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# *The Narrativist Turn in Healthcare and its Implications on the Experience of Perinatal Grief*

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ABSTRACT: The non-recognition of perinatal bereavement in society leads parents to an isolated condition that may hinder their psychological adjustment after the loss (Layne; Markin and Zilcha-Mano). Improving bereaved parents' experiences of communication in healthcare practice thus seems to be crucial to lessening the risk of dysfunctional grief. This paper presents a research project on the topic of perinatal death, *"Words Fail Me": Naming the Unnamable* (PERINAT), funded by the French National Agency for Research (2023-2027). By focusing on the metaphorical constructions used by bereaved parents in their narratives of perinatal death, PERINAT seeks to improve the communication experience of the bereaved by furthering health care practitioners' understanding of this grief. The study is conducted by means of a dataset collected in 2022-23 from interviews with a hundred bereaved parents in France. The preliminary findings of this ongoing project are meant to be used to inform and improve the support offered by health care providers who are likely to come across a bereaved parent in their professional capacity. More specifically, from a perspective of narrative medicine, this contribution seeks to explore what the study of metaphor can potentially offer to the development of narrative competence in the training of health professionals. By developing higher awareness of bereaved parents' narrative, more specifically of their use of figurative language, practitioners can make sense of parents' needs and emotional responses to their experience of loss in order to ease it. As Norwood (122) has it, metaphor, like poetry, "can make unknown known and the unspeakable speakable". This is also in line with the most recent promotion of a relationship-centered and patient-centred notion of care (Bensing; Pluut).

KEY WORDS: narrative competence; narrative medicine; narrative of bereavement experience; metaphor; quality of care; relationship-centered care

> To grow in our understanding of how patients tell of themselves and their bodies seems a pivotal and enduring effort in our willingness and ability to care for the sick. […] When we turn the corner toward affiliation and contact, we know that our narrative competence has yielded its most valuable dividends in enabling us to bear witness to suffering and, by that act, to ease it. (Charon, *Narrative* xi)

## INTRODUCTION AND AIMS

This paper investigates the discourse on perinatal death, which is a broad term encompassing stillbirth, medical termination in the second and third trimester following the diagnosis of lethal anomaly or rare disease, neonatal death and cases of palliative neonatal care for newborns with a life-limiting condition (World Health Organisation 19).

Perinatal death is also called the "invisible loss" (Lang *et al.*) as it is often left unspoken in society. The lack of social validation and open acknowledgement by others makes perinatal grief a type of disenfranchised grief (Doka), mainly because of the stigma attached to it (Markin and Zilcha-Mano). In their narrative, bereaved parents seem to confirm this as they lament feeling isolated, misunderstood or belittled (Barney and Yoshumira 87). This taboo remains deeply entrenched in private and public communication, despite the fact that perinatal death is a relatively common occurrence: according to statistics from the World Health Organisation (WHO), in 2019, 10 in every 1000 pregnancies in France ended with stillbirth or death in the first week of life[1].

The societal de-legitimization of perinatal bereavement causes parents who attempt to communicate their grief a feeling of isolation that is linked to the notion of "epistemic injustice" (Fricker): the idea that the absence of appropriate words and concepts to express one's experience interferes with the ability to make this experience intelligible to others. Against this background, communication surrounding perinatal

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[1] https://gateway.euro.who.int/en/indicators/hfa_84-1170-perinatal-deaths-per-1000-births/ Accessed 28 Jan. 2024.

death predictably plays a major role on the parents' grieving process and on their psychological adjustment after the loss (Layne; Markin and Zilcha-Mano). Improving the communication experience of the bereaved is therefore crucial to reduce the likelihood of a possible dysfunctional grief as well as its consequences at socio-economic level (e.g. excess costs for both the health care and social service sectors).

For most parents, whose first communication experience about the loss takes place at the hospital, the discursive practices employed by healthcare professionals have a profound effect on their experience of grief from the onset. As argued by Berry (604), health care practitioners (HCPs) can have an impact in mitigating the traumatic nature of the grieving experience by adopting a trauma-informed approach, for instance by acknowledging the loss, and providing follow-up care for at least one year after the perinatal loss experience. Often times however, the health care professionals who are expected to support the grieving individual lack the "experiential knowledge" (Borkman) of perinatal grief, i.e. they might hold an inaccurate belief about what exactly the grieving person is experiencing (Barney and Yoshimura 80). In this respect, metaphors can play a potentially beneficial role. Since we think metaphorically (Lakoff and Johnson), developing higher awareness of bereaved parents' figurative speech can provide healthcare professionals with a better insight into the cognitive and affective underpinnings of an emotionally challenging event (Semino *et al.*), like perinatal loss. This may help HCPs make more sense of parents' needs, improve communicative practices accordingly and ease the distress related to perinatal loss (Lang *et al.*).

