

Rejecting Perfection, Valuing Imperfection in Perinatal Care: a Mixed-Methods Study of Responsive Practice Through *The Five Misfits* by Beatrice Alemagna

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Abstract

Picture books are recognised within medical humanities as sophisticated narrative tools capable of supporting reflective practice, emotional awareness and professional development among healthcare practitioners. In perinatal care, where relational demands are high and emotional exposure is constant, such tools may help practitioners examine implicit professional models, including attitudes towards vulnerability, imperfection and paternalism. To explore how perinatal healthcare professionals interpret *The Five Misfits* by Beatrice Alemagna and how engagement with its characters supports reflection on responsive models of care. A mixed-methods study was conducted among 42 perinatal professionals participating in a postgraduate training programme. Forum-based written reflections following a facilitated reading of the picture book were analysed using inductive thematic analysis. Eight thematic dimensions relevant to responsive care were identified and quantitatively scored on a bipolar scale (−2 to +2). Statistical analyses were used to compare character profiles, integrating qualitative excerpts to contextualise quantitative patterns. Participants consistently rejected a professional stance characterised by perfectionism and solution-imposition, strongly associated with paternalism and negative emotional responses (≈90%). In contrast, symbolic representations of imperfection linked to flexibility, emotional openness and creative adaptation were predominantly valued (70–95% positive affect) as resources for responsive care. A third position, associated with passivity and exhaustion, elicited predominantly negative emotions (≈85%) while generating the highest levels of self-

reflection. Facilitated discussion enabled participants to acknowledge aversive reactions and reframe them, supporting more nuanced and empathic interpretations of vulnerability in care relationships.

Engagement with a metaphor-rich picture book supported professional development by enabling practitioners to confront uncomfortable emotional reactions and critically re-examine implicit norms of care. Exposure to a symbolic representation of passivity and vulnerability, although initially rejected, proved central to transformative reflection when adequately facilitated. These findings highlight the pedagogical potential of carefully guided picture-book engagement as a sophisticated tool for reflective practice in emotionally demanding healthcare settings.

Keywords: Responsiveness, Paternalism, Professional identity, Moral emotions, Narrative reflection

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1. Introduction

The integration of picture books, literature and bibliotherapy into the education of health workers has gained increasing attention as a means to foster empathy, reflective practice and holistic care. Qualitative research in this area explores how narrative and visual storytelling can enhance professional development, communication skills and patient-centredness among healthcare professionals [1–3]. Narrative medicine, which encompasses close reading, reflective writing and storytelling, has been shown to improve empathy, professional identity and interprofessional collaboration, with systematic reviews consistently reporting high participant satisfaction and improvements in competencies such as relationship-building, perspective-taking and resilience [4–8]. However, challenges remain regarding the consistency of outcomes, long-term impact and the need for robust qualitative methodologies [5,9].

Perinatal care represents a particularly demanding context for examining these educational challenges. The transition to parenthood constitutes a period of profound vulnerability for families, where the quality of professional–patient interactions can profoundly influence long-term outcomes. Evidence suggests that responsive caregiving, defined as the ability to understand and respond to children's cues and needs, is associated with improved socioemotional outcomes in children, reinforcing the need for interventions that enhance caregiver responsiveness [10]. Healthcare providers working in this field must navigate complex emotional terrain while maintaining clinical competence—a combination that places them at elevated risk of compassion fatigue and burnout. Recent evidence from our research group indicates that nearly half of midwives working in facilities exposed to perinatal loss cases report symptoms consistent with burnout, underscoring the urgent need for educational approaches that attend not only to technical competence but also to emotional sustainability [11].

Picture books offer a distinctive resource within the narrative medicine toolkit. Unlike traditional literary texts, picture books combine visual and textual elements in ways that engage multiple modes of cognition simultaneously. Qualitative studies report that visual narratives stimulate imagination, empathy and deeper engagement with patient experiences [2,3]. Their apparent simplicity belies considerable sophistication: high-quality picture books avoid didacticism while addressing fundamental human experiences through imagery and metaphor that invite interpretive engagement. This combination of visual and textual elements appears to facilitate engagement with complex caregiving concepts, particularly for professionals working in perinatal care [1]. Metaphorical thinking has been shown to clarify unwritten assumptions and motivators that shape professional behaviour, making it a valuable strategy for understanding and addressing complexities in practice [12,13].

In a previous study examining Beatrice Alemagna's *What is a Child?* with the same cohort of perinatal professionals, we have shown that engagement with this picture book facilitated reflection on nurturing care principles, with participants using the text's metaphorical language to articulate complex caregiving concepts and explore their professional identities [1]. That analysis revealed how picture books can function as sophisticated tools for professional development, creating shared spaces for dialogue while honouring diverse professional perspectives. However, the book's affirming, celebratory tone, while valuable for certain educational purposes, limits its capacity to elicit engagement with more difficult emotional material, including the shadow aspects of professional identity that all practitioners harbour but rarely examine openly. Another Alemagna's major picture book, *The Five Misfits* (original Italian title: *I cinque malfatti*, 2014; English translation 2017), offers a strikingly different orientation [14,15]. The narrative centres on five imperfect characters who live contentedly in their lopsided house until the arrival of a self-proclaimed 'Perfect' character who dismisses them as worthless. The misfits' response, asserting the value inherent in their apparent deficits, and the Perfect One's subsequent isolation creates a fable that indirectly addresses questions of professional identity, perfectionism and the value of imperfection. In the framework of our interpretative paradigm [16–19], the structure of this narrative makes it particularly relevant for exploring healthcare professionals' attitudes toward responsive versus paternalistic care models. The power of storytelling lies precisely in its capacity to make such dynamics visible and available for examination [20].

This study extends our previous work by examining how perinatal professionals engage with *The Five Misfits* in a structured reflective exercise. Our hypothesis was that engagement with this text would serve bibliotherapeutic functions for professional development, not in the sense of reading as remedy for individual psychological difficulties, but rather as a means of making explicit, examining and potentially restructuring tacit attitudes that shape professional practice. Such engagement, when properly facilitated, can yield insights unavailable through more comfortable reflective exercises, including recognition of one's own vulnerability and limits, themes central to sustainable professional practice in emotionally demanding healthcare settings.

2. Methods

Study design

This study examined forum-based discussions among perinatal professionals, conducted as part of an interactive, practice-oriented training module included in a postgraduate specialisation course on early childhood development and perinatal care (*I Primi Mille Giorni* – The First Thousand Days, offered by the University of Florence since 2023). This research forms part of an ongoing investigation into the use of picture books for professional development, following our previous study examining Alemagna's 'What is a Child?' within the same cohort [21]. The course aims to enhance professionals' understanding and application of responsive care principles, emphasising both theoretical foundations and practical implementation. The forum discussions analysed here were designed to serve as a dynamic and collaborative learning environment, where participants could engage deeply with the themes presented in carefully selected picture books. For this component of the course, participants were introduced to Beatrice Alemagna's '*I cinque malfatti*' (The Five Misfits) [14] and invited to reflect on its relevance to professional identity and care practices.

