Introduction

"We cannot solve our problems with the same thinking we used when we created them"

~ *Connolly and Rionoshek, 2002, p. 175*

"Alexandra's death, in the end, was much like her life - solitary, troubling and overlooked" (Allemang, 2009, F1). This is how journalist John Allemang leads his story of a woman he describes as forced to live independently in "an indifferent community" and, who, he is quick to add, was dead for a day or two before her body was discovered. As a features writer and columnist, Allemang knows how to zero in on details that will instantly catch a reader's attention, and evoking a painful image of person dying alone and undiscovered for days fits the bill. We feel there's something intrinsically wrong with consigning anyone to a solitary death.

This sense of what persons are owed likely underpins a basic inability to grasp the mindset of workers in US hospitals who reportedly ignored psychiatric patients dying right in front of them. In the first of two incidents taking place in 2008 Steven Sabock, a 50 year old man diagnosed with bi-polar disorder choked to death on medication while nearby workers played cards and watched television. Several months later, at a different psychiatric ward Esmin Green lay on the floor dying, and the only attention she received during her 24 hour wait for a bed "consisted of someone's prodding of her dead body with a foot" reported the *Mental Health Weekly Digest* (2008).

Such incidents tend to provoke calls for more regulations and greater control over healthcare practices and practitioners. In the story above it is noted that "these would

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include raising standards and regulatory expectations, and identifying and funding pilot programs to demonstrate best practices in psychiatric emergency, inpatient and community-based care." Meanwhile, Alexandria's lonely death caused her sister to conclude that "what we need is a 24-hour care system that's regulated and controlled, where she's got security, where she can get her medications administered in the right way, where her day has some shape to it and she doesn't have to take on too much responsibility."

A popular assumption is that both Alexandria and neglectful caregivers need better systems of management. No one quoted in Allemang's article – not case managers, family members, lawyers, or her Assertive Community Treatment(ACT) outreach workers – suggested that a helpful factor would be a greater number of people in Alexandria's life who, like her family, genuinely cared about her enough to support her and look out for her. This is true in spite of Allemang's recognition that "if it weren't for the attention, protection and advocacy provided by her family, whose patience she tested almost daily and whose love she could never quite exhaust, perhaps she wouldn't have lasted this long."[1] To show the importance of such obligation, he notes that after helping to clean smeared feces from the walls of Alexandra's room in a residence for the mentally ill, her sister asked "who's going to scrub the windows and the floors if the family doesn't do it … You can't stand the thought of your sister or your daughter sitting in that filthy room. You're doing it because you have to do it."

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[1] By all accounts, Alexandra was violent and difficult to deal with. She had threatened her own family members with a knife and was charged for assault after closing a car door on a stranger's head and made death threats to housemates.

Even living in the kind of facility described by her sister, Alexandria would require people who cared enough about her to poke their heads into her room to see how she was doing and who similarly could not stand the idea of leaving her to languish in squalor. That no one mentioned this very obvious gap in Alexandria's life is probably due to an implicit understanding that this is not something that social institutions are meant to provide. One cannot teach a person to care about another in the same way that one might impart a practical skill such as checking an IV or changing a bandage. We cannot make workers care on demand.

In spite of this implicit understanding, people are still aghast when hearing about a more recent case where inspectors entered a US psychiatric ward for the elderly and found some patients covered in feces. Others were cowering and fearful and several patients reported that the staff were unkind. "At any given time," during the visit, the inspectors wrote, "there were two patients crying"" (Conaboy, 2013). The president of the facility states that "a change in culture among unit staff is paramount," hence managers decided to have workers go though "patient rights training, which included watching a four-minute video on empathy." Such a minimal and inadequate response from the upper echelons suggests that a far more radical cultural shift needs to occur; one that includes both the administrative culture as well as that of workers dealing directly with patients.