This paper draws upon the preliminary results of an international research project (PERINAT, presented in Section 1) and seeks to further understanding of perinatal grief by looking at the linguistic choices made by bereaved parents with a view to improving their communication experience in medical settings. This is done by:

- Observing bereaved parents' narrative by means of semi-guided interviews on their experience of loss.
- Identifying the metaphorical representations that characterise their narrative.
- Developing awareness of bereaved parents' trauma narrative as a way of providing insight to HCPs.

The ultimate goal of this research is to: (i) engage bereaved parents in meaningful ways in order to get a 'way in' to their traumatic experience by means of a metaphor analysis of their accounts (Turner and Littlemore 37); and (ii) integrate this newly-derived knowledge into recommendations for better perinatal bereavement care. As a societal challenge, the PERINAT project intends to stimulate a debate among practitioners on the consequences of perinatal death and propose a transformational change in terms of the experience of bereaved parents, mainly by informing clinical practice. Perinatal bereavement care currently in place in French hospitals is characterized by a high degree of variability, hence the need to encourage the possible creation of a national pathway, also inspired by the "National bereavement care pathway for pregnancy and baby loss"[2] (NBCP) currently in place in the UK. NBCP provides a dedicated, evidence-

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[2] https://www.nbcpathway.org.uk/ Accessed 28 Jan. 2024.

based care pathway with guidance for professionals assisting bereaved families for greater quality and greater consistency in bereavement care. This aspect is in line with the increased relevance that has been given in the past few decades to the notions of "patient-centredness" (Bensing) and "patient-centred discourses" (Pluut), and dovetails with an increased interest in narrative medicine, a diagnostic approach that values patients' narratives in clinical practice. This study moves in the same direction as its results will be used to develop guidance and training material for HCPs.

## NAMING THE UNNAMABLE IN HEALTHCARE ENCOUNTERS: THE "ANALGESIC POWER" OF NARRATIVE

The non-recognition of perinatal grief and bereavement in society leads parents to feel isolated, hindering their psychological adjustment after the loss (Layne; Markin and Zilcha-Mano). Because of its specificities, perinatal mourning entails different psychological mechanisms compared to other forms of bereavement (Weiss), such as a deep sense of loss of parenthood status and a feeling of biological failure (Wallerstedt *et al.*). Perinatal death can have detrimental long-term effects on parents' lives, with a higher likelihood of complicated grief (Lundorff *et al.*) and predictably negative consequences on professional performance (Hazen) and on social roles in general. In the light of these issues, improving bereaved parents' experiences of care and communication seems to be crucial to lessening the risk of dysfunctional grief and avoid the consequences that the latter may trigger at personal and socio-economic level.

This study seeks to improve the communication experience of the bereaved by furthering health care practitioners' understanding of this grief. It draws upon an international research project on the communication surrounding perinatal death entitled "Words Fail Me": Naming the Unnamable[3] (PERINAT), recently funded by the French National Agency for Research. PERINAT is based on a corpus of interviews with one hundred bereaved parents in France. For the purpose of language analysis, PERINAT focuses on two linguistic elements that characterise parents' accounts of perinatal loss: a) metaphor as a commonly-used resource for expressing the inexpressible; and b) neologisms used to denote bereaved parents and their prematurely deceased babies. The reason for this dual focus is that while metaphors provide insights into people's extant conceptualisations of their experiences, neologisms are a powerful means of creating and voicing new concepts by giving them a linguistic label. These two elements are closely related as neologisms themselves often have a metaphorical basis.

