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HAPPINESS AND MENTAL ILLNESS: VIRTUE ETHICS IN DIALOGUE WITH PSYCHOLOGY

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This interdisciplinary article explores the intersection between the virtue ethics tradition and psychological therapies exploring the meaning of happiness for people living with a disabling mental illness. The logic of virtue ethics faces the challenge of mental illness, which is how to conceive of *eudaimonia* in the context of an illfness that targets happiness and potentially disrupts a person's capacity to function rationally and exercise virtue. Drawing on two illustrative case studies of schizophrenia and major depression disorder, this article identifies substantive points of contact between virtue ethics and the therapeutic strategies of recovery theory and Acceptance and Commitment Therapy. In so doing, it aims to provide ways of thinking about happiness that can help therapists and people with a mental illness conceive of flourishing, not despite mental illness, but by incorporating the experience into the storied meaning of life. And since mental illness reflects the vulnerabilities that are central to human life, its examination also expands the horizons of the virtue ethics tradition.

INTRODUCTION

With its origins in Greek philosophy, the virtue ethics tradition outlines a teleological conception of happiness, grounded in an anthropology that emphasises reason and will. While the logic of virtue has experienced a renaissance in departments of philosophy and theology, as well as the science of positive psychology, this article asks whether it has anything to offer individuals (and their loved ones) who suffer from psychological conditions that would seem to undermine happiness, the processes of reasoning, and the exercise of virtue. It is the fruit of a conversation between a clinical psychologist and a theologian and philosopher of disability and ethics, and explores ways of thinking about happiness, meaning, and agency in the context of the hardships that attend to the experience of mental illness. We focus the discussion on the disabling experiences of schizophrenia and clinical depression, and ask whether virtue ethics can speak meaningfully about the flourishing of people whose reason and will is being damaged by an illness that targets the brain, its mental state, and decision-making capacities. To that end, we explore the potential alignments between virtue ethics and emerging strategies for managing mental illness.

VIRTUE AND HAPPINESS

The virtue tradition is an exploration of the meaning of happiness (*eudaimonia*) and how to attain it. In modern parlance, the term flourishing might best capture its scope. A creature can

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be said to flourish when it fulfils its natural capacities. That which is distinctly human is our use of reason to transform our environment and our own naturalistic structure.[1] Within the limits of our biological and social horizons, reason enables us to choose the shape of our future and so to live meaningfully. Reason transforms every aspect of life. Even our fundamental passions can be directed towards chosen ends, such as when we make the decision to exercise and eat wisely to improve our physical condition, and restrain our sexual desires for the goal of a lifelong relationship.[2] Reason thus helps to shape our character, orienting us to virtue, which is a habit of character that helps to achieve desired ends.

Alasdair Macintyre suggests that the virtue tradition has a threefold shape. First, human nature with its untutored desires and passions needs to be steered by virtue for its own good. Second, these virtues are learned by reason and experience, modelled by traditions, and established by practice. We learn virtues so that we can practice them habitually; that is, they frame our character. Third, practical reasoning provides us our purposes and goals, and wisdom helps us to exercise virtue toward those ends.[3] In this light, the goal of moral training is to develop 'independent practical reasoners,' who are shaped by the moral tradition of their family and community, but are not controlled by it.[4]

We shall expand on constructions of virtue and happiness as the article develops, but for now this summary elicits the problem of the virtue tradition in the context of mental illness, which is that the illness has the potential to undermine the capacity of reason and the exercise of virtue, and thus seemingly renders *eudaimonia* impossible. The discipline of positive psychology has drawn on the virtue tradition in its empirical examination of happiness, and some work has been done to examine its implications for mental health.[5] The discussion in this paper complements the empirical science by examining theoretical issues and narrative based ways of exploring personal agency in the context of an illness that complicates that agency, especially in the therapeutic setting.

Mental illness covers a broad range of conditions. Rather than attempt to address them all, in this paper we set out two illustrative case studies, which are not intended to be all-encompassing or limiting but, rather, are used to provide an illustrative narrative to ground the theoretical imagination that follows. Given the interdisciplinary nature of this paper, case studies also help to orient those without expertise in psychology to the issues at hand.

