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Negotiating STI protection in intimate relationships among Chinese lesbian women: a discourse analysis based on in-depth interviews

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Abstract. This study investigates the negotiation of Sexually Transmitted Infection (STI) protection among Chinese lesbian women in intimate relationships using in-depth interviews and discourse analysis based on the symbolic interactionism, impression management theory and the Health Belief Model. The theoretical framework is applied to explain the effect of social norms, cultural taboos, personal experience, and interpersonal dynamics on safer-sex communication. Most participants framed protection issues frankly, but the discussion that followed was superficial. Others applied subtle or humorous strategies or drew on media content to relieve awkwardness; others employed educational or fear-based tactics. However, a considerable proportion were more sensitised to the interpersonal costs of protection-seeking, fearful that protection-seeking would erode trust, be seen as suspicious or withdrawn, or damage their ideal partner image. Heteronormative norms and sexual taboos within Chinese society supported these fears, while the marginalisation of lesbian identities only made negotiation more challenging. Negotiation was also influenced by power imbalances where one party is typically responsible for health, yet has no ultimate authority. In general, negotiation was weak when both partners lacked trust and were stigmatised, but became freer when partners developed intimacy and risk awareness. The research provides feasible recommendations for culturally sensitive, lesbian-inclusive sexual health education and interventions, which focus on reducing stigma, enhancing negotiation proficiency, and enabling equal decision-making. It also broadens the scope of health communication studies by demonstrating how risk perception, trust and gendered responsibility interconnect in non-Western settings, deepening symbolic interactionism and the theory of impression management.

Keywords: Chinese lesbian, sexually transmitted infections, sex negotiation

1. Introduction

Negotiation over protection against Sexually Transmitted Infections (STIs) in intimate relationships often constitutes a subtle yet overlooked health barrier. Heavily stigmatised and associated with feelings of shame and self-stigmatisation, STI-related discussions are rarely open or direct, even among partners [1-4]. In lesbian relationships, such negotiations are further complicated by cultural and emotional dynamics. In China, sexual topics are widely regarded as sensitive, and sexual shame is pervasive [5, 6]. For lesbian women, the challenges are even greater. Female same-sex intimacy is commonly viewed as deviant or non-normative [7, 8]. Moreover, any attempt to open up conversations on STI testing or protection may be perceived as a sign of distrust or promiscuity, which could jeopardise relationships [6, 9, 10].

As a result, lesbian partners may choose to avoid discussing topics related to STIs in order to preserve emotional equilibrium and social image. These discursive strategies mirror the impact of the Chinese shame culture, where sexual health concerns are often implied, rather than explicitly expressed. By taking into account the concepts of sexual shame and the Chinese context, this study emphasises the complexity of cultural contexts on communication boundaries within lesbian relationships.

This research further draws on symbolic interactionism as well as Goffman's theory of impression management to consider how lesbian individuals negotiate these sensitive issues. Situated within the dynamics of intimate partnerships, this study examines the way that Chinese lesbians negotiate and manage STI risk through daily communicative practices with their partners.

2. Literature review

2.1. Healthy communication in intimate relationships

Previous research on sexual health communication has mainly focused on negotiations around condom use among heterosexual couples, highlighting the critical roles of gendered power dynamics, trust, and risk perception in shaping safe sex practices. However, studies examining how lesbian populations negotiate STI prevention within intimate relationships remain extremely limited. In both academia and public health, the negotiation of STI prevention between lesbian partners remains severely understudied, with the Chinese context showing an especially notable lack of relevant studies.

A pervasive misconception exists that there is a negligible or non-existent risk of spreading STIs in sexual activity between women [11-13]. This misconception not only undermines awareness of STI risks but also neglects the unique challenges and lived realities that lesbian women face when discussing and practising sexual health. Many lesbian women assume that sexual activity between women carries no risk of infection and therefore lack sufficient knowledge of STIs, resulting in low adoption of safer sex practices [14-16]. As of 2022, except for male condoms, the use of protections like female condoms, finger condoms, and dental dams remains low across sexual orientations [17]. Additionally, many lesbian women prefer to reduce perceived risk by avoiding certain sexual behaviours considered high-risk, such as refraining from oral sex during menstruation, rather than using protective tools [14]. However, such strategies are insufficient to prevent the transmission of infections that are not limited to blood-borne routes [11, 12, 18, 19].

