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La définition de la souffrance est difficile à cerner, en particulier lorsqu'il s'agit de la souffrance dans les cas de maltraitance d'enfants. Diviser l'humanité en catégories « auteurs » et « victimes » est trop rudimentaire. Cette dichotomie déprécie le coût humain de l'« auteur » tout en ne rendant pas compte de la complexité de la « victimisation » et de la responsabilité communautaire/collective de la souffrance des personnes abusées. Cet essai présente deux termes issus de la théologie chrétienne féministe, la « souffrance radicale » et l'« insensibilité », afin de renforcer les définitions déjà établies de la souffrance dans le contexte clinique et la littérature bioéthique. L'objectif est de : a) décrire la souffrance d'une manière qui atténue les tendances déshumanisantes et b) attirer l'attention sur la responsabilité collective des cultures de maltraitance qui favorisent la violence et la violation.

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TÉMOIGNAGE / PERSPECTIVE

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R. Dawn Hood-Patterson[a]

Résumé
La définition de la souffrance est difficile à cerner, en particulier lorsqu'il s'agit de la souffrance dans les cas de maltraitance d'enfants. Diviser l'humanité en catégories « auteurs » et « victimes » est trop rudimentaire. Cette dichotomie déprécie le coût humain de l'« auteur » tout en ne rendant pas compte de la complexité de la « victimisation » et de la responsabilité communautaire/collective de la souffrance des personnes abusées. Cet essai présente deux termes issus de la théologie chrétienne féministe, la « souffrance radicale » et l'« insensibilité », afin de renforcer les définitions déjà établies de la souffrance dans le contexte clinique et la littérature bioéthique. L'objectif est de : a) décrire la souffrance d'une manière qui atténue les tendances déshumanisantes et b) attirer l'attention sur la responsabilité collective des cultures de maltraitance qui favorisent la violence et la violation.

Mots-clés
abus d'enfants, souffrance radicale, souffrance, insensibilité, culture de l'abus, plaidoyer, États-Unis

Abstract
The definition of suffering is difficult to pinpoint, particularly when addressing suffering within cases of child abuse. Dividing humanity into the categories of "perpetrators" and "victims" is too rudimentary. This dichotomy depreciates the human cost of the "perpetrator" while simultaneously failing to account for the complexity of "victimization" and the communal/collective responsibility for the suffering of those abused. This essay introduces two terms from feminist Christian theology, "radical suffering" and "callousness," as a way of bolstering already-established definitions of suffering within the clinical context and bioethics literature. The aim is to: a) describe suffering in a way that mitigates dehumanizing tendencies and b) direct attention to a collective responsibility for cultures of abuse that enable violence and violation.

Keywords
child abuse, radical suffering, suffering, callousness, culture of abuse, advocacy, United States

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INTRODUCTION

She had broken bones in multiple places and the skeletal survey showed fractures old and new. Nova,[1] our patient, was in this southern United States hospital that day because she had a traumatic brain injury. The electronic medical record had a growing, concerning image tab of scans that were a portrait of hard living — reasonable, perhaps, if her life had been filled with motorcycle rides or mixed martial arts fighting. With six months under her belt, such mythic sources of trauma did not meet her lived reality.

"A fall from my arms," Nova's dad, Justin, had explained. She was intubated to help her breath, she was not sedated, her eyes had fixed pupils, she had no gag reflex, all of which were concerning indications for serious neurological injury. Ashy hues cast shadows over her once walnut skin. A report was immediately filed with Child Protective Services (CPS). Nova died ten days later when the family chose to compassionately extubate and allow for a natural death. There were increased inconsistencies in Justin's story, the details of his narrative changed with some frequency. There were several unexplained past injuries, such as old bruising patterns on Nova's face and left shoulder; some of the injuries were blamed on rough play with Nova's two-year-old brother, all of which raised concerns that Justin had inflicted the injuries. He was taken into custody shortly after Nova was pronounced dead.

For ten days, Justin remained at bedside. CPS thought it would be in Nova's best interest to have her parents at bedside for end-of-life decision-making. When I first met with Justin, to introduce myself and ethics services, Justin maintained his innocence. He expressed concern about the treatment he was receiving from the healthcare team, CPS and police. He looked at me and said, "What am I even going to tell you? You have already made up your mind about me."

When conducting ethics rounds in the unit, the bedside staff expressed heightened moral distress because CPS did not restrict Justin's visitation; only to say that he could not be alone with Nova. At the time, we were not certain that Justin had perpetrated the violence but the whispers from the staff carried the tones that Justin had already been tried and convicted. Staff expressed reservations about their obligation to include Justin in shared decision-making. They made remarks like, "It feels like Justin should have lost his decision-making privileges when he hurt Nova." Or "It seems like he should have lost his parental rights the first time he beat her."

[1] Names and identifying details have been changed in this case report.