The suggestion that more intense management will somehow solve the problem of callous indifference from workers is a little mysterious. Closer monitoring and control over workers' activities may result in a cleaner environment and timelier services, but it

will not cause staff to become more kind. In fact, I argue that exerting more control over the work process is not only ineffective here, but actually contributes to the problem by encroaching on the time and space necessary for bonds between healthcare workers and patients[2] to take root. This is not to suggest that if workers are left to their own devices they are guaranteed to develop care for patients; rather, such moves need to take place within a workplace culture that explicitly prizes caring relationships and idealizes them within the professional sphere.

It is important to realize that the ability to develop a caring relationship hangs crucially on the ability to see and appreciate another person's uniqueness. For example, as a reporter intent on evoking our sympathies, Allemang knows precisely how to humanize his subject. Before he is more than a few lines into the story of her death, he tells his reader that "Alexandra Smith loved animals and showy jewelry, found companionship in coffee and cigarettes, adored Madonna's music and cherished the isolation of her tiny, private room." This information is key and appears at the top of the story because these small biographical details tell us that this is a unique individual worthy of our care. With a similar point in mind, Elyn Saks, a law professor diagnosed with schizophrenia, asks people to "portray [people with mental illness] sympathetically, and portray them with the richness and depth of their experience as people, and not as diagnoses" (2012). As will be shown in later chapters, learning to see others in this way can reconfigure a person's sense of what matters.

Such personalistic forms of knowledge do not carry great value for those working

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[2] It should be noted that through this work I use "client" and "patient" interchangeably.

at an administrative level, even in settings designed to provide professional caregiving.

Bureaucrats who manage by numbers are poorly positioned to see clients as individuals.

As a result they develop structures that severely constrain workers' ability to meet their

clients' needs, a condition that ends by harming the worker as well. Given the frustration

that so many workers experience in being barred from meeting patients' all-too-evident

personal needs, it should come no surprise that at least some workers resort to

dehumanizing patients and become inured to their suffering.

Trivializing the significance of relatedness and discourses on power

When examining the emotional dimensions of social relations, one obstacle a

researcher is apt to encounter is a subtle bias within academia and the professional sphere

against representing interpersonal relations and feelings as legitimate objects of discourse.

One of my informants featured in Chapter Four reveals the inferior status of such

information in the context of public discussion. Beth, a nurse with an assertive

community treatment team (ACT) was commenting on the influence of her parents on her

work. "I guess I learned—this sounds so unprofessional—but to just kind of have a heart

for people," she said. On further questioning Beth explained that it was the expression

"having a heart" that did not sound professional even if caring about one's clients was

important. "I don't think any of us would say that in a team meeting,[3] 'having a heart.'

That wouldn't stick to anything." An interesting contradiction is at play here where the

affective dimensions of the work are recognized as valuable and important, yet carry little

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[3] As I explain in greater detail in Chapter 4, ACT teams hold daily team meetings to get updated on the problems and progress of a roster of psychiatric patients the team for whom the team provides care.

weight in decision-making, nor should these be made explicit in the course of a formal discussion.

The notion that a prohibition might exist against explicitly endorsing such values within professional contexts is borne out by Joyce Fletcher's work which shows that relational work is often "disappeared" in the workplace (Fletcher, 1998). That is, in evaluating workplace performance, employers and employees alike systematically overlook the value of activities such as teambuilding, mentoring, and offering other forms of support to coworkers. Such activities, finds Fletcher, are neither cultivated nor recognized even though cooperative behaviour and friendly interactions are known to provide the glue that holds organizations together. As Mastracci et al, note, moreover, "emotional labour" or the ability to sense emotions in others and to respond appropriately is an essential skill, yet undervalued in service sector employees (2010, p. 124).