The picture book

'*I cinque malfatti*' tells the story of five unusual characters: *il Bucato* (The Punctured One, full of holes), *il Piegato* (The Folded One, covered in creases), *il Molle* (The Feeble One, always tired and soft), *il Capovolto* (The Upside-Down One, who walks on his hands), and *lo Sbagliato* (The Wrong One, a complete disaster), who live together peacefully in a crooked house until the arrival of *il Perfetto* (The Perfect One), who immediately begins criticising them and proposing solutions to 'fix' their perceived defects. Rather than accepting his judgement, the five misfits come to realise that their apparent imperfections are actually their strengths. The Punctured One lets anger pass through his holes without holding on to it; the Folded One stores precious memories in his creases; the Upside-Down One sees things others cannot see; and the Wrong One celebrates every small success with a party. After this collective realisation, the Perfect One, exhausted by the effort of being flawless, departs 'like a truly perfect fool', leaving the misfits content in their imperfect but authentic existence.

Forum prompts and data collection

The forum discussions were initiated following a live presentation of the book and a general overview of responsive care principles. This introductory session was deliberately kept broad, without providing detailed guidance on interpretation, so participants could freely explore and

develop their own connections between the book's content and their professional practice. Participants were presented with the following prompts:

(1) Who is the responsive healthcare professional? What does she or he do and not do? What does she or he bring and avoid bringing into the relationship with parents and their child?

(2) Indicate one misfit with whom you feel in harmony and one that repels you. Why?

We adopted a deadline-based approach, requiring participants to submit their initial reflections by a specific date; although the forum was visible from the outset, most participants posted close to the deadline, which helped reduce potential conformity bias for these initial posts. After making these initial contributions, participants had an additional month to revisit and elaborate on their thoughts in conversation with peers.

Mixed-methods analysis

This study employed a mixed-methods approach, combining qualitative thematic analysis with quantitative evaluation of thematic patterns across characters. This integration was designed to complement the depth and nuance of qualitative insights with systematic quantification of how participants attributed specific professional qualities to different characters, enabling statistical comparison of thematic profiles.

Thematic analysis. The qualitative analysis followed a primarily inductive (data-driven) approach, allowing themes to emerge from participants' reflections rather than imposing predetermined categories. This decision reflected the exploratory nature of this investigation: while our previous study on 'What is a Child?' employed deductive coding guided by the WHO Nurturing Care Framework [21], the present study sought to understand how participants spontaneously interpreted the characters and connected them to professional practice without the constraint of a predefined theoretical structure.

An initial AI-assisted coding process was applied following the methodology previously described [21,22]. Emerging themes and categories were subsequently reviewed, refined, and discussed by the research team through manual coding using MAXQDA 2018 (VERBI Software GmbH, Berlin, Germany). Through iterative refinement, eight thematic dimensions emerged that captured the core qualities participants associated with responsive caregiving: (1) Patient Autonomy: respect for family self-determination versus paternalistic imposition; (2) Relational Attunement: capacity for empathic listening and therapeutic alliance; (3) Personalisation: adaptation of care to individual needs versus standardised protocols; (4) Professional Humility: recognition of one's limits and value of teamwork; (5) Emotional Processing: ability to manage emotions constructively; (6) Perspective Taking: capacity to see situations from unconventional

angles; (7) Initiative/Activation: proactive engagement versus passivity; and (8) Self-Reflection: personal identification and introspective engagement triggered by the character.

Quantitative thematic scoring. To enable systematic comparison across characters and professional groups, each participant's reflection on each character was scored on the eight thematic dimensions using a bipolar scale ranging from -2 to +2. Positive values indicated that the participant attributed the quality to the character in a favourable sense (e.g., the character embodies good listening skills); negative values indicated attribution in a problematic sense (e.g., the character fails to listen or imposes their views); zero indicated absence of the theme. This scoring approach allowed the same thematic dimension to capture both presence and absence of a quality, as well as its positive or negative valence depending on the character being discussed.

Characters' mapping. To visualise the overall pattern of character reception, we constructed a bidimensional mapping based on two composite indices. The Y-axis (Perceived Emotional Connection) was derived from participants' affective responses, calculated as the percentage of positive feelings attributed to each character minus 50 (centering the scale at zero). The X-axis (Perceived Personal Dynamism) combined the Initiative/Activation thematic score (weighted $\times 30$) with a normalised measure of cognitive dynamism (Emotional Processing + Perspective Taking scores), capturing both behavioural proactivity and cognitive flexibility.

Participants' responses were organised by character section: theoretical descriptions of the responsive caregiver (serving as a normative benchmark), and reflections on each of the six characters from the picture book (the Perfect One, the Punctured One, the Folded One, the Feeble One, the Upside-Down One, and the Wrong One).

Facilitated discussion on the Feeble One. Given the particularly strong negative reactions elicited by the Feeble One in the forum responses, a dedicated 90-minute synchronous session was conducted to explore participants' emotional responses in depth. Participants were asked to imagine the Feeble One as a patient in their care and to identify their emotional reactions using Plutchik's wheel of emotions [23], rating the intensity of each emotion on a scale from 1 (minimal) to 10 (overwhelming). This exercise served both as a data collection method and as a bibliotherapeutic intervention, allowing participants to legitimise and process their negative reactions in a facilitated group setting. The discussion was transcribed and analysed thematically, with particular attention to: (a) the specific emotions elicited; (b) dual interpretations of the character (as colleague versus as patient); and (c) transformative insights emerging through the facilitated reflection.

Statistical analysis. Quantitative data analysis was conducted using Stata BE 18 (StataCorp). Thematic scores were coded on a discrete scale ranging from -2 to +2 and summarised into character-level and theme-level scores. Although individual codes were ordinal, thematic scores were treated as approximately interval-level summary measures for descriptive purposes, given the symmetrical scale and the need to preserve discriminative capacity across characters.

Descriptive statistics are therefore reported as means and standard deviations for thematic scores, and as frequencies and percentages for categorical variables. To account for the non-independence of observations arising from repeated character evaluations within participants, differences in overall thematic profiles across characters were assessed using linear mixed-effects models with random intercepts for participants. The overall effect of character was evaluated using Wald χ^2 tests. Pairwise comparisons between characters were conducted on estimated marginal means; p-values were adjusted for multiple testing using the Holm step-down procedure. Specific theory-driven comparisons, including contrasts between rejected (Perfect and Feeble) and valued characters, were assessed using paired t-tests on participant-level mean scores. Differences across professional categories, where each participant contributed to a single group only, were examined using Kruskal–Wallis tests. Emotional intensity ratings derived from the Plutchik exercise are reported as individual values alongside the corresponding emotion labels. A two-sided p-value <0.05 was considered statistically significant.

3. Results

Participants to the present research included a diverse group of 34 female perinatal professionals (median age 34 [29; 39] ranging from 25 to 71), comprised of psychologists (14), midwives (11), physicians (1), nurses (2), pharmacists (3) and early childhood educators (3), who brought perspectives grounded in their respective fields of expertise. The forum threads were initiated by the moderators (CR and AV) with open-ended prompts encouraging participants to reflect on the characters and concepts illustrated in Alemagna’s book and their relation to responsive healthcare professionals and their practice. These discussions generated a rich dataset comprising 126 posts, resulting in a total of 19783 words that were analysed qualitatively.

Overview of character reception

Participants’ responses revealed a clear polarisation in their reception of the book’s characters. The Perfect One and the Feeble One emerged as *rejected* figures, eliciting predominantly negative emotional responses (90% and 85% negative feelings, respectively). In contrast, the remaining four misfits—the Punctured One, the Folded One, the Upside-Down One, and the Wrong One—were consistently *valued* by participants, with positive feelings ranging from 73% to 95% (Figure 1).

