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Formulating parents' feelings: Analyzing parent-nurse conversations in family-integrated neonatal care to develop communication training

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ABSTRACT

Objective: The novel concept of Family-Integrated Care (FICare) requires nurses to be parents' partners in neonatal care. We combined analyses of real-life parent-nurse conversations and interviews to elucidate nurses' role in providing psychosocial support to parents. Findings inform the development of communication training on topicalizing parents' feelings.
Methods: Conversation analysis of 15 audio-recorded parent-nurse conversations, and thematic analysis of interviews with 2 nurses.
Results: In parent-nurse conversations, nurses showed a "balancing act" in formulating parents' feelings, revealing the complexities of addressing parents' feelings. Overall, parents confirmed nurses' formulations, but also expanded or modified them, or indicated restricted conversational space. In the interviews, nurses discussed four purposes of conversations with parents, emphasizing elaborating on parents' feelings, while discussing associated challenges.
Conclusion: Our conversation analysis revealed a continuum of nurses' formulations of parents' feelings, and nurses' reflections illuminated how and when the formulations were used to invite parents' "feelings talk".
Innovation: This study is the first to use conversation analysis to analyze parent-nurse conversations. Additionally, it pioneers combining these analyses with interviews, inviting nurses to reflect on how to incorporate the findings into FICare. This combination strongly informs the development of tailored communication training, drawing from real-life conversations and nurses' articulated needs.

1. Introduction

Newborns' admission to the neonatology department occurs in a challenging and emotionally charged context. Parents experience emotions like anxiety, guilt and helplessness during their infants' hospital admission [1-4]. Since hospitalization has a profound and long-lasting impact on parents, Family-Integrated Care (FICare) approaches were introduced more than a decade ago to provide the best care for newborns, while also addressing parents' psychosocial needs [5,6]. FICare in neonatal care recognizes the vital role of parents in the care process. It includes four pillars: a neonatal environment fostering prolonged parental presence, staff education, parent education to increase medical knowledge and skills, and offering psychosocial support to parents [6-9]. Implementing FICare still presents challenges, for instance when parents' emotional needs and providers' support are misaligned [8].

This study aims to contribute insights specifically to the fourth pillar: providing psychosocial support to parents. Adopting FICare especially redefines nurses' roles, shifting from their traditional role as primary caregivers for neonates to adopting a multifaceted role as partners in taking care of the infant [10,11]. Recognizing and addressing parents' feelings is deemed essential in this partnership, as is the value parents give to receiving emotional support and empathy [8,9,12]. Nevertheless, both parents and nurses find this challenging. For instance, parents sometimes feel a lack of acknowledgement of their feelings [13-15].

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Nurses, on their part, balance being close to parents while maintaining professional boundaries [10,16]. Occasionally, they struggle to navigate parents' conflicting feelings and offering support [17].

While previous studies stress the importance of studying actual conversations between healthcare providers and parents [18,19], most studies center on retrospective reflections. They conduct interviews or surveys with nurses and parents [17,20,21], or code and quantify analyst-defined communicative behaviors, like nurses' "empathic responses" [22]. What remains unexamined, are real-time practices in parent-nurse conversations, i.e. *how* parents' feelings are addressed, and what parents *themselves* treat as an "empathic response" or an "invitation to share feelings". Such an inductive analysis offers valuable insights for training healthcare professionals, based on what happens in real life, including what happens in subtle but nevertheless crucial details of talk [18,23].

This study is the first to combine two methods to analyze parent-nurse conversations in neonatal care:

1. Using conversation analysis (CA), we micro-analyze recorded parent-nurse conversations, highlighting nurses' real-life challenges and solutions to talking about parents' feelings.
2. Using a participatory approach to develop tailored communication training, we interview nurses to reflect on the recorded conversations and nurses' needs.

Given our focus on how nurses provide psychosocial support to parents, the ways nurses *formulate* parents' feelings attracted our analytic attention. With formulations, speakers summarize, gloss, or develop the gist of prior speakers' statements [24]. Prototypical examples are "So you're saying X?" or "So you feel X", which require recipients to (dis)confirm the information [25,26].

Research in CA has shown that formulating another person's feelings can be a conversational challenge given that people have epistemic authority over their own feelings [26-29]. In the field of CA, the study of "epistemics" centers on how knowledge claims are made, disputed, and defended in conversations [27]. We demonstrate this challenge, by showing how nurses formulate parents' feelings by cautiously presenting parents' feelings—treating parents as having epistemic authority over their feelings. We also show situations where nurses assert independent access to parents' feelings, positioning themselves as having epistemic access to what parents feel.

In using both inductive (CA) and participatory (interviews) methods, this research further contributes to work on "applied conversation analysis" [30]. Research within this field uses CA to address a question or practical problem in interaction. By employing these methods, our study not only deepens our understanding of how participants negotiate on claiming epistemic access to feelings [28], but also offers actionable insights for improving communication within healthcare settings.

2. Methods

2.1. Data

The dataset consists of audio-recorded parent-nurse conversations, and video-recorded interviews with nurses.

2.1.1. Recordings of parent-nurse conversations

To analyze real-life parent-nurse conversations, 15 audio-recordings were collected of conversations between 13 parents (10 mothers, 3 fathers), 5 nurses, and 4 neonatologists/pediatric residents in two Dutch hospitals with a post-intensive care/high care neonatal ward. Both hospitals have been increasingly applying FICare principles for over 10 years. We asked nurses to make audio-recordings of their conversations with parents (without researchers present), with participants' consent. Recordings were made between December 2021 and September 2022, and reflected various activities, including nurses being present during doctor visits, discussing the infant's condition, and daily care actions like diaper change. The recordings had an average duration of 26 min, totaling 6 h and 30 min (see Appendix A).

Nurses were informed about our study and were invited to participate. Upon their agreement, nurses signed an informed consent form, after which they approached parents, informing them about the study and asking for their involvement. Once parents had granted their consent, they signed an informed consent form. Nurses then requested parents' permission to record the conversations during their visits.

The recordings were transcribed using the Jefferson [31] transcription-system (Appendix B), capturing nuances of speech delivery, including emphasis, pitch, and pauses. These details enable analysts to discern when conversations are flowing smoothly and when, and how, challenges arise [18]. Transcripts presented in this paper are translated from Dutch to English (see Appendix C for Dutch transcripts).

The recordings were then analyzed using conversation analysis (CA), an inductive method used to examine how participants demonstrate their understanding of one another [32]. The analyses are firmly grounded in the turn-by-turn development of parent-nurse conversations, paying close attention to the actions achieved by participants (e.g., complimenting, comforting), and the sequences of speaking turns through which actions get realized [33]. The initial analysis was conducted by two conversation analysts (LvB,JL). The analyses were revised and refined through meetings with another conversation analyst (HtM). In initial conversations with nurses, they highlighted the complexity of addressing parents' conflicting feelings, prompting our focus on how nurses dealt with "feelings talk". Initial observations revealed that nurses formulated parents' feelings, but did so in different ways, claiming more, and less access to parents' feelings. After all these formulations were collected, the specific ways nurses formulated parents' feelings were identified. This involved an iterative analytical procedure with multiple rounds of analysis, examining individual instances, and considering common features of nurses' formulations.