Academia, it would appear, is not a particularly more hospitable environment for discourses on relatedness. Michael Hardt, who has been incorporating the concept of love into his political work notes "in many contexts, especially the normal university context, it's very uncomfortable to talk about love. When I start talking about love, people start squirming in their seats, they think I've been around Italians too long" (Hardt, 2007). While talk of emotions is not well tolerated within certain intellectual spheres, Hardt's example suggests that this attitude may well extend to the topics deemed worthy of scientific investigation. As psychologist Harry Harlow notes

> [t]he little we know about love does not transcend simple observation, and the little we write about it has been written better by poets and novelists. But of greater concern is the fact that psychologists tend to give progressively less attention to a motive which pervades our entire lives. Psychologists, at

least psychologists who write textbooks, not only show no interest in the origin and development of love or affection, but they seem to be unaware of its very existence (1958, p. 673).[4]

As the offspring of healthcare workers, where my father was a psychiatrist and my mother a nurse, I have become sensitive to the relational and affective underpinnings of healthcare work. In light of this background, and the consequent knowledge I have gleaned regarding the difficulties of their jobs, I harbour both care and respect for healthcare workers generally speaking, and find myself concerned about their working conditions. This is especially true of mental health workers who are willing to take on what I see as a crucially important role in patients' lives, but one that I myself could only assume with great difficulty. Undoubtedly, this attitude has coloured my analysis here and possibly opens me up to certain critiques. For example, in spite of borrowing from Foucault at certain points, I mainly focus on the emotional caring side of client/patient relations in lieu of a more critical analysis of the power deployed by healthcare workers.

Arguably, ACT teams in particular can somewhat easily be conceptualized as agents of Foucauldian governmentality (Foucault, 1991). Being workers who bring their practice into the community, ACT workers admittedly draw out the long arm of

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[4] Harlow's observations may appear dated, but a more contemporary example of an apparent aversion to sentiment in academic psychology is evidenced in Sebastian Kraemer and Jane Roberts' introduction to a book on attachment theory. In making a case for the importance of personal attachments, the authors note that "there is a serious risk that some readers will recoil from the argument, as if it were merely an invitation to 'love thy neighbor.'" The writers also take pains to distinguish their work from "an appeal to sentiment" stressing that it is "quite the reverse." Attachment theory makes a "serious contribution" they contend and is "hard headed stuff" adding that "if the notion of attachment means anything at all to the general reader it tends to conjure up a rather syrupy picture of loving contentment, such as a mother and baby enjoying each other's company." (1996, p. 6). It would appear that writers are anxious to position their work within the "hard" sciences as opposed to being perceived as champions of soft and syrupy sentiment, talk of which, or so they seem to assume, holds no rightful place in serious discourse.

surveillance into citizen's private homes. Workers also monitor for deviant behaviour, stress self-regulation to clients, and endlessly strive to win patients' compliance with treatment. Moreover, this is all done in the name of imposing a conception of normalcy upon patients' behaviour. None of the data I present here is inconsistent with such a view. However, as I note in Chapter One, such approaches represent well-trodden terrain. I would also argue that analyses of power relations, or examinations of the tactics and strategies used to modify people's behaviour, provides an incomplete picture of the social. For instance, ACT teams, as I shall show in later chapters, not only seek to manage and control clients, but they also aim to know and connect with patients as unique persons, and often seem to establish caring relationships along the way.

Generally speaking, the need to connect and experience care and nurturance are important motivators of human behaviour that stand to become obscured if we are only looking at a field in terms of power relations. This latter sort of theoretical framework, in fact, can cause valuable knowledge pertaining to affective care to recede from view.[5] The

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[5] Feminist philosophers have helped to drive home the point that we're missing something crucial about human existence when we ignore the less strategic and more emotional side of social relations. A short story some use to show this is Susan Glaspell's "A Jury of Her Peers," that was latter adapted into the play "Trifles" (Hedges, 2002). In this story a farmer John Wright has been murdered and some men gather to investigate. Meanwhile, alongside them, their wives sift through very personal clues. Barren furnishings reveal a stingy humourless husband, a half cleaned kitchen tells them of the wife's depression, otherwise immaculate stitching gone awry speaks to them of Minnie's agitation. Then, the dead body of a songbird with a broken neck cinches the deal. They *know* Minnie killed her husband. The song bird, as it turns out, was one of the few things that brought her any joy. Having known the woman for years, they knew how John Wright had stifled her and robbed her of love and care. Concurrent to the women's investigation, the men fruitlessly search for objective evidence of the murder, for instance the murder weapon, while dismissing or completely misinterpreting the same details the women find salient.