These findings reveal a significant gap in STI risk perception and prevention within the lesbian community. "Sex between women is safe" has become an assumed truth. As Whitlock points out, this cultural narrative can cause lesbian women to self-exclude from perceived at-risk populations and create a false sense of immunity from infection [13]. This misplaced sense of security not only diminishes the sense of urgency for STI prevention but also restricts the shared language and framework needed to talk about safe sex. Without awareness of STI risks or existing norms around communication, it is challenging for partners to have effective communication about protection.

2.2. Cultural contexts and barriers in lesbian STI negotiation

Influenced by Confucian values, Chinese society tends to discourage open discussions about sex, even within private relationships [5, 6]. Pressure exerted by stigma and conservative social norms has resulted in viewing sex as a taboo subject in China. This culture of sexual passivity reinforces a strong sense of sexual shame, which is further supported by cultural focus on maintaining social respect and preventing disgrace [5, 9], a notion often known as mianzi [6]. Research has indicated that those more afraid of losing mianzi are more likely to report higher levels of sexual shame, which may compromise their readiness and capacity to communicate openly and effectively about STIs in intimate relationships [6].

In the Chinese cultural context, lesbian couples face particular challenges in negotiating STI prevention. As a sexual minority, they experience double marginalisation: they are simultaneously stigmatised and rendered invisible by heteronormative society, and are excluded from gay-dominated queer communities [20]. This challenge mirrors that experienced by heterosexual peers, with women reporting that they avoid talking about condoms because they are embarrassed or worried about their partner's reaction [21-23]. However, unlike heterosexual peers, there are few established scripts or supportive systems for negotiating safer sex for lesbian women [13]. Furthermore, emotional attachment in intimate relationships may override rational considerations for health. Confronted with the threat of social judgement and possible relationship instability, individuals may purposely inhibit protection intentions to avoid negative interpersonal consequences [6, 24].

Under the influence of traditional Chinese sociocultural norms and sexual values, lesbians in a relatively disadvantaged position in society may experience heightened sensitivity and internal shame when exposed to sexual content. Consequently, they may be more likely to forego protective measures to maintain the harmony and emotional stability of the relationship and avoid losing mianzi. In sum, Chinese lesbian women face multilayered challenges in negotiating STI prevention within intimate relationships, through the intersecting forces of mianzi, cultural taboo, sexual shame, and relationship dynamics.

The paper addresses the following research questions:

- RQ1: How do Chinese lesbian women negotiate the use of STI protection with their partners within intimate relationships?
- RQ2: What linguistic strategies, emotional regulation tactics, or avoidance mechanisms do they employ during such negotiations?
- RQ3: What relationship power dynamics, cultural taboos, or psychological tensions are reflected in these negotiation practices?

3. Theoretical framework

In this study, Chinese lesbians' STI-protection negotiation is understood as a process of ongoing activity through which talk is translated into action. Partners jointly ascribe meaning to "risk, trust, intimacy, and protection" in daily interaction; negotiation may proceed via explicit proposals, hints, ambiguity, or strategic humour. This means that the "answer" to the negotiation of protection from STIs is not a simple yes or no, but rather a dynamic continuum that shifts between implicit and explicit forms across contexts, relationships, and time. This interpretation is consistent with symbolic interactionism: sexual meaning and its derivatives are not pre-given, but are constantly renegotiated, revised, and redefined through interaction between people who are socialised within diverse socialisation backgrounds (family, peers, media, religion, education) across multiple cultural contexts and individual life courses [25-27].

