



Original Article

Sexual health communication in adolescent nursing care: A concept analysis using Walker and Avant's method

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ABSTRACT

Background & Aim: Sexual health communication is central to adolescent nursing care, but its meaning remains conceptually inconsistent across nursing settings and adjacent disciplines. This conceptual ambiguity limits assessment, education, measurement, and service design. This study aimed to clarify sexual health communication in adolescent nursing care and identify its defining attributes, antecedents, consequences, and empirical referents.

Methods & Materials: Walker and Avant's eight-step method guided the analysis. CINAHL, PubMed/MEDLINE, Scopus, ERIC, and the Cochrane Library were searched for English-language literature published from January 2000 to December 2025. A focused update through June 2026 used PubMed and backward and forward citation tracking. Full texts were assessed against predefined conceptual and disciplinary eligibility criteria, and data were extracted into a structured matrix. Nursing-specific evidence was prioritized for defining the concept. Thirty substantive sources were included.

Results: Six defining attributes were identified: purposeful initiation and reciprocal adolescent participation; confidentiality enactment and interactional safety; accurate, clear, and developmentally responsive information exchange; responsive relational engagement during the encounter; timely, continuous, and care-linked communication; and contextually responsive and power-aware communication. Antecedents occurred at adolescent, professional, organizational, and sociocultural levels. Potential consequences included enhanced understanding, comfort and disclosure, follow-up, help-seeking, continued communication, and informed decision-making. Broader outcomes, including service access and equitable care, were considered potential distal implications. Existing measures capture selected components but not the complete nurse-adolescent concept.

Conclusion: Sexual health communication in adolescent nursing care is a purposeful, reciprocal, confidentiality-protective, developmentally responsive, and clinically integrated nurse-adolescent interaction. The clarified concept provides a nursing-specific basis for education, clinical assessment, intervention design, and measure development and future validation across diverse cultures and nursing settings.

Introduction

Sexual health includes physical, emotional, mental, and social well-being in relation to sexuality, together with safety, bodily integrity, informed decision-making, and access to sexuality-related information and education (1). Adolescence is a major developmental period characterized by identity formation, emerging relationships, changing social roles, and developing risk perception and decision-making abilities (2). Nurses meet adolescents in schools, primary care, community services, pediatric settings, sexual and reproductive health services,

mental health care, and specialist clinics. These encounters provide opportunities to identify concerns, correct misinformation, assess safety, and connect adolescents with appropriate care (3).

Nursing research shows that sexual health communication is considered important but is not consistently practiced. Pediatric nurses may recognize its importance yet report limited knowledge, comfort, and training (4). School nurses privacy, time, organizational support, parental concerns, formal preparation, and



professional confidence as factors influencing whether sexual health conversations occur (5,6).

Nurses' personal values and negative reactions may be experienced as judgment, discouraging adolescents from communicating openly and using sexual and reproductive health services (7). Studies indicate that young people value trusted, qualified professionals and active, participatory, and context-sensitive education, while access and implementation are shaped by service availability, provider attitudes, time, materials, parental involvement, and institutional policies (7,9,10). Recent evidence demonstrates that sexual health education interventions using curriculum-based, digital, training-based, and peer-group methodologies can improve adolescents' knowledge and attitudes (8).

Despite this nursing evidence, the term sexual health communication is often used without a stable nursing definition. It may refer to formal education, routine assessment, brief counselling, disclosure, risk communication, parent-adolescent discussion, or partner communication. These activities overlap, but they do not represent the same clinical concept. Carmichael and Amiri (11) conducted a concept analysis that clarified sexuality education for school-aged children and adolescents. Adolescent partner sexual communication has also been conceptualized and measured differently across behavioral and social-cognitive domains, including communication self-efficacy (12). Neither concept defines the individualized, care-linked nurse-adolescent interaction examined here. When conceptual boundaries remain unclear, privacy may be treated as both an environmental precondition and an interactional behavior, while confidence may be treated as both professional preparation and an observable quality of the encounter. These discrepancies weaken nursing measurement and make educational and clinical outcomes difficult to compare.

A concept analysis clarifies the defining characteristics of a concept and distinguishes them from conditions that precede it and outcomes that follow it. Walker and Avant's method was selected because it provides a structured approach for identifying uses, attributes, cases, antecedents, consequences, and empirical referents (13). Rodgers' evolutionary approach is more suitable when the purpose is to examine conceptual change over time, whereas

the hybrid model combines theoretical analysis with fieldwork (14). The present literature-based study aimed to establish clear nursing boundaries and identify observable clinical indicators; therefore, Walker and Avant's approach was considered appropriate. The aim of this concept analysis was to clarify sexual health communication in adolescent nursing care and identify its defining attributes, antecedents, consequences, and empirical referents.

Methods

Design

This literature-based concept analysis followed Walker and Avant's eight steps: selecting the concept, determining the purpose, identifying uses, defining attributes, constructing a model case, constructing additional cases, identifying antecedents and consequences, and specifying empirical referents (13). Walker and Avant's structured approach was selected because the study aimed to establish stable conceptual boundaries and observable nursing indicators without adding fieldwork.