From the perspective of metaphor analysis, this project is intended as a continuation of the scientific project "Death Before Birth: Understanding, informing and

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[3] At the time of writing this article, PERINAT had been recently funded by the French National Agency for Research (2023-27, AAP2022- PRC- CE36, 2023-27): https://perinat.univ-lille.fr/. Accessed 28 Jan. 2024.

supporting the choices made by people who have experienced miscarriage, termination, and stillbirth”[4] (henceforth DbB) conducted by an interdisciplinary team of UK researchers (P.I. Jeannette Littlemore) in 2016-2018. DbB focused on metaphor analysis as an effective tool in providing insights into the complexities and tensions of emotionally-charged experiences (Gibbs) that are not widely shared in society or that are otherwise difficult to express (Semino, “Descriptions”), such as pregnancy loss. Metaphor has been shown to be prevalent in individuals’ recounting of their experiences of pregnancy loss and a powerful tool that sheds light on the ways in which bereaved parents conceptualise their life-changing experience (Semino, “Metaphor”). By developing higher awareness of bereaved parents’ narrative, more specifically of their use of figurative language, practitioners can gain a better insight into the cognitive underpinnings of perinatal grief, and make sense of parents’ needs and emotional responses to their grief in order to ease it. As Norwood (*Metaphor* 122) has it, metaphor, like poetry, “can make unknown known and the unspeakable speakable”.

From a lexical standpoint, the study reflects on the lack of a specific term to designate either bereaved parents or their lost babies. The use of new identifying terms to designate them would allow the father/mother to feel recognised in their role as parents, thereby giving substance (conceptual reification) to their complex and emotionally challenging experience, but also breaking the taboo in private and public communication about the defunct baby. As defended by hypostatization theory in linguistics (Schmid), words have a “concept-forming power” (Leech) in the sense that the existence of a unique and/or special term renders the concept conceptually tangible to language users, creating the impression that there is a corresponding entity to which the word refers. The existence of novel/*ad hoc* created designating terms is so crucial in the process of conceptualizing and processing the experience of perinatal grief that new words are spontaneously making their first appearance in the French-speaking communities of bereaved parents, who are currently petitioning for the recognition of the term *parange* (a compound of ‘parent’ and ‘angel’ in French). These attempts to affirm parents’ bereaved identity are a way to tackle the invisibility of perinatal loss: the absence of a word implies the absence of a unified concept, of a “social meaning” (Fricker), which makes it difficult for this meaning to get accepted in the larger community.

For the purpose of this study, I will simply concentrate on the use of metaphor in parents’ recounts, which is observed and analysed by means of anonymised semi-structured interviews administered to a total of 100 bereaved parents in France. To enable a comparative study, the interviews follow the template used for data collection of the DbB project. The interviews serve to scrutinise the use of metaphor in parents’ narrative with reference to a number of different key moments of their experience: getting the news about their baby’s death; communicating their loss; opting for the type of funeral; leaving the hospital; returning to work.

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[4] https://deathbeforebirthproject.org/ Accessed 28 Jan. 2024.

In terms of method, metaphors are identified at the level of the phrase following a procedure produced by Cameron (2003). Within these phrases we ensure that the metaphorically used items are genuinely metaphorical by using an adapted version of the PRAGGLEJAZ Group (2007) Metaphor Identification Procedure by which a relationship involving similarity is identified. Metaphors are then classified into broad categories that reflect the semantic fields to which the vehicle terms belong. In the identification of these metaphor categories, no assumptions are made about conceptual metaphor or source domains, so not all of the categories of metaphor identified will be found in established metaphor lists (e.g. Lakoff and Johnson; Grady). In some cases, one linguistic metaphor is assigned to more than one metaphor category and some categories are more overarching than others. To avoid missing any important information, a maximally inclusive approach is adopted, by which all categories are treated at the same level despite the fact that some categories may presuppose others. At this point it is important to stress that the analysis of metaphor relating to abstract and emotional experiences, such as perinatal bereavement, poses some methodological challenges, for example the need for a different, and possibly less categorical, approach to metaphor identification and to the notion of metaphoricity. For this paper, we embrace the framework proposed by Turner and Littlemore, who suggest working on "potential" metaphoricity rather than metaphor in absolute terms. Since the aim of this research is to provide insights into people's lived experiences through the lens of metaphor, not to define metaphor as a linguistic phenomenon *tout court*, then a "flexible, maximally inclusive approach to metaphor identification including potential metaphors is appropriate" (Turner and Littlemore 42). While metaphors will be a central element in our investigation, they do not exhaustively characterise the data. A third level of analysis therefore consists in identifying all the topics that parents talk about, and the key things that are said, even if no metaphors are being used. By doing so, we get a full view of what is being talked about, and how. Within the metaphors identified, those that are creative are then marked up using an adapted version of the procedure employed by Müller (2010). These data will then be grouped in different ways in order to identify how parents conceptualise: their experiences of pregnancy and neonatal loss, and the communication they had with healthcare professionals and others.