SCHIZOPHRENIA

Schizophrenia is a frightening diagnosis. Historically, it has been understood to be a chronic and deteriorating condition, one about which there is rarely any good news; even managing the condition is difficult. It is common to treat schizophrenic patients over several years, journeying with them through phases of remission and relapse in what can seem like the deterioration of life. Even so, there is increasing evidence that recovery is possible.[6]

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5) specifies the key features of schizophrenia as including delusions, hallucinations, disorganized thinking, abnormal movement (such as agitation or catatonia), and negative symptoms such as diminished emotional expression and lack of self-initiated purposeful activities (including self-care).[7] Impairments are commonly across a range of functioning. For example, a person with the disease might show inappropriate affect (such as laughing in a sad situation), low mood, cognitive impairments (such as problems with memory, language, slower thinking, and poor decision making), social deficits (such as behaving appropriately and understanding what others might be thinking). Cognitive impairments 'may persist when other symptoms are in remission and

contribute to the disability of the disease' (DSM-5 p.102). Some people will show a lack of insight or understanding of their disorder. Additionally, hostility and aggression can be a feature, especially with younger males.[8] While no one individual is likely to have all or even most of these impairments, those with chronic schizophrenia are usually significantly disabled.

The diagnosis of schizophrenia is given to about 1% of the population.[9] Onset is usually in the period of adolescence to mid-30's. The course of the disease is not certain, with about 40-50% having a more favourable outcome, and some (up to 20%) recovering completely[10]. However, 'most individuals with schizophrenia still require formal or informal daily living supports, and many remain chronically ill, with exacerbations and remissions of active symptoms, while others have a course of progressive deterioration' (DSM-5 p.102). About 5% will die by suicide.[11]

Case Illustration with Willa: Willa, who is now 44 years old, has chronic schizophrenia. She was well educated with an honours degree in history. But soon after graduating and starting a job as a cadet journalist she had a psychotic breakdown. She lost touch with reality and developed a persecutory delusion about 'the secret service investigating me.' She was not able to continue working and had to go on a disability pension. She lost her independence and had to live with her widowed mother.

Gradually Willa became socially isolated, withdrawing from her previous friends and refusing to leave her house. She complained about panic attacks. In the early years of her illness she had three hospital admissions while in a floridly psychotic state but gradually antipsychotic medication stabilized her. Unfortunately, after each episode she was more troubled by a lack of motivation, withdrawal, and had an oddness which people noticed. She has long relied on the support of her mother.

Willa remained with psychotic symptoms over the next twenty years and was never totally free of hearing voices. She could understand that the voices 'were not real' and that she did not have to 'obey them,' for example, when she was told to kill herself. Willa could be described as having some *insight*. She had a rich fantasy life and she felt she could have conversations with Hollywood stars who would respond in conversation through the voices. She also thought, at times, she could transmit her thoughts to other people. She amused herself by writing romantic novels of herself with various movie stars such as Johnny Depp. She said, 'I know they are not really in love with me, but I like to feel that they are. It helps me feel less lonely. And it comforts me being able to talk to them when I want.'

Willa joined a charismatic church and she was told she was 'demon possessed.' After an unsuccessful exorcism she no longer attended worship services. Her counsellor encouraged her to attend more sedate traditional services which she found more helpful. She did not feel she had to interact with people and could come and go as she pleased; but, nevertheless, this new church engagement gave her the opportunity to slowly develop social networks she had previously shunned.

Willa saw her psychiatrist every couple of months. She took her antipsychotic medication even though she struggled with some of the side effects. She was helped to accept her voices, learning how to cope with their intrusion into 'my mental space.' Over time, Willa emerged from the worst debilitations of her illness, and with the help of her mother and other social services attained a level of functioning that enabled her to build a steady and meaningful life, volunteering in church and making a small circle of close friends.

MAJOR DEPRESSIVE DISORDER

Depression is commonly thought of as the 'common cold' of mental illness. Major depressive disorder, as a clinical condition, carries a risk of mortality through suicide. In the USA 12

month prevalence is approximately 7% while it is higher for young people aged 18-29 and less for individuals aged 60 and older, data that is mirrored in Australia.[12] While it may appear at any age, the likelihood of onset increases markedly with puberty (DSM 5, p. 164-165). Episodes often repeat after a period of recovery, with risk of further episodes remaining. Some bipolar illnesses begin with depressive episodes.