Data sources and search strategy

A comprehensive literature search was conducted in CINAHL, PubMed/MEDLINE, Scopus, ERIC, and the Cochrane Library for English-language sources published between January 2000 and December 2025. Search terms combined sexual health communication terms ("sexual health communication," "sexuality communication," "sexual health discussion," "sexual health counselling," and "sexual health education") with nursing terms (nurs*, "school nurse*," "paediatric nurse*," "adolescent nursing," and "nurse-led"), adolescent terms (adolescen*, youth, and teen*), and practice terms (assessment, counsel*, educat*, confidentiality, privacy, and referral). Boolean operators, phrase searching, truncation, and database-specific subject headings, including MeSH and CINAHL headings where available, were used. A focused update through June 2026 was conducted in PubMed, supplemented by backward and forward citation tracking of included nursing studies. Reference lists of relevant reviews and concept analyses were also screened. International guidance was considered when it defined ethical, developmental, or service standards relevant to nursing communication. The

term blocks, database coverage, limits, and update procedures are summarized in Supplementary Table S1.

Eligibility and disciplinary classification

Sources were eligible when they contributed directly to the definition, use, observable features, enabling conditions, outcomes, or measurement of sexual health communication relevant to adolescent nursing care. Eligible materials included empirical nursing studies, nursing reviews, measurement studies, nurse-led intervention studies, and international clinical guidance. The concept was restricted to professional communication in which a nurse or nursing service addressed an adolescent's sexual or reproductive health questions, concerns, safety, knowledge, decision-making, or access to care.

Sources were excluded when they addressed sexuality without a communication component, described general health education without relevance to a nurse-adolescent interaction, reported only biomedical outcomes, duplicated another included report, were unavailable in English, or lacked sufficient conceptual detail. A source was classified as nursing-specific when nursing was the primary focus, participants were nurses or nursing students, the intervention was nurse-led, or the study examined nursing practice, nursing education, or a nursing service. Adult nursing studies were eligible only when they contributed a nursing-specific interactional behavior, communication model, empirical referent or measurement construct that was not adequately represented in adolescent nursing literature. Such evidence was treated as supporting evidence and was not transferred without developmental and contextual qualification. Evidence from adjacent disciplines was retained only when it clarified a conceptual element not adequately specified in nursing literature and was applied cautiously to adolescent nursing care.

Screening and data extraction

Potentially relevant citations were identified and organized, and duplicate records were removed before screening. One primary analyst examined titles and abstracts against the eligibility criteria. Full texts were then assessed for direct conceptual contribution. A source was included when it contributed at least one

definition, use, defining attribute, antecedent, consequence, or measurable indicator relevant to nurse-adolescent sexual health communication. Uncertain eligibility decisions were discussed with a supervisory reviewer with expertise in adolescent health communication. The supervisory reviewer checked uncertain full-text decisions and their disciplinary classification; the primary analyst maintained responsibility for the complete screening record and final inclusion decisions. The outcome of full-text appraisal is presented in the Results section.

Data from each included source were entered into a structured extraction matrix containing author and year, country, discipline, study design, population, nursing context, definition or use of the concept, attributes, antecedents, consequences, barriers, facilitators, and empirical referents. Exact conceptual statements and supporting passages were recorded before synthesis. Screening and extraction were conducted by one primary analyst. Written eligibility criteria, comparison across multiple sources, and consultation on uncertain cases were used to reduce researcher interpretive bias. Formal risk-of-bias appraisal was not undertaken because the purpose was conceptual clarification rather than estimation of intervention effects. Preference was given to peer-reviewed nursing studies, systematic or integrative reviews, nursing measurement studies, and authoritative guidance.

Conceptual analysis

Analysis followed Walker and Avant's eight-step framework. Extracted definitions and uses were first compared within nursing specialties and then with relevant adjacent disciplines. Recurring terms and descriptions were grouped into preliminary conceptual clusters. A cluster was retained as a defining attribute when it described an observable quality enacted during the nurse-adolescent interaction, was supported across multiple nursing sources, distinguished therapeutic communication from one-way information delivery, and could be represented by a clinical indicator. Related dimensions were organized under well-ordered attributes when they represented one coherent interactional quality. Conditions that had to exist before the interaction were categorized as antecedents, whereas outcomes following

enactment of the concept were categorized as consequences. Candidate empirical referents were identified by linking each attribute to existing instruments or observable clinical behaviors. Model, borderline, related, and contrary cases were then developed to test the conceptual boundaries. The extraction matrix was reviewed iteratively to ensure that each final element was supported by the included literature.

Results

Selection of sources

The final full-text screening set contained 39 potentially eligible sources. Thirty sources met the conceptual and disciplinary criteria, and nine were excluded because they did not provide a sufficient conceptual contribution or did not meet the required nursing or adolescent-health relevance. The 30 included sources formed the conceptual dataset: 19 were nursing-specific, 9 came from adjacent fields, and 2 were international guidance documents (Supplementary Table S2).