The impetus for this study has been the paucity of literature on perinatal death from a linguistic perspective (Raschini), a topic thus far mainly explored in the fields of psychology and anthropology. Some existing research in linguistics has explored the analgesic and healing value of discourse in situations of vulnerability. More specifically, Ruchon ("Des vertus") has highlighted the "analgesic power" of discourse in communication surrounding infant loss (in utero or in the months following the birth), an aspect which has been thus far little investigated. The PERINAT project seeks to fill this gap by bringing together, probably for the first time, those affected by this loss and academic scholars in the frame of a participatory study. Another innovative aspect of PERINAT, also in relation to the DbB project, is the inclusion of male respondents.

Bereaved fathers, typically construed in discourse as mere 'supportive partners', are in the minority in other studies focusing on bereaved parents (Cacciatore *et al.* ; Kelley *et al.*).

## THE IMPORTANCE OF PATIENTS' NARRATIVE TO IMPROVE PERINATAL BEREAVEMENT CARE

Perinatal grief prompts parents to engage in the reconstruction of a narrative about the baby and their relationship with them, and in the development of a new sense of self post-loss (Barney and Yoshimura 78). A study on the communication surrounding perinatal death cannot therefore overlook insights derived from narrative medicine as an approach to promote better perinatal bereavement care.

Most prior research on perinatal death consists of studies designed solely by researchers (Farrales *et al.*). This contribution offers a different perspective as it is an instance of participatory research that includes a vulnerable population (individuals affected by perinatal loss) to help them voice their experiences, and empower their status - and agency - as parents. As previously mentioned, this study is based on transcribed semi-guided interviews in which participants describe their lived experiences dealing with perinatal death. This active involvement of patients is predicated on the belief that their accounts of healthcare can offer unique and valuable perspectives for research (Baker *at al.*). By means of an analysis of parents' direct personal narrative of the loss, the study seeks to gain a deeper understanding of perinatal grief in order to make sure that parents' (communication) experience is responsive to their actual needs.

As argued by Coulehan (87), patients understand their experience of illness and trauma in a narrative way, "whether their physicians realize it or not". Ignoring or devaluing narrative in clinical settings is therefore likely to produce a negative impact on the grieving experience, and this is also the reason why the regenerative role of narration is currently being revalued in the medical field. This is, slowly but progressively, leading to a different approach to health known as narrative medicine, which is aptly summarized by Charon ("What to do" 1265) as "clinical practice fortified by narrative competence". One of the tenets of narrative medicine is that patients' personal stories should be listened to by HCPs, and responded in ways that enhance their care. This type of perspective, which encourages the coupling of health sciences and social sciences, seeks to prevent the shortsightedness and limitations of a merely traditional bio-medical approach. In their clinical training and practice, HCPs are made increasingly aware of the need to develop and enhance a narrative competence, meant as "the set of skills required to recognize, absorb, interpret, and be moved by the stories one hears or reads" (Charon, "Narrative" 862). The development and use of narrative skills in practicing medicine aims to improve communication in healthcare environments by promoting the idea of patient- and relationship-centered care. In the words of Lamprell and Braithwaite (569), narrative competence “widens the clinical gaze beyond logico-scientific cognition” and enables HCPs to have more proximity with the vulnerable ones. Narrative thus becomes functional to sharing experience and building a renewed post-loss identity, and this is a major step in overcoming the condition of isolation and of “epistemic injustice” in which parents find themselves at the loss of their babies.