The following criteria are listed for assessing a Major Depressive Episode, with at least five symptoms presenting for a period of at least two weeks determining the diagnosis: Depressed mood most of the day nearly every day for the two weeks; diminished interest in almost all normal activities; poor appetite and significant weight loss when not dieting, or alternatively, increased appetite and significant weight gain; insomnia or hypersomnia; psychomotor retardation or agitation; loss of energy or fatigue; feelings of worthlessness, self-reproach, excessive or inappropriate guilt; complaints or evidence of diminished ability to think or concentrate, such as slowed thinking, or indecisiveness; and recurrent thoughts of death, suicidal thoughts, or a suicide attempt (DSM-5 p. 160-161).

Case Illustration with Ralph: Ralph has been in treatment for chronic depression since August 2008, having about 45 sessions which were scheduled at times of need. He was diagnosed with Major Depressive Disorder chronic with moderate to severe symptoms.

Ralph is 55 years old, the oldest of three children born in a stable family. Both parents may have had some history of depression, and both his siblings have, at times, been on medication for depression. It was concluded that Ralph had a biological vulnerability to clinical depression.

Ralph is a biologist with a BSc hons degree. Two years after graduating he began PhD studies but later withdrew from the program. For the last twenty or so years Ralph has worked in a lab at a local university. He expressed disappointment that he has remained a research assistant, without any leadership roles in research projects. In the last two years his depression has led to time off work and a work crisis when his supervisor insisted on dropping his pay grade. He faces the risk of redundancy.

Ralph reported a history of depression with a consistently low mood — feeling ‘weighed down’ — for the previous 5-6 years and. He reported depression related symptoms such as not being able to sleep, waking often at 4 a.m. and not getting back to sleep, diminished interest in activities, poor concentration, low motivation, some comfort eating of ‘junk food,’ regular use of alcohol (2 to 3 glasses most nights), low self-esteem, and suicidal thoughts. He has been prescribed antidepressant medication, but this has generally been somewhat ineffective. He maintains that his depression is episodic and sometimes his mood is normal. He is sometimes angry, and perhaps counterintuitively claims that anger makes him feel better, providing a sense of agency.

Ralph provides a classic example of a hard-to-treat depression. His situation elicits the question at hand; is it possible for Ralph to flourish in the context of his depression? The answer will depend upon how we conceive of flourishing, which is the focus of the remainder of this paper. For now, we can note that Ralph has shown evidence of resilience in his struggle with the illness. He has built up his financial reserves even though his job situation is difficult and tenuous, and maintained several satisfying friendships. He has a healthy and supportive family networks. He has been in a four-year relationship and has recently become engaged. All these factors provide a base of hope for the future, even in the context of his long-term depression and the challenges attendant to it.

HAPPINESS, PLEASURE, AND MEANING

As with Ralph, one of the more obvious impacts of mental illness is on mood, such that the illness generally diminishes happiness, or at least what we normally mean when we use that term

— i.e., the experience of pleasant emotions. The virtue tradition, however, begins by reorienting our understanding of happiness away from the primacy of pleasure. Aristotle, for example, was sharply critical of hedonists, who, he says, live the slavish life of fatted cattle.[13] Instead, happiness is a long-term goal, achieved in the pursuit of meaning, by exercising virtue in the ups and downs of life. Such a life will have its pleasures, including moments of joy, laughter, play, sensuality, celebration, and the like. But pleasure is put in its place as one dimension of a rich life; a consequence of flourishing and not, in and of itself, a primary end. The advantage of this way of thinking is that it embraces the hardships that are an inherent part of every human life, even if grounded in infinitely different causes. In the case of Willa and her family, it can enable them to appreciate that schizophrenia is not necessarily the enemy of happiness, but the context in which it might be achieved.

The power of this reversal of thinking should not be underestimated. The diagnosis of schizophrenia, depression, and other mental illnesses can be shattering (it can also be freeing, since diagnosis is the first step toward healing).[14] Learning to manage the disease will require a move from denial and devastation, to acceptance, and eventually to working toward long-term management and improved functioning; ideally to recovery. In emerging therapies and practices, recovery is necessarily a loosely defined and open notion. It may entail the elimination of all symptoms and the return to 'normal' functioning, but more commonly it is a journey that may be lifelong, in which a person comes to understand their illness and its implications and, by actively managing symptoms, to learn that recovery is possible, that life can be meaningful, and that positive relationships with family, friends, and the wider environment are achievable.[15] An important part of this process will be to follow medical advice and to take seriously the value of medical interventions. But there is now widespread evidence that for people suffering from mental illness, hope, determination, personal agency, and openness to new discoveries and experiences is a vital complement to medicine.[16] Hope is itself a product of meaning, just as hopelessness is a consequence of the loss of meaning. But how do we access the meaning of a human life?