       Women are always concerned with "mere trifles" one of the men says in the story, which helps to encapsulate the dismissal of the special brand of knowledge the women deployed in search of answers. Another example of this dismissive attitude is Donna Haraway's story about highborn women openly expressing their dismay while Robert Boyle slowly suffocated a live bird at a public demonstration of his vacuum. Boyle's response to this was to hold demonstrations well past the hour when any wellborn lady

value of discourses on power is that these tend to invite critiques of oppressive or coercive social relations. Less, however, gets said about what should exist in place of this. Contributing to an alternative kind of discourse, one that reflects upon ideal social relations, strikes me as equally worthwhile, and hence I aim to do this here. None of this is contrary to critiques of power. Rather, I see it as complimenting such critical perspectives, or ones that so often point the way towards that which divides and conquers. My work, conversely, aims to shed light on factors that stand to strengthen, as opposed to those which dissolve, relationships and communities.

Methodology

It should be evident then that one of my main motivations in carrying out this work was to challenge the kinds of biases that drive talk of relatedness from the field of public, and especially academic, discourse. My primary question was whether rationalized modes of organization tended to squeeze the affective dimensions out of professionalized caregiving, especially within psychiatry, and, if so, what the moral implications might be. Is rationalized healthcare harmful to patients in some specifiable way? And what about the workers themselves? When healthcare is scripted by efficiency algorithms and "best practice" protocols, what remains of the satisfactions of caring for others that likely drew many to their careers in this field? The case of persons diagnosed with severe mental illness is of special interest, given the lack of elementary human

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would be seen in public (1997, p. 27). Rather than entertaining the notion that the women might have seen relations that were genuinely amiss, they were merely excluded from discourse.

community that so many of them experience. Does highly rationalized care respond to this problem or serve only to deepen it further? Questions of this kind call for an interdisciplinary approach that draws on both critical social theory and moral philosophy, applying them in ways that can illuminate the results of observation from the ground floor of practice.

My effort to understand the human effects of rationalization was most informed by the work of Max Weber. Like Weber, I have tried to examine the internal structure of rationalized systems and their general ideological consequences, while prefacing out, to some degree, questions about the particular political interests being served. I also draw to some extent on the work of other well-known critical theorists including Marx, Lukács, Marcuse and Foucault, as all have insights into the effect of highly rationalized modes of organization on social relations.

My own focus, however, is both broader and narrower than that of most of these thinkers. It is broader in the sense that I am not concerned specifically with a capitalist context, but rather contexts that essentially rely upon standardized procedures to administer or medically treat large populations. However, my problem is also more narrowly defined in that I am asking about the negative impact on human relationships that such systems might have. Hence, while critical theory represented a starting point for my enquiries, I present my own formulation of the ideological parallels linking the three dominant forms of rational technologies, which are mass production, bureaucracy and science, as well as the consequences for human relationships in settings governed by these technologies. In order to demonstrate the converging impact of these technologies

on patients and workers in healthcare, I then turn to ethnographic research conducted in both general healthcare settings and institutions specializing in psychiatric care.

In trying to theorize the moral contradictions at play in these settings, I soon realized that the problem had its counterpart in a divide between two very different kinds of moral theory. One of these is the rationalistic, universalist, rule-bound approach to morality that has dominated ethical debate in its various (and often conflicting) forms since the time of Kant and Bentham. This is the type of moral discourse that typically serves to guide and at times justify healthcare policies. The other approach is one that has developed much more recently in the field of care-based ethics, as exemplified in the work of Gilligan, Noddings and Dillon. While rationalistic ethics helps us to understand the moral reasoning behind the standardized procedures that inform most healthcare settings, care-based ethics shows us what those procedures invariably miss: the critical and irreducible importance of the personal encounter between caregivers and patients.