Quantitative analyses confirmed significant differences across characters in their overall thematic profiles. A mixed-effects model accounting for within-participant clustering showed a significant main effect of character (Wald $\chi^2(6)=38.47$, $p<0.001$). Pairwise comparisons indicated that the Feeble One differed significantly from the responsive caregiver and from several valued misfits, including the Punctured One and the Upside-Down One, whereas the Perfect One displayed a distinct but less extreme profile. These findings remained robust after adjustment for multiple comparisons using the Holm procedure.

No significant differences were observed across professional categories (Kruskal–Wallis $\chi^2=3.82$, $p=0.576$), indicating that these interpretive patterns were shared across psychologists, midwives, educators, and other professionals, regardless of their specific training background.

Figure 1. Overview of character reception: positive and negative feelings. Horizontal bar chart showing the proportion of positive (blue, right) and negative (red, left) feelings attributed by participants to each character. Percentages represent the proportion of participants expressing positive or negative affect toward each character.

The responsive caregiver and the 5 misfits

When asked to describe the characteristics of a responsive healthcare professional, participants articulated a coherent ideal that served as the normative benchmark against which characters were evaluated. From a quantitative point of view, this theoretical responsive caregiver was characterised by high scores on Relational Attunement (mean 1.56, SD 0.61), Personalisation (mean 1.32, SD 0.64), and Professional Humility (mean 0.88, SD 0.73), while showing strong rejection of paternalistic approaches (Patient Autonomy mean -1.21, SD 0.77; the negative value reflecting explicit criticism of paternalism rather than absence of the quality).

Participants emphasised that responsive caregiving requires standing alongside families rather than above them, listening actively without imposing predetermined solutions, and recognising the limits of one's own expertise. As one midwife articulated:

The responsive carer is one who knows how to stand beside the person, or the family if we are talking about the first thousand days, 'without placing themselves above.' Using their specific competencies to the fullest, they know how to establish an authentic and respectful professional relationship with those they assist. At the same time, they recognise their own limits and the importance of networking.

Table 1 reports the thematic profiles attributed by participants to the responsive carer (here included as a theoretical benchmark based on participants' definition of responsive caregiving) and to each character of the book, expressed as mean scores (SD) on eight thematic dimensions derived from the inductive qualitative analysis. Positive values indicate that a theme was attributed to the character in a favourable sense (e.g. supportive of responsive caregiving), negative values indicate attribution in a problematic or critical sense (e.g. paternalism, passivity), and zero indicates absence of the theme in participants' reflections.

The depth of analysis devoted to each character reflects the actual distribution and density of responses generated in the reflective forums. The emphasis on certain figures, most notably the Feeble One, did not arise from a priori thematic choices, but rather emerged inductively from the emotional intensity and psychological complexity evident in participants' narratives. The Feeble One, in particular, elicited markedly stronger reactions, more elaborate reflections, and deeper identification struggles, warranting extended exploration on both psychological and clinical grounds. By contrast, other characters, such as the Folded One, were mentioned more sparingly and are therefore treated in proportion to the interpretive engagement they provoked.

Mapping character reception: a bidimensional perspective

Figure 2 maps the six characters on two composite dimensions derived from the quantitative analysis. A clear spatial segregation emerged between rejected and valued characters. The Feeble One and the Perfect One occupied the lower-left quadrant, characterised by negative values on both dimensions, though their positions differed meaningfully: the Feeble One showed the most extreme negative position on Personal Dynamism, consistent with its highly negative Initiative/Activation score (mean -1.71, SD 0.46) and participants' strong rejection of passivity. The Perfect One, while closer to neutral on dynamism, showed the lowest Emotional Connection, reflecting the overwhelmingly negative affective response (90% negative feelings) to this character's paternalistic stance. In contrast, the four valued misfits (the Punctured One, the Folded One, the Upside Down One, and the Wrong One) clustered in the upper-right quadrant. The Upside Down One occupied the most favourable position, consistent with both its high Perspective Taking score (mean 1.92, SD 0.29) and the highest proportion of positive feelings among all characters (95%). The Punctured One, distinguished by its elevated Emotional Processing score (mean 1.31, SD 0.79), also positioned favourably on both dimensions.

Figure 2. Mapping the misfits on two dimensions of responsive caregiving qualities. The Y-axis (Perceived Emotional Connection) derives from the proportion of positive versus negative feelings attributed to each character. The X-axis (Perceived Personal Dynamism) combines Initiative/Activation scores with cognitive dynamism measures (Emotional Processing and Perspective Taking). Rejected characters (Perfect, Feeble) occupy the lower-left quadrant; valued characters cluster in the upper-right quadrant.

The Perfect One: embodiment of rejected paternalism

The Perfect One emerged as the anti-model of responsive caregiving, embodying the paternalistic healthcare professional that participants unanimously rejected. This character showed the most negative score on Patient Autonomy (mean -1.62, SD 0.51), significantly differentiating it from all other characters on this dimension (Kruskal-Wallis $\chi^2=90.69$, $p<0.0001$).

Participants interpreted the Perfect One's arrival 'from who knows where' and his immediate prescriptive stance ('*You need a purpose, a plan, an idea!*') as exemplifying the healthcare professional who imposes solutions without understanding context. One psychologist reflected:

The Perfect One represents everything that, in my humble opinion, should not characterise a responsive carer. First of all, because 'arriving from who knows where' is certainly not a good starting point. The responsive carer should be that professional figure who listens, guides, informs, and makes parents and children aware and involved, truly making them protagonists of their own story.

Several participants noted that while the Perfect One might initially appear to be what a mentor 'should be' (i.e. knowledgeable, solution-oriented, decisive) his fundamental inability to listen and his positioning above the others disqualifies him from responsive practice. As one participant observed: '*The mentor, the responsive carer, should be the Perfect One. Should be, because from the very first description he reveals himself to be quite the opposite.*'

The valued misfits: complementary qualities of responsive care

The four valued misfits (the Punctured One, the Folded One, the Upside-Down One, and the Wrong One) were interpreted as embodying complementary qualities that together constitute responsive caregiving. Each character displayed a distinctive thematic profile, with specific dimensions emerging as particularly salient when compared with the other figures.

The Punctured One emerged as the character most strongly associated with Emotional Processing (mean 1.31, SD 0.79), with pairwise comparisons from the mixed-effects model indicating significantly higher scores on this dimension relative to the other characters. Participants connected his 'holes' to the capacity for emotional permeability, allowing difficult emotions to pass through rather than accumulating. As one participant noted: *'Maybe I never get angry. Anger just passes through me: this represents the ability to let emotions flow, to not hold onto negativity.'*

The Folded One and the Upside-Down One were both characterised by particularly high scores on Perspective Taking (means 1.33 and 1.92, respectively), significantly exceeding those of the other characters. The Folded One's capacity to 'keep all memories in the folds' was interpreted as the ability to hold and remember each family's unique history, while the Upside-Down One's ability to 'see things others don't see' represented creative, non-conventional approaches to understanding families' needs.

The Wrong One showed elevated scores on Emotional Processing (mean 1.13, SD 0.74), which participants associated with resilience and the capacity to celebrate even small successes. His attitude that *'when I manage to do something right, it's time to celebrate'* was valued as modelling realistic expectations and the ability to find meaning and satisfaction in incremental progress.