## METAPHOR: A TOOL TO ACCESS AND MAGNIFY THE EXPERIENCE OF GRIEF

One straightforward way to improve our understanding of perinatal death is to ask parents about their experiences and analyse the narratives they produce. However, simply looking at what the bereaved say may not be enough. It is also important to look at *how* they say it. One analytical tool that is useful in this respect is metaphor. As Norwood (113) argues, metaphor is a precision instrument for probing, magnifying and capturing the experience of grief in a way that provides rich insights into what is inaccessible by means of an analysis of the content alone (also see Littlemore and Turner “What Can Metaphor”,”Metaphors”). Norwood (120) carries on by saying that “Experience that is mysterious, unfamiliar, frightening, lacking in stories, can be made sense of if parsed through the terms of something familiar, safe, known and validated”. Studying the metaphors that parents use to describe their intense traumatic experiences is thus a powerful way to see through the eyes of those affected by reproductive loss, which remains a social taboo (Layne).

For the purpose of developing HCPs’ capacity for communication and affiliation with bereaved parents in order to improve the effectiveness of care, this study foregrounds the role of metaphor as a tool to express, share and learn about the experience of trauma and grief. As suggested by Lamprell and Braithwaite (587), taking metaphor as one of the variables into account when thinking about a patient’s story “navigates healthcare providers directly into the patient-centred point of view that enriches the quality, safety and relevance of clinical assessment and overall care”. Thanks to a narrative medicine approach focused on metaphor use in parents’ narrative, HCPs can better understand, and acknowledge, what bereaved parents are going through. As Reisfield and Wislon (4024) suggest, metaphors “can have a powerful influence on the practice of medicine and the experience of illness” in the sense that they can serve as the basis for a shared understanding of clinical reality in patient-physician relationship. By means of metaphor analysis, practitioners can gain an insight into the cognitive underpinnings of perinatal grief (how grief is concretely experienced) and respond to bereaved parents’ actual needs accordingly, for instance by encouraging long-term initiatives for postnatal care or new clinical procedures.

Metaphors used in the semi-guided interviews of the PERINAT corpus can be seen as a tool for identifying and revealing problematic aspects concerning the bereavement care provided to parents during or after perinatal loss. As can be seen from the passages extrapolated below, parents use metaphorical representations to flag up elements/aspects that may have intensified their traumatic experience and for which there is scope for future improvement in terms of bereavement care policies or hospital procedures.

When a parent experiences perinatal death, or is about to, their perception of themselves and of their baby can understandably be altered (Turner *et al.* ), and this is evidenced by means of metaphor use in the narrative analysis of parents' accounts. In the examples below, drawn from the PERINAT corpus, I will discuss the case where the baby is still alive in the womb, but awaiting termination for medical reason following a diagnosis of lethal anomaly or rare disease. Apart from the actual moral dilemma that these parents face, this extremely demanding moment is sometimes made more emotionally challenging for parents by a series of circumstances. Many parents may be deprived of the emotional support needed by refraining from consulting others on their decision to terminate (or from seeking help from support groups) because of fears of stigmatisation (Zaręba *et al.*). Additional distress is caused by the fact that more time than expected might elapse between the prenatal diagnosis announcement and the actual interruption of pregnancy. During this waiting period, parents lament an interruption in the continuity of care: there might be little to no medical consultation in between, which also means reduced chances to receive support from the clinical environment, also in terms of the information on the termination procedure itself. In the interviews that can be ascribed to these specific instances, parents deplore the lack of information and assistance received by HCPs during this time, which risks having a negative impact on the way they live and conceptualise the experience (e.g. by developing a feeling of injustice and/or guilt). As it can be evidenced from the examples below, the baby awaiting pregnancy interruption is metaphorically described as someone "on suspended death sentence" whose days are numbered, and the medical interruption as an impending doom (Caliendo and Marinato):

(1) *euh donc la décision a été prise acceptée on m'a expliqué euh plus ou moins euh les étapes à suivre que je serai hospitalisée la nuit avant l'accouchement euh […] j'ai y a eu quelques jours d'attentes quand même et donc c'est à ce moment-là que c'est devenu compliqué parce que j'avais l'impression d'avoir un de porter* ***un petit bébé en sursis*** *quoi […] je m'excusais tout le temps je lui disais je suis désolée je suis désolée je suis désolée dans quelques jours quelques heures c'est fini tout ça.*

// ehm so the decision had been taken accepted they explained to me more or less the different steps of the procedure that I would be hospitalised the night before the delivery ehm […] I had to wait a few days before that anyway and that's when it got tough as **it** felt like I was carrying **a little baby on suspended death sentence** like […] I would apologise to him all the time I would tell him I'm sorry I'm sorry I'm sorry in a few days and in a few hours this will be over. (02_TM95_#52)

