions only arising from differences in language or culture. Because Freud's analysis of dreams heavily suggests a structural system of signification that is held in common among members of society, the same structures used in encryption must mean the same thing to an interpreter given identical background knowledge. Having teased this out, it now becomes clearer that mind interface takes meaning itself as the very precondition for thought. At the level of subjective experience, thoughts must be meaningful to even be recognized as items in consciousness.

Though the strong case of the argument is put forward here in my own imagining of Freud's metaphysics, I will be clear that I also think that Freud himself needed to make the same assumptions. Psychoanalysis, like mind interface theory, seems to require that both patient and physician have thoughts which are composed of the same materials and that the category of the materials are the same. To take an example, one could not describe sandpaper to a person blind from birth and expect them to have the same mental picture as that of a sighted person. The only means that could be used are the input modalities which are shared; in this case, the sandpaper could be described by words, such as rough, or tactilely by guiding the hand of the blind individual over the paper so that they perceive its texture. Freud's big assumption is that physicians can treat the mind because human beings share the same kinds of sense data, which

are then represented in the mind, as well as an identical rule system to make meaning with that stored sense data.

Extending this presumption to the woman with the rituals, both she and Freud had working sensory systems that had the same types of perception, as well as a shared body of rules to make meaning of that data. The only aspect in which they were different was in Freud's knowledge of sexual inuendo and medicine. Given an identical knowledge base, his interpretation of the cause of her behavior could have been constructed by the woman herself. This is due to the fact that the materials of mind are held in common, and their commonality would allow for them to signify relatively similar concepts in certain arrangements. In this respect, the ritual can be read by both doctor and patient as a group of symbols that has rules governing the meanings it can convey.

This case illustrates that to serve the exigence that Freud intended—to heal without knowledge of physical causation—mind interface, and psychoanalysis, relies on principles that take for granted the compositionality of the mind as simply a set of percepts, symbols, signs, and the correspondent will within the individual that shapes them into meaningful arrangements. From here forward, I will appeal to the minds' compositionality to justify how it can be conceptualized from the perspective of user interface design and utilized to procure healing. Through this discussion, I want to demonstrate how mind interface theory is emblematic of the approach taken in programming. I then want to examine the utility of this general approach in providing an alternative means of medical description and practice.

The first step any interface designer faces is the problem of formulating a general statement of what the programmer wishes to accomplish.[7] Typifying user interface principles,

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[7] Haoxian Chen, "The Philosophy of Programming – FreeCodeCamp.org," FreeCodeCamp.org, June 06, 2018, , accessed November 18, 2018, https://medium.freecodecamp.org/the-philosophy-of-programming-e901bd37363a.

mind interface builds on Freud's problem description for psychiatry of developing a method of treatment which renders understanding the physical causes of mental illness unnecessary. This step allows for the better-known stage in programming where the programmer breaks the problem descriptor into a series of graduated steps. In his article, "The Philosophy of Programming," Haoxian Chen speaks of this second essential step in the development of any program, the "translation of a real-world problem into a set of simple instructions.[8]"

It is worth noting that, as in many such cases, the actual redefinition of the problem is what allows for it to be oriented in a new manner. An interface reading of the lectures would posit that Freud's creation of psychoanalysis depended on something that came prior: a variable definition of mind as the total set of inputs, along with the somatic faculties of will and emotions that direct their arrangement.

As already discussed, creating this new variable definition of mind, in turn, depended on the expansion of medical metaphysics discussed earlier, particularly those concepts related to causation. Improving concepts of causation allowed for inferences concerning the mind's composition and the relation of its constituents to the onset of symptoms. All of these developments, however, assumed just that there was a psychic cause that must be made of the sense data, in addition to language, signs, and symbols. These presumptions did not give any data concerning how such psychic causes may be accessed. Nor did it give any idea as to what the process of healing might look like on a cultural level. Thinking about the system that Freud created in terms of a user interface allows us to surmount a number of these issues and also orients humanists practically, demonstrating how a complicated theory can arise out of clinical interactions.

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[8] Hoaxian Chen, *The Philosophy of Programming*, n.p.

What the lectures indicate is that a general theory of humanistic healing can emerge just from breaking a patient treatment plan into a problem and then revising the problem description in response to the patient's progress. Very broadly, thinking of the lectures in terms of user interface design allowed me to theorize the way in which technicalities could be reduced to something more familiar to both humanist and physician. In order to aid in healing, both parties must have a familiar system of metaphors from which to understand the process. Thinking of the mind as an interface composed of sense data, culture, and signs gives doctors and humanists a shared foundation from which to pursue healing.

Since user interfaces are also oriented towards performing a very specific function, thinking of the mind as an interface allows for us to capture medicine's pragmatic aim of promoting health. With its philosophy of programming, mind interface confers the broad goal of healing, but also can be thought of as having case specific sub goals. In any clinical case, the goal should be to make an input into the patient's mind which draws out the psychic cause responsible for the symptoms.

What is interesting is that getting to these psychic causes requires a fair degree of ingenuity. The larger goal in mind interface of deriving a potential psychic cause for a constellation of symptoms is informed by Freud's finding that patients rarely, if ever, rendered the cause up to the analyst. As a matter of fact, this is likely what made Freud come to think of treatment as a sort of extraction process and posit theoretical reasons why patients were often so obdurate in their hesitancy to allow the cause to surface that they put up active resistance.

From the perspective of a design problem, this reality poses a restriction—a roadblock that that the mind interface, as a user-interface, seeks to surmount. There must be some means of entry into the problem. Something it can incorporate into the process of interaction which reveals

at least a silhouette of the true cause of symptomology, even if the patient finds it too damaging to accept or has repressed the content to such a degree that they are no longer aware of it. The desire of the interface to know, for it to find that the shadowy lineaments and contours from which it can surmise and interpret, ultimately, becomes its final purpose. The user-interface, as a process, then, faces a problem common to all humanists; it must find an appropriate body of material to perform its analysis and unearthing.