The Feeble One: a problematic figure triggering intense reflection

The Feeble One occupied a unique position in participants' interpretations. Although sharing a *rejected* status with the Perfect One, this character elicited a qualitatively different response, marked by intense negative affect alongside an unusually high level of Self-Reflection (mean 1.00, SD 0.72), the highest among all characters. At the same time, the Feeble One showed the lowest scores on Initiative/Activation (mean -1.71, SD 0.46), markedly lower than those attributed to the other misfits. Pairwise comparisons from the mixed-effects model confirmed that this dimension sharply distinguished the Feeble One from the remaining characters. This pronounced passivity, described as being *'always tired, always asleep'*, was experienced as deeply disturbing by participants, who struggled to reconcile it with their professional expectations and norms of active engagement.

Forum responses revealed that the Feeble One evoked visceral rejection:

The misfit that repels me is the Feeble One. In contrast to the others, he doesn't express himself (he collapses asleep). He evokes the image of a resigned carer,

lacking enthusiasm, who settles into the context without wanting to make a difference.

The one I find hardest to tune into is the Feeble One, always tired, without objectives.

Given the intensity of negative reactions to the Feeble One in forum discussions, a dedicated 90-minute synchronous session was conducted to explore these responses in depth. Participants were asked to imagine the Feeble One both as colleague and as a patient in their care and to identify their emotional reactions using Plutchik's wheel of emotions [23], rating intensity from 1 to 10. Twenty-three participants generated 59 emotional attributions (mean 2.6 per participant), with the predominant emotional families being Sadness (33.9%) and Anger (28.8%), followed by Fear and Disgust (15.3% each). Only 3.4% of responses fell within positive emotional categories (Trust, Acceptance), confirming the predominantly aversive reaction to this character. Figure 3 displays the intensity distribution for emotions reported by at least two participants.

Figure 3. Intensity distribution of emotional responses to the Feeble One during the facilitated Plutchik exercise (n=23 participants). Emotions are ordered by median intensity (descending). Individual data points are shown alongside boxplots. Only emotions reported by ≥2 participants are displayed.

The highest intensity ratings were observed for Anger (median 7.5) and Disapproval (median 7.5), followed by Vigilance (median 7.0). Irritation, while most frequently reported (n=14), showed moderate intensity (median 6.0, range 5–7). Sadness displayed the lowest median intensity (5.0) but the widest range (5–9), suggesting heterogeneous responses: for some participants, the Feeble One evoked profound grief, while for others the reaction was more contained. Representative responses illustrate the emotional complexity:

Irritation 6, vigilance 8, disgust 3, pensiveness 5, sadness 5

Disapproval 9 (alas, I'm being judgmental...)

At first it makes me angry 8, then a lot of anguish 7, and sadness 5

I think the Feeble One has so much insecurity (sadness 9)... if then I see that even working on it he stays feeble, then irritation 7 and anger 7

The facilitator (CR) first normalised participants' emotional reactions by situating them within a recognised framework of human affect, emphasising that irritation, vigilance and discomfort were expected responses rather than professional failures. She then introduced a reframing focused on practice, suggesting that intense negative emotions elicited by passivity or withdrawal may hinder clinicians' ability to mobilise their full professional competencies, particularly in encounters with parents experiencing perinatal depression. This intervention enabled participants to move beyond an initial rejection of the Feeble One as an unworkable colleague and to recognise a parallel interpretation of the character as a patient with depressive features. In this light, the Feeble One became associated with familiar perinatal scenarios involving emotionally withdrawn parents, whose disengagement activates frustration, helplessness and a sense of threat in professionals, thereby illuminating the affective burden embedded in such clinical encounters. Several participants reported transformative shifts during the discussion. One changed her rating from 'disapproval 9' to 'anguish 4, trust 7,' commenting: *'I hadn't thought of the Feeble One in these terms.'* Another reflected: *'Looking at the situation from another angle that goes beyond the first reaction, I also feel sadness, pensiveness, apprehension.'* A third participant proposed a radical reinterpretation: *'What if we read the feeble caregiver as "welcoming," capable of accepting the other? Who welcomes the other for what they are, non-judgmental, capable of adapting to the personality of whoever is in front of them.'* The facilitator concluded by distinguishing between the Feeble One as a permanent state versus a temporary condition requiring different timing for recovery: *'Sometimes our feeble patient won't remain feeble forever but needs time to function that cannot be that of the Perfect One... the time of healing, especially for mental illnesses, is not the time of the healthy.'*

4. Discussion

4.1 From rejection to recognition: the Perfect One as a unanimously refused model

The unanimous rejection of the Perfect One represents the most robust and unambiguous finding of this study. With 90% of participants attributing negative emotions to this character and the lowest scores on Patient Autonomy across all characters (mean -1.62 , SD 0.51), the Perfect One clearly emerged as the anti-model of responsive caregiving. This rejection was not merely affective but coherent across all thematic dimensions, including Relational Attunement,

Personalisation and Professional Humility, indicating a systematic repudiation of the paternalistic stance embodied by this figure. What lends particular weight to this finding is its consistency across professional groups. No significant differences emerged between psychologists, midwives, educators, nurses, physicians and pharmacists ($\chi^2=3.82$, $p=0.576$), suggesting a shared interpretive framework rather than profession-specific sensitivities. This cross-professional convergence points to a broader cultural shift in how contemporary perinatal healthcare professionals conceptualise their relationship with families. The Perfect One was rejected not simply because he is “unlikeable,” but because he represents a mode of practice that is experienced as epistemologically and ethically illegitimate. Participants’ interpretations consistently emphasised this epistemological dimension. The Perfect One’s opening assertion “*You need a purpose, a plan, an idea!*” was widely read as emblematic of a professional who imposes solutions without understanding context, history or lived experience. As one participant observed, he exemplifies “*the healthcare professional who imposes solutions without understanding context*”. In doing so, the Perfect One positions himself as the sole bearer of knowledge, denying families recognition as experts in their own experience. This stance directly undermines what narrative medicine has described as narrative competence: the capacity to acknowledge, interpret and act upon others’ stories [24]. This rejection aligns with well-documented transformations in healthcare theory and practice. Over the past decades, paternalistic models have increasingly given way to patient-centred care and shared decision-making [25]. Importantly, this shift is not only normative but empirically grounded. In perinatal settings characterised by high emotional and ethical complexity, shared decision-making has been associated with higher satisfaction and reduced decisional conflict. Evidence from the Italian context shows that shared decision-making in difficult perinatal conditions is significantly associated with higher maternal satisfaction, while paternalistic approaches are linked to poorer experiential outcomes [26]. Our findings suggest that these principles are not merely aspirational but have already been internalised by professionals engaged in advanced perinatal training. Several participants explicitly connected the Perfect One to their own experiences of paternalistic healthcare culture. One nurse reflected that healthcare professionals “*often position themselves as knowledgeable, and the patient frequently perceives themselves as inferior*”, noting how even the etymology of the word *patient* encodes asymmetry and endurance rather than agency. Such reflections resonate with philosophical critiques highlighting how medical language itself can reproduce epistemic hierarchies [27]. Importantly, participants did not reject competence or expertise *per se*. Rather, they rejected its deployment in ways that silence or diminish families’ agency. As one participant noted, the responsive caregiver “*listens, guides, informs and makes parents and children aware and involved, truly making them protagonists of their own story*”. This distinction reflects a responsive approach to care in which professional knowledge is held relationally rather than hierarchically, supporting families rather than directing them [28]. The narrative outcome of the

Perfect One, left alone *“like a truly perfect fool”* while the misfits depart together, was widely interpreted as a cautionary message about professional isolation. Several participants noted that the Perfect One *“arrives from who knows where”* and assumes he can immediately solve everything without belonging to a relational context. This rootless expertise mirrors precisely the professional posture that contemporary healthcare education seeks to overcome.