Definition and uses of the concept

In school and community nursing, sexual health communication includes confidential conversations, screening discussions, education, provision of accurate information, safety assessment, and referral. School nurses may act as educators, sources of health support, and links to further care (3,15). School nurses may provide informal sexual health guidance when formal sexuality education is absent or restricted, but their ability to respond effectively may be influenced by preparation, privacy, time, organizational support, and trust (5,6,10). Developing school-based sexual health services also requires engagement with young people, addressing parental and institutional concerns, and collaboration with school staff (16). Pubertal communication focused mainly on physical changes, menarche, and menstrual hygiene, with limited attention to contraception, STI prevention, and pregnancy prevention; available materials were limited, and some topics were restricted within the school context (17).

In pediatric nursing, sexual health communication includes screening, counselling, education, and discussion. Nurses' comfort, self-rated knowledge, and training experience are associated with their engagement in sexual health discussions with adolescents (4). Adolescents' access to sexual and reproductive healthcare may

be influenced by nurses' attitudes, clinic hours, privacy, and the extent to which the interaction is youth-friendly and perceived as non-judgmental (7). A nurse-led, interactive sexual and reproductive health program was associated with improved knowledge, comfort discussing sexual health with nurses, and willingness to disclose HIV status among adolescents living with HIV (18).

In nursing education and adult sexual health nursing, studies describe communication behaviors such as permission-giving, empathic listening, clear information, and referral, while nurses' confidence and awareness of personal values influence practice (19-23). These studies are not all adolescent-specific; however, they identify professional communication behaviors and measurable nursing barriers that require developmental and contextual validation before application to nursing care.

Evidence from adjacent disciplines was considered contextual rather than defining for the nursing concept. These sources informed broader communication dimensions but were interpreted cautiously within nurse adolescent clinical interactions. Family communication research indicates that effective parent-adolescent sexual health communication is associated with openness, appropriate timing, broad and repeated topic coverage, and the wider family and cultural context (24-27). However, these findings cannot be considered equivalent to sexual health communication in adolescent nursing care because the relational roles, responsibilities, and goals differ from those of family communication.

Healthcare communication reviews indicate that embarrassment and uncertainty about professional responsibility may inhibit sexual health discussions, while conversational practices may either restrict or encourage patients to raise sexual concerns (28,29). These findings informed understanding of communication barriers within healthcare settings but were not used to establish the defining attributes of nurse-adolescent sexual health communication.

Adolescent partner-communication research provides limited contextual insight into relational communication and negotiation; however, these findings are not directly equivalent to the nurse-adolescent clinical interaction examined in this analysis and require cautious interpretation within nursing contexts (12).

Equity-focused nursing perspectives highlight the importance of recognizing social context, diversity, and unequal access and power dynamics when considering health communication (30). These perspectives contribute to understanding contextual influences on communication; however, nursing evidence remains the primary basis for identifying the defining attributes of the concept. International guidance supports age- and developmentally appropriate, rights-based, and culturally responsive sexuality education, alongside rights-respecting and context-sensitive sexuality-related communication in healthcare (31,32). These sources informed the interpretation of ethical and developmental considerations but were not used as substitutes for nursing-derived evidence in identifying the concept's defining attributes.

Operational definition

Sexual health communication in adolescent nursing care is a purposeful, reciprocal nurse–adolescent clinical interaction through which nurses and adolescents engage in

discussions about sexual health concerns, information, safety, and care needs. The interaction is characterized by confidentiality protection, responsive information exchange, relational engagement, continuity of care, and adaptation to the adolescent's developmental, social, and contextual circumstances (3,6,18,33). Through this communication process, nurses may support adolescent participation, understanding, disclosure when appropriate, and connection with suitable care pathways while maintaining respect and dignity (3,6,18,33).

Defining attributes

Six defining attributes of sexual health communication in adolescent nursing care were identified. Each reflects an observable characteristic of the nurse-adolescent interaction, and is distinct from antecedents, resources, or professional capacities. Related dimensions were combined when they represented the same interactional quality. Table 1 summarizes the attributes, observable indicators, and supporting nursing evidence.

Table 1. Defining attributes, observable indicators, and supporting evidence

Higher-order attribute	Observable indicators	Evidence
Purposeful initiation and reciprocal adolescent participation	Purposeful initiation; permission-seeking; open-ended questions; attention to adolescent perspectives; shared direction of the conversation	(3,20,21)
Confidentiality enactment and interactional safety	Private communication; explanation of confidentiality boundaries; protection of disclosed information; respectful and nonjudgmental responses; adolescent-perceived safety during the interaction	(5,7,16,33)
Accurate, clear, and developmentally responsive information exchange	Assessment of existing knowledge; accurate and understandable information; adaptation to developmental level, health literacy, and clinical needs	(4,17,18)
Responsive relational engagement during the encounter	Attentive listening; validation of adolescent concerns; empathy; supportive responses; responsiveness; openness to continued discussion	(4,20,21,34)
Timely, continuous, and care-linked communication	Routine opportunities; preventive timing; repeated communication; referral; continuing support; clear routes to further care	(3,7,8,10)
Contextually responsive and power-aware communication	Inclusive and non-assumptive language; adaptation to individual and social context; recognition of cultural, religious, gender, and sexuality-related factors; attention to developmental vulnerability and professional authority	(6,7,19)

1. Purposeful initiation and reciprocal adolescent participation

The nurse purposefully initiates discussion, seeks permission, uses open-ended questions, attends to the adolescent's perspectives, and supports shared participation in directing the conversation. Nursing evidence emphasizes permission-giving, empathic understanding, and collaborative participation in sexual health encounters (3,20,21).