2.1.2. Interviews with nurses

For the participatory approach to tailoring communication training, nurses were interviewed about the purposes and challenges of their interactions with parents in the FICare-context, building on the analysis of recorded parent-nurse conversations. The interviews were conducted in the exploratory phase, so as to inform the development of the training. Two nurses participated in four audio-stimulated interviews [34,35]. These experienced nurses were specifically interviewed, as they were intensively involved in the project from the start. They were able to switch between the recordings they made, their experiences in talking to parents about (conflicting) feelings during hospitalization and (team) discussions about putting FICare principles in practice. It was the specific aim to invite these reflections, alongside the findings from the analysis of parent-nurse conversations. The aim of the interviews, therefore, was not to test the accuracy of the findings of the CA study or to form a representative sample, but to start a conversation of whether and how nurses recognized the analyses. Upon reviewing recordings of their conversations with parents, nurses were prompted to describe their conversational purposes, motivations, and challenges. The interviews, video-recorded with permission, lasted 51 min on average, and totaling 3.5 h. The semi-structured interview protocol is based on prior work on stimulated interviewing [34,35] and insights from the analyses of parent-nurse conversations (see Appendix D).

Thematic analysis [36], was used to investigate nurses' descriptions of purposes, motivations and challenges when addressing parents' feelings. For this purpose, recorded interviews were verbatim transcribed, (re)read, and systematically coded in ATLAS.ti (version 23). In the following phase, LvB identified two overarching themes encompassing all codes and created code groups. After JL had coded the data, code groups were further refined. All code groups were reviewed through multiple discussions. In the final phase, a detailed interpretative analysis of the codes was carried out (see Appendix E) and written up. In

line with the particular interview purposes, the thematic analysis centered on how interview topics aligned with the conversation-analytic findings, and how nurses' reflections contributed to developing tailored FICare communication training. Further development of the training is based on principles from the Conversation-Analytic Role-play Method (CARM [37]) and the Discursive Action Method (DAM [38]).

2.2. Ethics

The project was submitted to the Medical-Ethical Committee of the Amsterdam UMC, location VUmc, who decided that the study is not subject to the Medical Research Involving Human Subjects Act (2019.596). Moreover, the governing board of the hospitals in which the research was conducted approved the study.

3. Results

3.1. Nurses' formulations of parents' feelings

We found nurses to vary in the degree of caution with which they used formulations to claim access to parents' feelings. Nurses sometimes claimed more independent knowledge of parents' feelings, while at other times nurses' formulations shifted the balance towards more epistemic authority for parents.

We found that nurses' formulations can be placed on a continuum ranging from "cautious formulations" to "assertive formulations" of parents' feelings (Fig. 1).

In this section, we elucidate the four types of nurse formulations and provide an example for each one.

3.1.1. Cautious "My-side"-formulations

One type of formulation nurses used to "cautiously" formulate parents' feelings, were "my-side"-formulations. "My-side" formulations have been extensively investigated in conversation-analytic work [39,40] as situations where speakers express their own sensations to make claims about another person's experiences (e.g., "That *seems* terrifying *to me*"). In our dataset, nurses formulated their own feelings or perspectives in a way that suggests knowledge of parents' feelings without claiming the right to (further) define these feelings. In doing so, nurses navigated the epistemic challenges associated with claiming feelings that are not your own [29].

See Extract 1, where a nurse is talking to a mother of a girl (born at 26.3 weeks of gestation). The baby had initially been admitted to another hospital before being transferred to the current one. The nurse references the mother's "setbacks" at the previous hospital when the baby's condition deteriorated (lines 1–2), inquiring whether she has encountered similar setbacks here (line 4). The mother indicates that she experienced a setback just last week when the baby required high flow[1] and CPAP[2] again (lines 5–7), stating they experienced this "all the time" in the prior hospital (line 10). Using a euphemism ("a little bit of a bummer", line 14) and laughter [41], she downplays the complaint and avoids any appearance of being eager to complain [42]. The mother's euphemism enables the nurse to tailor her subsequent response to the mother's experience: the nurse provides a "my-side"-formulation, "That *seems* a little bit discouraging or something *to me*" (line 17). Using this type of formulation, and explicitly claiming that she is speaking on someone else's behalf (line 18), the nurse orients to the difficulty of claiming epistemic access to someone else's experience.

Extract 1

Recording of parent-nurse conversation [O1]

01	Nurse	And in the- in the [Name Hospital] you also had quite
02		some setbacks again every now and then?
03	Mother	<yes,>
04	Nurse	Do you have that here as well?
05	Mother	.mt uh no only last week then=uh (0.5) when
06		that u::h high flow needed to return again?
07		[and the CPAP?
08	Nurse	[Yes.
09	Mother	but uh (0.4) in general=uh
10		that's what we had there all the time.
11	Nurse	[Yes
12	Mother	[with all those uh beep=uh from CPAP
13	Nurse	Yes.
14	Mother	that was a little bit of °°a bummer°° .hh °hehe°
15		(2.1)
16	Mother	((to baby)) *we're going to put you on your belly girl,*
17	Nurse	That seems a little bit discouraging or something to me=
18		=yes now I'm putting words in your mouth
19	Mother	[That's it.
20	Nurse	[but-
21	Mother	That's it.
22	Nurse	Yes.
23		((sound of rubbing hands)) (1.4)
24	Mother	because then they keep on saying (.) "well: we- we're
25		going one step lower again"=and then you think "uh huh?"
26		(0.4)
27	Nurse	"Yeah, sure".
28	Mother	"of course." (.) seeing is believing.

Rather than merely confirming the nurse's formulation, the mother emphatically confirms it (line 19). By repeating this (line 21), she shows that the nurse has formulated exactly what she feels. The mother shows her epistemic authority in reporting on her feelings by expanding on the formulation and discussing her skeptical attitude towards cues by previous healthcare providers (lines 24–28).

3.1.2. Cautious formulation + tag

Nurses also employ "cautious formulations" coupled with a tag to show caution in formulating parents' feelings. "Tags" are brief phrases used by speakers to elicit recipients' confirmation, agreement, or response [43]. These are typically appended to the end of a statement, like "isn't it?" or "right?". Nurses appended a tag to formulations to signal their lower epistemic status regarding parents' feelings.

This is shown in Extract 2, where a mother is talking about her and her partner's shifting thoughts during their son's hospitalization (born at 28.1 weeks of gestation). Initially hoping to go home without a feeding tube (lines 1–3), they later hoped for a discharge without the need for home oxygen (lines 5–6). The nurse responds by formulating the mother's feelings. She transforms the content of the mother's description [44], proposing that the mother "has been pushing her limits constantly" (lines 17–18). By adding a tag ("right"), the nurse indexes the mother's epistemic authority over her feelings, inviting her to confirm:

[1] Respiratory support

[2] Continuous positive airway pressure

Extract 2

Recording of parent-nurse conversation [A9]

01	Mother	Yes, at the very beginning uh we thought "↑oh we hope he
02		can go home without a feeding tube"=
03		and [eh now I think "yes, that's not that bad at all."
04	Nurse	[Yea:h
05	Mother	Now of course we hope that he can go ho(h)me without
06		oxyge(h)n but that feeding tube that uh
07	Nurse	↑yes
08	Mother	can be worked with.
09		[Yes oxygen eventually too,
10	Nurse	[Yes
11	Mother	but that feeding tube [made it-
12	Nurse	[Yes
13	Mother	£If it's only the feeding tube it's a lot easier.£
14	Nurse	Yeah, yea:h.
15	Mother	£with wiring and all£ [hu:hHehe
16	Nurse	[£yea:h yeah.£
17	Nurse	**↑>Yeah< and of course that's how you have been pushing**
18		**your limits constantly over the past few weeks [right?**
19	Mother	[Yeaheah
20	Mother	£certainly. (.) [that's true yes.£
21	Nurse	[huHEhehe
22	Nurse	°Yes°=
23	Mother	=At the very beginning, you think, "But yes we'll
24		certainly not be going home with all sorts of bells
25		[and whistles."
26	Nurse	[Yes,
27	Mother	And at some point it becomes- (.) it all becomes so
28		usual.