Analysis is made necessary due to resistance. Like a text, a person does not simply yield the latent meaning that reside within, but represses those meanings deep within themselves, or distorts them so they are not easily arrived at. The interface can gather no material from repressed content because the mind is devoting resources to keeping content from beyond the bounds of self-recognition. The Freudian assumption is that if the psychic cause were recognized, it would cause agony, so, ironically, the conscious effort of pushing thoughts from one's mind is used to keep thoughts unconscious. This is a Freudian logic that, while not strictly necessary, is helpful in understanding the procedure which Freud used to navigate from being in a restricted state of knowledge, to a goal state where knowledge of the psychic cause had been reached.

In cases where psychic content that could be potentially causing a disruption is not proffered up by the patient, then it becomes the goal of mind interface to extract the content. Analysts go about this task in a variety of ways, mostly through making request of the patients. That is, they make contextually relevant input in response to the output that they have received. Inputs usually take the form of requests for focused reflection, free association, mirroring, elaboration requests, and interpretations of the collective outputs received from the patient.

When trying to extract a psychic cause, a frequently encountered defense mechanism is distortion—the process of presenting content related to the cause in place of the cause itself. A child afraid of her abusive father might distort the content of their interaction so that in her memories, he was actually replaced by a monster. In this case, the goal of analyst would be inferring the actual cause from the presented cause. From the accounts of distortion contained within the lectures, a great deal can be surmised.

 Currently, I have outlined the goal of mind interface as the arrival of knowledge concerning the psychic cause, but sheer knowledge of the cause itself is oftentimes insufficient to treat the illness. Through a thorough analysis of Freud's treatment of distortion, I establish reprocessing as the mechanism of healing he presupposes in the lectures and then identify it as the same healing mechanism on which my own theory relies.

In conducting this analysis of distortion, I begin with one of the fundamental hypotheses that shaped Freud's own investigation of distorted content, and this is that distorted content surfaces more freely during sleep. Broadly, he begins with the observation that patients more readily access maladaptive psychic causes in hypnotized states.[9] He then generalizes from this claim that psychic causes must also be accessible in resting sleep.[10] The fact that the dreamer remains unconscious during resting states supposedly prevents them from being able to actively repress content. As a consequence, Freud claimed that in order for sleep to serve its function of shielding the sleeper from outside world, it must count on the mind to devise another strategy to prevent maladaptive psychic causes from surfacing and causing the sleeper to wake. He

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[9] Sigmund Freud, *An Introduction to Psychoanalysis*, 179.

[10] Sigmund Freud, *An Introduction to Psychoanalysis*, 55.

identified distortion as a solution to this problem and the dream as the natural product of this process.

To review, his claim is that when awake, patients can simply repress, or push distasteful thoughts out of their mind. Upon entering sleep, the sleeper loses the ability to divert attention to pushing thoughts from the mind. To remain asleep, the mind needs to encrypt the content in such a way that it is not shocking enough to wake the dreamer up. Under this paradigm, dreams exist so that a psychic cause could be transformed into a format that was more palatable. Instead of the dream disturbing sleep, as might be thought, Freud cast its character as being its un-thanked guardian. He is very much of the mind that, in this giant misapprehension of the dream, critics cast on it an aspersion:

> We fail to understand that it is a guardian of sleep, whose duty it is to quell disturbances. It is true, we think we would have slept better if we had not dreamt, but here we are wrong; as a matter of fact, we would not have slept at all without the help of the dream. That we have slept so soundly is due to the dream alone. It could not help disturbing us slightly, just as the night watchman often cannot avoid making a little noise while he drives away the rioters who would awaken us with their noise.[11]

By describing the process through personifying the central characters, the lectures work to convey that dreams are acts of censorship by the mind. Despite the fact that the dreamer is asleep, specific cognitive resources are devoted to making sure that the maladaptive psychic causes are not allowed to fully present themselves. Though the relationship of the dream to watchman is unclear, one way of understanding it is that dreams act as a process of encryption

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[11] Sigmund Freud, *An Introduction to Psychoanalysis*, 71.

that dampens the content so that the watchman can allow it to exit, without feeling it necessary to wake the sleeper.[12]

I have taken this picture as one that imagines that the psychic content in the mind as never at rest and always competing for recognition with other thoughts. It is in this environment that the sleeper, having lost the mind's primary means of defense, must devise new methods of keeping maladaptive psychic causes at bay with fewer executive resources at hand. This weapon is the process of distortion, which results in the dream. Below, I provide an interface reading of the process which uses the concept of encryption to understand how distortion might be actualized. The mechanics of this process, which I provide here, are attempts to fill in the gaps as to how content might be encrypted. Furthermore, and most importantly, while I use Freud's discussion of dreams as a model of the encryption process, I seek to apply the metaphor of encryption to understand the process of healing more generally.

In this respect, Freud's discussion of the dream is an essential process that informs my interpretation but is not central to mind interface overall. I am more interested in why distorted content can be used to reliably indicate the nature of psychic cause that was encrypted when analyzed appropriately, as well as how understanding this process of encryption actually allows it to effect healing. Mind interface extends Freud's metaphysics to provide potential answers to these questions. It begins with the doctrine of there being no uncaused event and takes it to mean that a psychic cause cannot dissipate or be completely erased. In his discussion of dreams, Freud makes it clear that such psychic causes must be continually released, implying that thoughts

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[12] This is the interpretive position that I take, and it the reading on which my description of the rest of the user interface is predicated. Such a small interpretive choice, however, should not be taken as necessary condition of its development; a plethora of other routes exist in which translation becomes the central feature of the interface, but it is with this one which I shall proceed.

cannot be eliminated, but also that they continually rise to the surface. Here, he supposes that a principle of conservation seems to follow from the no uncaused event principle.