Anyway, the unanimity of this rejection should not be read as evidence that paternalism has disappeared from practice. Rather, it suggests that paternalistic care has lost normative legitimacy within this cohort. The Perfect One thus functions not as a straw figure but as a diagnostic mirror, making visible a model of care that participants have learned to recognise, critique and reject, even as its subtler forms may persist in everyday clinical settings.

4.2 The valued misfits: responsive care as distributed competencies

The rejection of the Perfect One tells only half the story. Equally revealing is the pattern of selective appreciation for the four valued misfits, each embodying specific competencies that together constitute responsive caregiving. The quantitative mapping confirms this distribution (Figure 2). The valued misfits cluster in the upper-right quadrant, yet each occupies a distinct position: participants did not collapse them into a single category of 'good' alternatives but recognised each as offering something particular and irreducible. The Punctured One scored highest on Emotional Processing (mean 1.31, SD 0.79), his 'holes' interpreted as capacity for emotional permeability. One participant explained: *'Anger just passes through me: this represents the ability to let emotions flow, to not hold onto negativity.'* The Folded One excelled on Perspective Taking (mean 1.33, SD 0.67), his folds understood not as closure but containment: *'He keeps all memories in his folds... ready to open them at the right moment, discovering unique treasures.'* The Upside-Down One achieved the highest overall reception (95% positive feelings) with exceptional Perspective Taking scores (mean 1.92, SD 0.53), valued for seeing *'things that others don't see.'* The Wrong One, despite being *'a complete disaster'*, generated positive responses through his resilience: *'When something works out, we celebrate!'*. Crucially, no single misfit embodies all qualities participants associate with responsive caregiving. Statistical comparison confirmed significant differences across valued misfits on Emotional Processing ($\chi^2=8.94$, $p=0.03$), Perspective Taking ($\chi^2=12.67$, $p=0.005$), and Initiative/Activation ($\chi^2=9.21$, $p=0.027$). Participants attributed specific strengths to specific characters in a differentiated manner. This finding suggests participants were implicitly conceptualising responsive care as what we term 'distributed competencies': a constellation of relational capacities necessarily distributed across persons, contexts, and moments. This aligns with research on interprofessional collaboration emphasising that effective outcomes depend

not on finding perfect individual practitioners but on building teams whose members contribute complementary strengths [29]. Participants articulated this understanding directly. One midwife observed: *'It's absolutely necessary to work in multi-disciplinarity... to place ourselves as a system, where there are many parts, equally important, that only together can achieve the intended goal.'* Another reflected: *'No leader can be such without a winning team. We must remember that no one is perfect and omniscient.'* The narrative structure reinforces this interpretation. The misfits' strength lies not in individual qualities but in collective response: they articulate what each can offer and depart together, leaving the Perfect One *'alone like a truly perfect fool.'* This collective reframing of apparent deficits as complementary contributions models precisely the professional stance that interprofessional education seeks to cultivate [30].

The theoretical implications are substantial. If responsive care is distributed rather than unified, then the 'ideal caregiver' requires fundamental reconceptualisation. Traditional models imagine the ideal professional possessing all competencies to a high degree. The 'misfits model' shows that no single figure can embody complete excellence, and that attempting to do so produces isolation and sterility, exactly the Perfect One's fate. This has practical consequences for professional education and burnout prevention. The perfectionist model places unsustainable demands on practitioners who may internalise failure when they cannot single-handedly meet all needs. The distributed model offers a sustainable alternative: practitioners contribute characteristic strengths while appropriately depending on colleagues for complementary capacities. One participant captured this eloquently: *'The Punctured One is responsive because he sees the difficulties of all of them and responds by stimulating each to find their best personal solution, without being judgemental.'* The misfits thus model something radical: competence emerges not from perfection, but from the capacity to inhabit and integrate imperfection within a web of complementary relationships.

4.3 The Feeble One Paradox: rejection, self-recognition, and the dual embodiment of professional struggle

The Feeble One occupies an anomalous position within our findings, generating emotional responses that diverge markedly from both the rejected Perfect One and the valorised misfits. While the Perfect One's rejection reflects a conscious repudiation of paternalistic values, and the positive misfits' embrace signals identification with responsive care attributes, the Feeble One elicits something more complex: a visceral rejection frequently accompanied by moments of uncomfortable self-recognition.

Participants' initial responses to the Feeble One clustered around high-intensity negative emotions, with irritation, vigilance, and disapproval predominating. One participant articulated this reaction directly: *'The character I find irritating is the Feeble One, who can sleep even while the Perfect One criticises him harshly. I am repelled by his passivity and complete lack of response to stimuli. Perhaps he repels me because this attitude lurks deep within me, and I often fear it might take over.'* This confession reveals the paradox at the heart of the Feeble One's reception: the very qualities participants found most aversive were those they recognised, with evident discomfort, within themselves.

The facilitated discussion revealed that this rejection operates through what might be termed 'projective disavowal', the simultaneous recognition and repudiation of one's own vulnerability to passivity, exhaustion, and withdrawal. As one midwife reflected: *'Because we live in a performative culture where "not doing" or even just "not managing to do everything" is often seen as something feeble and weak. Perhaps I should be more welcoming towards the Feeble One, who makes it legitimate to take breaks.'* This insight captures how professional norms of constant productivity and responsiveness may leave practitioners without internal permission to experience or express their own states of depletion.

The dual embodiment of the Feeble One, as both problematic colleague and difficult patient, emerged organically from participants' interpretations. One nurse working in neonatal intensive care stated unequivocally: *'If I think of him as a caregiver, I could never work with him; I already struggle with patients... but they are patients!'* This distinction between tolerable patient passivity and intolerable colleague passivity reveals deeply held professional expectations. When the facilitator introduced the possibility of viewing the Feeble One as a patient experiencing depression, emotional responses shifted notably. One participant wrote in the chat: *'I hadn't thought of the Feeble One in these terms, so I'm changing from disapproval to anguish 4, trust 7'.*

This shift from judgement to empathy shows the bibliotherapeutic potential of emotionally challenging characters. A psychologist offered a nuanced clinical reading: *'I was thinking about contextualising the feebleness... behind it there might be such aggression that it leads to constantly demanding care, a feebleness connected to the demand that the other must nurture. But perhaps a person who is feeble as an expression of major depression, the emotions they evoke might be different.'* This observation demonstrates how the fictional character enabled practitioners to articulate distinctions between different forms of 'feebleness': strategic withdrawal versus genuine incapacity, masked aggression versus authentic depression.

The facilitator's intervention proved crucial in transforming initial rejection into reflective engagement; by legitimising participants' difficult emotions while reframing the Feeble One as

representing genuine clinical presentations, the discussion enabled what the literature describes as 'structured emotional processing' in narrative medicine interventions [30]. The recognition that '*there exists feeble within feeble*', as the facilitator concluded, captures the essential insight that emerged from this discussion: the need for professionals to develop differentiated responses to presentations that superficially appear similar. This capacity for distinction, cultivated through the safe distance of fictional engagement, represents a core competency for professionals working with perinatal mental health presentations where passive, withdrawn, or apparently unresponsive behaviours may signify vastly different underlying states requiring different clinical approaches.