In following these questions from the realm of theory into the arena of everyday life in actual healthcare settings, I wanted first of all to learn about the impact of rationalistic administrative systems on the quality of care as reflected in the experience of patients and caregivers. What harms, if any, seemed to arise from rules that suppressed personal connections between caregivers and patients? I also wanted to know whether workers themselves valued relatedness, and whether institutional settings gave rise to moral contradictions stemming from conflicts between a personalistic ethos and rationalistic demands. It was also important to try to understand what it was about their work that caregivers themselves viewed as morally worthwhile.

To throw light on these issues I began by reviewing a number of ethnographic studies of conventional healthcare in both general medical (Campbell and Rankin, 2006) and psychiatric settings (Rhodes, 1995, Letendre, 1997, Cleary 2004, and Donald, 2001). The results of this review are summarized in Chapter Two. It was in light of this background that I sought to understand the contrasting world of ACT, a more individualized approach to psychiatric outpatients that held out the hope of embodying some of the concerns at the focus of care ethics.

While my decision to study ACT was shaped partly by circumstance and the good fortune of a local ACT team prepared to host me as an observer for six months, I quickly realized that ACT was ideally suited to my research for three reasons. Firstly, a great deal of ACT work is focussed on the long-term maintenance of the therapeutic relationship with clients. Hence, there was reason to suppose that such caregivers would be apt to value relatedness, and might even have something to teach us about an ethics of care not yet fully captured by moral theorists. In such a vein, it was also possible that workers possess a fine-tuned understanding of what is required to form solid relationships. Such insights, in turn, might better reveal existing limitations imposed by institutional frameworks on relatedness, while also further informing work in care-based ethics.

Secondly, ACT developed largely as a response to the shortcomings of conventional systems in providing a decent level of psychiatric care. Insofar as ACT represents a departure from standard psychiatric practice as well as a sustained attempt to provide individualized care, the program design offers an instructive response to the

limitations of rationalized healthcare systems. Finally, as I learned over the course of my research, ACT work is literally spreading across the globe and may well come to represent the future of psychiatric treatment for people diagnosed with severe mental disorders. Hence understanding the program and tracking its development becomes important in appreciating what may be at stake in this transformation.

My approach to ethnographic research has been guided in large measure by the precepts of interpretive phenomenology as practiced by Patricia Benner and others (Benner, 1994, Smith et al, 2009, Lopez and Willis, 2004). This is a qualitative method used to observe a small number of informants which aims to understand another's lived experience in her own terms. Given that ACT teams typically have less than sixteen members, this method was appropriate. Interpretative phenomenology requires the researcher to dwell empathetically and imaginatively in research participants' experiential worlds while engaging in reasoning and analysis that aims to discern their practical concerns and lived experiences. A researcher aims to go in with as few preconceptions as possible in order to allow genuine patterns to emerge.

Due to limitations imposed by the research ethics review board for the ACT team's home institution, and in the name of patient privacy, I was not able to include observations of clients as part of my research. Hence, my observations were largely limited to interactions among workers in team meetings, and these were further supplemented with interviews near the end of my study period. Fortunately the team meetings proved to be an excellent and very natural setting for ethnographic observation,

and the exchanges that took place there turned out to speak directly to the kinds of questions guiding my research.

Given that talk around a boardroom table is necessarily a limited way of revealing value, I also found it necessary to supplement my own observations with the findings of Paul Brodwin (2008, 2010, 2011), an anthropologist whose ethnographic study of an ACT team over two years fortunately extended to observation of the team's interaction with patients in the field.