Instead of simply confirming the formulation, the mother *emphatically* confirms this ("certainly", line 20), claiming her epistemic authority [45]. Her repeated confirmation (line 20), and her elaboration of the issue to further indicate her shifting thoughts (lines 23–28), assert more authoritative rights over the issue [45].

3.1.3. Modifications to formulations

Given that formulations preserve some elements of parents' talk, while unavoidably deleting or transforming other elements [24], parents not only expand but also *modify* nurses' formulations. See Extract 3, where a nurse is talking to a father and mother, who had twin girls (born at 33 weeks of gestation). We show how the mother responds to the nurse's formulation by confirming *and* modifying it.

Before, the nurse mentioned that the doctor had asked her to notify the parents about the upcoming discharge this weekend. The mother responded by resisting this announcement, explaining that she thought this to be "too soon". In Extract 3, the mother continues to raise concerns: she mentions that her partner and her mother are both at work (lines 1–4) and suggests she would rather have someone at home with her when the twins come home (lines 6–7). The nurse responds to the father's question about the time of discharge by suggesting it can also be planned for in the afternoon (lines 10–12). The father agrees with the nurse's suggestion by indicating that either he or his mother-in-law would then be available (line 13). What is relevant next, is the mother accepting or rejecting this suggestion (e.g., "Okay, let's do that"). The mother, however, merely acquiesces, producing a neutral, softer pronounced and unelaborated "yes" (line 14) that still shows resistance. The subsequent long silence (line 15) also indicates a problem. The nurse takes the mother's words up as reluctant acquiescence, by pursuing information about the day that the infants can go home (line 16). Another extended silence (line 18), and a softly uttered "yes" by the mother (line 19) follow, which indicate reluctance. The nurse does not leave this unattended but formulates an inference from the mother's prior talk [25]: ">And you find it really scary right?"(line 20).

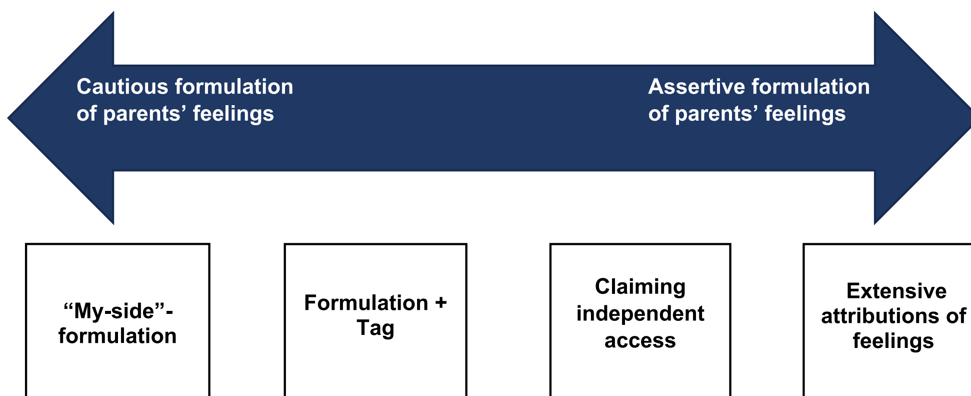

Fig. 1. Nurses' formulations of parents' feelings.

Extract 3
Recording of parent-nurse conversation [A1]

01	Mother	But Friday you are at work and my
02		mum is at work as well.
03		(0.4)
04		You know?=so:
05	Father	Yes then I have to [( )
06	Mother	[So then I would rathe:r (.) have a:
07		da:y that someone is just there [so to say.
08	Father	[but
09		is that Friday morning=afternoo:n?
10	Nurse	Yes if you say like you know "daddy is in the ev-
11		in the afternoon at home" then you can also pick them
12		up in the after↑noon.
13	Father	Yes because vo- in the afternoon one of us is the u:h
14	Mother	°Yes.°
15		(2.2)
16	Nurse	that you do it after the feeding at two o'clock.
17	Father	I work until two.
18		(2.8)
19	Mother	°Yes.°
20	Nurse	**And you find it really scary right?=**
21	Mother	=Yes=
22	Father	[hehe
23	Nurse	[yes.
24	Mother	Yes [but I also think it's soon.
25	Father	[Yes but
26		your mother can also help.
27	Mother	((sniffs))
28	Father	[No(h)no(h) it will be fine baby.
29	Nurse	[Noh:: £sorry girl£
30		hehe[he
31	Father	[It will all be fine love.
32	Mother	((sniffs deeply))

The nurse's formulation (line 20) casts the prior interaction as having insufficiently dealt with what the "real problem" might be [46]. She thereby redirects the conversation from practical objections about the babies' discharge, to associated emotional aspects. The mother confirms that she finds it scary, but then also modifies the nurse's formulation. Adding she also "thinks it's soon" (line 24), the mother partly resists the nurse's formulation. Her modification challenges the idea that her resistance is solely about her feelings, emphasizing its connection to timing.

3.1.4. Summary cautious formulations

The prior two sections demonstrated cases where nurses exercise caution in claiming access to parents' feelings, revealing that parents, not nurses, hold greater epistemic authority over their feelings. Parents typically emphatically confirm and expand on nurses' formulations, claiming greater epistemic access to their feelings, or they modify nurses' formulations, indicating some resistance to the formulation's content.

3.1.5. Assertive formulations: claiming independent access

Nurses also employ assertive formulations that are less cautious, where nurses do not downgrade their claims, but rather claim independent access to parents' feelings [26]. Nurses thereby show their aggregated experience in the neonatal context: often marked by the adverb "of course", nurses' formulations treat parents' feelings as recognizable and position nurses as having professional expertise.

See Extract 4, where a mother of a boy (born at 28.6 weeks of gestation), evaluates her experiences in the current hospital. Preceding this extract, she mentioned that she was not particularly concerned about her son's health, and was enjoying him greatly, mentioning she "just keeps on smiling" (line 1). When the mother does not continue (line 4), this signals her willingness to yield the floor to the nurse. The nurse formulates the mother's feelings (lines 5–6), transforming the mother's description of a mere facial expression to also represent a feeling of confidence: "of course that also gives you great peace of mind" (lines 9–10). Contrary to the cases in the prior section, the nurse does not downgrade her claims, but claims independent access to the mother's feelings:

Extract 4
Recording of parent-nurse conversation [A9]

01	Mother	£I just keep on smiling£ [heheHEhe
02	Nurse	[£Yes£ hehehe
03		°Yes°
04	Mother	<Yes.> Yes.
05	Nurse	**Yes of course that also empowers you greatly.**
06		**if you just (.) have so much confidence in him.**
07	Mother	Yes [absolutely.
08	Nurse	[**and the whole situation.**
09		**and uh. (.) yes, of course that also gives you great**
10		**peace of mind.**
11	Mother	Absolutely. (.) Yes.
12	Nurse	°Yes (.) yes°
13	Mother	Yes. (.) certainly.
14	Nurse	°Yes.°
15	Mother	I sometimes also have to realize tha(h)t you shouldn't
16		alwa(h)ys view everythi(h)ng only from a po(h)sitive
17		perspe(h)ctive.

The mother immediately displays agreement with the nurse's formulation, but also claims stronger epistemic access to her own feelings through an upgraded acknowledgement [47]: "Yes absolutely" and "Yes certainly" (lines 7,11,13). However, she modifies the formulation by indicating, while laughing, her awareness that she "shouldn't always view everything only from a positive perspective" (lines 15–17).