Against this backdrop, impression management theory [28-30] draws attention to how audience configuration, concerns about shame, and the socially constructed labels associated with lesbian identity in China constrain the content, modes, and timing of communicative expression. This theory highlights the fact that negotiation does not follow a particular pattern but moves on a continuum from implicit to explicit forms of discourse. It further conceptualises social interaction as a form of performance, in which individuals, acting on the "stage", create desired selves through the deliberate management of appearance, conduct, and framing of situations to gain recognition and maintain credibility [28]. To maintain such performance, Chinese lesbians may employ a range of impression management strategies, such as offering explanations to mitigate disapproval, joking, and conformity. Within this framework of performativity, engaging in STI testing or offering protected sex within an intimate relationship is not simply a rational choice to stay healthy, but an act of self-representation. Individuals negotiate these choices while managing their partner's perception and balancing the need to maintain trust, relational harmony, and a desirable image against the imperative to address risk and safety.

Lastly, the Health Belief Model (HBM) explains the psychological motives of negotiation. The model comprises six main constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, self-efficacy, and cues to action [31, 32]. The functioning of these six elements determines if and how lesbians negotiate. For example, the more susceptible people perceive themselves to be to STIs, the more severe they believe the outcome to be, and the greater their explicit communication efficacy, the more likely they are to use direct and assertive strategies to implement the protective behaviour. Conversely, when perceived barriers are high or self-efficacy is low, they may resort to silence or avoidance.

By integrating the three theoretical frameworks discussed above, this study conceptualises sexual protection negotiation between Chinese lesbian intimate partners as a multilayered process embedded within sociocultural contexts. Symbolic interactionism provides a micro-level theoretical framework that helps uncover the social construction of negotiation discourse; the meso-level phenomena of impression management illuminate the play of relational identities within a negotiation; and the HBM accounts for individuals' risk perceptions and psychological motivations at the macro-level. The integration of these three levels enables a more comprehensive understanding of how lesbian partners negotiate STI protection through situated discursive practices shaped by both interactional dynamics and broader cultural narratives.

In addition to these explanatory paradigms, this study uses constructivist grounded theory as the analytic strategy. Grounded theory uses inductive coding from interviews to develop categories [33, 34], which is important so that results are not removed from what participants say. The derived categories are then discussed in relation to the conceptual frameworks mentioned above, thus bringing the data-based analyses into contact with abstract theoretical viewpoints.

4. Methodology

4.1. Constructivist grounded theory

This study used constructivist grounded theory [33, 34] as a guide for analysing interview transcripts. Rather than imposing predetermined categories, this approach involves an iterative engagement with data, in which coding, comparison, and interpretation are concurrent. Interview transcripts were systematically coded to capture participants' accounts of negotiation, emotions, and relational dynamics. Codes were compared across interviews to identify recurring patterns, while memos were used to refine categories, and the analysis remained iterative: as new essential aspects emerged, earlier transcripts were revisited, and later interviews were adjusted to probe these issues further. The categories derived from this process form the empirical basis for interpretation and are subsequently connected with the conceptual frameworks outlined earlier to explain how and what different factors shape STI protection negotiation among Chinese lesbians.

4.2. Participants

This study recruited 16 self-identified lesbian individuals who currently or previously had a stable female partner lasting over two months. Inclusion criteria include being at least 18 years old and able to participate in an interview in Mandarin Chinese.

The sample reflected diversity in age, education level, and geographic location, all data shows in Table 1.