EUDAIMONIA, STORY, AND IDENTITY

Whatever the abstractions used to answer the fundamental question of life's meanings, whether theological or philosophical, what we take to be the good life is understood and communicated by way of stories, both individual and corporate. Describing the framing of eudaimonia for an individual life, Macintyre notes that 'our concept of selfhood … resides in the unity of a narrative which links birth to life to death.'[17] Thus:

> A central thesis then begins to emerge: man [sic] is in his actions and practice, as well as in his fictions, essentially a storytelling animal. He is not essentially, but becomes through his history, a teller of stories that aspire to truth. But the key question for men is not about their own authorship; I can only answer the question 'what am I to do?' If I can answer the prior question 'of what story or stories do I find myself a part?'[18]

Herein lies the challenge of schizophrenia, and the seed of a response. The eudaimonic conception of happiness is oriented to storied meaning, but schizophrenia compromises memory, language, and rational thinking, and stimulates hallucinations, and so makes it difficult to extract meaning from past experiences in order to envisage healthy and intelligible personal narratives.[19] But just as the illness disorients, turning storied self-identity bleak and even incoherent, the long-term goal is to reorganise and rewrite that story; 'to find a new strand of continuity that

bridges the past with the future in an intelligible fashion.'[20] But how is this rewriting achieved for a person struggling with schizophrenia?

It is noteworthy that delusions are themselves stories, even if they bear little resemblance to reality. Psychologists suggest that delusional narratives are, at least in part, a rhetorical strategy, stories that people with schizophrenia tell in order to make sense of their of their vulnerability and distorted sense of self.[21] Depending upon the nature of the delusion, these stories may provide some help to a person in regulating their sense of self. It is noteworthy, for example, that Willa's conversations with Hollywood stars helped her to express her hardship and manage her loneliness. Their meaningfulness in this instance did not depend on their grounding in objective reality.

It is apparent that we are multi-storied. Ideally, each story contributes depth to a more nuanced yet integrated and comprehensive life story. While delusion may be one story, as is the narrative of a person's depression, there are many narratives that make up our storied self, and many ways to tell our stories. Each can enhance a person's overall life story, or detract from it. In either case, awareness of the story itself provides the possibility of 're-framing, re-telling, re-storying, re-authoring, questioning and reformulating one's life story' to identify the positives of the experience and give it new meaning.[22]

Identifying a disability story is not to trivialize the consequences of mental illness. Sometimes permanent changes result in the brain. Catherine Malabou has called this 'destructive plasticity,' in recognition that the brains capacity to heal itself is limited.[23] There are elements of destructive plasticity in the case of severe mental illness, as illustrated in the intractability of Willa's delusions and Ralph's depression, and this fact complicates the process of re-storying. How, then, can a person living with the psychological constraints of a mental illness rewrite the story of their life?

At the least, there is an ability to change the relationship to the disability story. This can become one of acceptance and integration. If accepted as one of – but not the only – story that makes up one's identity, it can add to the richness of the overall life story. There are some potential disadvantages in using the term 'acceptance.' Some will hear acceptance as resignation, and this is not what is intended. Acceptance involves a willingness to face the reality of one's situation, including its limits and possibilities. In the therapeutic context, acceptance is 'being open to one's whole experience while also actively and intentionally choosing to move in a valued life direction.'[24] Acceptance (which can also be expressed as willingness) needs to be understood in an active way. Radical acceptance is a skill to be learned and mastered. It is a skill which is built on facing up to the good and bad experiences of life, including one's own weaknesses and incapacities. Acceptance enables a person to move past the denials and struggle that are otherwise intractable.