(2) *Et donc on rentre chez nous et pour moi c'est comme si ma grossesse était finie. […] C'est comme si* ***notre fille elle était condamnée*** *qu'y avait rien de d'envisageable.*

// So we go back home [following the diagnosis] and for me it's as if the pregnancy was over […] it was as if **our daughter was condemned to death** that there was nothing we could do. (14_SC87_#58)

> (3) *<Intervieweuse> : Comment s'est passé le moment où vous avez partagé l'annonce de l'IMG à votre entourage ?*
> *<SV> Euh alors euh je sais plus trop exactement moi en fait le le premier coup de fil dont j'ai vraiment souvenir c'est le jour fin de la seconde première échographie en fait quand je suis retournée chez un autre chez une autre échographiste et là là je suis sortie donc j'étais effondrée là j'ai appelé ma mère de suite. Et bah c'était ça ça valait un peu pour équivalent fin c'était un peu une équivalence puisque fin* ***elle avait condamné le bébé*** *en fait dans le discours hein donc euh donc euh donc c'était de facto l'annonce que j'allais me séparer de ce bébé.*
> //<Interviewer>: Can you tell me about the moment you shared the news of the medical interruption with your family?
> <SV> Uh so uh I don't remember exactly but the the first phone call I really remember is the day of the second first ultrasound actually when I went back to another another echographist and there there I came out so I was devastated there I called my mother immediately. And well it was it was a bit like the equivalent well it was a bit an equivalence because well **she had condemned the baby** actually in the conversation so uh so uh so it was de facto the announcement that I was going to say good-bye to this baby. (79_SV32_#23)

It could be argued that the use of expressions to qualify the baby as someone who is "condemned (to death)"/"doomed" (examples (1)--(3) above) suggests the same overarching metaphorical idea of lack of agency (and autonomy in decision-making): the baby is portrayed as relentlessly faced with an inescapable doom. In the examples above, the baby awaiting termination is likened to someone who is living "on borrowed time". In this creative comparison, a human being who was until then free is now described as awaiting conviction, which suggests the idea of an impending capital punishment (death caused by the feticide) after weighing evidence. These figurative representations undisputedly bring to the fore the underlying psychological distress related to this specific, and in itself extremely delicate, stage of the perinatal story and the need for more clinical interventions for termination coping (Major *et al.*), such as making sure that while waiting for pregnancy interruption parents: are supported to make informed decisions; feel that their decision is not disapproved of by any medical staff member; see that their baby is recognised in their dignity (also by selecting certain designating terms over others); receive information about relevant support groups and coping resources. The way this specific phase is experienced (and metaphorically conceptualised) by patients shows that it needs to be given more weight within clinical encounters if the aim is to reduce the likelihood of ensuing emotional complications and post-traumatic stress disorders.

Rationalising the decision to terminate, also thanks to mechanisms of social and medical support, is indeed a key element of the recovery process (Zaręba *et al.*). This is also suggested by the National Bereavement Care Pathway (NBCP[5]), an initiative led throughout the UK for the development of a series of national guidelines for healthcare

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[5] https://nbcpathway.org.uk/. Accessed 28 Jan. 2024.

staff to increase the level of quality standards in bereavement care for pregnancy and baby loss. The NBCP recommendations for cases of TOPFA (Termination of Pregnancy due to Fetal Anomaly)[6] clearly stress that:

> Women should be offered **continuity of carer** when they have decided to terminate a pregnancy. It is important that parents receive **supportive, empathetic, non-judgemental care** and information from staff so that parents can make decisions that are right for them. **Empathetic care** is crucial for parents who can fear being judged for their decision. Parents may experience additional distress if they perceive staff to be unsupportive or disapproving of their decision to terminate the pregnancy. Once parents have decided to have a termination, staff should offer to **discuss the woman's options** for her care including the termination procedures. Parents need to be given **adequate information** so that they know what to expect and can make **informed choices about their care**. It is important that staff offer to repeat information to parents and that parents have **a named contact who is available to discuss any questions** and concerns the parents may have. Staff should acknowledge the difficulty for parents who are planning a termination for a wanted baby. They should also ensure that they use **the language that parents use when referring to their baby**. For example, the word **"baby"** or **"fetus"**. Some may be distressed by terms like "products of conception."