2. Confidentiality enactment and interactional safety

The nurse protects confidentiality and promotes interactional safety through private, respectful, and nonjudgmental communication, including clear explanation of confidentiality boundaries, protection of disclosed information, and responses that enable adolescents' willingness to discuss sensitive sexual health concerns. Evidence indicates that confidentiality concerns, inadequate privacy, and negative provider attitudes may discourage adolescents from accessing services or disclosing sensitive concerns (5,7,16,33). Privacy, institutional policies, and available private spaces are antecedents that enable communication, whereas

confidentiality protection and interactional safety are observable features of the nurse–adolescent interaction.

3. Accurate, clear, and developmentally responsive information exchange

Communication involves accurate and understandable information tailored to the adolescent's existing knowledge, developmental level, health literacy, and clinical needs. Nursing evidence identifies limitations when communication is confined to selected biological topics or when nurses lack preparation, while nurse-led interventions have demonstrated potential to support interactive and responsive education (4,17,18).

4. Responsive relational engagement during the encounter

Responsive relational engagement is an observable interactional quality characterized by attentive listening, validation of adolescent concerns, empathy, supportive responses, and responsiveness to the adolescent's perspective. The nurse acknowledges the adolescent's perspective, provides supportive responses, and maintains openness for continued discussion. Evidence indicates that empathy, supportive communication, and responsiveness influence adolescents' willingness to engage in sexual health discussions, whereas discomfort, uncertainty, and perceived judgment may restrict communication (4,20–22,34). Nurse confidence, training, and self-efficacy are considered antecedents because they enable the nurse to demonstrate this interactional quality but are not themselves components of the attribute.

5. Timely, continuous, and care-linked communication

Sexual health communication is integrated into routine encounters, may be initiated before urgent concerns arise, and is linked to referral and continuing support. Timeliness involves using appropriate opportunities to address concerns, while continuity involves repeated communication and clear routes to further care. Nursing evidence supports preventive discussion across healthcare settings and sexual health education delivered consistently over time (3,10). Service

availability, accessible hours, and youth-friendly provider attitudes are associated with adolescents' use of services (7,8). Organizational support, adequate time, collaborative planning, and accessible referral pathways are antecedents that enable continuity-oriented and care-linked communication (5,6,16).

6. Contextually responsive and power-aware communication

Contextually responsive and power-aware communication refers to the nurse's recognition that cultural, social, developmental, and professional factors may shape adolescents' willingness to communicate and their experience of sexual health discussions. The nurse uses inclusive, non-assumptive language, responds to the adolescent's individual context, and reflects on how professional authority, personal values, and institutional norms may influence the interaction. Nursing evidence indicates that provider values, judgmental attitude, assumptions about sexuality, institutional expectations, and professional authority can shape sexual health communication (6,7,19). Related family and equity-focused evidence further highlights cultural and religious norms, intersecting identities, and structural disadvantage, although these findings require cautious application to nurse-adolescent encounters (27,30).

Model case

A model case is a clear example that contains all defining attributes of the concept (13). A 16-year-old student attends a school health clinic for a routine health visit. The nurse arranges private time and explains confidentiality and its safety-related limits. She says, "I ask all young people about body changes, relationships, consent, safety, and sexual health because these issues affect health. Is it acceptable if we discuss them?" The adolescent agrees and asks whether pubertal changes are normal and whether information shared by friends about sexually transmitted infections is accurate. The nurse listens, asks what the adolescent already understands, and provides clear, age-appropriate information. She corrects misinformation without criticism and uses teach-back to confirm understanding. She asks inclusive questions about relationships and

safety without assuming partner gender or sexual activity. She discusses consent, coercion, and trusted sources of support, responds respectfully to the adolescent's religious concerns, offers a confidential referral, and arranges follow-up.

The case includes all six attributes. The nurse initiates the topic and supports participation, creates confidentiality protection and interactional safety, provides accurate and developmentally responsive information, demonstrates responsive relational engagement through empathy and supportive communication, links the discussion to follow-up and referral, and addresses contextual factors through respectful and non-assumptive communication.

Additional cases

Borderline case

A borderline case contains some, but not all, defining attributes (13). A nurse gives a 17-year-old adolescent accurate information about sexually transmitted infections during a clinic visit. The nurse speaks politely and provides a leaflet, but the door remains partly open, confidentiality is not explained, the adolescent is not invited to ask questions, and no follow-up or referral is offered. The interaction contains accurate information and professional intent, but it lacks reciprocal participation, enacted privacy, interactional safety, continuity, and contextual assessment. It is therefore a borderline case.