3.1.6. *Assertive formulations: Claiming independent access + expansion*

Nurses also claim independent access to parents' feelings by extensively ascribing feelings and thoughts to parents, thereby *expanding* their formulation. In this way, they claim even more epistemic authority over parents' feelings than 'merely' claiming independent access (see prior section). See Extract 5, where a nurse is talking to a mother of a girl (born at 26.5 weeks of gestation). The baby had been hospitalized in another hospital before being transferred to the current hospital, where the parents were assured that the baby would show improvement within forty-eight hours. However, the baby's condition actually worsened upon arriving at the current hospital. Before, the mother talked about the ineffective communication with the prior hospital. She mentions that, because of this, she "started off already behind" when entering the current hospital (line 1). She shows difficulty in formulating her feelings (lines 3,5), which is also how the nurse treats the mother's words. As in Extract 4, the nurse claims independent access to the mother's feelings, demonstrating her own experience with similar situations (lines 6–16). She does so by expanding her formulation in a way that extensively ascribes thoughts and feelings to the mother (lines 27–28,30-31,33-34,36,38-45,48–57):

Extract 5

Recording of parent-nurse conversation [A8]

```
01    Mother   And- and then you start off already be↑hind=e:h=
02    Nurse    =Yes=for sure,
03    Mother   when she- when she with u:h
04    Nurse    Yes,
05    Mother   yes when we all see this.=
06    Nurse    =Yes .hH well yes you know look for me eh (.) for us (.)
07             g- it doesn't matter much=but you (.)
08             .hH well (0.3) >look< you have a certain
09             ↑image of a hospital of course,
10             [of how things are going with her in particular=
11    Mother   [°yes°
12    Nurse    =that- there,- that's the most important [thing?
13    Mother                                            [°yes°
14    Nurse    hH and if (.) <you>- if it changes,
15             of course you will doubt everything because she
16             ↑is already so fragile [and you don't want to lose her.
17    Mother                          [yes
18             No.
19    Nurse    and if you are here, (.) and you suddenly see that she
20             is deteriorating very much- at least:? (0.3) that
21             suddenly everything [is
22    Mother                       [Yes
23    Nurse    going up?(.) where she's probably
24             never been [↑on before?=
25    Mother              [↑No
26             =No.
27    Nurse    then you think "huh?"(0.3)"what's going
28             [o:n,"
29    Mother   [Yes "what is this."
30    Nurse    .hH "doesn't she get terribly sick,"
31             "Shouldn't we use antibiotics,"
32    Mother   Yes,
33    Nurse    "shouldn't we go back."
34             ["are things going well in her head,"=
35    Mother   [yes
36    Nurse    ="is her tummy doing well,"
37    Mother   Yes
38    Nurse    "is she going to spit,"
39    Mother   °Yes°
40    Nurse    "does she have no bowel movement,"
41             All problems, (.) [that you know?
42    Mother                     [°Yes° everything.
43    Nurse    you suddenly see here [in rapid succession
44    Mother                         [°↑Yes°
45    Nurse    ↑happen[ing and you: think "my ↑child."
46    Mother          [°Yes°
47    Mother   °Yes°
48    Nurse    So of course (.) it's logical that you think (.)
49             "what is this."
50    Mother   °Yes°
51    Nurse    And "what twerps."
52    Mother   Y↓es
53    Nurse    ["Because I have been warned about it,"=
54    Mother   [yes that is- yes
55    Nurse    ="it did not happen,"=
56             ="now I am in [Hospital Name] and now it is happening
57             all at once."
58    Mother   ↑Yes (0.5) °Yes°
59    Nurse    So [I really get you.
60    Mother      [Yes, exactly that.
61    Nurse    I get you [really
62    Mother             [°Exactly that.°
```

The nurse starts by saying that “for me”, but corrects this into “for us” (line 6), suggesting that she is not expressing her personal view but rather an aggregate professional perspective, that of the hospital. In so doing, she suggests her experience with such situations, emphasizing that for health staff, these scenarios are routine and not as alarming. By mentioning “you have a certain image of a hospital of course” (lines 8–9), followed by “of course you will doubt everything because she’s already so fragile and you don’t want to lose her” (lines 15–16), the nurse claims access to the mother’s inner experience. Using adverbs like “of course” (lines 9,15,48) and “logical” (line 48), she normalizes the mother’s feelings, treating this as feelings any parent would have. She uses similar formulations to claim access to the mother’s feelings when the baby was deteriorating (lines 19–21,27), which she expands with extensive and directly reported claims of the mother’s feelings (lines 27–57). While the mother mostly provides listening tokens (“yes”), on several occasions she also provides more extensive confirmatory phrases (“Yes what is this”, line 29, “yes everything”, line 42), that not only show agreement but also convey stronger epistemic rights than the nurse concerning the issue. Moreover, the mother’s extensive phrases indicate moving out of a recipient role and projecting further speaking [48]. This is also visible when she overlaps the nurse’s speech (“yes that is-", line 54). She does not finish her sentence, given that the nurse continues talking—revealing the mother’s limited speaking opportunities. The nurse concludes by asserting she “really gets” the mother (line 59), emphasizing it with repetition (line 61). In this way, she shows her strong understanding of the mother’s feelings.

Notably, the mother does not show signs that the nurse’s claims about the mother’s feelings are unwarranted. However, the mother does claim stronger epistemic authority [47] when upgrading her acknowledgement of the nurse’s formulation (lines 60,62).

3.1.7. *Summary assertive formulations*

The prior sections demonstrated cases where nurses assert access to parents’ feelings without caution. Overall, parents treat nurses’ claims of direct access to their feelings as unproblematic. However, parents do respond by claiming more epistemic access to their feelings than nurses, which becomes visible in parents’ uptake, showing expansions and modifications of the nurses’ formulated claims [47]. Nurses’ expanded formulations may also limit parents’ speaking opportunities.

3.2. *Nurses’ reflections on purposes and challenges*

Our thematic analysis of the interviews revealed two overarching but intertwined themes relevant to “talking about parents’ feelings”. The first theme was **purposes of conversations with parents**, which included 1a) building trusting relationships; 1b) helping parents articulate and understand their feelings; 1c) giving parents conversational space; and 1d) reaching a “deeper layer”. Reflections on purposes were closely linked to the second theme, **experiencing challenges in conversations with parents**, where we identified in particular: 2a) parents resisting nurses’ conversational moves; 2b) parents holding (unrealistic) expectations, and 2c) experiencing boundaries to communicative conduct. We will now discuss these purposes, and their associated challenges, as articulated by nurses.

3.2.1. *Building trusting relationships*

Nurses stressed the importance of parents trusting them, as parents entrust them with the care of their newborn child, see Extract 6. Previously, the nurse emphasized the importance of her open communication with parents, ensuring they feel comfortable discussing anything. She also makes a distinction between the importance of a trusting relationship and the necessity of there being a special bond:

Extract 6
Interview with nurse [A4-031123]

01	Nurse	So personally, I always find it very important that
02		parents… well, they do not have to have a super
03		connection with me, but they do need to have the trust
04		that:
		“my child is in good hands with you.”

However, nurses also noted a challenge connected to this purpose. Despite their endeavors to foster trust, *parents’ resistance to nurses’ conversational moves*, such as their reluctance to respond to nurses’ inquiries or invitations, does significantly impede nurses’ efforts. This was also related to another challenge nurses mentioned, where they run into *boundaries to their communicative conduct.* Nurses mentioned that despite ongoing attempts, parents may not ratify nurses’ efforts.

