**Character education of the sick person: a new challenge for Europe**

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**Introduction**

Human beings spend a considerable part of their lives suffering, being sick or disabled, but the moral flourishing and good life of the “sick person” have received little scientific attention. Research in this field has been mainly focused on what pain is, what defines suffering, and which treatments can cure a certain disease effectively. Also within care ethics and virtue ethics, philosophers have concentrated more on those traits that might help health care professionals and on virtues that might help the patient’s relationship with physicians and nurses. Thus, the sick person as such has often been left behind and sometimes treated as a mere “object” of care.

However, the impact of character on the way the subject can respond to illness might have a huge potential. In the last few years - and in some cases even earlier -, some research has started to be done on the relationship between illness, suffering and virtue (Brady, 2018; Carel, 2016, 2019; Fowers, 2017; Kidd, 2012, 2015; Miles, 2019; Navarini, 2020, 2022), hypothesizing that illness does not prevent the sick person from flourish. On the contrary, a good adaptation to this experience might lead the subject to build a reservoir of strengths, developing new character traits and dispositions. Also, some researchers has ventured that virtues may not just be positive outcomes of the illness experience, but also a big help to react to it positively and to experience higher and deeper levels of well-being.

In our talk we will argue in favor of the compatibility between illness and flourishing (1). Also, we will point out that (2) if a person is accompanied in the adaptation process through a pathway that does not focus only on physical symptoms management, but also on the subject’s global well-being (and therefore on the psychological, moral, and spiritual levels), they might be able to react positively to illness and fragility, developing new character strenghts and virtues. Moreover, we will maintain that (3) the development of new character traits helps the subject respond better to the experience of illness, suggesting a triplet of virtues which – according to literature and reflection – seem suitable for the purpose, although (4) focusing only on the virtue of hope. Finally, we will venture that (5) specific interventions could be created or adapted to foster these virtues in ill people, also considering that, in the European context, medical progress has led to the chronification of many deadly diseases, to the aspiration to a high quality of life of chronic patients, to an increasing number of senior elderly who want to be *fit*.

1. **The compatibility between illness and flourishing**

To discuss the relationship between illness and virtue, we have to take into account some evidence. A first and ineliminable fact is that dealing with a progressive chronic disease involves a certain amount of suffering.

There are many definitions of suffering, but we will refer her to a definition derived by Michael Brady's one, according to which “a subject suffers when and only when they have an unpleasant or negative affective experience that they perceive as having a deep intensity, which they therefore wants to get rid of, and of whichthey minds; where to mind some state is to have an occurrent desire that it not be occurring, in virtue of the importance and meaning it has for the subject”.

As Karen Lebacqz writes, illness is an “unwelcome intruder” which brings with it a “more onerous citizenship” (Lebacqz, 1985, p. 278). This onerous citizenship changes the everyday dynamics, the body of the sick subject; how the person perceives themselves on an identity level and is perceived by others; how they experience their relationships, and so on. These aspects can generate suffering and can lead the sick person to experience a sort of short-circuit.

As a matter of fact, illness leads the subject to experience, in some way, suffering, yet by its very nature suffering tends to generate a desire to get rid of that unpleasant experience. However, the main characteristic of some chronic diseases is precisely the fact that the subject cannot get rid of them, just as they cannot get rid of several of their consequences. This creates a mechanism of frustration that can lead the patient to feel trapped: “if I cannot put an end to the source that generates my suffering, I won’t never experience well-being again, I won’t never be happy again”, and so on.

However, several real world cases testifies the contrary. Indeed, there are subjects who are ill yet happy, and flourish by virtue of - or despite - this experience. Illness and suffering do not represent a definitive threat to the subject’s well-being; this threat rather looms in the way the patient responds to their disease. Putting it in philosophical terms, we can say that a certain amount of suffering is inescapable in human life. However, life is generally conceived as something good and precious. Therefore, if life is something good, its goodness has to be somehow preserved along with the suffering which is necessarily interwoven with it.