Acceptance and Commitment Therapy (ACT) is an approach to psychological intervention that resonates with the logic of virtue ethics. In brief, it incorporates a number of cognitive processes that include: Acceptance, which is to embrace one's history, including the hardships, injustices, anxieties, feelings, pains, and psychological distortions that go with mental illness; Being present, rather than living in (and judging oneself according to) the past or the future, and so responding more flexibly to events as they unfold. Being present requires one to understand oneself not by a fixed identity, but as an identity in process; Values, understanding that acceptance and being present 'are not ends in themselves [but], rather they clear the path for a more vital, values-consistent life'; and Committed Action, which encourages 'the development of larger and larger patterns of effective action linked to chosen values.'[25] ACT now has an increasing body of scientific literature grounding its effectiveness, including the application to depressive conditions and psychoses such as schizophrenia.[26] For our purposes, its alignment

with virtue ethics is clear, especially its emphasis on self as process, which parallels the emerging, storied, construction of self, and its elevation of values and committed action that establishes patterns of behaviour.[27] This gets to the essence of virtue, which is a habit of character habituated by active practice.

After acceptance, the goal of recovery to reconstruct the self, which can take a storied shape, incorporating the illness and the process of recovery from it, even if recovery is only partial and tentative. This reconstruction will set out to explain the continuity and discontinuity between the former and present self, and identify the strengths and capacities that help to meet the challenge of the illness. There is a growing formal and informal literature of recovery memoirs for schizophrenia and depression.[28] Among other things, these show that there is surprising meaning to be found in the journey of mental illness, which gets to the heart of what it is to be human. Ours is a species that tell stories to make sense of our vulnerabilities and provide direction to our future. 'In recovery narratives, what appears most important is that the person becomes the protagonist, the hero, of her own story.'[29] In recounting the challenge of a mental illness, it is possible for a person with an illness, or a therapist, to identify the ways in which he or she has exercised virtue to navigate the obstacles presented by illness.

While self-identifying narratives are central, the virtue tradition adds the vital reminder that every person constructs their story along with that of their family, friends, and broader society, so that we need to ask, 'of what stories do I find myself a part?' Against the tendency to think of mental illness as an individual's problem, the challenge of imagining a new story may need to begin with family and friends, who can take up the narrative of a loved one who is unwell. Even though the illness might be characterized by social withdrawal, ideally (and inevitably), healing is a shared journey. Of course, families do not always provide constructive support, and some people experience recovery as an empowerment to escape from destructive family cultures, in which case, the formation of new, healthy, and creative social networks is central to long-term recovery.[30]

Caregivers are in no way immune to the trials of schizophrenia, and so their own sense of self is at risk as the illness plays itself out.[31] But while the heartache and burden of loving care should not be discounted, there can also be surprising joy to be had as a caregiver. Caregiving can provide new meaning, and exercising the virtues of care can be deeply satisfying (if only in retrospect). Even so, the long-term challenge of caregiving is that the responsibility and virtues of care need to be exercised whatever the outcome, and sometimes the personal imagination struggles to envisage hope.[32]

In giving attention to the stories of which 'I find myself a part,' there is the invitation to consider the contribution of religious or spiritual meaning to the storied life.[33] Religious meaning can be negative, as it was with Willa in her charismatic church's assertion that she was demon possessed. Such practices are grounded in the anachronistic assumption that equates mental illness with spiritual views of ancient Jewish and Greco-Roman society.[34] At its best, however, religious faith can help a person to transcend the limits of their own story, placing it in a larger context, and providing new bases of hope. Christian faith, for example, elevates the paradox of the cross and the resurrection of Jesus, and people facing every type of suffering (including mental illness) have found solace and empowering hope in the gospel narrative.[35]

Religion is not the only basis for transcendent meaning. The shared struggle against social exclusion and cultural prejudice has empowered many people to re-author their personal story, as people with disabilities (including mental illness) form communities of power to bring about political and socio-cultural change. In these communities, mental illness is released from presumptions of devastation and shame, and transformed into a mark of resilient, 'mad pride.'[36] Mad pride draws on key tenets of disability theory and advocacy, which rejects the medical

model of disability, the assumption that disability is something wrong with the individual that medical practitioners need to fix and eliminate, with the social model, which recognises that disability is created and sustained by social and cultural attitudes, values, and structures that disempower, alienate, and oppress.[37] Disability theory is based on the fundamental assumption that happiness and disability are not antithetical; in our case, that the good life and mental illness can go together, if society changes its values and structures. While earlier disability theorists tended to understand the medical and social model in opposition to one another (a tendency of some mad pride theorists), it is increasingly recognised that disability is both a medical and social reality.[38] To think therapeutically of serious mental illness in terms of disability is to face its permanence as the context in which the good life might be achieved, and to identify the complex interaction between a person's medical needs and social identity. As a communal exercise, mad pride provides an opportunity to realise *eudaimonia* in the struggle to change the social world.