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How do healthcare workers manage to care for patients with non-accidental traumas when we assume a perpetrator of violence sits in our workspace? How do we foster moral spaces when the legal deciders may be violent? How do we reconcile the sheer evil of child abuse with the reality that people who commit these atrocities are human, and not a lesser degree of human? Do we reconcile this in our minds by thinking that perpetrators of violence are the "bad apple," a distortion of a full humanity? How do we hold perpetrators of violence accountable without vilifying them? How do we account for reverberating bias within the ethics consultation process?

These are the questions that clinical ethicists should wrestle with as they help care teams advocate for patients. It is insufficient to tend to the moral distress or the questions about parental authority without first understanding the undergirding biases that may influence our recommendations. Our capacities to care for patients and advocate in institutional and public domains are dependent upon this inquiry. Child abuse appears to be child- or patient-specific but increased attention to social determinants of health illuminate a community-contextual component that cannot be ignored (1-2).

Justin's rhetorical question lingered in my mind, but his proposed answer is what sat with me on sleepless nights: had we already made up our minds about him? The questions from the healthcare teams, "After what he has done, can this dad make decisions that are in the best interest of his daughter?" suggest that we had pre-emptively made up our minds. Additionally, these questions also skirt past the complexity of this case; potentially reinforcing systemic bias and failing to address the systemic factors that culminated in Nova's injury, and Justin's arrest. Advocacy should start with recognizing systemic complexities, without which our starting assumptions and recommendations are incomplete.

ANALYSIS

At the core of this analysis resides a need to make sense of a) suffering and b) our human capacity to commit violence. By introducing the work on "radical suffering" and "callousness" from feminist, Christian theologian Wendy Farley (3), I will offer two definitions that will coalesce to deepen an understanding of suffering. These definitions provide theoretical underpinnings that shift the narrative away from individual suffering, encouraging ethicists to consider the impact and implication of collective suffering and responsibility within cultures of abuse.

This analysis *does not* excuse perpetrators of violence. Perpetrators of violence must be held accountable for their actions. When we dare contemplate the parameters of suffering, our capacities for compassion for Justin, and his victimization at the hands of faltering social support, fails. Understandably so. It is a balm to a collective soul when we place the responsibility for what was done to Nova on someone. When we attach responsibility to an individual they will be apprehended, tried, and incarcerated. Justice for Nova will have been served. And that is one essential aspect of justice — individual consequences for action.

I intend to flip the mirror, however, and help those of us in healthcare better evaluate our complicity and complacency in the culture of abuse that saturates these circumstances. I will argue that the responsibility for child abuse is also communal. Clinical ethicists miss something important if our ethical evaluations fail to consider the structural and systemic injustices that Justin readily pointed to when he said, "You have already made up your mind about me." He was pointing to a collective misery in which he was both perpetrator and victim. We cannot control the violence initiated by others, but we can aim our indignation and our advocacy toward the reform of systemic evils that enable that violence. As we bear witness to the suffering of Nova and the consternation of the healthcare team, we recognized that suffering is more than an accumulation of feelings or somatic responses to stimuli, it is collective (4-7).

Radical Suffering

Cases like Nova's illustrate "radical suffering," which Farley defines as a form of suffering that erodes our sense of identity, worth, and dignity. We become accomplices in each other's destruction by dehumanizing each other. Radical suffering is a category unto itself; suffering from violence, social oppression, marginalization — enacted upon us or our community. The effect debilitates or erodes access to power or resources (3). In addition, our contexts compromise our capacities for compassion (3). Without communal or familial support, Justin's compassion for a crying Nova is eroded. When we say that Justin is a "bad apple," we are eroding his innate worth as a human, potentially even cutting off access to meaningful childcare resources because we have deemed Justin "unworthy." Without attention to the fractured familial support in the United States, Justin's access to safe childcare or parental support offers him no respite. Radical suffering occurs when Justin has nowhere to turn when Nova won't stop crying. Radical suffering transpires when we view Justin as a *bad man* rather than a man who has done a bad thing.

What sets radical suffering apart from other definitions of suffering available within current medical, nursing, and clinical ethics literature is that it: a) seeks social justice determinations rather than merely punitive resolutions, b) describes how suffering impedes on our identity and capacities for compassion, and c) is enacted by individuals and institutions in ways that seem innocuous. Radical suffering is perpetuated by ordinary people swallowed up by destructive, demoralizing, and dehumanizing systems.

Radical suffering gives us language to grapple with the injustices of suffering while probing the assumptions that goodness and morality underlie the cosmic order. The very conditions and contexts of our existence dismantle our capacity to innately

act lovingly or morally. We want to believe that we are morally superior to the *Justins* of the world. It is much easier to dismiss Justin by minimizing his humanity — "othering" him. It is harder to reconcile any responsibility we may bear for a shared culture of abuse, marginalization, or oppression that enables or perpetuates non-accidental traumas. It is our responsibility as ethicists to analyze a shared role and responsibility for income inequality, housing discrimination, racism, inadequate childcare, inequitable access to mental health, familial, or medical support that leads to child abuse in the first place. This argument, however, does not hold together without also defining callousness.