1. **Coping with suffering through virtues**

Admittedly, pain and suffering are part of our life, and being part of our life we are “naturally equipped” to adapt to them (Schultz et al., 2022). This does not mean that adaptation is easy or immediate, because, as Katlin Schultza and colleagues writes, “it can encompass internal elements such as grief/loss, feelings of uncertainty, changes in thinking processes, and alterations in identity/self-concept and sense of self-efficacy, as well as external elements, such as learning to navigate one’s environment and social spaces with a disability, and addressing structural and systematic barriers and exclusion” (Schultz et al., 2022, p. 132).

The process of adaptation does not always end positively; on the contrary, the subjects may respond to the traumatic event by reporting feelings of loss, chronic sorrow, frustration, guilt, anger, loss of connectedness, and struggling with change. However, this is not the only possible response. As a proof of this, many studies - such as Mystakidou and colleagues’ (2008) - have shown that although a disease can destroy a person’s life, relationships, roles, values, beliefs, and so on, it can also cause positive changes in character and behaviours.

Interestingly, Alastair Campbell and Theresa Swift conducted an experimental study on this topic, involving 44 patients with different chronic diseases (rheumatoid arthritis, endometriosis, end–stage renal disease, and mood disorders) in four different countries (Denmark, Great Britain, Italy, and Netherlands). Results showed that a positive adaptation to illness with a consequent development of virtuous traits seems to be possible.

This kind of positive adaptation, resulting from a traumatic experience such as discovering a life-threatening disease, has been defined by Richard Tedeschi and Lawrence Calhoun as “Post–Traumatic Growth” (PTG) (Tedeschi & Calhoun, 1995), which can be described as a positive psychological change that can follow after having struggled with very challenging life circumstances (Tedeschi and Calhoun, 2004).

The positive change which may occur by experiencing PTG is generally reflected in one or more among the following areas: spiritual development; embracing new opportunities; development of new character strengths and dispositions; improvements in one’s relationships; increased sense of gratitude and appreciation of life.

By saying so, we do not want to trivialize the challenges faced by ill people, nor do want to simplify the process that leads to flourishing, since illness is a traumatic experience which brings with it changes, hard moments, bad feelings. However, we claim it also may have a transformative power. The transformation which can occur does not depend on suffering itself, but on the sufferers’ response to their suffering.

It is therefore important to help the sick person in dealing with suffering. Palliative care in this sense is a fundamental resource, as it does not only take care of the physical dimensions, but it can also help patients in managing and overcoming their trauma; in re-signifyingthe experience of illness; in developing new tools which will help them to live a “good” and happy life.

Some authors even maintain that illness and suffering might be seen as a pathway to virtue, if the sick person is helped to deal with it and to adapt well to it.For example,Jennifer Cole Wright, Nancy Snow and Micheal Warrenhave tried to integrate Aristotelianism with Whole Trait Theory (WTT) by Will Fleeson and Eranda Jaywickreme. Wright and colleagues writes that “suffering provides an opportunity to develop [virtues] – an opportunity that people may not get elsewhere” (Wright, et al., 2020, p. 65).

Without dwelling too much on WTT, we can say in summary is that according to Wright, Snow and Warren particularly traumatic experiences, such as living with cancer and its consequences could transform the subject by repeatedly exposing them to certain circumstances that represent a relevant stimulus for the activation of certain virtuous behaviours such as being brave, or being perseverant, and so on.

To cite an example offered by the authors, dealing with illness may require to develop greater problem-solving skills; the ability to observe a situation from different angles; and to reflect carefully. These traits recall the virtue of practical wisdom. So practicing these aspects will help the subject to become practically wise. Also, illness will not expose the sick person only once to deliberative situations of this kind, but many times: therefore, the more they will be asked to be capable of practicing practical wisdom and to frequently be practically wise, the more they will be able to consistently respond with phronesis. Also, they will learn to apply that virtue even when situations will be very complex, and to avoid using it when it is inappropriate to do so.

Thus, a person can be transformed by the experience of illness as they are for example exposed to certain circumstances which asks for the activation of practical wisdom or perseverance or courage. This will slowly modify their narrative identity which will also include the new traits.

Notably, PTG or the acquisition of new dispositions must not be taken as automatic acquisitions. To be exposed to certain circumstances is not enough for developing certain traits, otherwise we would all be virtuous. However, our claim aims at showing that if the sick person is helped to positively adapt to the experience of illness, they can find in the small or big daily challenges imposed by illness the opportunities and inspiration for developing and strengthening several virtues over time.