VIRTUE AND VICE

The logic of the virtue tradition is that happiness – the good life – is achieved by the exercise of virtue. A virtue is a habit of character that enables a person to succeed in the tasks she sets herself. Aristotle held that virtues are in the mean or thereabouts, between vices of deficiency and excess.[39] For example, the habit of courage is in the balance between its deficit, cowardice, and its excess, rashness. If the journey of mental illness is narrated as a struggle against substantive obstacles, it cannot be faced without courage, and both fear and rash denial will be destructive. Virtues (and vices) are learned from the teaching and modelling of parents and other family members, schools, religions, and so forth, and if practiced, come to be exercised habitually. Either virtue or vice (or, more likely, some combination of the two) will frame a person's character. Virtues are not sufficient for the good life, but they are its pre-requisite. Temporal pleasure might be available to the virtuous and un-virtuous alike, but character is the prerequisite to *eudaimonia*.

Aristotle's analysis of human nature is now more than two millennia old, but has garnered 21st-century empirical support in the studies of positive psychologists, who likewise argue that the happiness earned through gratification and meaning is achieved by the exercise of strength and virtue.[40] But what often goes unacknowledged is the extent to which virtue is outside of a person's control.

Aristotle recognised that luck contributes to virtue and happiness; the luck of being born a wealthy, male, citizen with the resources, education, freedom, and opportunity to live virtuously, and not a woman, slave, poor or disfigured person, who, so he believes, lacks one or all of these fortunate characteristics.[41] He also observed that the lack of self-restraint attendant to vice can result 'through disease, for example, epileptics, or through madness.'[42] Moral luck is the dilemma that personal agency seems to lie at the heart of what it is to be an ethical person, yet so much of our circumstances, character, and action are outside of our control, and 'thus infected by luck, good or bad.'[43] This is nowhere more obvious than when a person struggles with a mental illness. Willa's schizophrenia not only causes delusions, but it impaired her capacity to make wise decisions, and undermined the self-control that grounds all virtues. Depression, likewise, sapped Ralph of energy, slowed his thinking, and lethargy undermined his capacity to take virtuous actions. These traits feed into the feelings of worthlessness and guilt that generate suicidal thoughts and thus entrench the cycles of illness. Indeed, felt emotions are central to virtue, as the virtues and vices are not only dispositions to act, but are experienced emotionally

as impulses to action — they impel us to feel good or bad about acting in a particular manner — and this further complicates the application of virtue ethics for people suffering from the negative emotions that are common to mental illness.[44]

That exercising virtue is not the *solution* to mental illness is now a scientific and therapeutic given, even if Western culture is replete with judgements against sufferers of a mental illness, who are too often blamed for their failure to think positively, act virtuously, and take control of their thoughts and actions.[45] Even so, pharmaceutical interventions provide only part of the answer, and their use is not set against virtue, but intends to help recreate the mental capacities that make personal agency possible. In fact, every person lives with the constraints of their history, vulnerabilities, and limitations, and virtue is needed precisely because life is a struggle and peace and contentment hard-won. 'Courage, integrity, compassion, humility, dignity, and grace could not mean all that they do for us in a morally hazard-free world.'[46]

In the context of a mental illness, acceptance is a virtue that enables one to take responsibility for life in the face of moral bad luck. Lisa Tessman, examining the moral damage incurred by people subject to oppression, highlights the importance of self-acceptance, which is the disposition that 'helps one to not assign *too* much responsibility (to oneself or others) when it is not deserved. It helps one to say, "This is the best I (or she, or he) can do under the circumstances of bad luck."'[47] Its deficit is denial, which makes change impossible, and its excess is blame, which becomes self-destructive. But to accept one's own vices, weaknesses, imperfections, and history is to take responsibility without condemnation. To do so takes humility and courage, and so makes space for the habits of virtue to take root.