Another aspect that leaves room for improvement in terms of provision of care concerns the moment parents leave the hospital following the delivery of their baby. Non-existent, inconsistent or insensitive hospital discharge procedures may intensify bereaved parents' discomfort. In their interviews, participants often speak about the uncertainty of their baby's whereabouts after birth, and prior to burial or cremation as being a cause of agony and tribulation, especially if their fears are not openly talked about and acknowledged in clinical encounters (Farrales *et al.* 5). This is why leaving the hospital is one of the most challenging moments for these parents, as it can be evidenced by examples (4)--(6) below, in which participants describe the way they experience this moment as if they were abandoning their baby, as if their baby was still alive. This metaphorical thinking unearths the connection between the moment of hospital discharge and the unnatural, unimaginable scenario in which a newborn baby is left behind. The physical distance, a consequence of parents leaving the hospital, is directly associated to the idea of absence of (emotional) care, and therefore of physical and metaphorical abandonment of the baby.

> (4) *<Intervieweuse> : Est-ce que vous pouvez me parler du moment où vous êtes partis de l'hôpital après l'accouchement ? Comment ça s'est passé ?*
>
> *UM : et c'était un moment c'était un moment assez spécial qu'on a eu parce que on a tout fait pour ne pas pleurer et on avait quand même un sentiment quand on a quitté l'hôpital on avait quand même un sentiment d'abandon. On avait l'impression qu'* ***on abandonnait notre bébé*** *et ouais (c'est vrai que ça a été difficile).*
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[6] https://nbcpathway.org.uk/pathways/termination-pregnancy-fetal-anomaly-topfa-bereavement-care-pathway. Accessed 28 Jan. 2024.

> <Interviewer>: Can you tell me about the moment you left the hospital after delivery? How did that go?
> UM: and it was a moment it was a pretty special moment that we had because we did everything not to cry and we still had a feeling when we left the hospital we still had a feeling of abandonment. We felt like **we were abandoning our baby** and yeah (it's true it was tough). (43_UM00_#72)
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> (5) *<Intervieweuse> : Est-ce que vous pouvez me parler du moment où vous êtes partis de l'hôpital après l'accouchement ? Comment ça s'est passé ?*
> *<LD> : […] Après c'était c'était à la fois un soulagement de pouvoir se dire bon ben moi c'est fini y a plus de plus de souffrances physiques possible pour elle. Et puis aussi un petit peu de euh de tristesse de laisser* ***de la laisser toute seule*** *là-bas parce qu'on savait qu'elle repartait du coup dans la chambre mortuaire centrale qui est pas super fun comme bâtiment on va pas se mentir.*
>
> // Interviewer: Can you tell me about the moment you left the hospital after delivery? How did that go?
> <LD>: […] Then it was both a relief to be able to say to myself, well, it's over, there are no more physical sufferings possible for her. And then also a little bit of, uh, sadness to **leave her there all alone** because we knew she would be going back to the central mortuary room, which is not a fun place, let's be honest. (69_LD19_#15)
>
> (6) J'ai peu de souvenirs en fait je me vois dans la voiture je nous revois quitter le quitter le ouais quitter le quitter l'hôpital quoi mais je me souviens aussi du premier soir quoi c'est-à-dire que j'en parlais pas à ma femme et je me disais alors le le le le petit là **il est à l'hôpital** [...] **mort quelque part tout seul** quoi y avait y avait un espèce de truc je je voulais même pas y penser parce que ça me faisait un peu peur en fait. [...]
> //I have few memories actually I see myself in the car I see us again leaving the leaving the yeah leaving the leaving the hospital like but I also remember the first evening like I didn't talk about it to my wife and I said to myself the the the the little one **he is in the hospital** [...] **dead somewhere all alone** like there was something I didn't even want to think about because that actually scared me a little. (61_GL28_#79)

The mental representation of the physical separation from the baby is metaphorically associated by the parent to absence of care. Since a parent should naturally be looking after their baby, holding the baby close to them, this moment is permeated by a sense of guilt and disbelief, so much so that the father in example (6) above has a hard time sharing with his own wife the thought that "the baby is all alone" in the hospital, as if he was still alive and needed care.