1. **Virtues as a positive response to illness**

We wish now to go more deeply into the relationship between suffering and flourishing (Fowers, Richardson, & Slife, 2017). In the first paragraph we have maintained that suffering and flourishing are not contradictory concepts, therefore it makes sense to search for the sufferer’s virtues, or also the patient’s virtues. This has two possible meanings: a) to search for the virtues which better help the sufferer bearing their burden; b) to search for the virtues more frequently allowed or induced by suffering. In the first case, we begin from the reality of suffering as a fact, and interpret the virtues as a means to promote flourish in any case. In the second, we might interpret suffering as a means (optional or necessary) to obtain the virtues. Here, we adopt the first perspective, thus distancing ourselves from accounts such as Michael Brady’s and James Kidd’s.

A few ethical models have underlined a positive relationship between suffering and flourishing, suggesting the first be mediated by virtue development in general (Miles 2019; Wright, Snow, & Warren 2020), or by specific clusters of virtues, such as the triplet of courage, hope, and practical wisdom. This intriguing cluster was originally suggested by Karen Lebacqz (1985) and subsequentially resumed by Campbell & Swift (2013). The proposal can be a satisfactory explanation to a number of “surprising” ethical facts, namely, the different moral reactions of people to their own suffering experience. It might also explain why some people are “better sufferers” and how they can often preserve some joy and peacefulness within suffering, as Miles (2019) puts it: “why do some people flourish despite their chronic illness while others languish?” (p. 141).

To describe the plausibility of this cluster, a powerful starting point is Miles’ assertion that “Virtuous patients adjust their expectations and find ways to continue flourishing even when their prior state cannot be recovered” (Miles, 2019, 147). These words summarize the entire program of a virtue ethics applied to the condition of illness and pain, which can be addressed as *illfuness* (Ricci, forthcoming). Indeed, this definitory sentence synthetically represents the possibility of human flourishing despite suffering through virtues, and specifically through certain virtues. We do not have time here to examine the triplet of courage, phronesis, and hope in their general mutual relationships, and with respect to the multifaceted experience of suffering. In addition, a distinction should be made between practical wisdom and “the virtues”, since there are good reasons to assign to phronesis a different meaning and level. We therefore limit ourselves to consider the virtue of hope

**(4) Hope as a moral resource**

To deal with the accessibility of a good is indeed a prerogative of hope, which is typically a transcendent virtue, for being directed towards the future (beyond the present) and towards the “other” (beyond the self). In turn, these aspects have been classically described in terms of desire and perseverance. As a matter of fact, the hopeful person strives to overcome the obstacles and aims at a positivity which goes further than probability calculations. Transcendence allows hope being strictly connected to courage, and consequently to *phronesis*, by means of perseverance, which is precisely the quality of remaining directed towards the objective despite unsatisfactory results.

Moreover, perseverance permits the distinction between hope and optimism: while optimism is the confidence to achieve a goal, hope is wider and not necessarily related to good results, because it can be employed even if the aim is not accomplished, so showing its similarity and complementarity with courage. Aristotle differentiates the virtue hope from hybrid forms like optimism, defining the latter a pseudo-hope, which corresponds to pseudo-courage, that is, to naïve self-confidence. Examples of naïve self-confidence are: the acritical certainty that “everything will be fine”, blindly trusting one’s good luck, the ignorance of perils, and so on. It is not coincidence that Aristotle introduces hope precisely with reference to courage, showing how the first contributes to the second.

Fröding, interpreting Aristotle, clarifies that the hopeful is not necessarily courageous, because they might be only emotionally hopeful (as opposed to virtuously hopeful), whereas courage would always entail hope, since the courageous person must be confident regardless of fear and danger. In short, apparently Aristotle claims that hope implies courage, through the mediation of “confidence” or “trust”, which could work – as G. Scott Gravlee (2000) suggests – as the medium term of the following syllogism: “courageous ones are confident. Confident ones are hopeful. Therefore, courageous ones are hopeful” (p. 465). Importantly, this confidence does not descend from certainties, but rather from the opposite, namely, from uncertainties transformed by virtue hope. As Adam Kadlac (2015) synthesizes it, hope “represents a corageous response to an uncertain future” (p. 342).