Related case

A school nurse delivers a well-designed classroom lesson on puberty, relationships, consent, and prevention. The lesson is accurate, inclusive, interactive, and developmentally appropriate. It is related to sexual health communication, but it is group education rather than an individualized nurse-adolescent clinical interaction. Private assessment, personal disclosure, individual safety assessment, and care-linked referral are not part of the meeting. The case clarifies the boundary between sexuality education and the concept analysed here.

Contrary case

A contrary case demonstrates the absence of the concept (13). A 15-year-old adolescent asks a nurse about puberty and a

relationship concern. The nurse provides brief, general information about normal physical changes but does not address sexuality, relationships, consent, safety, or available support. The nurse does not explore the adolescent's concerns, invite further questions, assess individual needs, or provide referral options. Although some information is provided, the interaction lacks reciprocal participation, confidentiality protection, relational engagement, contextual responsiveness, and care-linked communication. Therefore, the defining attributes of sexual health communication in adolescent nursing care are not demonstrated.

Antecedents

Antecedents are conditions or events that must exist before the concept can occur (13). Adolescent-level antecedents include willingness or readiness to engage in discussion, perceived confidentiality, and expectation of trustworthy care (4,6). Yip et al. identify emotional preparedness, readiness to disclose, and confidentiality concerns as influences on adolescents' willingness to communicate (4) while Silivri et al. emphasize trust and confidence as enabling conditions for discussion (6).

Professional antecedents include nursing knowledge, relevant education and training, confidence, and awareness of personal attitudes and beliefs (4,22,34). These studies identify knowledge, training, confidence, discomfort, beliefs, and perceived patient acceptance as factors associated with sexual health practice. Organizational antecedents include private space, adequate time, relevant resources, supportive collaboration, service accessibility, and referral routes (5,6,16).

Sociocultural antecedents include cultural and religious acceptability, parental and institutional support, reduced stigma, and attitudes that support respectful communication about diverse identities (5,6,16).

Consequences

Consequences are outcomes that follow the occurrence of the concept (13). Proximal consequences include enhanced knowledge and understanding, greater comfort discussing sexual health, increased willingness to disclose sensitive

information, and confidence in asking questions. Intermediate consequences include return engagement, follow-up questions, help-seeking, and continued communication with healthcare providers. Evidence from nurse-led interventions has been associated with improvements in knowledge, attitudes, comfort discussing sexual health, willingness to disclose HIV status, and understanding of STI testing (18). Nonjudgmental school-nurse communication

may encourage adolescents to return with further questions (6).

Broader outcomes, including improved service access, reduced stigma-related barriers, and more equitable care, are considered potential distal implications rather than direct consequences because they depend on wider healthcare, organizational, and social conditions. Provider attitudes and health-system factors are associated with adolescents' access to sexual and reproductive health services (7,8).

Table 2. Conceptual structure of sexual health communication in adolescent nursing care

Antecedents	Defining attributes	Consequences and distal implications
Adolescent-level • Willingness and emotional readiness to disclose sensitive information • Expectation of confidential and trustworthy care Professional-level • Nursing knowledge • Relevant education and training • Confidence • Awareness of personal attitudes and beliefs Organizational-level • Private space and adequate time • Relevant resources • Supportive collaboration • Service accessibility • Referral routes Sociocultural-level • Cultural and religious acceptability • Parental and institutional support • Low perceived stigma • Inclusive attitudes toward gender and sexuality	1. Purposeful initiation and reciprocal adolescent participation Purposeful initiation; permission-seeking; open-ended questions; attention to adolescent perspectives; shared direction of the conversation. 2. Confidentiality enactment and interactional safety Private communication; explanation of confidentiality boundaries; protection of disclosed information; respectful and nonjudgmental responses; adolescent-perceived safety. 3. Accurate, clear, and developmentally responsive information exchange Assessment of existing knowledge; accurate and understandable information; adaptation to developmental level, health literacy, and clinical needs. 4. Responsive relational engagement during the encounter Attentive listening; validation of adolescent concerns; empathy; supportive responses; responsiveness; openness to continued discussion. 5. Timely, continuous, and care-linked communication Routine opportunities; preventive timing; repeated communication; referral; continuing support; clear routes to further care. 6. Contextually responsive and power-aware communication Inclusive and non-assumptive language; adaptation to individual and social context; recognition of cultural, religious, gender, and sexuality-related factors; attention to developmental vulnerability and professional authority.	Proximal consequences • Improved knowledge and understanding • Greater comfort discussing sexual health • Increased willingness to disclose sensitive information • Confidence in asking questions Intermediate consequences • Return engagement • Follow-up questions • Help-seeking • Continued communication with healthcare providers Potential distal implications • Improved service access • Reduced stigma-related barriers • More equitable care

Empirical referents

Empirical referents are observable indicators that demonstrate the existence of a concept in practice or research (13). No instrument identified in the reviewed literature measured all six attributes simultaneously within nurse-adolescent sexual health communication. Existing instruments should therefore be regarded as partial referents rather than measures of the complete concept. The Consultation and Relational Empathy Measure may inform assessment of patient-rated empathy and relational quality in sexual health nurse consultations, although it is not adolescent-specific or designed specifically for sexual health communication (20).