Virtues are flexible, shaped by their context and the needs of the situation. The recovery literature identifies the importance of engaging with the challenge of recovery, utilising hope, optimism, self-efficacy and empowerment, which are personal virtues. Because virtues are passed on by familial, religious, and cultural traditions, they can add richness to conceptions of value, and help a person explore the commitments needed to negotiate the challenges of the day. The Western tradition, for example, has elevated four cardinal virtues, prudence, justice, courage, and temperance, as well as three theological virtues, faith, hope, and love. While a full treatment of these virtues is beyond the scope of this paper, it is noteworthy how each may be compromised by mental illness, and yet still an important trait for the journey of recovery. For example, prudence, which is wisdom for everyday living (Aquinas *ST* 2.2.*47.2*), may be affected by the negative thinking that attends to depression, but the practical acts that constitute prudence — seeking council, making judgements, and committing to action — are essential to the pursuit of therapeutic help, taking prescribed medicine, and committing to the slow and up-and-down process of recovery.

Temperance is a virtue that, at its most basic, is a habit of the moderation of physical pleasures, eating, drinking, and sex. More broadly, it is a cardinal virtue because it describes the self-control that moderates the exercise of other moral virtues and vices. One of the virtues sometimes subsumed within temperance is forgiveness, which entails moderation or letting go of the passions of anger, bitterness, resentment, vindictiveness and claims to a debt owed (Aquinas ST 2.2.157.3). Forgiveness is an action in response to specific events, but a person can also develop a forgiving character, a willingness to be a forgiving person (As Jesus commands, 'forgive not seven but seventy times seven times' Matt. 18:22). This willingness to let go of injustice and hurt relates forgiveness to the virtues of love and generosity, since it seeks the good of the other. And since forgiveness releases the personally damaging passions of anger and resentment, it is psychologically healthy. Indeed, there is now substantive evidence that the exercise of forgiveness makes a positive difference to mental health and well-being.[48] In the context of ACT therapy, forgiveness is a means of accepting the events of the past. Trauma

and abuse are a major cause of depression, and a traumatic life story can cement in a person's mind the idea that their own depression is an inevitable result of their mistreatment, unable to be changed.[49] Forgiveness can be a means of loosening the grip of the traumatic story. Since the act of forgiving brings release, it can empower a person to rewrite their story and thereby to take back some control of the future.[50]

The understanding of forgiveness in psychological therapy and virtue ethics are mutually supportive. What the virtue tradition adds to psychological science is a rich history exploring the meaning of virtues as well as their ambiguities. Forgiveness is a virtue in the mean between an excess of anger, on the one hand, and passive capitulation to injustice on the other. The act of forgiveness is not just a psychological tool. It also has a social context, and so demands wisdom, especially in situations where there is an imbalance of power. There is an inherent danger that asking a person subject to abuse to forgive the person who has abused them will sustain the abuse. By way of contrast, in the gospels forgiveness normally flows in a downward direction, from God to humanity, rich man to debtor, master to servant.[51] Even the offer of Jesus' forgiveness to the soldiers and religious leaders who had nailed him to the cross was a statement of power (Luke 23:34). Sometimes anger and even rage are the necessary motivators to seek freedom and justice [52]. This helps to make some sense of Ralph's claim that anger helped him feel better, giving him a sense of agency and power. Yet, done at the right time and in the right way, forgiveness can be empowering.

Our earlier recognition that serious mental illness is a disability reminds us that virtuous anger can be directed at the social exclusion and injustice that is the daily experience of people who continually deal with prejudice about their illness. Whether face-to-face, on social media, or in other public forums, it takes courage to confront prejudice, patience to persevere against intractable attitudes, wisdom to know what to say and do to affect change, and social virtues to work with others to participate in advocacy networks.

FAITH, HOPE, AND LOVE

Faith, hope, and love are the theological virtues, understood in Christian tradition to be gifts of God's grace that orient a person to the love of God and neighbour, but they also have a universal applicability. In virtue ethics, hope is found between the vices of pessimistic hopelessness and ungrounded confidence, and the hopeful person has sufficient faith about the future to empower perseverance through the trials of life. At first glance, ACT challenges the efficacy of hope. Creative hopelessness is a key intervention strategy intended to move a person toward acceptance.[53] Its target, though, is not to undermine the virtue of hope, but to unmask the vice of ungrounded hope, since people tend to persevere in seeking to control their own behaviours despite mounting evidence that such control is near impossible. Creative hopelessness is thus about revealing destructive attempts at self-control and finding a more realistic object for hope.