4.4 Bibliotherapy in Action: the Transformative Architecture of Facilitated Engagement

The “bibliotherapeutic process” here described offers a clear illustration of how picture books can function as bibliotherapeutic instruments for professional development. Rather than transmitting knowledge about “difficult patients” through didactic instruction, the intervention created conditions in which practitioners could encounter, examine and rework their own emotional responses through the mediating presence of a fictional character. The process unfolded through four interconnected phases that together constitute an *emotionally grounded professional reflection*.

It is important to clarify that the present analysis does not treat “The Five Misfits” as a text specifically about healthcare practitioners or perinatal care. Rather, our approach is grounded in the idea that certain picture books do not describe or prescribe professional action, but instead evoke symbolic configurations and affective responses that stimulate reflective questioning across diverse fields [see 21]. In this sense, an exploratory engagement with fictional figures like the Perfect One or the Feeble One parallels the phenomenological engagement with literary texts in narrative medicine: both create experiential spaces in which readers negotiate emotional responses and professional meanings without being constrained by domain-specific prescriptions. Within this framework, the book functions as a transversal stimulus for exploring relational patterns, professional norms, and affective encounters, rather than as a didactic resource tied to specific categories such as “difficult patients” or “hard-to-work-with colleagues”. The facilitated discussion draws its relevance directly from the capacity of the narrative artefact to externalise implicit emotional landscapes and tacit professional assumptions.

Phase 1: Legitimising the aversive

The first phase consisted in creating explicit permission for participants to acknowledge emotions that professional norms often render unspeakable. When the facilitator introduced Plutchik's wheel of emotions and invited participants to rate the intensity of their reactions to the Feeble One imagined as a patient, she conveyed the message that these emotions are part of the human range and their recognition is a prerequisite for professional growth rather than a sign of inadequacy. By explicitly framing emotional responses as normal phenomena *"Plutchik started from fundamental emotions and then graduated them, combining them into different constructs"* the facilitator shifted the interpretive frame from moral judgement to phenomenological observation. Participants articulated this reframing directly: *"Grading one's own emotions is a beautiful work of awareness: clearly, there are no emotions more beautiful than others."* Emotional awareness, rather than emotional suppression, thus emerged as a marker of professional competence. Consistent with the narrative medicine literature [31], this phase was essential in allowing participants to name reactions such as irritation, disgust and vigilance without defensive rationalisation. The Feeble One's stylised simplicity functioned as a projection surface for emotions that would be difficult to articulate in relation to real patients or colleagues.

Phase 2: Contextual reframing

Once aversive reactions had been legitimised, the facilitator introduced a clinically grounded reframing that connected the fictional character to familiar perinatal contexts. She observed that *"the risk is not being able to work at the maximum of our competencies because of this wave of emotions we feel with women or fathers with depression."* This intervention reinterpreted participants' emotional reactions as occupational hazards rather than personal failures, while simultaneously introducing depression as a clinically meaningful explanatory framework. This reframing shifted the discussion from moral evaluation to clinical recognition. Participants spontaneously generated scenarios that mirrored the Feeble One's presentation, including parents with masked depression, emotional withdrawal or apparent disengagement. As one participant noted, *"The Feeble One can be imagined as a carer, or as a patient, or simply as a human being."* This interpretive multiplicity proved pedagogically productive, exposing implicit assumptions about who is permitted to be "feeble" in healthcare settings. Several participants drew sharp distinctions between tolerable patient passivity and intolerable colleague passivity, revealing deeply held professional norms. At the same time, others problematised the expectation that healthcare professionals themselves should remain unaffected: *"There's the problem of considering the caregiver as someone who should be non-*

human and not have bad moments." The facilitated discussion thus opened space for recognising professional vulnerability as structurally embedded rather than individually deviant.

Phase 3: Differentiated understanding

The third phase involved the development of what we term *differentiated understanding*: the capacity to distinguish between superficially similar presentations that require fundamentally different clinical responses. This represents one of the most clinically significant outcomes of the bibliotherapeutic process. Participants articulated distinctions between forms of "feebleness" associated with relational control and those expressing genuine depressive incapacity. As one psychologist observed, *"Behind feebleness there may be aggression that demands constant care, or it may be an expression of major depression, and the emotions they evoke are different."* This distinction mirrors a central challenge in perinatal mental health care, where passivity and withdrawal may signify exhaustion, depression, hostility or dissociation, each requiring different responses. Importantly, participants extended this framework beyond individual patients to institutional contexts, describing organisational inertia and outdated systems as "feeble" and emotionally draining. The facilitator acknowledged this explicitly, noting that practitioners navigate not only difficult patients but also structurally "feeble" institutions. The phrase *"there exists feeble within feeble"* captured the emergent insight: similar surface presentations may conceal profoundly different underlying dynamics. This capacity for differentiation aligns with research identifying pattern recognition and contextual discrimination as hallmarks of clinical expertise [32]. Our findings suggest that fictional engagement can support this competence through a distinct pathway: by eliciting strong emotional reactions that practitioners are then guided to examine and differentiate.

Phase 4: Integrative transformation

The final phase involved integrative transformation, in which participants began to reconfigure their initial aversive responses into new relational possibilities. Several participants reconsidered emotions initially experienced as defensive. One asked whether vigilance might also represent *"monitoring and careful attention,"* prompting reflection on the boundary between protective attunement and overcontrol. More strikingly, some participants publicly revised their emotional ratings: *"I'm changing from disapproval to anguish and trust."* This shift from moral distancing to empathic engagement exemplifies the kind of attitudinal restructuring that professional development programmes aim to foster but rarely achieve explicitly. Others proposed more radical reinterpretations, suggesting that feebleness might in some contexts represent receptivity rather than deficit: *"What if we read the feeble caregiver as welcoming, capable of accepting the other without judgement?"* Such reframings transformed passivity

from a pathology to a relational stance, while simultaneously prompting reflection on professional cultures that equate value with constant activation. Several participants connected this insight to self-care and burnout, noting that the Feeble One “*makes it legitimate to take breaks*” within a performative culture that stigmatizes non-doing. In this sense, the character functioned not only as a mirror for difficult patients but also as a symbolic challenge to unsustainable professional norms.

5. Conclusions

This study demonstrates that engagement with *The Five Misfits* functions not merely as a reflective exercise, but as a structured bibliotherapeutic intervention capable of eliciting, examining and transforming tacit professional attitudes in perinatal care. Across quantitative mapping, forum discussions and facilitated dialogue, participants consistently rejected the Perfect One as an anti-model of care, while recognising responsive practice as a constellation of complementary competencies distributed across persons and contexts rather than embodied by a single ideal professional.

The most theoretically generative finding, however, concerns the Feeble One. Initially experienced as profoundly aversive, this character elicited intense negative emotions alongside the highest levels of self-reflection. Through facilitated engagement, the Feeble One became a symbolic site where practitioners could confront not only difficult patients and colleagues, but also their own vulnerability to exhaustion, passivity and emotional withdrawal. This dual embodiment—at once patient and professional—revealed how rejection often operates through disavowal of aspects of professional experience that remain culturally unspeakable within performative healthcare environments.