3.2.2. *Helping parents articulate and understand their feelings*

One central purpose nurses recognized when listening back to their conversations was *helping parents articulate and understand their feelings.* In Extract 7, the nurse reflected on her conversation with a mother whose baby had experienced unexpected deterioration (see Extract 5). We see how the nurse characterizes herself literally as “spokesperson”, helping the mother to articulate and understand her feelings and describes nurses’ conversational role as “the words to parents’ thoughts” (lines 8–9):

Extract 7
Interview with nurse [A4-031123]

01	Nurse	This mother suppressed everything a bit.
02		And e:hm (1.5) I think that if I wouldn’t express it in
03		words, or if a colleague wouldn’t express it in words, it
04		might eventually lead to an outburst where she would be
05		so angry because the baby had become so ill in our
06		hospital while she had expected that in our hospital she
07		would do better.
		[…]
08		I think that very often we are the words to
09		parents’ thoughts.
10		For some parents, communication comes easily, and they
11		express everything very easily, but this mother uhm she
12		was kind of uhm… you could notice that she was angry.
13		You could feel that when you were with her.
14		But she didn’t express this, only occasionally with a
15		comment, but for the rest, it didn’t all come out.

Nurses also highlighted two challenges associated with this role: *parents’ resistance to nurses’ conversational moves* and the *boundaries to their communicative conduct*. Nurses mentioned that there is “only so much they can do” to help parents articulate or understand their feelings. Nurses linked this to what they perceived as another challenge: *parents’ (unrealistic) expectations*. For instance, nurses indicated a desire to assist parents in expressing their feelings, yet parents sometimes remained (unjustifiably) optimistic, even when their child likely required an extensive recovery period.

3.2.3. *Giving conversational space*

A central goal for nurses in conversations with parents is to give them conversational space. For instance, see Extract 8, where the nurse continues reflecting on the conversation in Extract 5. The nurse raises concerns about her formulation of the mother’s feelings, mentioning “I hear myself talking the whole time” (line 1):

Extract 8
Interview with nurse [A4-031123]

01	Nurse	At some point I hear myself talking the whole time.
02		Then I think: "Let the mother do the talking" ((laughs)) […]
03		Yes, then I hear myself and then I think: "Oh, I
04		should have kept my mouth shut for a while."

The nurse acknowledges the importance of allowing space for conversation, yet recognizes how in the recorded conversation, her communicative behavior is quite the opposite: she tended to dominate the conversation, restricting the mother's opportunity to speak. By doing so, the nurse orients to the norm of allowing parents to express themselves and engage actively in conversations. At the same time, nurses experience the challenge that parents may not articulate strong emotions such as anger, as they *resist nurses' conversational efforts*, which impedes the communicative goals nurses aim to achieve.

3.2.4. Reaching a "deeper layer"

A fourth purpose nurses mentioned upon reviewing their conversations was *reaching a "deeper layer"* regarding parents' feelings. In doing so, nurses expressed their motivation to make a transition from the things parents say, to exploring any underlying emotions of what is being said. In Extract 9, one nurse explicated this by referring to the mother's resistance to the practical solutions she was offering (see Extract 3). This led the nurse to think she was not "getting anywhere with practical solutions", which was what made her believe there was "something underneath" (lines 6–7):

Extract 9
Interview with nurse [A3-271023]

01	Nurse	I try to come up with practical solutions, like, you
02		know, you can go home on Friday as soon as dad finishes
03		work, it doesn't matter. Yes, and then you can tell she's
04		resisting it. That word "yes" was clearly a sign of
05		resistance (laughs), I remember.
06		And then I thought: "Okay, but I'm not getting anywhere
07		with practical solutions. There's something underneath."

The nurse further reflects on what the "layer underneath" would be:

Extract 10
Interview with nurse [A3-271023]

01	Res1	I was also thinking about that layer underneath, if you
02		had to give it a name, what is that layer? You just
03		mentioned resistance, didn't you? What do you think is
04		underneath, if there is something?
05	Nurse	The emotion of being anxious, well... How should I put
06		it? You're naturally focusing on the practical aspect,
07		I always find that a rather superficial layer. Of course,
08		you also need to think practically, but that's quite
09		superficial, and there are solutions for that.
10		But with that deeper layer, she has to deal with it
11		herself. I can have conversations with her, but she will
12		have to do something about finding it scary.

The nurse considers the "practical aspects" a "rather superficial layer" (lines 6–7), and a substitute for something else. Here, the mother's emotion of being anxious (line 5). In indicating that the mother will need to deal with that "deeper layer" herself (lines 10–12), the nurse emphasizes the need to balance between expressing empathy towards parents and empowering them.

Nurses also pointed out other challenges associated with this purpose, emphasizing *parents' resistance to nurses' efforts* to reach a "deeper layer". For instance, nurses mentioned instances where parents seemed to be "holding back". They also reflected on challenges involving *boundaries of their communicative conduct*. Nurses acknowledged that they cannot eliminate the fact that parents find the situation stressful, and that issues on this deeper level also imply solutions that extend the domain of conversations. A final challenge nurses mentioned in this respect was related to *parents' holding (unrealistic) expectations*. Nurses struggle to reach a "deeper layer" when parents fail to recognize ongoing challenges in caring for a preterm baby post-discharge.

4. Discussion

4.1. Discussion

This study used an innovative combination of two methods to focus on neonatal nurses' role in the fourth pillar of FICare: providing psychosocial support to parents. More so than for doctors, a core part of nurses' changing role is to provide such emotional support [49].

Our analyses of recorded parent-nurse conversations addressed how nurses formulate parents' feelings, revealing "balancing practices" in claiming more, or less epistemic access to parents' feelings. Moving beyond self-report data, these real-life conversations are evidence for the nurse's role in providing psychological support to parents. We found four different ways in which nurses formulated parents' feelings. The first two types showed that nurses claimed less epistemic access by cautiously produced, downgraded claims. These cautious formulations enable nurses to make claims about parents' feelings, while nevertheless giving parents the opportunity to make adjustments, and respecting parents' authority over their feelings. Conversely, the two other types of assertive formulations demonstrated nurses asserting direct access to what parents feel. Hence, while prior research implies that people usually treat others' feelings and experiences as "owned" by the other [28,43], and speakers exercise caution in making claims about them, our research shows situations where speakers assert stronger epistemic access to others' feelings. Comparable findings were found in conversation-analytic research on therapeutic communication, where therapists claimed direct access to clients' feelings without epistemic downgrading [26]. These similar findings suggest that therapists and neonatal nurses share a similar conversational (institutional) task of addressing (underlying) emotions [50].

Overall, parents responded by ratifying nurses' formulations, and most often did so quite readily. This shows that, especially in instances where nurses asserted having direct access to parents' experiences, nurses have a considerable "degree of latitude": parents allow or tolerate nurses to claim what parents feel, even though such claims belong to parents' epistemic domain. In this FICare-context, where nurses offer psychosocial support to parents, this shows that nurses can help parents in articulating complex and conflicting feelings. However, as we demonstrated, claiming access to parents' feelings may lead them to claim stronger epistemic authority over their feelings through upgraded acknowledgements [45] and expansions on, or modifications of, nurses' formulations. This suggests parents' desire to articulate their feelings in their own terms. Moreover, nurses' formulations can sometimes dominate the conversation, limiting parents' opportunities to speak. Hence, these findings concerning the formulation of parents' feelings imply a potential risk. Such formulations might result in parents being preoccupied with elaborating on or altering the formulations' content, thereby impeding their ability to express their feelings in their own way.