Simultaneously, courage has a protective role against despair and hopelessness, as Simon Wein argues: “A courageous state of mind is a powerful antidote to loss of hope” (p. 42). This allows me to conclude provisionally that courage has the prerogative of mediating between opposite emotions (scare and lack of fear), although the *medietas* of courage is not an arithmetical centre between them, but a middle position tending more to recklessness than to cowardy, as the first sounds more akin to audacity, which is an emotion often associated to courage.

At the same token, fear is co-essential to courage (Navarini & De Monte, 2019). In this respect, the courageous continues to be afraid while they exercise this virtue, however, for being virtuous, they generally overcome their fears without too much effort. Consequently, the disposition of courage is not primarily qualified by objective dangers, rather by the perceived fear by the subject. To take an example, a claustrophobic will have to activate the virtue courage to enter into a lift, as much as a paratrooper for a complex parachute jump.

The experiences of illness and pain induce a constant elaboration of fear, from the diagnosis all along the history of the pathology, involving sub-fears like the fear of a surgery, fear of pain, fear of losing the hair, of losing autonomy, of being forever unable of doing certain things again, of dying. Each sub-fear calls for the virtue courage that, when it is full-blown, may represent a protective factor against the anguish typically associated to the late phase of disease. The interaction of hope and courage can lead to innovative articulations of failure experience, thanks to moral imagination, which finally becomes – as Mavis Biss claims - imaginative excellence (2013, p. 949).

Hope, for its projective dimension, might sound inappropriate to a condition like suffering or illness, which frequently narrow one’s potentialities and perspectives. However, several palliative care studies have demonstrated that hope is one of most wished dispositions among seriously ill or even dying people. This finding is shared by the thanatologist Elizabeth Kübler-Ross, who have always maintained that hope is the bulwark that never yields completely during the patient’s disease history. The discovery of a new treatment, a medical error, a miracle, or a terrific reaction of the body to the therapy: every remote hope can be a foothold for the sick. Even if these hopes might be seen more as emotion hope than as a virtue hope, it is nevertheless interesting that this feeling does exist in so many sufferers’ experience, because this might be the ground on which a program of moral development for the patient might take place, in order to help them optimize their resources and goals. Although hope, in this case, can’t be directed towards a full recovery, it can point at other relevant objectives, such as the highest possible wellbeing, life after death, the good of the beloved ones, a renewed ability to better comprehend oneself and the others, etc. The sick might, in other words, work on themselves in order to become a better person, thus gaining deep satisfaction e intimate peace.

Not surprisingly, a lot of psychological and psychiatric research associates the lack of hope to death wish and risk of suicide. Indeed, many studies suggest that the lack of hope correlates with depressive tendency and disengagement towards life more than the disease itself, and that hopelessness seems to be tied to defying or absent early palliative care. Also, Yechiel Michael Barilan underlines that – particularly in terminal illness – hope is crucial element, although in this stage of life it would not be any more a matter of projection towards the future, but rather the aspiration to realizing some personal important value.

The tendency to self-fulfillment which stems from hope can be, in this respect, independent of time-projection – as it is typical of youth and healthy people - , and be instead compatible with suffering and serious illness, since it might regard an “interior projection”. Therefore, this virtuous attitude can be characterized by the ability to develop certain fundamental traits, enabling the sufferer to better grasp their ultimate goals and overall flourishing. In her studies about hope in terminal illness, Kaye Herth, also author of the still widely used *Hope Herth Scale* *-* has hypothesized that the deepest component of hope is something stable and unchanging, whereas particular hopes might be changing and engage over the core hope.

This characterization of hope, together with other conceptualizations that either within psychology or philosophy have been elaborated, reinforces the idea that hope entails a constant reference to transcendence, which also implies the ability to search for different solutions when our way of reaching the goal is unsuccessful, as already clarified. Hence, the disposition to look for alternative ways when the foreseen path is not available, as stated in the programmatic quotation of Miles, represents a constitutive aspect of this virtue, displaying its essential components of tenacity and perseverance in approaching the end.