The facilitated discussion revealed a consistent four-phase process of bibliotherapeutic change: legitimisation of aversive emotions; clinical reframing; differentiated understanding; and integrative transformation. Participants were first invited to acknowledge emotions such as irritation, disapproval and vigilance as normal human reactions rather than professional failures. This permission was essential in enabling subsequent reflection. Clinical reframing then connected these emotional responses to familiar perinatal contexts, particularly depression, shifting the interpretive frame from moral judgement to clinical recognition. Differentiated understanding emerged as participants learned to distinguish between superficially similar forms of “feebleness” that require fundamentally different professional responses, from relational control to major depression to institutional inertia. Finally, integrative transformation

occurred when participants reconfigured initial rejection into new relational possibilities, including reframing vigilance as attentive care, passivity as receptivity, and feebleness as a legitimate human state rather than a deficit.

Crucially, this transformation did not arise spontaneously from the text itself but depended on skilled facilitation that guided movement between these phases. This finding aligns with narrative medicine scholarship emphasising facilitation as the determining factor in whether engagement with texts produces genuine professional insight rather than defensive intellectualisation. Picture books combine symbolic immediacy with emotional salience in ways that grant them a distinctive pedagogical role: they allow emotionally charged material to be encountered at a safe symbolic distance, where implicit professional reactions can surface and be collectively examined.

The implications for professional development and burnout prevention are substantial. Perinatal care is characterised by high emotional load, where practitioners are routinely exposed to grief, depression and prolonged uncertainty. Aversive reactions to withdrawn or unresponsive patients are common and often silently borne, contributing to emotional exhaustion and moral distress. By legitimising these reactions and providing tools for their differentiated understanding, bibliotherapeutic interventions may support what can be termed *sustainable professional presence*: the capacity to remain emotionally available without depleting one's own resources.

Initially rejected, the Feeble One ultimately emerged as a productive figure through which practitioners could recognise, examine and integrate aspects of their professional experience that typically remain unspoken. In this sense, the discomfort elicited by this character was not a limitation of the intervention but its most generative feature. Together, these findings suggest that facilitated engagement with carefully selected picture books can function not only as an educational strategy but as a preventive intervention, supporting reflective capacity, relational competence and emotional sustainability in perinatal healthcare professionals.

6. Declarations

Acknowledgements

We wish to express our gratitude to all the participants of Florence University “I Primi Mille Giorni” course 2024-25, who contributed to the forum discussions and participated in the in-class dialogues that inspired the reflections elaborated in this work. While their contributions

do not qualify them for authorship, we deeply appreciate their engagement with the themes presented in this study: Arianna Balestracci, Giada Barbirato, Elena Baritello, Simona Bensi, Elisa Bertilorenzi, Francesca Casartelli, Chiara Castracani, Marina Ceragioli, Cecilia Cirilli, Valentina D'Alesio, Giulia Fava, Anisia Fazzi, Irene Graziani, Marcella Marcone Terzago, Nausicaa Martino, Chiara Mauri, Federica Minelli, Albina Mingaj, Valentina Modolo, Tosca Mori, Miriam Morici, Laura Mosconi, Alice Pasquini, Noemi Passalacqua, Chiara Poli, Anna Pomes, Chiara Rossini, Althea Iris Salerno, Valentina Scarpello, Ambra Sciascia, Maria Selene Tarascio, Silvia Zanette, Alessandra Zani, and Laura Zaroni.

Contributors

CR (conceptualisation; investigation; writing—original draft preparation; review and editing: project administration) and AV (conceptualisation; writing—original draft preparation; investigation; data management and analysis; review and editing). AV is the guarantor.

Funding

The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Declaration of AI

Artificial intelligence (AI) tools, specifically ChatGPT 5.2 and Claude Sonnet and Opus 4.5, were used in this study. These tools supported the thematic quantification of forum discussions, as detailed in the Methods section. Additionally, they were employed for the reformulation, editing and translation of specific concepts from Italian to English. The AI tools functioned as supportive instruments under the direct oversight of the authors, ensuring the integrity and originality of the research content. All intellectual and analytical contributions remain the sole responsibility of the authors.

Patient and public involvement

Patients and/or the public were not involved in the design, or conduct, or reporting, or dissemination plans of this research.

Patient consent for publication

Not applicable.

Ethics approval

This study analysed anonymised contributions from a professional forum. While no personal data were collected, participants consented to the use of their forum posts for research purposes. This consent is explicitly mentioned in the forum's participation guidelines. Additionally, all participants are acknowledged in the manuscript for their valuable contributions.

Provenance and peer review

Not commissioned; externally peer reviewed.

Data availability statement

Data are available upon reasonable request.

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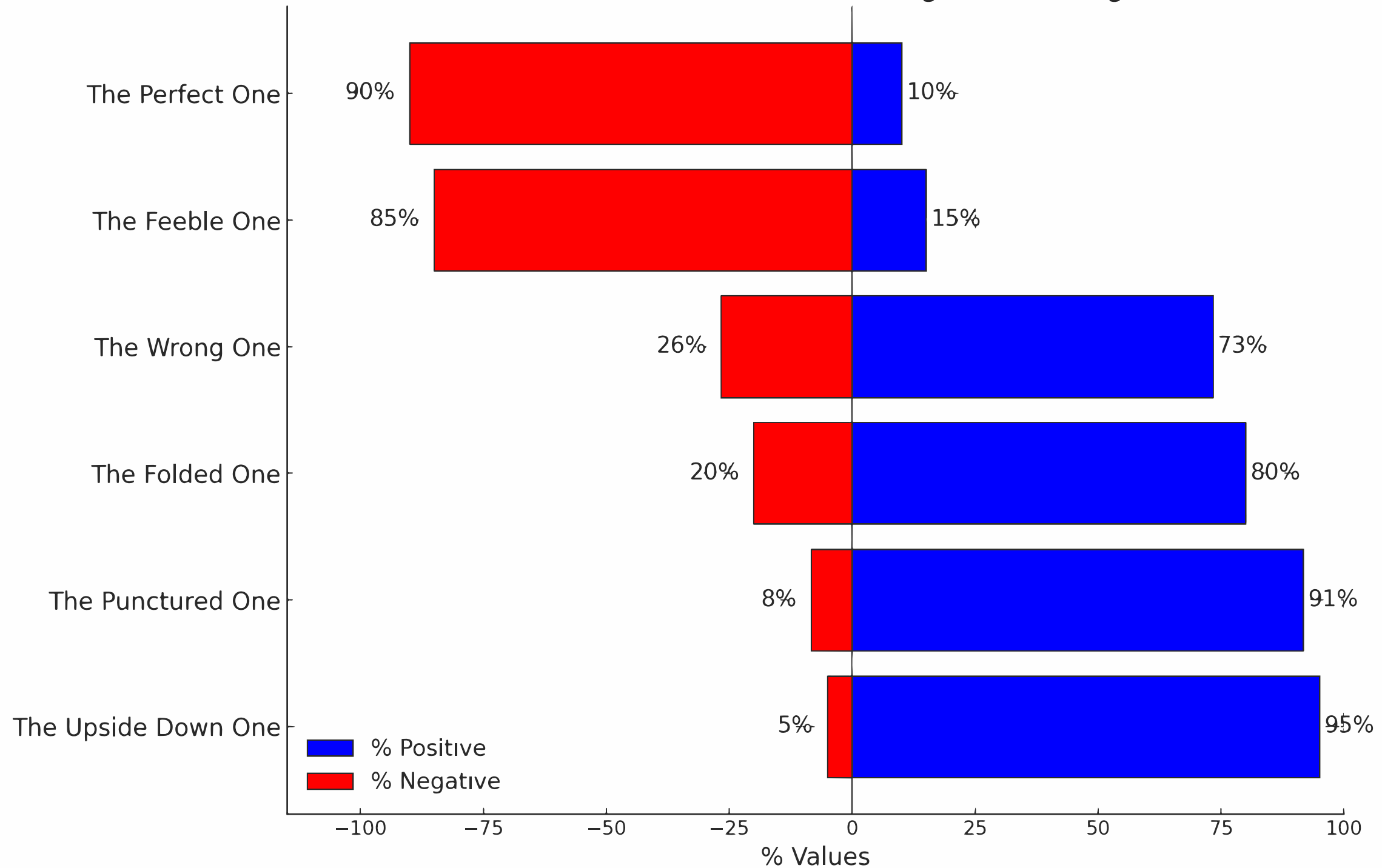
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Table 1. Thematic scores by character and statistical comparisons