The whole endeavor of psychoanalysis depends intimately on the idea that nothing ever leaves the mind once it has been produced. There is assumed to be no type of material in the mind that is capable of deleting any other. Patients are able to consciously push thoughts into the unconscious, but not to eliminate them altogether. Freud implies throughout the lectures that even forgotten material does not vanish but is simply inaccessible. Since the cessation of the maladaptive symptoms would constitute an event without a cause, because the mind has no material capable of deleting any other, psychic causes, thus, must remain in the mind awaiting reprocessing, or substantive alteration.

While it does not necessarily involve distortion, the way in which the mind interface seeks to heal relies on this reprocessing principle, the principle that a psychic cause must be altered so that it comes to mean something else than it originally signified. This reveals a mode of healing that mirrors principles found in distortion but is individuated from it by being something else entirely. I refer to this something as reprocessing and believe it be present in every case of healing by an analyst. It is the ultimate goal of the interface, the state which is always desired and that guides practitioners as they seek to bring it about.

To be sure that reprocessing is this foundational aim, however, it would be responsible of me to provide further proof of why a psychic cause must by altered. In the next section, I outline, very briefly, somewhat of a proof for the fact that the meaning of a psychic cause must be substantively altered by the mind, or else repressed. I am using distortion as an example to demonstrate this principle of the mind and have assumed that once a principle has been

uncovered, it applies, broadly and universally, to all aspects of the mind, and would, therefore, also hold for reprocessing.

The case I am modeling is meant to demonstrate that there is only one way in which distortion can proceed. In what follows, I try my best to disprove the only alternative means of distortion possible, what I call a randomized encryption logic. I use encryption to refer to what occurs during distortion when content gets transformed into more palatable content. Thinking of distortion as encryption aids my description of mind interface as a user interface because it is able to liken a complex process to one more accessible through the vocabulary of modern computing.

It is well known that one encrypts data in order to protect it and that, once it has been encrypted, the data can only be accessed with a certain key. By randomized, I mean encryption which follows no logical maneuver to encrypt content, or replace it, and that the encryption must use the original content. This would seem to prevent the mind from say, using a random series of ones and zeroes to encrypt dreams about a traumatic life event. Regardless of how abstract an encryption logic the mind chooses, it must use a logic that relates back to the content in some manner because to do otherwise would essentially function to delete the psychic cause. Due to the conservation principles that Freud assumes, where there is no material of the mind capable of deleting any other, there is not the possibility of random encryption.

When imagined in the context of the dream, the reasoning for why a randomized encryption process ultimately fails becomes even more clear. Even without supposing the erasure of the psychic cause, a randomized dream that exhibited no correspondence with the psychic cause it was substituted for would leave it unscathed and fail to prevent it from surfacing. A dream concerning a past fall from a moderate height, for instance, could not be replaced by series

of letters because this would go against, yet again, another Freudian assumption—the assumption that thoughts and memories are in perpetual motion. Here, Freud can be taken at his word, as his lectures constantly mention the surfacing and resurfacing of psychic content. Such a word choice implies perpetual motion, and this is only corroborated by the fact that he discusses psychic stimuli as in need of release.

Due to both the impossibility of deletion and the perpetual motion of thoughts and memories, reprocessing proves the only mechanism through which a maladaptive psychic cause can be dispelled. While in distortion, a thought is encrypted so that it is a dampened version of the psychic cause of disease, reprocessing also involves a more permanent alteration of the psychic content—a reframing, or coming to terms with. In this respect both can be seen as the interaction of content so that the original content is in some way modified. In the case of distortion, the true psychic cause is replaced with something that resembles it in some capacity, that allows it to be released and thought without unsettling the patient. The price of this substitution is that the psychic cause that gets distorted can have real effects on the patient's health, even after it has been transformed into something else.

Taking again the example of a patient who has suffered some form of parental abuse, the very fact that the perpetrator has been substituted for a monster within the dream only makes it slightly more bearable in the short term. Lurking beneath the surface is the same traumatic experience wreaking havoc and provoking symptomology. What seems to be altogether different about reprocessing is that it results in the termination of symptoms, but not because it has successfully distorted or deleted the cause, but because it has framed the maladaptive psychic cause in such a way that the patient can now cope with it more effectively in their life.

In using distortion to establish the fundamental aim of mind interface as reprocessing, I have offered an interpretation. While I have tried to draw out many of the tacit assumptions that Freud's claims seem to require, this does not mean that there are no other imaginings of the mechanics behind the dream encryption process. There arguably are ways for encryption to work without making some of the additional assumptions that I have made here. While I feel that Freud's work suggest that psychic content can never be deleted and that thoughts and memories are in perpetual motion, this does not mean that this claim is the reality of the matter, or even that Freud would have stated these convictions in the way I have articulated them in my mind interface reading of this lectures. Had I been strictly trying to convey his arguments, this would most likely not have resulted in the substantive reading I offer here, as there are gaps left open to the reader's imagination. In fact, the lectures form a discourse where the underlying assumption for Freud's claims are completely omitted and can be infered with different degrees of certainty. The interface reading that I have provided in these pages walks a very fine line. On the one hand, it must try to fully make sense of these gaps, requiring its author to imagine the conditions under which such claims could actually obtain.

Such a state of affairs forces me, as it would any reader, to fill in the holes; therefore, if the holes are presented as only being capable of being patched in one way, it is because I cannot imagine any other. I do not deny that lack of imagination on my part could have worked considerably to save them from mention, but I will also not pretend that this project was concerned with producing an authoritative reading of Freud to begin with, as much it was in producing a plausible reading which could inform the conceptualization of the medical humanities.