**(5) Interventions and dissemination**

Richard Snyder (1994) developed the best known psychological theory of hope and created instruments to measure it, on the bases of two fundamental characteristics of hope: the will to pursue one’s reachable goals, called agency, and the knowledge of how to reach them, called pathways. He subsequently defined hope as “a positive motivational state that is based on an interactively derived sense of successful (1) agency (goal-directed energy) and (2) pathways (planning to meet goals)” (Snyder, Irving, & Anderson, 1991, p. 287). Thus, “hopeful thought reflects the belief that one can find pathways to desired goals and become motivated to use those pathways” (Snyder, 2002, p. 257). This approach is helpful when facing obstacles and impediments, since evidence showed that high-hope people are more successful in finding multiple workable alternatives to achieve goals (Snyder et al., 1998).

Having a fundamentally cognitive perspective, Snyder’s theory implies that hope is not itself an emotion (Farina, Hearth, & Popovich, 1995); instead, positive emotions flow from it: “goal-pursuit cognitions cause emotions” (Snyder et al., 2002, 258). Furthermore, pathways and agency thoughts activate an iterative process, which determines a reinforcement of hopeful goal-directed thinking and a feedback process composed of the particular emotions that result from perceived successful or unsuccessful goal attainment (Snyder et al., 2018).

Snyder’s (1994; 2000) definition of hope refers to any age and health condition, predicting positive outcomes for several psychopathological conditions (Cheavens, 2006) but also academic achievement and other personal skills improvements (Curry et al., 1997; Snyder et al., 2002; Ciarrochi et al., 2007 ). From a psychometric point of view, all the scales developed by Snyder – the Dispositional Hope Scale, the Adult State Hope Scale, the Children Hope Scale, and the Domain Specific Hope Scale – showed significant reliability.

We suggest that Snyder’s Hope Therapy (HT, Lopez et al., 2000) could be adapted to suit any ill people, particularly chronically ill patients, in order to promote their personal growth and flourishing despite their prolonged suffering. As a very initial and tentative hypothesis, we would like to provide an a HT intervention to a selected group of patients, showing homogenous parameters, and hypothesize that hope measured at 2-4 weeks post-HT will predict hope increase and hopelessness decrease over the following 6 months post-HT; this relationship might be mediated by increased purpose in life measured at 4-5 months post-HT.

Since the triplet of hope, courage, and prudence has been proposed as a cluster, it might be argued that concentrating on one virtue only is not enough. This is very likely true, and more efforts should be done to design an articulated protocol including the training of at least the most validated character traits for patients. Unfortunately, this goal is still far away, because the public sensitivity on this issue around Europe is still under construction.

However, it is necessary and urgent to activate some practical interventions to advance a proper, inclusive, and non-judgmental “moral education” for ill people, in a set of countries – namely, Europe – which grows progressively older and older, and where the great achievements of medical care, clinical prevention, and therapy do not prevent citizens from many kinds of suffering related to the co-habitation of illness or frailty and life expectancy. This suffering has to be address “morally”. Employing validated interventions that have already given positive results might be a reasonable starting point in this direction.

**Conclusion**

In conclusion, we can state that out inquiry has been bringing us towards a full account of ill-full flourishing, which entails theoretical and possibly empirical arguments. We are aware, as admitted in the beginning, that, while cultivating virtues can be difficult, doing so within the experience of illness can be even more challenging (Kidd, 2012, p. 513). However, if we think that the experience itself lays the foundations for flourishing and that this can be the positive consequence of a good coping with circumstances, it can be understood that the development of positive traits in a certain domain like that of illness is not an easy job, but neither is it an impossible commitment. On the contrary, the consequences that illness often brings with it call for the exercise of certain virtues; therefore, the work of the sick person on their inner world can foster the character development. In this sense the importance of a palliative care pathway has a comeback.

Illness and virtue – therefore – are not mutually exclusive concepts, but although in some cases the illness experience can be too brutal to draw anything good from it, it can also positively transform the subject experiencing it. In a word, illness brings with it unprecedented flourishing spaces which the subject can profit from through working on their new condition.

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