Table 1. Basic information table of the interviewees

Code	Gender	Age	Occupation (Present)	City	Education level
Interviewee 01	Female	31	Freelance	Nanjing	Master
Interviewee 02	Female	26	Freelance/Platform Blogger	Dalian	Bachelor
Interviewee 03	Female	26	Piano coach	Jiangyang	Bachelor
Interviewee 04	Female	23	Doctor	Ma'anshan	Bachelor
Interviewee 05	Female	21	Student	Yichang	Bachelor
Interviewee 06	Female	23	Student	Ma'anshan	Bachelor
Interviewee 07	Female	21	Student	Shenzhen	Bachelor
Interviewee 08	Female	23	Student	Jurong	Master
Interviewee 09	Female	24	Bartender	Ma'anshan	College
Interviewee 10	Female	23	Dance coach	Changzhou	Bachelor
Interviewee 11	Female	26	Financial Analyst	Hongkong	Master
Interviewee 12	Female	18	Student	Ningbo	Bachelor
Interviewee 13	Female	23	Student	Chengdu	Bachelor
Interviewee 14	Female	24	Student	Hefei	Bachelor
Interviewee 15	Female	31	Dancer	Dazhou	High School
Interviewee 16	Female	33	Dancer	Nanjing	College

4.3. Procedure

Participants in this study were recruited through multiple avenues, including social media platforms (e.g., Xiaohongshu, TikTok), WeChat groups, and offline outreach, aiming to ensure a relatively diverse sample. Potential participants who expressed interest in participating received more extensive information about the study and were asked to agree to the ethical aspects. Interviews were conducted either online (via platforms Zoom and Tencent Meeting) or face-to-face, depending on the participants' preferences. Before each interview, the interviewer clearly presented the study's aims, the interview process, confidentiality measures, and participants' right to withdraw at any time. Both verbal and written informed consent were obtained, and all individuals read and signed an informed consent form as proof of their voluntary participation after receiving an exhaustive explanation about the study's objectives, methods, and potential hazards.

The researcher employed a semi-structured interview guide to ensure consistency across sessions, while allowing participants the flexibility to express themselves freely, thereby generating richer and more nuanced data. All interviews were fully audio-recorded with participants' permission. The recordings were later transcribed verbatim, and personal identifying information was removed during transcription to protect privacy.

4.4. Measurement

The interviews focused on STI-related negotiation practices within intimate relationships. Key areas included:

1. Language strategies (e.g., indirect hints vs. explicit expressions).
2. Emotional responses (e.g., shame, anger, avoidance).
3. Relational power dynamics (e.g., decision-making control).
4. Timing and settings of the conversations.

4.5. Pilot test

Prior to formal data collection, a pilot test was conducted to evaluate the comprehensibility, applicability, linguistic clarity, cultural sensitivity, and feasibility of the interview guide. The aim was to provide an empirical foundation for refining the subsequent research methodology. Two self-identified lesbian adult participants were recruited for the test. Both were currently or previously engaged in a stable intimate relationship lasting more than two months, were able to read Simplified Chinese, and agreed to participate in an interview. Recruitment was carried out through WeChat community groups, social media platforms, and offline outreach.

4.6. Reflective journal

The researcher, an academic in communication and strategic public relations, shared cultural and language similarities with the participants. This "insider" situation fostered trust and openness, but also carried risks, such as taking silences for granted or overlooking their cultural meanings. To address this, the researcher sought to critically reflect on taken-for-granted factors such as traditional norms that foster sexual shame and silence. The investigator's gender influenced some potential participants to decline interviews, particularly lesbian women with heightened privacy sensitivity whose distinct perspectives it would be worth capturing. The researcher's study abroad experience also facilitated engagement with SGM communities, enhancing awareness of stigma and health disparities while underscoring the need to avoid uncritically applying Western discourses to the Chinese context.

4.7. Ethical consideration

All participants participated voluntarily and consented after being fully informed about the study. They were reminded that they could decline to answer any question or withdraw at any time without consequence. To ensure confidentiality, pseudonyms were used and all personal identifiers removed. Audio data and transcripts were retained in an encrypted file available only to the researcher and will be deleted following the completion of the study. Given the sensitivity of topics such as sexual health and minority identity, interviews were conducted respectfully and with cultural sensitivity to minimise potential discomfort. As compensation for their time and contribution, each participant received a payment of 50 RMB. The process of member checking was undertaken by providing each participant with their transcribed and summarised interview data for verification. All participants affirmed the accuracy and appropriateness of the materials.