Outline of the Argument

In my first chapter I show how a worldview dominated by mechanistic logic strengthens an intellectual climate in which relational concerns are devalued. Rational technologies, or assembly-line styled processes, are colonising an ever-broadening share of the human services. One assumption of this dissertation is that rationalized systems are necessarily ill-equipped to accommodate human beings in all their complexity. Inevitably, particular persons each situated within their own unique particular contexts outstrip the resources of mechanistic apparatuses designed to work on a large scale by producing a limited range of outputs. When this occurs, however, the blame usually falls on the person rather than the system.

Along with Georgy Lukács, I challenge the mechanistic logic that reduces persons to "mere sources of error," and hold that instead we ought to cast a critical eye at the broader machinery that deforms workers in sometimes painful ways. As I shall show, there is a marked tendency in rationalized bureaucratic systems to assume that in the

event of a discrepancy between the system's outputs and the requirements of particular persons, the fault lies with the person rather than the system. The same is true of workers unable to meet the demands such systems place on them.

When we layer what I call the rational techno-scientific (RTS) paradigm[6] onto such assumptions, then complaints of people being served by, or working within the framework of, such systems are apt to remain unheeded. This is especially true if their difficulties stem from concerns about the inferior quality of the human attachments they are capable of forming. As I shall describe at length, a paradigm which prioritizes economism and efficiency, objectivity, quantifiability, and standardization, but which deemphasizes interpersonal concerns, is very much at home within bureaucratic, productive and scientific spheres. Given the convergence of these three intersecting arenas in a wide range of healthcare settings, systems designed in the name of efficiency end up encroaching on the time and the space necessary for personal relationships – in other words, for the "caring" part of healthcare.

In my second chapter, I showcase the human consequences of such influences by looking to ethnographies describing healthcare practices. Here it becomes apparent that the logic that locates persons as sources of error serves to "other" particular kinds of clients or construe them as less worthy of care and concern. Workers' own empathetic distress, as it pertains to the harms produced by rationalized systems, tend to be minimized and similarly treated as a source of error. Meanwhile in psychiatry we see that

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[6] Rational in this term is meant to capture the emphasis this mindset places on instrumental reason, techno refers to the mechanistic view of nature, and scientific evokes the enormous importance of objective forms of knowledge for this worldview.

discipline becomes a key treatment modality for patients who are themselves quintessential sources of error relative to their rationally prescribed societies.

In Chapter Three I engage in a moral assessment of the modern healthcare environments described so far. First, however, I show the deficiencies of a ratio-centric style of moral theorizing for navigating interpersonal relationships. I then advance a care-based ethics to address the shortfalls of more conventional, and largely academic, ethical approaches. I also introduce a set of practices that will be used later to analyse ACT work, and which some theorists contend can, at minimum, inform a moral agent about the outline of an attitude consistent with care. In light of reflections from an ethics of care it becomes evident that imposing the technologies of mass production onto the provision of human services is intrinsically problematic. Meanwhile, relying exclusively on rationalistic moral theories, and hence failing to heed intensely felt responsibilities occasioned during face-to-face encounters, can create potentially painful paradoxes for workers.

Finally, I seek to challenge the assumption that the suffering workers themselves experience in the course of their working day is a mere source of error. The empathic suffering of workers represents crucially important information for assessing the acceptability of rationalized technologies that we have trusted to determine care. Workers, I conclude, are a crucial first line of defense against systems that have gone morally astray. Ignoring their input and restricting their freedom to respond to others could potentially cause them to become inured to the suffering of their charges, or even the stunt the development of workers' own moral wisdom.

Up to this point, however, I have only been assessing inpatient care. However, ACT, a treatment modality unlike anything that had come before now brings treatment into patients' own homes and communities. As I show in Chapter Four, ACT work represents the vanguard of mental healthcare for those diagnosed with severe mental illness, and is hence an important area for any researcher aiming to provide a complete picture of the state of modern psychiatry. Meanwhile, the very need for this brand of program speaks to the deficiencies of population-based approaches for the provision of adequate human caregiving. At the end of this chapter I also describe the current state of ethical debates around ACT in order to better situate the morally-focused ethnography that follows.