The Sexuality Attitudes and Beliefs Survey, Sexual Health Care Scale-Attitude, Nursing Attitudes on Sexual Health Care scale, and Sexual Healthcare Questionnaire assess

nurses' or nursing students' attitudes, knowledge, perceived barriers, or self-efficacy rather than observable characteristics of nurse-adolescent sexual health communication encounters (21,22,34,35). The Sexual Healthcare Questionnaire specifically assesses knowledge, attitudes, and self-efficacy among nursing students (35).

The Sexual Communication Self-Efficacy Scale assesses adolescents' confidence in communicating with sexual partners and would require adaptation and validation before potential application to nurse-adolescent encounters (36). A future nursing-specific measure could incorporate adolescent-reported experiences, nurse-reported practice, and observable indicators such as permission-seeking, privacy, confidentiality protection, open questions, accurate information exchange, inclusive language, empathy, referral, and follow-up. Development should involve

adolescents, nursing experts, cultural adaptation, and psychometric testing.

Discussion

This concept analysis clarifies sexual health communication as a distinct nursing interaction rather than a broad label for sexuality education, counselling, or information delivery. Previous nursing studies have examined particular dimensions of the phenomenon, including nurses' knowledge, comfort, and practice; school-based facilitators and barriers; adolescents' access to services; and school nurses' communication experiences, but have provided limited integration into a nursing-specific definition of the concept (4-7). The present analysis integrates these findings into six defining attributes of nurse-adolescent communication. The source classification shows that nursing-specific studies formed the primary conceptual dataset, while adjacent evidence was used selectively to clarify elements not fully developed in nursing literature. This strengthens the concept's relevance to nursing assessment, education, service organization, and measurement.

Purposeful initiation and reciprocal participation help distinguish therapeutic nursing communication from passive availability and one-way advice. Adolescents and healthcare professionals may avoid or delay sexual health discussions because the topic may be perceived as sensitive, uncomfortable, or difficult to initiate, and because professionals may be uncertain about their responsibility (28,29). Silence may not necessarily indicate an absence of concern. Pediatric nursing evidence suggests that limited knowledge, training, and comfort may restrict engagement in adolescent sexual health care, while school-nursing evidence highlights trust, youth participation, and interactive educational approaches as factors supporting adolescent engagement (4,10). Nurse-led intervention evidence suggests that structured, interactive sexual and reproductive health education can improve adolescents' knowledge, attitudes, comfort discussing sexual health, and willingness to disclose HIV status (18). These findings suggest that routine permission-seeking, open questions, and shared direction may represent important nursing behaviors.

The finding regarding confidentiality protection and interactional safety extends previous literature by separating environmental

privacy from the adolescent's actual experience of confidentiality. A private room and confidentiality policies are important organizational antecedents, but they do not guarantee that an adolescent will experience the interaction as safe. Adolescents may experience safety through the nurse's explanation of confidentiality, tone, response to disclosure, protection of information, and willingness to provide private time. Evidence from school-based and adolescent services indicates that concerns about privacy and confidentiality may inhibit disclosure, while parental objections, institutional restrictions, service-related stigma, and judgmental provider attitudes may discourage access to and continued use of sexual and reproductive health services (5,7,16,33). Confidentiality should therefore be treated as an observable nursing practice rather than an assumed feature of the setting.

Accurate and developmentally responsive information exchange is strengthened by comfort and relational confidence. Accurate facts alone may be insufficient when the nurse uses technical language, does not address the adolescent's actual concern, communicates discomfort, or fails to check understanding. School-nursing research shows that communication may focus primarily on physical changes, menarche, and menstrual hygiene, while contraception, STI prevention, and pregnancy prevention may receive less attention in the context of limited materials, time constraints, and school-management restrictions (17). Nursing education, pediatric, and adult nursing studies similarly identify limited knowledge or training, discomfort, attitudes, low confidence, and uncertainty about patient acceptance as barriers to sexual health care (4,21,22,34). Nursing competence therefore requires both technical accuracy and the ability to communicate calmly, responsively, and without shame.

Continuity-oriented and care-linked communication recognizes that adolescents' changing needs may be better addressed through routine assessment, clarification, referral, and follow-up rather than isolated or crisis-based discussions. School-nursing evidence emphasizes comprehensive, accessible education delivered consistently over time, while nursing practice literature positions nurses to integrate sexual and reproductive health into

routine care across school, community, public health, and acute-care settings (3,10). Continuity care communication is facilitated by adequate time, organizational support, collaborative planning, clear guidance, and accessible service pathways (5,6,16). The attribute is clinically realistic when continuity is understood as routine opportunities, documentation, referral, and a clear pathway for return rather than a lengthy conversation at every encounter.