Religion, which can be a source for hope, can also engender false hope. In the case of Willa, for example, she attended deliverance ministry hoping that prayer would give back to her control of her thoughts. In letting go of the hope for deliverance and healing, she was invited to look for a healthier concept of prayer, one that imagined a meaningful future achieved by managing rather than escaping mental illness, in her case, by asking for God's help to live well with schizophrenia. Whether religious or not, hope can also be directed toward other ends, such as the stories of others further along the journey, the support of friends, the expertise of psychologists and therapists.

Finally, because human meaning is social, the virtues are oriented to love. A person suffering with a mental illness never suffers alone, so we might explore the happiness of and virtues needed for the family and friends responsible for caring for a person with a mental illness, which are complicated by the fact that love may not seem to be reciprocated during the worst stages of the illness. In such cases, compassion and empathy are virtues that help us to see another's sufferings as our own and to give of ourselves without expectation of return.[54] Likewise, we might attend to the character needed for professionals to undertake their various responsibilities, such as the need to balance compassion with professional distance, and exercise the humility that resists the paternalism that diminishes the agency of the client.[55] Given our focus in this paper on the person with a mental illness, the challenge is to conceive of love and the social virtues in situations such as that of Willa, who became socially isolated, withdrew from friends, and had 'an oddness' that made social interactions awkward, and Ralph, who was forced to give up his work, and whose anger and depression tended to leave him feeling isolated. Again, ACT and recovery therapies encourage acceptance of one's limitations, and a subsequent commitment to developing the social capacities that remain or that can be resurrected. Although illness reduced their social horizons, Willa relied on her mother and Ralph sustained a long-term relationship. Love means that the story of their happiness and the exercise of virtue was a shared effort.

Elevating the virtue of love opens a person to the gift of grace, the realisation that love flows from love. The deeper meaning of faith and spirituality is (or should be) that one is loved and valued unconditionally; that the gift of grace demands nothing. There might be any number of sources of grace, but to receive such a gift is to move toward self-acceptance and the healing that that can enable love to be returned to others.

SUICIDE AND FLOURISHING

It is tempting to conclude on the positive theme of the importance of love, but we must, at least tentatively, face the ultimate challenge to virtue notions of flourishing with a mental illness, which is that recovery (even when broadly defined) is not always achieved, and despite their own best efforts and that of loved ones and professional healthcare workers, some people with severe mental illnesses will commit suicide. This fact stands as a vital counter to the false positivism of shallowly conceived notions of recovery, ACT, virtue, and flourishing. Human life is fragile, short, difficult, and inevitably full of hardship and pain, and heroic virtue cannot elude its dictates. Even so, entrenched illness and tragic endings do not, in and of themselves, exhaust the meaning of human life. When someone commits suicide we rightly mourn the loss of life and its potential, and lament the psychological suffering that brought it about. But there remains the possibility of family and friends finding meaning; of the retelling of the story of a life that admits its limitations and failures, but also draws out its strengths, riches, and contribution to our shared flourishing.[56]

CONCLUSION

The primary objective of this interdisciplinary paper was to explore whether the eudaimonic conception of happiness that draws from the Greek tradition of virtue ethics is helpful in conceiving of the happiness of people suffering from disabling mental illness, in this case focusing on schizophrenia and depression as illustrative. Because virtue ethics understands happiness as transcending pleasure, as earned over the course of a life lived meaningfully, and as conceived

of and communicated by story, it advances a theory of happiness capable not only of envisaging the good life *despite* mental illness, but of incorporating the experience of the illness into storied meaning. It also revealed the striking confluence between recent psychological notions of recovery, ACT, and the virtue ethics tradition. It follows that the virtue tradition's construction of happiness as flourishing, and virtue as habits of character that help a person navigate the challenges of life, can assist people with a mental illness to rewrite the story of their life, and do so in such a way that accepts the constraints of their illness but nevertheless elevates personal agency. The experience of mental illness also speaks in the other direction, reminding proponents of virtue ethics of the limits of individual virtue and contemporary culture of the poverty of individualism. Virtues and the good life are always a shared achievement.

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