Callousness

A callous on our bodies occurs when our skin rubs in one place, time and again. Our attention is not directed toward the accumulating effect of skin growth, and we may only notice the callous after it has formed. In a similar fashion, callousness, as defined by Farley, is the human propensity to ignore the accumulation of injustices and acts of violence that cause suffering (3). We rub against the deception that we are immune to the gnawing impact of violence and dehumanizing brutalities of inequality time and again. This eventuates in callousness toward each other and the systemic and social injustices that cause radical suffering.

Callousness manifests individually and communally. As Farley notes, "Callousness is not present in a community through a handful of criminals but as a characteristic of the community itself. The community mediates attitudes and values that make violence and cruelty normal" (3, p.47). Our capacities for empathy are diminished as we become more calloused. We become indifferent or apathetic toward each other and the cultures of abuse around us. Principled people, righteous and upstanding — or rudimentarily moral — instigate, ignore, or perpetuate suffering and the cultural milieu that fosters abuse. We are calloused to the undergirding factors that may have contributed to Justin's abuse of Nova.

While we express outrage over Nova's preventable death, we also have an obligation to prevent the social factors that enabled Justin's abuse such as inadequate respite for depleted parents, underfunded childcare or family programing, livable pay, and policies that make work-life balance attainable for all parents. Our advocacy for the Novas we encounter cannot end at her death, we cannot become calloused to the work ahead.

Action within Cultures of Abuse and Communal Responsibility

Taylor Tate suggested that suffering, particularly pediatric suffering, is a "social and political event" (4, p.143). Suffering unfolds within a broader social or communal paradigm. In a robust response to the suffering of children (and the ethical dilemmas and moral distress it generates) we cannot turn a blind eye to the conditions that enabled the abuse to occur in the first place. A culture of abuse is the denial of resources, the systemic oppression and marginalization of families inequitably caught within our child protective systems, and our callousness toward violence and systemic inequities (8-10).

Healthcare workers are not impotent in the face of radical suffering. The World Health Organization suggested that "people have the right to participate actively in shaping the social and health policies that affect their lives" (11, p.58). Advocating for moral spaces on the individual, institutional, or social level can help reclaim power potentially lost in the morally distressing circumstances of abuse and non-accidental traumas (11). We should first recognize the creeping callousness that may quell our advocacy. A dismissal of Justin as a "bad apple" alerts us to the insidiousness of callousness and the treacherous impact of radical suffering.

CONCLUSION

It is imperative for ethicists to analyze the social-systemic function of suffering — expanding the peripheries of an individually-situated notion of suffering. Ethicists have a responsibility to consider radical suffering and the impact of callousness for a robust assessment of the ethical questions and moral distress initiated in case consultation. Not only do these terms illuminate the social-contextual aspects of abuse but they also help to shine a collective light on a shared responsibility for cultures of abuse. Ethicists hold a responsibility to cultivate the moral spaces beyond the bedside, especially with increased evidence of the impact of social determinants of health. Understanding abuse as a systemic concern can augment advocacy efforts. Attention should shift, in part, toward institutional and societal reform. The objective of advocacy should be to reform cultures of abuse that enable callousness and radical suffering. This helps to shift the accountability for abuse away from the sole focus of individual responsibility, energizing collective efforts to rectify systemic inadequacies and broaden access to services.

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REFERENCES

1. Ruffolo LI, Gaba H, Dale BS, et al. Outcomes after child physical abuse and association with community-level social determinants of health. Journal of the American College of Surgeons. 2022;235(5):810-18.
2. Puls HT, Chung PJ, Anderson C. Universal child care as a policy to prevent child maltreatment. Pediatrics. 2022;150(2):e2022056660.
3. Farley W. Tragic Vision and Divine Compassion: A Contemporary Theodicy. Louisville, KY: Westminster John Knox; 1990.
4. Tate T. What we talk about when we talk about pediatric suffering. Theoretical Medicine and Bioethics. 2020;41(4):143-63.
5. Amonoo HL, Harris JH, Murphy WS, Abrahm JL, Peteet JR. The physician's role in responding to existential suffering: what does it mean to comfort always? Journal of Palliative Care. 2020;35(1):8-12.
6. Salter EK. The new futility? The rhetoric and role of "suffering" in pediatric decision-making. Nursing Ethics. 2020;27(1):16-27.
7. Cassell EJ. Recognizing suffering. Hastings Center Report. 1991;21(3):24-31.
8. Ledbetter EO. An ethical approach to intervention/prevention of child maltreatment. Advances in Pediatrics. 2003;50(1):215-229.
9. Palusci VJ, Botash AS. Race and bias in child maltreatment diagnosis and reporting. Pediatrics. 2021;148(1):e2020049625.
10. Puls HT, Hall M, Anderst JD, Gurley T, Perrin J, Chung PJ. State spending on public benefit programs and child maltreatment. Pediatrics. 2021;148(5):e2021050685.
11. World Health Organization. A conceptual framework for action on the social determinants of health: Social determinants of health discussion paper 2. Geneva: WHO; 2010.