Here I think the framework I have provided is of considerable use. Chapter I was primarily aimed at introducing a metaphysical system that Freud seemed to assume, what I have referred to as his medical metaphysics and the bearing of that system on how the mind interface proceeds in moving towards its objectives. This took the form of exploring how certain key inferences were made about causation and then applying these inferences to creating an interface in which mind is defined phenomenologically and its contents enumerated. This second chapter then articulated my own theory of mind interface and used Freud's discussion of distortion to identify reprocessing as its mechanism of healing.

Chapter III. Conceptualizing MIT as A Normative Model of Medical Humanities

Research

The final chapter will work to apply mind interface to the medical humanities, demonstrating how its goal of reprocessing makes it a useful normative theory for the field. I have situated this discussion in the context of current scholarship on medical humanism. I begin with David Grieves' article, "The Nature and Role of The Medical Humanities," as it is also concerned with the role of medical humanism. In placing myself in conversation with Grieves, I am going to be arguing that defining the set of things that constitute work in this field is insufficient for orienting it.

My claim is essentially that while Grieves' human value-based vision of the medical humanities provides a good litmus test for if scholarship falls under the medical humanities as a category, such a test cannot answer questions about field objectives. While descriptive definitions of the medical humanities, like the one Grieves provides, are useful, they are not capable of orienting scholars. They are not even, in a way, suited to examine medicine in relation to the field.

Ultimately the insufficiency of descriptive theories of medical humanities has prompted me to put forward mind interface as alternative means of conceptualizing the field and its ambitions. Later in the chapter, I will argue that mind interface opens up the possibility for medical humanities scholars to engage in two forms of patient advocacy scholarship: product0-based and process-based. These forms of activity allow the medical humanities to not just treat medical related topics, but to seriously engage in the treatment and betterment of patient health. Because mind interface theory provides a linkage between cultural products and causation, it

opens the possibility to treat patients using signs and symbols, while also allowing for vibrant collaboration between medical humanists and physicians.

Before I begin to apply mind interface to the field of medical humanities, however, I think it is important to capture past efforts to encapsulate the discipline. Of these, Grieves' article is representative of the type of descriptive accounts of medical humanism that partially worked to delimit the field's scope. The primary argument of his article is that there is a need to move away from disciplinary conceptualizations of the medical humanities, where the humanities' role in medicine would be defined as the residual aspects of the field not subsumed by the sciences.[13] Grieves' concern is that medical humanities will be seen as only covering medical topics which medical scientists and practitioners do not have time to attend to—that medical humanities is simply supplemental and that the humanities portion of medicine will be seen as entirely separable from its other aspects. These, as Grieves so thoughtfully points out, are mistaken notions, and they are also notions which are interrelated.

The notion of medicine as primarily a science is the same which supposes that it is less of an art, and that its artistic components are, at best, supplementary. Those which deem medicine to be an art take the opposite position. As in most cases of two contending theories, an intermediary has emerged between the sides, with medical arts coming to be seen as counterbalance to medicine. This vision, however, is one which remains unsatisfactory. The same problem of disciplinary dominance still applies here, even when the arts are seen as a necessary counterweight to the austere practice of medical science.

Moreover, Grieves is right in raising the concern that the humanities may still be seen as a way to "humanize the medical enterprise, without providing any fundamental challenge to it."[14]

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[13] Martyn, Evans and Ilora G. Finlay. 2001. *Medical Humanities*. London: BMJ Books.13-23

[14] Martyn, Evans and Ilora G. Finlay. Medical Humanities. 15

I believe he is correct, then, in introducing a new method, but I think the method he introduces does not exert enough force towards identifying orienting objectives for the field, or in meeting his own vision of its potential. His own method, which aims at defining medical humanism by the extent to which a medical issue is related to concerns of human value, affords a way to make positive identifications of medical humanities issues and scholarship, but proves ultimately insufficient in many respects. Though Grieves' theory eschews splitting medicine into two aspects and assigning them various weights—science-related aspects of medicine and humanities aspects—it does not confer much insight into the role that medical humanism is best suited to serve.

It is this purposeful dimension that is lacking when medical humanism is equated with an issue in medicine that pertains to human values and interests. Medical humanist scholarship has, of course, seen a host of such works that meet Grieves' criterion; however, if nothing can be said of its capacity to orient, its potential to reveal something about best practices in the field is also limited. The issue is very much akin with David Hume's famous remark that one can never rightfully derive an ought from an is[15].

Grieves himself opines that he is desirous of "promoting medical humanities," which he deems to require "not just an addition to the curriculum but a permeation and change in the orientation of the culture of medicine, which will transform not only clinical practice but also the theoretical basis and social structures of medicine.[16] I would like to draw attention to the fact that this is a pretty big ought, which unfortunately cannot be derived from the litmus test he introduces for identifying work which is medical humanities oriented.

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[15]Hume, David. *A treatise of human nature.* Courier Corporation, 2003. 334

[16] Martyn, Evans and Ilora G. Finlay. Medical Humanities.22

What is needed to supplement Grieves' descriptive account is a normative theory which has the capacity to tie disparate, but important, threads in the medical humanities together. It is one that must have the capacity to meet Grieves' own objectives for the field and that places humanists and doctors in a relationship where collaborative research is possible. This is not just inviting humanist and medical practitioners to participate in the same conversational space but delimiting a territory for accomplishing unifying objectives and giving both parties a sense of their role in accomplishing these goals, as well as their counterparts'.

The move from *is* to *ought* is imperative. In seeking to establish an approach that confers a greater sense of orientation, I examined work which clearly illuminates areas of concern for medical humanism, but which also seemed to have no underlying theoretical basis. This absence has led me to put forward my theory of mind interface to fill what I feel to be a necessary gap. The relationship between theory and scholarly action is a complicated one; ideally, of course, not only should a theory suggest a mode of activity, but it should also be a well of reflection by which knowledge can be drawn and then applied to make that activity more effective.