5. Results

5.1. RQ1: how do Chinese lesbian women negotiate the use of STI protection with their partners within intimate relationships

In intimate relationships, participants showed significant differences in STI risk perception, directly shaping how protection negotiations began. Many underestimated risks, framing them as "gynaecological issues" or "cleanliness problems." For instance, T2 assumed "girls are naturally clean, rarely unclean or injured," while T12 stressed that sex between women "does not involve key reproductive organs," thus posing little risk. In contrast, some displayed sharper awareness: T6 noted "risks of gonorrhoea and HIV," and T14 mentioned HPV and possible "shared-item transmission." These differences set the stage for negotiation—some raised protection proactively, while others treated it as optional.

Health incidents and personal health experiences often triggered negotiation. After experiencing an episode of inflammation after sex, T5 proposed protection directly. T8 emphasised early in her relationship that "health comes first," choosing to address it directly. Some justified protection through formal health reasoning, as T13 did. Trust also influenced negotiations. While a few participants worried that proposing protective measures might imply distrust, most resolved this concern through communication. As T8 emphasised, only "open dialogue" can clarify that "protection ≠ distrust."

Overall, whether lesbian women negotiated STI protection depended on risk perception, health triggers, and trust logic. Although most participants did not equate protection with distrust in principle, in practice, trust often replaced protection, leading to unstable use of preventive measures. From impression management [28-30] and symbolic interactionism's perspective [25, 26], the findings suggest the meanings of the terms protection and trust are not static but constantly negotiated and renegotiated in interpersonal situations. For most Chinese lesbian couples, discussions about STI protective measures function as a symbol of caring and responsibility, without stigma, distrust, or offence. Over time, as intimacy deepens, partners are less likely to perceive protective measures as threatening to trust or damaging to the partner's image. This reflects the stage/backstage re-organisation [28, 30] in intimate relations: early discussions of protection may be seen as breaches of trust, occurring on the 'stage,' where relationships are less stable and impressions more fragile. As intimacy develops, partners engage in "backstage" exchange, co-creating affective relations through which identities and relational assumptions are reformulated. Protection talk can then arise organically as a language of responsibility and care, reducing the perceived offensiveness of such discussions.

5.2. RQ2: what linguistic strategies, emotional regulation tactics, or avoidance mechanisms do they employ during such negotiations

Most participants reported they could raise protection directly, treating it as common sense and a shared health responsibility. Direct communicators (T5, T6) routinely initiated the topic without avoidance or concern, and some framed directness as a

marker of a healthy relationship (T6). However, even when raised plainly, discussions often remained superficial or were timed immediately before intimacy, revealing a pattern of "direct but delayed", where direct does not equal effective.

In addition, respondents used subtle or humorous cues to reduce awkwardness (T7, T10), relied on external triggers such as shared health posts and online information to seed discussion (T3, T13 and T14), and adopted educational appeals that drew on videos or risk-based messaging, including fear-based nudges to encourage seriousness and compliance (T4, T7).

Overall, lesbian women employed a range of strategies in protection negotiation: directness, subtlety, humour, external triggers, and educational approaches, alongside emotional regulation through destigmatisation and avoidance through delayed talk. These choices can also be read through impression management, as participants strategically calibrated their talk to manage shame and preserve intimacy, often using humour or hints to soften the threat of appearing accusatory.

5.3. RQ3: what relationship power dynamics, cultural taboos, or psychological tensions are reflected in these negotiation practices

Negotiation of protection was not simply a matter of health behaviour; it also revealed tensions arising from gendered power issues, cultural taboos, and psychological conflict.

First, in terms of gendered responsibility, some believed the initiator or certain roles should bear greater protective duties. T7 and T16 noted that the "T role" was often expected to take charge of hygiene and safety, resembling the male role in heterosexual settings; older partners were likewise seen as carrying more responsibility. This division meant that those who proposed protection bore extra health responsibility, while decision-making power often lay with the other party, creating a separation between the right to propose and the right to decide. By contrast, most participants emphasised shared responsibility, highlighting a more collaborative model.