Our findings contribute to work on parent-nurse conversations in the context of FICare. Past empirical research highlighted the need for healthcare providers to use language that provides emotional support, conveys empathy, and acknowledges parents' concerns [8,9,12,22,50]. These studies revealed that healthcare providers' communicative

behavior does not consistently fulfill this need; a finding supported in systematic reviews on NICU communication [9,10,12]. Nurses sometimes find providing emotional support and dealing with parents' conflicting feelings challenging, due to a reported lack of proper training and guidelines [17]. Moreover, for parents to share their feelings may not be easy, nor self-evident [51]. Consequently, although nurses' formulations analyzed in the current study may carry risks, they can also serve as a tool to bring attention to parents' (implicit or alluded-to) concerns, and as conversation starters. Differences in the formulation's style (cautious versus assertive) also reflect these functions.

Using an innovative method to analyze parent-nurse conversations proved valuable for gaining insight into the "black box" of real-life parent-nurse conversations [18]. Examining how nurses articulate parents' feelings and delicately manage making such claims, highlights ongoing negotiations on what nurses are entitled to claim regarding parents' feelings within parent-nurse FICare "partnerships" [10,52-54]. Interviews where nurses reflected on their interactions provided additional insight into nurses' "balancing act" in addressing parents' feelings. This revealed key purposes and significant challenges, indicating focal points for a communication training we developed for neonatal nurses.

The communication training we developed based on our research is unique because it incorporates real-life conversations between parents and nurses, rather than hypothetical scenarios, and addresses the practical questions and issues nurses encounter in these interactions. This leads to greater recognition of what happens in these conversations and areas for improvement among nurses compared to other training programs. Future studies should evaluate the effectiveness of communication training that involves nurses reflecting on their actual interactions to enhance nurses' responses to parents discussing their feelings. Such work could, for instance, use controlled experimental designs, in which one group of neonatal nurses receives the communication training we developed, and a control group does not. The effectiveness of the training could then be measured by comparing outcomes between the two groups, such as the quality of "feelings talk" within nurse-parent interactions, parent satisfaction, and parents' emotional well-being. Additionally, qualitative feedback from nurses could provide deeper insights into the training's impact and the extent to which it addresses the specific questions or issues that nurses have, identifying areas for improvement and highlighting successful elements that could be further refined.

Our study contributes to work in "applied conversation analysis" [30], by providing more insights into how analyses of real-life conversations and interviews can be combined to develop communication training. There have been several academic discussions on the use of both interaction data and interviews, and their theoretical compatibility and affinity e.g., [55,56]. Importantly, in our study we have treated the analyses of real-life conversations as standing on their own. While nurses contextualized our analyses in the interviews, the insights gained from the interviews do not 'compete' with or 'correct' the insights obtained from the fine-grained interactional analysis [57,58]. Rather, both interviews and analyses of conversations contribute separate and unique insights to understand conversations between nurses and parents.

The study's limitations pertain to the fact that parent-nurse conversations were only audio-recorded, lacking insights into non-verbal communicative aspects that most probably also play a role in how formulations of feelings are presented and taken up in the conversations. Additionally, this study focused on an interesting phenomenon that involves "feelings talk" in neonatal care, but has only been able to address a few aspects of formulations of parents' feelings. This study, nevertheless, provides clear analytical entry points for further empirical investigations into interactions in neonatal care, and healthcare interactions more generally. Importantly, we only interviewed one "partner" in parent-nurse partnerships; future investigations should also include parents, to better understand their views on the real-time communicative practices in conversations with nurses, which could also provide insights for communication training, from *parents'* perspective.

4.2. Innovation

This research adds to the expanding literature on parent-provider communication in FICare [9,10,12]. Unlike previous studies, we uniquely explore *nurses' real-life conversations* with parents. This study pioneers the use of an inductive, conversation-analytic method to parent-nurse conversations and explores the communicative dynamics of FICare. Moreover, it is the first research combining these insights with interviews, collaborating closely with nurses to collect their reflections on purposes and challenges, alongside conversation-analytic findings. This rich and combined understanding has informed the development of communication training tailored to address nurses' needs, challenges, and interests, *in their own terms.*

5. Conclusion

Our analysis of "feelings talk" in parent-nurse conversations highlighted the continuum of nurses' formulations of parents' feelings, and nurses' reflections addressing the purposes and challenges related to "feelings talk". Moving beyond mere self-report data, we analyzed nurses' real-time conversational practices. The subsequent interviews gave us a good insight into the communicative challenges in FICare, as expressed in nurses' own terms, and thus help us to tailor communication training to these complex and multifaceted demands.

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CRediT authorship contribution statement

Lotte van Burgsteden: Writing – review & editing, Writing – original draft, Visualization, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Joyce Lamerichs:** Writing – review & editing, Visualization, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization. **Annemarie Hoogerwerf:** Writing – review & editing, Validation, Supervision, Resources, Investigation, Data curation. **Hedwig te Molder:** Writing – review & editing, Visualization, Validation, Methodology, Conceptualization. **Miranda de Jong:** Writing – review & editing, Validation, Resources, Investigation, Data curation.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Outline of recorded conversations

Type of conversation	Participants	Baby, gestational age at birth	First child(ren)?	Duration
Discharge conversation	Nurse Father Mother	Twins, 33 weeks	Yes	21:00
Visit of Nurse	Nurse Father Mother	Boy, 28.1 weeks	No	5:38
Visit of Nurse	Nurse Father Mother	Boy, 37.1 weeks	No	19:30
Visit of Doctor	Neonatologist Pediatric resident Nurse Father Mother	Boy, 28.6 weeks	No	10:44
Visit of Doctor	Neonatologist Pediatric resident Nurse Mother	Twins, 33.1 weeks	No	28:21
Visit of Nurse	Nurse Mother	Boy, 33.1 weeks	No	8:09
Evaluation with Nurse	Nurse Father Mother	Twins, 33.1 weeks	No	25:06
Evaluation with Nurse	Nurse Father Mother	Girl, 26.5 weeks	No	35:34
Evaluation with Nurse	Nurse Mother	Boy, 28.6 weeks	Yes	31:24
Changing diaper	Nurse Father Mother	Boy, 28.6 weeks	Yes	4:29
Visit of Nurse	Nurse Mother	Girl, 26.3 weeks	No	20:29
Visit of Nurse	Nurse Father Mother	Boy, 28.1 weeks	No	21:22
Evaluation with Nurse	Nurse Mother	Girl, 26.3 weeks	Yes	18:10
Visit of Doctor	Neonatologist Nurse Father Mother	Girl, 27.8 weeks	No	25:59
Visit of Doctor	Neonatologist Nurse Father Mother	Boy, 37.1 weeks	Yes	26:02
				~6.5 h

Appendix B. Transcription conventions

Based on Jefferson (2004).
(1.5) Silence with duration of indicated seconds in between brackets
(.) Silence shorter than 0,2 s
text= There is no observable silence in between two adjacent turns-at-talk
=text2 of two different speakers, or in between two adjacent turns-at-talk
of same speaker
[speaker1 these two conversation partners start their turn simultaneously
[speaker2 Falling intonation
Slightly rising intonation
? Strongly rising intonation at the end of particular part of utterance
↑ Sharp rising intonation
↓ Sharp falling intonation emphasis
Underscore stress/emphasis

stre::tch Prolongation/stretching of sound
(h) Laughter
£ Smiley voice
HELLO Pronounced relatively loud
°**hello**° Pronounced relatively soft
hel- Speaker terminates production of a word or utterance-part abruptly
>word< Increased speaking rate (speeding up)
Decreased speaking rate (slowing down)
.Hh Hearable in-breath; every ‘h’ indicates duration of app. 0,2 s.
Capital ‘H’ indicates relatively louder in-breath
((moves)) Characterization of non-verbal activities or other remarkable phenomena
( ) Parentheses indicate inaudible speech
(something) Parentheses indicate uncertain word

Appendix C. Original Dutch transcripts

Extract 1
Recording of parent-nurse conversation [O1] – Dutch.