Contextually responsive and power-aware communication recognizes how culture, religious, gender, sexuality related, age, and unequal authority shape adolescents' ability to disclose. Nurses should avoid assumptions and use inclusive, respectful, and safety-focused communication. Nursing evidence indicates that provider values, judgment, attitude, heteronormative assumptions about sexuality, and institutional norms may affect sexual health communication and adolescents' service experience (6,7,19). Related family and equity-focused evidence highlights cultural and religious norms, gender-related expectations, intersecting identities, and structural disadvantage, although cautious application to nurse-adolescent encounters is required (27,30). Contextual sensitivity should guide respectful language and appropriate adaptation of communication; however, it should not justify withholding accurate information, avoiding assessment of consent and coercion, or compromising the adolescent's dignity and safety.

These findings inform nursing education, practice, and research. Curricula may incorporate assessment of communication, confidentiality protection, inclusive language, safety assessment, referral, and follow-up, while services may benefit from privacy, standardized guidance, accessible materials, supervision, and clear referral pathways. Existing instruments identified in this analysis assess selected elements such as empathy, attitudes, beliefs, barriers, or self-efficacy, but none measured the complete adolescent experience of a nurse-led sexual health interaction (20,22,34–36). The six attributes therefore provide a framework to guide future development of a nursing-specific measure.

The analysis was limited to English-language literature, relied on one primary analyst, and drew on evidence from geographically diverse but unevenly represented nursing settings. Adult evidence was used selectively, distal outcomes

cannot be attributed to a single interaction, and the proposed attributes would benefit from validation across diverse cultural and legal contexts.

Conclusion

Sexual health communication in adolescent nursing care is a purposeful, reciprocal, confidentiality-protective, developmentally responsive, and clinically integrated interaction. It is defined by six attributes: purposeful initiation and reciprocal adolescent participation; confidentiality protection and interactional safety; accurate, clear, and developmentally responsive information exchange; responsive relational engagement during the encounter; timely, continuous, and care-linked communication; and contextually responsive and power-aware communication. Nursing knowledge, preparation, policy support, privacy, adequate time, and referral systems may facilitate the occurrence of the concept. Effective enactment may facilitate adolescent disclosure, understanding, trust building, safety assessment, referral, and informed decision-making. Broader outcomes, including service access, are considered potential distal implications and require empirical validation.

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Ethical considerations

This literature-based concept analysis did not involve human participants, identifiable information, or primary data collection. Ethical approval was therefore not required because the study involved analysis of published literature only. The model, borderline, related, and contrary cases are hypothetical composites created for conceptual illustration.

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Conflict of interest

The authors declare no conflict of interest.

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Supplementary Table S1. Data sources and search strategy

Data source	Coverage/ update	Search framework/ procedure	Limits/ notes
CINAHL	January 2000 to December 2025	Four concept blocks were combined using Boolean operators, phrase searching, and truncation; CINAHL headings were used where available.	English-language sources.
PubMed/MEDLINE	January 2000 to December 2025; focused update through June 2026	Four concept blocks were combined using Boolean operators, phrase searching, and truncation; MeSH headings were used where available.	English-language sources; focused update supplemented by backward and forward citation tracking.
Scopus	January 2000 to December 2025	Four concept blocks were combined using Boolean operators, phrase searching, truncation, and database-specific search functions.	English-language sources.
ERIC	January 2000 to December 2025	Four concept blocks were combined using Boolean operators, phrase searching, truncation, and database-specific search functions.	English-language sources.
Cochrane Library	January 2000 to December 2025	Four concept blocks were combined using Boolean operators, phrase searching, truncation, and database-specific search functions.	English-language sources.
Backward/forward citation tracking and reference-list screening	Focused update through June 2026	Backward and forward citation tracking of included nursing studies was conducted; reference lists of relevant reviews and concept analyses were also screened.	Supplemented the database search for additional eligible sources.
International guidance	Considered during source selection and synthesis	International guidance was considered when it defined ethical, developmental, or service standards relevant to nursing communication.	Used to inform ethical, developmental, and service interpretation.

Sexual-health communication block: “sexual health communication,” “sexuality communication,” “sexual health discussion,” “sexual health counselling,” and “sexual health education.”

Nursing block: nurs*, “school nurse*,” “paediatric nurse*,” “adolescent nursing,” and “nurse-led.”

Adolescent block: adolescen*, youth, and teen*.

Practice block: assessment, counsel*, educat*, confidentiality, privacy, and referral.

Boolean operators, phrase searching, truncation, and database-specific subject headings were used where available, including MeSH and CINAHL headings. A focused PubMed update through June 2026 was supplemented by backward and forward citation tracking of included nursing studies and screening of reference lists from relevant reviews and concept analyses.