In Chapter Five I depart from standard critique and begin by highlighting certain valuable aspects of ACT work as seen through the lens of care ethics. As Fletcher's work shows, such acts are liable to be "disappeared," hence an analysis of this kind holds value while also showing us concrete examples of those aspects of the work worth preserving. It would appear, moreover, that these morally valuable aspects of the work are achievable in part because workers have the necessary authority, time, and space to carry their work out as they see fit. Despite such positive evaluations of ACT work, I shall also demonstrate that the RTS paradigm constrains ACT work in ways that ultimately cause workers to suffer. Having already argued in Chapter Three that workers' own suffering matters deeply for our moral assessments of caregiving, and this is especially true if this suffering stems from a felt concern for clients' wellbeing, I go on to examine other sources of defeat that ACT workers are prone to experience due to the limitations on their

ability to significantly improve their clients' lives. My own modest proposal to address challenging working conditions is to encourage workers to also employ the space of the team meeting to arrive at a richly intersubjective and more nuanced understanding of their clients.

Having shown how an emphasis upon the values of objectivity and quantification impinge upon ACT work by making an already difficult job more emotionally trying, in Chapter Six I draw my earlier discussions of reification, economism and efficiency as well as standardization back into my discussion to inform a prospective look at ACT work. In this chapter we see that clinical researchers are using the concept of "fidelity" to signify remaining true to an abstract model of ACT. By showing that this model has been designed primarily to achieve cost savings, I suggest that this use of the term departs significantly from an everyday use of the term implying loyalty to and support of a particular person.

In fact in this chapter I suggest that if it becomes standard practice to employ scales devised to measure program fidelity, ACT teams may be altered in ways that erode some of the more morally valuable aspects of the work carried out by the team I observed, a team whose work is not currently subject to such assessments. Based on my arguments from Chapter Three, I conclude that if workers' concerns go unheeded and the "fidelity" model remains unchecked by those situated at the ground floor of practice, we risk seeing ACT workers gradually turn away – like so many in other care settings – from the needs of their suffering clients.

It is important to acknowledge here that this thesis is not about individuals such as Alexandria directly, or even her family. Admittedly, it is vitally important that firsthand accounts of modern psychiatric care come to light and to hear from patients themselves about the quality of the care they receive in modern mass societies. Hence, it is not without reservation that I focus almost exclusively on the situation of healthcare workers in the following chapters. Current ethical restrictions relating to psychiatric patients' capacity to consent, however, represent a systemic barrier for academic researchers interested in unearthing their stories. Moreover, issues related to the appropriation of marginalized voices mitigate against aiming to speak on behalf of persons diagnosed with SPMI. Fortunately, a growing consumer-survivor literature base exists that allows researchers to draw on the voices of clients themselves, and I have employed such work where appropriate in what follows.

Finally, although patients do remain my central, albeit tacit concern, insofar as I strive here to identify and articulate conditions best suited for the cultivation of wise and caring workers who work with people such as Alexandria as well as other vulnerable persons. In psychiatry caring workers who are skilled at cultivating relationships are doubly important, given that a key deficit clients suffer from is an inability to relate to and connect well with others. There is something to be said then for nurturing modern care workers both for their own sake, and for the sake of their clients. To do this adequately, however, will require an understanding of professional caregivers' unique situation if one wishes to grasp how workers can be pulled in different directions by competing demands and how such contradictions cause them suffering. Conflicted and

distressed workers likely do not make the best caregivers. There is a good chance that most people will one day find themselves occupying the role of a vulnerable other within a modern healthcare environment. Hence, we all ignore at our own peril the suffering of workers laboring under the conditions described in this work.