Second, cultural taboos posed major barriers. Some respondents came from traditional families where sexuality and same-sex relations were unspeakable. T11 explained that her family saw homosexuality as a "failure of education," making any discussion of protection impossible. Broader social conservatism and lack of sex education reinforced avoidance and silence, while discrimination in the healthcare system added psychological strain. In contrast, online spaces provided alternative resources, enabling some respondents to break the silence and legitimise protective communication.

Finally, there was widespread psychological conflict. On the one hand, trust often outweighed health considerations; some respondents prioritised their partner's feelings and stopped raising protection. On the other hand, fear of causing misunderstanding or emotional strain led others to opt for subtlety or compromise. From the aspect of the HBM [31, 32], the findings suggest that many Chinese lesbians face high perceived barriers to negotiating protection, largely due to an acute sensitivity to the interpersonal costs of such discourse. Through the lens of impression management, participants expressed concern that seeking protective measures might harm their preferred image in their partner's eyes - appearing distrustful, distant, or overly cautious. This fear of losing mianzi or disrupting relational harmony, combined with low perceived susceptibility and severity of STIs, often resulted in avoidance, curtailed communication, or concession, allowing emotional and relational concerns to override health priorities. Nevertheless, when risk appraisal was clearer and self-efficacy higher, as in T9's refusal to have sex without protection, fear did not lead to capitulation but to protective refusal.

Overall, STI protection negotiations reflected three structural tensions: unequal gender roles that created a divide between proposal and decision, cultural taboos and social discrimination that encouraged silence, and trust and health needs that created psychological conflict. Consequently, protection negotiation did not stand out as an isolated individual decision-making practice but as a socially situated activity, influenced by gender structures, cultural context, and psychological mechanisms. In line with symbolic interactionism, these negotiations highlight that "risk" and "responsibility" were continuously negotiated symbols—shaped not only by cultural taboos and power asymmetries but also by everyday relational meanings that participants co-constructed.

6. Discussion and conclusion

6.1. Summary of findings

The findings demonstrate that Chinese lesbian women's negotiation of STI protection is shaped by a constellation of factors addressing the three research questions. Regarding RQ1, negotiations were shown to depend on risk awareness, personal health experiences, and the degree of trust within the relationship. Some participants underestimated the risks of female–female sex and viewed protection as unnecessary; others—often after experiencing health issues—initiated explicit discussions about safer practices. In many cases, trust came to replace protection: partners equated the reduction of preventive measures with intimacy, rather than neglect.

In relation to RQ2, the study showed that the participants used a large repertoire of communicative strategies. While some participants used direct strategies—explicitly framing discussions of protection as a reflection of a healthy partnership—others

used indirect cues, humour or external referents (such as online health information) to ease the sensitivity of the topic. Emotional regulation strategies, such as reframing and humour, reduced awkwardness, while avoidance occurred when conversations were delayed or evaded. These different strategies reflect how women negotiated the imperative of safety with the desire to maintain relations.

Finally, addressing RQ3, the findings highlighted profound power dynamics, entrenched cultural taboos, and compelling psychological conflicts. Specific roles—such as the "T role" or the older partner—were often expected to shoulder responsibility for health, thereby creating a division between those who could propose protection and those who decided whether to adopt it. The persistence of these role expectations constrained participants involved in intimacy negotiations, reflecting underlying implicit hierarchies. Deeply held cultural taboos around sexuality, as well as discriminatory health care practices, further discouraged open discourse; psychological conflicts influenced decision-making; many participants privileged trust over health concerns. Nevertheless, a subset of participants drew firm boundaries, rejecting intimacy without protection.

6.2. Comparison of findings

In this research, some participants used humour or a light tone when introducing protection against STIs to defuse tension and avoid confrontation, thus opening up conversations. These findings align with Dolan and Davis on lesbian constructions of STI risk [35] and Ussher and Mooney-Somers on the desire and subjectivity of young lesbians [36], both of which indicate that humour can de-stigmatise sexual desire and ease awkwardness during protection negotiation.