01	Nurse	En in ‘t- in ‘t [Name Hospital] had je ook best wel
02		af en toe toch nog weer een terugslag?
03	Mother	<ja,>
04	Nurse	Heb je dat hier nu ook?
05	Mother	.mt eh nee alleen dan vorige week = eh (0.5) dat
06		die e::h high flow weer terug moest?
07		[en de CPAP?
08	Nurse	[Ja.
09	Mother	maar eh (0.4) over et algemeen = eh
10		dat hadden we daar steeds.
11	Nurse	[Ja
12	Mother	[met al die uh piep = uh van CPAP
13	Nurse	Ja.
14	Mother	dat was een beetje °°jammer°° .hh °hehe°
15		(2.1)
16	Mother	((tegen baby)) *we gaan jou lekker op je buikie leggen meissie,*
17	Nurse	**dat lijkt me ook een beetje demoti↑verend of zo=**
18		**=ja dat vul ik nu voor je in**
19	Mother	[Dat is het.
20	Nurse	[maar-
21	Mother	Dat is het.
22	Nurse	Ja.
23		((sound of rubbing hands)) (1.4)
24	Mother	want dan zeggen ze steeds (.) “↑nou:: we- we gaan weer
25		een stapje lager” = en dan denk je “hm hm?”
26		(0.4)
27	Nurse	“Het zal wel.”
28	Mother	“Tuurlijk.” (.) eerst zien dan geloven.

Extract 2

Recording of parent-nurse conversation [A9] – Dutch.

01	Mother	Ja helemaal in het begin uh dachten we nog van “↑oh we
02		hopen dat ie zonder sonde naar huis mag”=
03		=en [eh nu denk ik “ja dat is helemaal niet zo erg.”
04	Nurse	[J:a
05	Mother	Nu hopen we natuurlijk dat ie zonder
06		zuursto(h)f naar hui(h)s mag maar die sonde dat uh
07	Nurse	↑ja
08	Mother	daar valt wel mee te werken.
09		[Ja zuurstof uiteindelijk ook wel,
10	Nurse	[Ja
11	Mother	maar die sonde [maakte et-
12	Nurse	[Ja
13	Mother	£Alst alleen de sonde is is het nog een stuk makkelijker.£
14	Nurse	Ja, ja:.
15	Mother	£met bedrading en zo£ [hu:hHehe
16	Nurse	[£ja: ja.£
17	Nurse	**↑>Jaha< en zo ben je natuurlijk ook gewoon de afgelopen**
18		**weken steeds je grenzen aan het verleggen geweest [he?**
19	Mother	[J:aha
20		£zeker. (.) [dat is ook zo ja.£
21	Nurse	[huHEhehe
22	Nurse	°Ja°=
23	Mother	=Helemaal in het begin, denk je, “Maar ja we gaan
24		toch niet naar huis met allerlei toeters
25		[en belle.”
26	Nurse	[Ja,
27	Mother	En op een gegeven moment wordt het- (.) wordt het allemaal
28		zo eigen.

Extract 3

Recording of parent-nurse conversation [A1] – Dutch.

01	Mother	Maar vrijdag ben jij aan het werk en is mijn
02		moeder ook aan het werk.
03		(0.4)
04		Snap je?=dus:
05	Father	Ja dan moet ik [( )
06	Mother	[Dus dan heb ik lieve:r (.) een:
07		dag: dat er gewoon e:h ook iemand is [zeg maar.
08	Father	[maar
09		is dat vrijdagochtend middag?
10	Nurse	Ja als je zegt van weet je “papa is ’s av- ‘s
11		middags thuis” dan kan je ze ook
12		’s ↑middags ophalen.
13	Father	Ja want vo- ’s middags is een van de twee et e:h
14	Mother	°Ja.°
15		(2.2)
16	Nurse	d’t je et na de voeding van twee uur doet.
17	Father	Ik werk tot twee.
18		(2.8)
19	Mother	°Ja.°
20	Nurse	**En je vindt het heel spannend he?=**
21	Mother	=Ja=
22	Father	[hehe
23	Nurse	[ja.
24	Mother	Ja [maar ik vind et ook wel snel.
25	Father	[Ja maar
26		je moeder ken ook wel helpe.
27	Mother	((snuft))
28	Father	[Nee(h)ee(h) komt wel goed schatje.
29	Nurse	[No:: £sorry meis£
30		hehe[he
31	Father	[Komt allemaal goed lieverd.
32	Mother	((snuft diep))

Extract 4

Recording of parent-nurse conversation [A9] – Dutch.

01	Mother	£blijf gewoon stralen£ [heheHEhe
02	Nurse	[£Ja£ hehehe
03		°Ja°
04	Mother	<Ja.> Ja.
05	Nurse	**Ja dat maakt je natuurlijk ook heel krachtig.**
06		**als je gewoon (.) zo veel vertrouwen in hem hebt.**
07	Mother	Ja [zeker.
08	Nurse	**[en de hele situatie**
09		**en uh. (.) ja, dat geeft jezelf natuurlijk ook wel**
10		**heel veel rust.**
11	Mother	Absoluut. (.) Ja.
12	Nurse	°Ja (.) ja°
13	Mother	Ja. (.) zeker
14	Nurse	°Ja.°
15	Mother	Ik moet soms ook wel realiseren da(h)t je niet altijd
16		a(h)lles allee(h)n maar van een po(h)sitieve kant moet
17		bekij(h)ken hoor

Extract 5

Recording of parent-nurse conversation [A8] – Dutch.

```
01   Mother  En- en dan sta je d'r al met twee nul ↑achter=e:h=
02   Nurse   =Ja=sowieso,
03   Mother  als zij- als zij mette:h
04   Nurse   Ja,
05   Mother  ja als we dit allemaal zien.=
06   Nurse   =Ja .hH naja weetje kijk voor mij eh (.) voor ons (.)
07           g- maakt et niet heel veel uit=maar jullie (.)
08           .hH nou (0.3) >kijk< je hebt een bepaald
09           ↑beeld van een ziekenhuis natuurlijk,
10           [van hoe het maar haar gaat met name=
11   Mother  [°ja°
12   Nurse   =dat- daar,- dat is het belangrijks[te?
13   Mother                                     [°ja°
14   Nurse   .hH en als (.) <je>- als het ver↑andert,
15           je gaat natuurlijk aan alles ↑twijfele want ze
16           ↑is al zo fragiel [en je wil d'r niet ver↑lieze.
17   Mother                    [ja
18           Nee.
19   Nurse   en als je hier be:nt, (.) en je ziet dat zij ineens
20           heel erg achteruit gaat- tenminste:? (0.3) dat wij
21           ineens alle[s
22   Mother             [Ja
23   Nurse   om↑hoog gaan gooie? (.) waar ze daar waarschijnlijk
24           nog nooit heeft [↑aan gelege?=
25   Mother                  [↑Nee
26           =Nee.
27   Nurse   dan denk je "huh?" (0.3) "wat is er aan de
28           [ha:nd,
29   Mother  [Ja "wat ↑is dit."
30   Nurse   .hH "wordt ze niet ontzettend ziek,"
31           "moeten we geen antibiotica,"
32   Mother  Ja,
33   Nurse   "moeten we niet terug."
34           ["gaat het in haar hoofje goed,"=
35   Mother  [ja
36   Nurse   ="gaat het in haar buikje goed,"
37   Mother  Ja
38   Nurse   "gaat ze spuge,"
39   Mother  °Ja°
40   Nurse   "heeft ze geen ont↑lasting,"
41           Alle prob↑leme, (.) [die je ke:nt?
42   Mother                      [°Ja° alles.
43   Nurse   zie je hier ineens allemaal [in een sneltreinvaart
44   Mother                              [°↑Ja°
45   Nurse   ↑ko[me en je: denkt "mijn ↑kindje."
46   Mother     [°Ja°
47           °Ja°
48   Nurse   Dus natuurlijk (.) is het logisch dat je denkt (.)
49           "wat is dit."
50   Mother  °Ja°
51   Nurse   En "wat een prutsers."
52   Mother  J↓a
53   Nurse   ["Want ik ben er voor gewaarschuwd,"=
54   Mother  [ja dat is- ja
55   Nurse   ="het is niet voorgekome,"=
56           ="nu ben ik in [Naam Ziekenhuis] en nu gebeurt het
57           allemaal in één keer."
58   Mother  ↑Ja (0.5) °Ja°
59   Nurse   Dus [ik snap je echt.
60   Mother      [Ja, dus precies dat.
61   Nurse   Ik snap je [echt
62   Mother             [°Precies dat.°
```

Extract 6

Interview with nurse [A4–031123] – Dutch.