Supplementary Table S2. Classification and conceptual contribution of included substantive sources

Source	Classification	Evidence context	Primary conceptual contribution
Akinwale et al., 2022	Nursing-specific	Youth-friendly adolescent SRH services	Service accessibility, youth-friendly provider attitudes, referral pathways, and service use.
Annerstedt & Glasdam, 2019	Nursing-specific	Oncology nursing	Nurses' role, comfort, values, and barriers in communication about sexual health.
Aranda et al., 2018	Nursing-specific	School nursing / school-based sexual health	Young people's preferences, access, trust, privacy, and confidentiality in school nursing services.
Bikker et al., 2017	Nursing-specific	Sexual health nurse consultations	Empathy and relational quality; supports the CARE Measure as a partial empirical referent.
Brewin et al., 2014	Nursing-specific	School nursing	Privacy, time, parental concerns, organizational support, and administrative barriers affecting sexual health communication.
Christopher & Ozturk, 2025	Nursing-specific	Nurse-led adolescent HIV care	Interactive nurse-led SRH communication associated with knowledge, comfort discussing sexual health, and willingness to disclose HIV status.
Gündüz & Demirci, 2025	Nursing-specific	Nursing education	Knowledge, attitudes, and self-efficacy measures relevant to sexual health care among nursing students.
Hayter et al., 2012	Nursing-specific	School-based sexual health services	Service development, youth engagement, privacy, collaboration, and management of parental and institutional objections.
Huang et al., 2013	Nursing-specific	Nursing education / clinical practice	Permission and initiation of sexual-health discussion, attitudes toward sexual health care, and encouragement of patient communication.
Jackson, 2011	Nursing-specific	School nursing	School nurse roles in sexual health education, clinical guidance, and linkage to further care.
Jonas et al., 2019	Nursing-specific	Adolescent SRH nursing services	Provider judgment and attitudes, privacy, youth-friendly care, and factors influencing adolescents' access and service use.
Kim et al., 2011	Nursing-specific	Clinical / oncology nursing	Nurses' discomfort, uncertainty about patient acceptance, and environmental support as barriers or antecedents to sexual health care.
Mrad et al., 2022	Nursing-specific	Oncology nursing	Educational interventions and communication practices intended to improve nurse-patient sexual health communication.
Nymo et al., 2026	Nursing-specific	School nursing	School nurses' contribution to positive sexual health education, sustained communication, and continuity over time.
Reynolds & Magnan, 2005	Nursing-specific	Clinical nursing	Attitudes and beliefs that influence sexuality assessment and counseling; supports the Sexuality Attitudes and Beliefs Survey as a partial reference.
Salau & Ogunfowokan, 2019	Nursing-specific	School nursing	Pubertal communication topic coverage, methods, limited materials, and school-management restrictions.
Santa Maria et al., 2017	Nursing-specific	Adolescent nursing across care settings	Nursing role in routine initiation, screening, education, assessment, referral, and continuing care.
Silivri et al., 2023	Nursing-specific	School nursing	Trust, open and nonjudgmental communication, organizational conditions, gender identity, culture, and continued discussion.
Yip et al., 2015	Nursing-specific	Pediatric nursing	Nurses' knowledge, comfort, training, and frequency of sexual health discussion with adolescents.
Harris, 2016	Adjacent field	Parent-adolescent sexual communication	Openness, timing, topic coverage, and family context; used contextually rather than as defining nurse-adolescent evidence.
Hyde et al., 2013	Adjacent field	Parent-child safer-sex communication	Family communication processes and context; applied cautiously because relational roles differ from nursing care.
Hutchinson & Wood, 2007	Adjacent field	Parent-based adolescent sexual-risk communication	Parent-adolescent communication and risk-related relational processes used as contextual evidence.
Usonwu et al., 2021	Adjacent field	Parent-adolescent SRH communication	Cultural and religious norms, taboo, gender, and family context affecting communication.
Engelen et al., 2020	Adjacent field	Healthcare professional-adolescent communication	Embarrassment, uncertainty about professional responsibility, initiation barriers, and communication context.
Kelder et al., 2022	Adjacent field	Sexual-health conversations in medical settings	Conversational practices that may restrict or encourage patients to raise sexual concerns and perceptions of professional role.
Widman et al., 2022	Adjacent field	Adolescent partner communication	Relational communication and negotiation; used only as limited contextual insight for nurse-adolescent interaction.

Source	Classification	Evidence context	Primary conceptual contribution
Noh et al., 2024	Adjacent field	Equity-focused sexual-health communication	Racial/ethnic background, sexual orientation, gender identity, social context, structural disadvantage, and unequal power.
Quinn-Nilas et al., 2016	Adjacent field	Adolescent partner communication measurement	Sexual communication self-efficacy as a partial empirical referent requiring adaptation for nurse-adolescent encounters.
UNESCO et al., 2018	International guidance	Comprehensive sexuality education guidance	Age- and developmentally appropriate, rights-based, and culturally responsive standards informing ethical and developmental interpretation.
World Health Organization, 2015	International guidance	Sexuality-related communication in healthcare	Rights-respecting and context-sensitive clinical communication and counseling standards for sexuality-related healthcare discussions.

The conceptual dataset contained 30 substantive sources: 19 nursing-specific sources, nine adjacent-field sources, and two international guidance documents.