From the state of the field, it is obvious that there have been many stellar activities and applications, so the question may arise as to why it needs a theory, or at least an orienting force. This question is very warranted, as sometimes theories introduce superfluous complexity that renders the original activity much harder to comprehend. Though unfruitful theories eat up valuable time and resources, a good theory should be a continual resource from which to improve an activity. In an important sense, then, I introduce mind interface as an orienting theory to guide medical humanism because of its potential to help humanist scholars work backwards. My goal is for it to improve our current set of activities: major threads in our productions and

conversation which have most distinguished what it is to perform medical humanities. Their integration then paves the way for two new activities within medical humanities scholarship.

For the sake of economy, I have only touched on three of these threads in the current chapter—medical humanism as a field of activity, as a product, and as a process—but I believe mind interface theory has much to say concerning others as well. In the rest of the work, I first explore a symmetry that exists between Grieves' conception of the medical humanities and François Matarasso's definition of art, arguing that the two are captured in my own description of reprocessing. I then discuss the ways in which the mind interfaces' concept of reprocessing has the capacity to orient medical humanism. This orientation is made possible largely by drawing again on Matarasso's work, more particularly his discussion of art as a polysemous construct that can be thought of at the level of production, and at the level of process. I use these two perspectives to inform my theory of medical humanism as reprocessing, showing that views of reprocessing from the perspective of product and process make possible two types of advocacy that leverage strengths in humanist methodologies and that invite further opportunities for interdisciplinary collaboration.

The first part of this approach is in noticing a relationship between descriptions of art and humanism. François Matarasso's article, "No Appealing Solution: Evaluating the Outcomes of Human Health Initiatives," charts the ways in which art is identical with human activity and exploration[17]. Along with being performative and processual, art is communal. Such a view can be extended from art to the broader category of humanities. Grieves' description of humanism as the investigation of questions of human significance is nearly identical to art as a process for understanding and coming to terms with human experience. A mind interface reading would

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[17] Martyn, Evans and Ilora G. Finlay. Medical Humanities. 36-49

suggest that not only are humanism and art functionally related, but that they capture the same fundamental construct of reprocessing. The exploration of experience and posing reflective questions concerning its human value are captured when human minds think, reevaluate, and produce.

The grouping of these two concepts under the more capacious term reprocessing not only makes them more tangible, but automatically links them to causality and medicine. Under this paradigm, medical humanism can simply be thought of as the employment of reprocessing in medicine, attaching both concepts to the pro-social goal state of promoting healing. Being oriented in this manner, humanism and art are then put into a substantive relation with health. The key to seeing the equivalence is realizing that when humans evaluate, or produce works of art, they are integrating that work with their prior thoughts and memories. All that is done with the incorporation of mind interface theory is grafting on of a goal to that reprocessing and situating it within a metaphysics that connects it to causation.

Through the channel of causation, mind interface is able to connect humanities to health, giving physicians and humanists a unified vocabulary from which to work jointly and promote health outcomes. More specifically, mind interface theory provides a theoretical basis for the crucial distinction between two different kinds of health—normative and subjective—while also relating these concepts to one another. The distinction comes long before my mind interface theory, with Matarasso originally making the distinction between subjective and normative health.

When first pondering the subject, health seems pretty straight forward. Most people visit the doctor and are automatically prescribed their health status. This prescription is one which is accepted in a cursory manner by the patient—most of the time for good reason—due to the

disparity of expertise inherent within their relationships with health care providers. The general effectiveness of this system means that it can be hard for the contemporary observer to see health as anything but a definite entity. As Matarasso rightfully points out, however, the idea of being ascribed such a health status by a doctor is dependent upon a normative comparison in which the patient is always compared in relation to some reference group.[18] In appraisals of normative health like the one just described, the criteria examined are almost always measurable, and, as a consequence, highly empirical.

Strangely, what this dominant idea of health masks is an even more common notion: one encountered each time someone wakes up to greet the arrival of a new day. This is health as experienced subjectively by the person. While it may seem harder to capture, it is of equal importance. Though normatively one could be in optimum health compared to others who fall under a similar demographic, there are still cases where a person would not experience the feeling of being healthy. These instances, almost by definition, fall outside of the reach of traditional empirical methods, but are not entirely outside of the sphere of medicine. Because medicine is an art as well as a science, it can function as a study of subjective experience. Its practitioners operate on an individualized basis with each patient that they treat, treating the person, instead of just solely the illness, as is a common practice in medicine. However, it is not one that lends itself well to total immersion.

A doctor's relationship with each of their patients is individualized and diverse. Their objective is not to discover how an individual's subjective health comes to be constituted, simply to cultivate practices and treatment regimens that cultivate enhanced wellbeing. Oftentimes, doctors even try to link empirical regimens to a patient's greater experience of health, but this is

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[18] Martyn, Evans and Ilora G. Finlay. Medical Humanities. 38-39

guided by no theory connecting subjective experience to the sphere which they know best: that of physical and bodily causation.

From this perspective, in spite of Greives' leeriness of bringing in disciplinary considerations, it might be beneficial to look at how humanist methodologies are better suited to perform this work. Whether it is commonly recognized or not, the methodologies familiar to stakeholders should bear greatly on their ability to make certain types of contributions to the medical field, irrespective of how the term medical humanities is being defined. With this being said, the real project of orienting humanist scholars seems to actually bear little on the question of the potential set of work that could be done that would constitute valid contributions to the medical humanities field, but what work medical humanities is best outfitted to perform. Like scientists, humanist methodologies have their own distinct evolutionary history.

The humanities, as a body of knowledge, has been directed towards deriving certain insights about human subjectivity, as the humanities study how members of society process and understand their experience and how that processed experience gets enacted into particular forms of self-expression. Rhetoric aims at persuading through affecting the subjectivities of others, literature to interpret by positioning oneself within the constituted bounds of another's subjective self. Like medicine, the practice of humanism is also largely reflexive. This is to say, that as a body of knowledge, medicine is constituted by a study of the principles underlying its products. Medicine studies the outcomes of a treatment regimen and humanistic disciplines the effects, subjectivities, and inner workings of artistic products: of letters, of novels, of code, of craftmanship, of painting, of speeches, etc.