01	Nurse	Dus zelf vind ik het altijd belangrijk dat ouders…
02		ja ze hoeven niet een super klik met mij te hebben,
03		maar ze moeten wel het vertrouwen hebben van:
04		"mijn kindje is in goede handen bij jou."

Extract 7
Interview with nurse [A4–031123] – Dutch.

01	Nurse	deze moeder die kropte het allemaal wel een beetje op.
02		En e:hm (1.5) ik denk als ik er geen woorden aan zou geven
03		of als een collega er geen woorden aan zou geven, dan
04		zou het misschien op een gegeven moment een ontlading
05		worden waarbij ze zo boos zou zijn omdat eh het kindje zo ziek
06		was geworden bij ons in het ziekenhuis terwijl ze juist had
07		verwacht dat het bij ons juist in het ziekenhuis beter zou gaan.
08		
		[…]
08		Ik denk dat wij heel vaak de woorden zijn van
09		de gedachten van ouders.
10		Sommige ouders zijn natuurlijk heel makkelijk in die
11		communicatie, en die uiten alles gewoon heel gemakkelijk maar deze moeder e:hm die was een soort van ehm…
12		
12		je merkte aan haar dat ze zichbaar boos was.
13		Dat voelde je als je bij haar was.
14		Maar dat uitte ze niet, en dat was dan af en toe met een
15		opmerking, maar voor de rest kwam het er niet allemaal uit.

Extract 8
Interview with nurse [A4–031123] – Dutch.

01	Nurse	Op een gegeven moment hoor ik mezelf de hele tijd kletsen.
02		Dat ik denk: Laat die moeder verder kletsen ((lacht))
		[…]
03		Ja dan hoor ik mezelf en dan denk ik: “Oh, ik had I
04		wel even mijn mond mogen houden tussendoor.”

Extract 9
Interview with nurse [A3–271023] – Dutch.

01	Nurse	Ik probeer dan praktische oplossingen mee te geven, van:
02		weet je, je kan ook vrijdag naar huis zodra papa klaar is
03		met werken, dat maakt niet uit. Ja, en dan merk je dat ze
04		in de weerstand gaat. Dat woordje “ja” was echt in de
05		weerstand ((lacht)), dat weet ik nog.
06		En toen dacht ik: “Oké, maar ik kom er zo met praktische
07		oplossingen niet uit. Er is een laagje onder.”

Extract 10
Interview with nurse [A3–271023] – Dutch.

01	Res1	Ik zat nog wel te bedenken: dat laagje eronder, als je
02		daar nou een naam aan zou moeten geven, wat is dat laagje dan? Je zei net over weerstand, wat zit er dan voor laagje
03		onder volgens jou? Zit er iets onder?
04		
05	Nurse	De emotie van et spannend eh, ja… Hoe moet ik dat
06		zeggen? Je blijft natuurlijk daarboven op het praktische
07		zitten. Dat vind ik altijd een vrij oppervlakkig laagje.
08		Tuurlijk moet je heel praktisch nadenken ook, maar dat is
09		vrij oppervlakkig, en daar zijn oplossingen voor.
10		Maar met dat laagje dieper moet ze zelf iets.
11		Ik kan gesprekken met haar aangaan, maar daar zal zij zelf
12		iets mee moeten doen.

Appendix D. Topic guide for interviews with nurses.

Type	Topic	Prompts
Introduction	• Catch up with nurse • Introduction: We have organized this meeting to let you reflect on and discuss with you some of the conversations that you have had with parents. We will play the recording, alongside the transcript, and you can indicate to us what you see happening.	
Listening to recorded conversation no.1	• Intro: We will now play the recording, and we will also let you read the transcript so that you can follow the conversation. And then we want to ask you to reflect on what you see happening in the conversation?	• *After nurse's response:* Can you elaborate on what you mean with X? • So if I understand you correctly, you say X. • How do you evaluate X?
Listening to recorded conversation no.2	• Intro: We will now play another recording, and we will also let you read the transcript so that you can follow the conversation. And then we again want to ask you to reflect on what you see happening in the the conversation?	• *After nurse's response:* Can you elaborate on what you mean with X? • So if I understand you correctly, you say X. • How do you evaluate X?

Appendix E. Codebook

This codebook presents the final themes with the corresponding codes.

Theme: Purposes of conversations with parents

Code	**Description**	**Example from transcript**
Building trusting relationships	Nurse describes a trusting relationship with parents as one of the purposes of conversations with parents	"So I always think it is very important that parents, yes, they do not have to have a great connection with me, but they do need to have trust that my child is in good hands with you."
Giving parents conversational space	Nurse describes giving parents conversational space as one of the purposes of conversations with parents	"Yes, then I hear myself and I think: 'Oh, I should have kept my mouth shut for a while.'"
Helping parents articulate and understand their feelings	Nurse describes formulating parents' thoughts and feelings as a way to help them understand their feelings	"This mother kind of bottled it all up. And, um, I think if I did not express it in words, or if a colleague did not express it in words, it might eventually lead to an outburst where she would be angry because her daughter became so ill in our hospital, while she had expected things to go better in our hospital."
Reaching a "deeper layer"	Nurse describes 'reaching a deeper layer' of parents' experiences as a way to reach a 'deeper layer' and make a connection with parents	"I am constantly sensing what parents need and you plug into that. Yes, you really have to make a connection to be able to have those good conversations, I think."

Theme: Challenges in conversations with parents

Code	**Description**	**Example from transcript**
Parents' (unrealistic) expectations	Nurse describes parents' (unrealistic) expectations (e.g., about what babies should be like) as a challenging factor in conversations with parents	"And what I notice is that today's mothers (3.0 s of silence) erm (6.5 s of silence) when you bring home a premature baby, it is not an ordinary baby. And Instagram is full of normal babies who go from here to here and with the nicest bows and things and um… but many of our babies end up having eating problems, sleeping problems, crying a lot, because parents just don't get attuned to their child."
Parents resisting nurses' conversational moves	Nurse describes parents resisting nurses' attempts to reach a deeper layer of parents' experiences and feelings as challenging in conversations with parents	"Almost… you feel… they don't literally do it, but you feel that they are holding you back, because they are still in survival mode perhaps, I think that's the case. If I start there, then… ((makes a stop gesture)) then, no, you are not allowed to go there right now."
Nurses' boundaries to professional behavior	Nurse describes the boundaries of their own professional behavior as challenging in conversations with parents	"I can't take away the fact that she finds it stressful. I can have conversations with her, but she will have to do something with it herself."

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