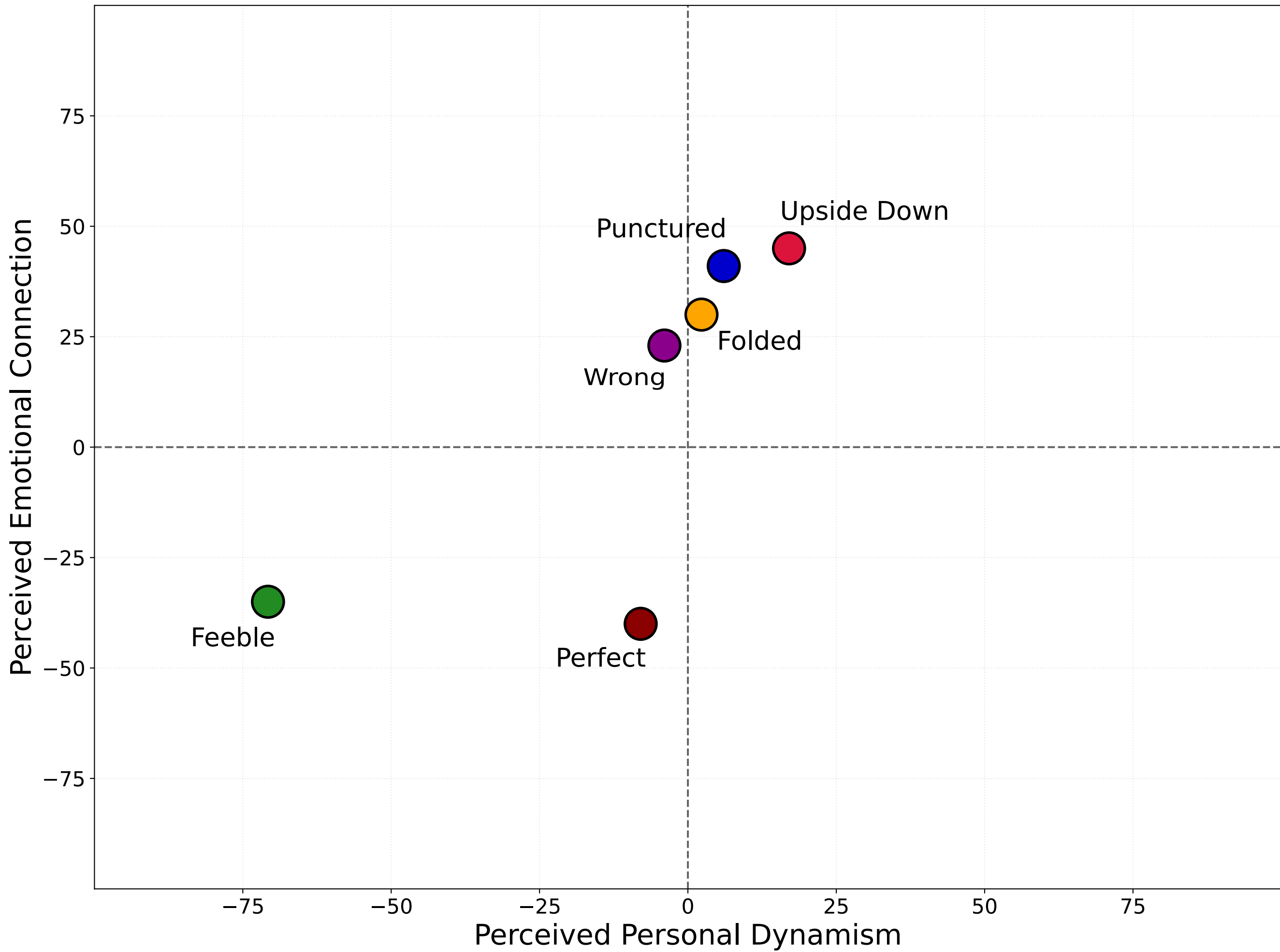
Character	Patient Autonomy	Relational Attunement	Personalisation	Professional Humility	Emotional Processing	Perspective Taking	Initiative / Activation	Self- Reflection
Responsive Caregiver	-1.21 (0.77)	1.56 (0.61)	1.32 (0.64)	0.88 (0.73)	0.41 (0.65)	0.47 (0.66)	0.71 (0.72)	0.26 (0.56)
Perfect One	-1.62 (0.51)	0.62 (0.77)	0.62 (0.65)	0.46 (0.66)	0.31 (0.63)	0.69 (0.63)	---	0.54 (0.78)
Punctured One	-0.12 (0.33)	0.25 (0.45)	0.06 (0.25)	0.31 (0.48)	1.31 (0.79)	0.25 (0.45)	---	0.62 (0.62)
Folded One	---	---	0.25 (0.45)	0.25 (0.45)	0.08 (0.29)	1.33 (0.65)	---	0.25 (0.45)
Feeble One	---	0.12 (0.33)	0.04 (0.20)	0.25 (0.44)	0.25 (0.53)	0.29 (0.55)	-1.71 (0.46)	1.00 (0.72)
Upside Down One	---	0.33 (0.49)	0.17 (0.39)	0.17 (0.39)	0.08 (0.29)	1.92 (0.29)	---	0.42 (0.51)
Wrong One	0.07 (0.26)	---	0.07 (0.26)	0.07 (0.26)	1.13 (0.74)	0.27 (0.46)	-0.20 (0.56)	0.53 (0.64)

Values are mean (SD). Scores range from -2 to +2. Null values "0.00 (0.00)" are reported as "---" for better readability. Overall differences between characters were tested using a mixed-effects model with random intercepts for participants (Wald $\chi^2(6)=38.47$, $p<0.001$). Overall differences between thematic dimensions were tested using Kruskal–Wallis tests ($\chi^2=245.59$, $p<0.001$). Differences across professional groups were also assessed using Kruskal–Wallis tests and were not significant ($\chi^2=3.82$, $p=0.576$).

The 5 Misfits: Positive and Negative Feelings



Mapping the Misfits: Emotional Connection vs. Personal Dynamism



Emotional Responses to the Feeble One

Intensity Distribution (Plutchik's Wheel Exercise, n=23 participants)