This means that, while the scientific method has specifically evolved to study observable phenomena, humanistic methods and practices have specifically evolved for the study of

constituted subjectivity. The course of development of our methodology means that humanists are particularly well positioned to study the second half of the health duality, that of subjective health, though not by any means confined to it. Mind interface's goal of reprocessing leverages the separate courses of development of the respective disciplines and seeks to unite them. While it does not limit medical humanism to investigations of subjectivity, it does suggest that efforts in the field may be best directed towards this purpose.

Any surgeon, for instance, could perform a study of subjectivity, but the question that remains is if he or she has been trained in methods that might be helpful for doing so. Both the generality of the human intellect and the occasional joys found in dilettantism, should push medical humanists away from drawing disciplinary boundaries too tightly, of failing to allow the physician an opportunity to analyze literature, and the literary scholar to take an active interest in the empirical findings of science. Such divergent evolutionary histories, however, are useful for indicating where humanist might prove most helpful in impacting medical humanities.

Grieves' insistence that medical humanism not be concerned with disciplinary divisions is well intentioned, however, it operates on the assumption that considering disciplinary distinction will eventually relegate the art of medicine to the periphery. I think skill acquisition and divergence of methods are both relevant considerations and will not result in humanities becoming second order to medical science. I am confident of a unification in which the art and the science of medicine are deemed to be of equal importance, and yet disciplinary advantages are considered in determining what role medical humanism is best fit to serve. The interface interpretation that I have derived from Freud's lectures is aimed at clearly defining this study of subjective health and linking it to the onset of symptoms.

It is capable of functioning in this manner because of its capacity to link constituted subjectivity to causation. It presupposes a medical metaphysics that allows the subjective to enter into the same discourse with the empirical, and this is immediately useful for a number of reasons. The first is that the study of subjectivity is not seen as in opposition to the laws of causation but seen as part of its spectrum.

My theory's primary means of orienting the medical humanities is in its framing of subjective evaluations of health and the role of these evaluations in shaping observable symptoms. Mind interface posits that this process occurs through reprocessing. In keeping with the picture of the mind that I outlined in chapters I. and II., an interface reading sees health status as a complex of many psychic causes always competing for recognition that can never be erased or replaced. Instead, symptoms disappear when the psychic causes are modified. From these basic principles, studying subjective health can be thought of as simply an attempt to arrive at the set of all psychic causes that contribute to a person's subjective experience of health. Mind interface would then suggest that to improve subjective health, psychic causes would have to be materially altered.

While health status is being envisioned as subjective, as compared to one's normatively assessed health, the interface is more fluid in its conception of this line than might be imagined. Subjective health, as the current set of psychic causes which shape one's subjective experience of health, impacts normative health to the extent to which these psychic causes affect changes in symptoms. Consider the case of a patient with a certain disease.

A patient can be imagined whose experience of health may not have causally affected his normative health in any substantive manner before. After some time, however, it would be entirely possible that, at some future point, symptoms result from a new conception of his

perceived health, or from the unfruitful processing of other experience. This contingency of

perceived health impacting normative health outcomes is actually borne out rather well in

medical research. As early as nineteen ninety-nine, the Journal of Gerontology noted that:

> A GROWING body of research shows that self-perceptions of health are linked to mortality, even when more "objective" health measures are controlled (see Idler & Benyamini, 1997, for a review). The unique contribution of health perceptions to mortality is substantial for both older adults and general population samples, with people rating their health as "poor" being between 1.5 and 3 times more likely to die than individuals who perceive their health as "excellent." The relation between health perceptions and mortality is a robust one and persists when statistically controlling not only for objective health measures, but also for numerous other variables, such as health related behavior like alcohol use, exercise, or smoking.[19]

Subjective health status, then, as well as other types of psychic causes, may play a much

larger role in normative health than might at first be imagined. Even in cases where symptoms

are not precipitated by psychic causes, one's experience of health and identity prove still

invaluable to making the most out of the longevity that their health is able to afford. For this

reason, it is wise that humanists reflect on the prospect of providing a much-needed service to

patients. Because mind interface links the observable with the subjective and cultural, it

characterizes the terrain of the mind as one intimately familiar to those with training in

humanistic pursuits. The compositionality principles I outlined in Chapter I, essentially create a

world where the minds' materials are nothing but percepts, signs, and symbols. Thanks to the

social nature of sign and symbol usage, and the common ways in which individuals learn to

make meaning within their respective cultures, the outputs of the mind can most likely be

interpreted fairly accurately by all.

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[19] Verena H. Menec, Judith G. Chipperfield, and Raymond P. Perry. "Self-perceptions of health: A prospective analysis of mortality, control, and health." *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences* 54, no. 2 (1999): P85-P93.

The fact that psychic causes are made from the cloth of culture and semiotic activity has deeper ramification regarding the modes of analysis best suited for their study. As has already been remarked, while scientific and empirical methodologies have evolved to deal with issues of observation, causality, and induction, humanistic methodologies, centering around qualitative analysis and close reading, have evolved around the study of culture and semiotic activity.

Given that medical humanities already focus a great deal on patient subjectivities, there is not much of conceptual leap to be made. Scholars are already applying humanistic methods to the study of the subjective health of many unique patient demographics. Recent articles by both Kelly Pender and Bernice Hausman have focused on the experience of different medical populations.

In the case of Pender's article, "Genetic Subjectivity in Situ," the focus is almost entirely analytic—with the objective being to understand the way that "discourses of genetic determinism and genetic opportunity operate in biosocial communities.[20]" Hausman's article, "Immunity, Modernity, and The Biopolitics of Vaccination Resistance." also predominately deals in a methodology aimed at understanding the rhetorical constitution of different expressions of subjectivity—particularly the expression of those not in favor of vaccination.[21] In an important way, these two studies are indicative of an already structured study of subjectivity.