In example (7) below, which is rather telling in this respect, the respondent had asked for autopsy of their baby's body following delivery. The fact that the baby's body had been transported elsewhere for autopsy somehow relieved the parent from the emotional burden of leaving the hospital under the impression that they were abandoning their baby:

> (7) on a demandé l'autopsie et du coup c'est pour nous le corps de [PRÉNOM du BEBÉ] était plus à l'hôpital donc en fait, **c'était plus facile dans ce sens-là parce que du coup on le quittait mais, on l'abandonnait pas en fait**.

> / we requested the autopsy and so for us the body of [BABY's NAME] was no longer in the hospital so actually, **it was easier in that sense because ok we left but, we didn't actually leave him**. (44_JM28)

The hypothesis that some stages of the perinatal loss experience can be particularly problematic for parents, such as the moment they have to give their farewell to their stillborn baby at discharge from hospital, is confirmed by findings by Lindgren *et al.*. In this study mothers describe the separation from the child when leaving hospital empty-handed as unnatural and clashing against the biological instinct of motherhood and protection of the offspring felt during pregnancy. The findings of our study, with specific reference to the use of metaphor, corroborate the need for recommendations for national policy procedures, for example for the introduction of a routine for a dignified goodbye at the hospital, including designating a deputy guardian into whose arms a parent could place the baby to facilitate the separation. The possibility of leaving the baby in the arms of someone known to the parents should be an option for parents who choose to take farewell of the child at the hospital, as it is already the case in countries like Sweden (Lindgren *et al.*), where the psychological benefits of this procedure have been validated. These initiatives reflect the central need for acknowledgement of the baby, both in the immediate hospital setting and in the community, which is much needed by bereaved parents to counter the experience of societal de-legitimization (Farrales *et al.*) and disenfranchisement (Doka; Norwood). The metaphorical rituals associated with certain procedures can constitute an important part of the grieving process. This is why care offered to parents should focus on specific steps of the grieving experience with a view to improving relevant hospital interactions.

The analysis has shown that metaphor is especially adept at expressing meaning that seems to exist beyond words, including meaning that is, in some way, corporeally bound (Littlemore and Turner, "Metaphors"; Norwood and Boulton 4). It is by means of metaphor that people can express the corporeal and the incorporeal elements of a lived experience simultaneously in order to make sense of its often varied, if not contradictory, aspects. The metaphorical language used in parents' narratives testifies to their suffering, and at the same time evidences that practitioners are in need of guidance to: better interact with parents, acknowledge their loss and provide emotional assistance and information throughout the experience of grief.

## BY WAY OF CONCLUSION

This article describes the first step of a much larger study, which engages bereaved parents to highlight clinical areas in need of change. With the ultimate goal of having a direct impact on the wellbeing of bereaved parents, this study intends to translate its findings into guidance and support for practitioners in health care services. Embracing a practice-based perspective on the study of metaphor (Reisfield and Wilson), the insights gathered from parents' figurative representations of their grieving experience can be used to improve the quality (and national consistency) of perinatal bereavement care experience in France. This goes hand in hand with the importance to educate HCPs to trauma-informed, compassionate care, which is key to avoid trauma symptoms for parents after the stillbirth of a baby that may endure for years and even decades (Farrales *et al.* 7). The development of narrative competence cannot be overlooked in this respect, ideally by means of bereavement care training material "to supply health professionals with the equipment to interpret and make sense of the stories of others" (Charon, "Narrative" 863). For this purpose, the research associates of the PERINAT project are currently working to strengthen an existing network of contacts with the hospital (para)medical teams, also relying on the mediation role played by a number of French charities participating in the project that are involved in the support of bereaved parents and whose members are sometimes also medical doctors.

The study also observed the way in which the narrative of trauma can become a way to empower the bereaved. Norwood and Boulton (122) makes reference to the notion of empowerment when she argues, quoting Guilfoyle, that a greater sense of enfranchisement might be clawed back through this process of narrating when, by creating their own story, the parent becomes an agent of their own narrative rather than its passive recipient. The concept of empowerment, still rather underexploited in linguistics, is a great help in studies that cover 'sensitive corpora' and seems to be necessary when vulnerable individuals are being dealt with (Caliendo and Ruchon). In their accounts of perinatal loss, bereaved parents take action by denouncing the problematic aspects of their bereavement care experience that could be potentially improved. Narrative thus becomes functional for parents to voice their discomfort and overcome the feeling of isolation triggered by their disenfranchised status in society.

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