What my theory adds to such invaluable investigations is not an alteration of methods, but an additional way to apply these same techniques towards a medical focus. Mind interface, with its system of metaphysics linking causal and subjective phenomena, provides a way to apply these analytic techniques that study patient subjectivity to the process of healing. Through

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[20]Kelly, Pender. "Genetic subjectivity in situ: A rhetorical reading of genetic determinism and genetic opportunity in the biosocial community of FORCE." *Rhetoric & Public Affairs* 15, no. 2 (2012): 339.

[21] Bernice L. Hausman. "Immunity, Modernity, and the Biopolitics of Vaccination Resistance." *Configurations* 25, no. 3 (2017): 279-300.

studying expressions of subjectivity found in patient narratives and fostering creative events which give rise to such artifacts, medical humanities scholars could actually play a very important role in promoting the subjective and normative health of many patients.

These two objectives are foisted open theoretically by reprocessing and its incorporation of Matarasso's distinction between product and process.[22] While he originally applies this line of reasoning to the ways in which art can be conceived, I have extended it here to the general aim of the interface—that of reprocessing. Under a mind interface interpretation, humanists now have a theory for two ulterior types of advocacy—a product centered view that seeks to unearth ways in which patients can reconstitute their subjectivity and health, as well as the process centered path noted in Matarasso's discussion of the implementation of medical arts projects.

Broadly, these means of advocacy can be thought about in terms of a processing of experience as a product and as an activity. The first is simply an extension of the work already being performed by scholars in the medical humanities. It is one where an analysis of patient subjectivity is pieced together from products: conversations, writings, or any other form of media. As in Pender's article concerning a particular biosocial community, the collected expressions of subjectivity become data. In the case of this particular employment of the mind interface theory, however, the data is not used to make claims about the rhetorical forces of discourse but used to unearth narratives that can be used to improve the subjective health of the targeted patient demographic.

To the extent to which it is informed by mind interface theory, such advocacy can serve as a refined basis for the practice of narrative medicine. Its advantages are numerous, conferring on the medical humanities a much more powerful theoretical foundation from which to operate.

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[22] Martyn, Evans and Ilora G. Finlay. Medical Humanities. 37-38

The greatest of these advantages is the fact that the practice of narrative medicine will have a missional focus on improving a patient's condition, not just being content with improving a clinician's interviewing skills, sensitivity, or "the propensity of society to be moved by stories of illness.[23]"

Because this product centered mode of scholarship is best demonstrated through example, I will use the mind interface reading derived from the lectures as a basis from which to theorize about how to go about this work. I hope to show that this corpus of theory can actually make a potentially daunting task seem more doable than was conceivable before its application. One of the most important ways in which mind interface informs theorizing for this mode of advocacy is its focus on how the subjective notions of self, figure so much into our experience of health.

In Chapter I., I noted a number of these cases in which the patient's perception of themselves was particularly relevant in their experience of illness. The most notable of these was, of course Anna O., where psychic causes related to her self-concept actually worked to ensure her paralysis until they were reprocessed in a more efficient manner. This points precisely to the fact that determinations of health are not just something experienced, but deeply tied to our sense of identity and the meaningful social relationships which play a part in that identity. Narrative medicine is more than a growing cognizance of these issues; it is a confidence that they can be used to promote better subjective and normative wellbeing. Humanists should use extant data collected from patients; however, instead of purely looking for rhetorical strategy, they should also look for the possibilities that emerge in dealing with subjectivities of health and identity.

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[23] "About Narrative Medicine." Narrative Medicine. January 18, 2019. Accessed February 20, 2019. https://www.narrativemedicine.org/about-narrative-medicine/.

They should search for the possibilities of living within a specific illness, or patient demographic, and research how that can be effectively navigated. Some research question made possible by the study of patient products are: what are the range of ways in which terminally ill cancer patients experience their health? What habits of life could they tie their stories to that would enrich their experience of health and of themselves? How can members of such medical cohorts create vibrant community and dialogic exchange with others that would mitigate the risks of diseases of the mind, such as depression, that are often correlatives of severe illness?

This is the narrative cultivation that needs to be engaged in and perhaps the most useful object to which humanist methodologies and theories of analysis can be applied. It comes bearing a social commitment which is always incomplete and under development, and it is this commitment that should move humanists not to perceive this task as social engineering, but merely an extra step of analysis. It is a chronicling and compiling, a deeper analysis of the strategies at play in coping with illness, instead of a top-down affair. Patient populations are always in the driver seat and the goal of the medical humanities under the mind interface is to simply aid in the reprocessing of the subjectivity of illness. Humanists draw connections between rhetorical strategies for navigating specific types of illness; they do not engineer confabulated narratives that they then push patients to adopt.

A prime candidate for this sort of activity can be found in a demographic not typically associated with discourses of medicine, and that is the population of adults with a clinically diagnosed learning disability. Though learning disabilities, or LD's, as they are commonly called, are extremely variegated in their types and manifestation, as an aggregate, they raise the probability of suicide a great deal. A Canadian study found that adults with LDs were actually

forty six percent more likely to attempt taking their own life, "even when [taking] into account a broad range of other risk factors.[24]"

Medical humanities should be interested in the why. While it would be difficult, scholars could look at specific expressions of disabled subjectivity and even discourses where individuals with disabilities remark upon their perceptions of health and vitality. At the same time in which physicians and psychologist are seeking to map out profiles of disability, the medical humanities could map how narrative expressions of disability differ in regard to the type of LD and the other demographic categories into which a disabled author may fall.

Like in the world of medical science, variance itself would constitute an irremovable feature of the project. Humanist are well aware that expressions of self and health are likely to vary significantly from individual to individual, even within certain patient populations, and that there is not likely to be a "one size fits all" means of dealing with specific types of illness. Despite this fact, I think scholars who embark on this line of work should still be sensitive to trends. Individuals with learning disabilities, for example, might frame their relationship to their disability in a means more conducive to their health than others within the same group. Studying the ways in which they rhetorically construct themselves in relation to their disability would more than likely be most helpful to other patients with a disability.

Since this work has primarily been theoretically oriented, I will choose not to attempt to hash out the practicalities of such an extension of narrative medicine now but return to how the mind interface orients and warrants extensions of this type. It should be remembered that the warrant of which I write is not only that our methodologies are outfitted to analyze expressions of patient subjectivity, they are also supported by the theory of mind interface more generally. Its

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[24]Esme, Fuller-Thomson, Samara Z. Carroll, and Wook Yang. "Suicide Attempts Among Individuals With Specific Learning Disorders: An Underrecognized Issue." *Journal of Learning Disabilities* 51, no. 3 (May 2018): 283–92. doi:10.1177/0022219417714776.

emphasis on how the subjectivity of the person can influence health is paramount and orienting. Discovering how specific patients rhetorically and narratively navigate health and identity has ramifications beyond increasing subjective experiences of happiness and vitality, however.

Freud's lectures actually point to instances where the simple reprocessing of information in a different manner, or context, actually stopped psychic causes which provoked the onset of symptoms. The interpretation of mind interface seeks to consolidate this by suggesting that the only way to stop a maladaptive psychic cause is to reprocess it: effectively to change its meaning. This interpretation tends to support the idea of analyzing effective strategies for approaching the subjectivities of specific illnesses and then disseminating these methods of interpretation among that specific patient population.

Such an implication invites doctors to join with humanists in researching patient narratives while also inviting them to work in the sphere in which they know best, normative health. The space for scholarly collaboration is, in fact, considerably broadened because the metaphysical system that the mind interface supposes joins subjectivity to causation and to normative means of appraising health. Once a particular strategy for navigating a target illness has been identified, physicians could collect data on patients that utilize similar strategies and correlate those narrative and rhetorical strategies with normative health outcomes.

While it is true that any data collection and communication necessary for this endeavor would be quite hairy, problematic, and imperfect, it would also prove immensely beneficial. Whatever inconveniences may follow would be a small price for greater unification among practitioners of medicine and scholars in the medical humanities—and an even smaller price for the better subjective and observable health outcomes that could result from such a collaborative venture. The truth of the matter is that imagining effective collaboration can only stem from a

way of linking subjectivity to cause and observation, consequently tying humanism to health and medicine's objective of healing. Thus, while descriptive definitions of medical humanism, like the one offered by Grieves, do give scholars an idea of potential projects, they seem to neglect the projects that the discipline would be most suited for and also fail to leverage distinctive disciplinary advantages.

The mind interface, as a normative theory aimed at healing, is not, then, in opposition to descriptive accounts of the discipline, but a reminder that medical humanities scholarship can be humanistic in the highest sense of the word by aiding in patient service. Promoting flourishing and reprocessing of experience has been inscribed on the practice of humanism for millennia, and it is one that should continue to inform humanist practices. Besides providing an interface for healing, where healing can occur without knowing the physicality of the cure, mind interface is also capable of grounding the second means of advocacy—process centered advocacy— discussed in Matarasso's exposition of medical arts programing.

Returning to his description of the arts as an activity, or process, it will be fruitful to think of how medical humanism could also feed into work aligned with the healing objectives of mind interface. The most obvious potential position comes from examining the direction in which we want the reprocessing of subjective health and patient subjectivity to flow. As I hope to have made clear, a medical humanism that is informed by the mind interface averts social engineering and also tries its best to avert the potential of psychoanalysis to gaslight patients, or simply confabulate damaging rationales for their behavior.

For this reason, those studying medical humanities should make every effort to encourage communal gatherings in which patient cohorts have the opportunity for creative expressions of their subjective health and identity. In encouraging these gatherings, the foci should be open

discussion and production of work that speaks to the authenticity of the everyday experience of patients. This form of advocacy does not work from premade products but encourages the process in which those artifacts will be forged.

To prevent the biasing of the artistic products generated through this process, protocol could be adopted to ensure that humanists were not imposing their perceptions of patient illness on the specific patient population gathered in pursuit of artistic expression. Outside of the gathering's productive purposes, humanists should also explore how members of these meetings could construct community and solidarity with one another. Numerous medical studies speak to the value of community on normative health outcomes, and these gatherings could serve precisely the prosocial purposes that have been observed to be negatively correlated with mortality rates and positively correlated with enhanced subjective wellbeing. Creating solidarity is no new task for humanism, as it has worked to create human cooperation and friendship since its inception.

The correct imagining or process-based advocacy, I believe, is one in which the scholar becomes an organizer and facilitator, but not a member of the artistic community. He, or she, analyzes the expressions of subjectivity and health that are produced in these gatherings, analyzes narrative and rhetorical strategies that seem to prove effective in coping with, and treating the illness. Their work unearths and explains these strategies, disseminating them to members of the patient community, and then to the broader community. The latter serves one of the most prominent purposes of narrative medicine; to facilitate the experience of "being moved by stories of illness" and working to expand the circle of understanding.

This vision, both in its expansion of narrative medicine and facilitation of artistic activity, is a product of a mind interface reading of the lectures. It is unfortunately very broad in its

prescriptions, but this does not speak to the theoretical unviability of the interface for hashing out specifics. Instead, it is rather the intentions of this author that possibilities afforded by mind interface be explored, both in their theoretical viability and practicality, before the scholarly community. I hope in writing this work that I have provided both a nascent reading of Freud's lectures, and outlined a vision in how mind interface offers a pro-social vision of medical humanities that could easily be realized by allowing it to inform scholarship.

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