A number of participants also reported difficulty negotiating protection due to power imbalances: initiators of safer sex bore responsibility for health but lacked final decision-making authority. This echoes Leblanc et al., who define negotiated safety as a prescriptive risk-reduction approach that works best when supported by trust and balanced relationship power; otherwise, negotiated safety may fail [37]. Similarly, Crankshaw et al. observe that power inequality and lack of trust in many women's relationships prevent effective protective negotiation [38]. Although many respondents in this study reported stable partnerships, similar power imbalances and negotiation obstacles were evident, underscoring the significance of trust and equality in effective safer sex agreements.

The study also found that despite the ability of lesbian couples in China to discuss the issues of protection, heteronormativity and cultural stigma continued to shape inadequate perceptions of STI risk, leading to shallow conversations and reduced willingness to engage in sustained protection. This is in line with Whitlock, who notes that the dominant discourse of lesbian sex being virtually risk-free has resulted in many lesbians having inadequate risk perceptions and having inadequate knowledge and performance in safer sex [13].

Moreover, the study has found an unexplored phenomenon in previous studies: one participant stated that she was unsure about the exact meaning of female-to-female sexual activity, and she always felt confused about what this type of sex was. Such a knowledge gap hindered her and did not allow her to evaluate risk and define what behaviours required protection. This lack of basic sexual knowledge can form a silent obstacle to successful protection negotiation among lesbians, and should be specifically addressed in future health communication and education programmes.

6.3. Contributions

This study makes several important contributions to the scholarship on sexual health communication and lesbian experiences in non-Western contexts. First, it challenges the pervasive misconception that sex between women carries negligible STI risk, documenting how this assumption not only shapes negotiation practices but also undermines consistent protection. By highlighting how lesbian women themselves grapple with risk perception, trust, and intimacy, the study extends health communication research beyond its dominant focus on heterosexual or male homosexual populations.

Second, the findings illuminate the nuanced communicative strategies employed by lesbian partners to navigate STI discussions in a cultural environment where sexuality remains taboo. The identification of direct, indirect, humorous, and avoidance-based strategies provides a more complex understanding of how individuals manage sensitive negotiations under conditions of stigma and sexual shame. This, in turn, adds theoretical depth to symbolic interactionism and impression management frameworks, demonstrating that protective practices function not only as health behaviours but also as relational performances of trust, care, and intimacy.

Third, by situating negotiation within broader structures of gender roles, cultural taboos, and healthcare discrimination, the study underscores the intersectional pressures that shape lesbian women's agency. The documentation of "role-based responsibility" (e.g., expectations of the "T role") and the tension between the right to propose and the right to decide together constitute a novel contribution to understanding the gendered dynamics of same-sex relationships in the Chinese context.

Finally, the study contributes methodologically by applying constructivist grounded theory to generate empirically grounded categories that bridge micro-level discourse with macro-level cultural and structural conditions. This integrated approach, linking interactional practices with systemic forces, offers a useful framework for future research, as it demonstrates how everyday

communication reflects larger structural inequities. Marginalised populations often negotiate health risks under conditions of stigma and silence, and such negotiations illuminate critical intersections between agency and constraint.

6.4. Limitations and future research

This study offers valuable insights into the negotiation of STI protection among Chinese lesbian women; however, several limitations should be acknowledged. First, the sample size was relatively small (16 participants) and drawn largely from urban, digitally connected populations. While this yielded rich qualitative data, it limits the representativeness of the findings, particularly for lesbians in rural areas or those with restricted access to online platforms. Second, the reliance on self-reported accounts may have been affected by recall bias or by participants' desire to present themselves in socially acceptable ways, especially given the sensitivity of discussing sexuality within the Chinese cultural context. Third, the study's emphasis on discourse and communicative strategies did not capture behavioural outcomes directly; therefore, the extent to which reported negotiations translated into consistent protective practices remains uncertain. Finally, the researcher's gender and "insider–outsider" position may have shaped participants' willingness to disclose certain experiences, potentially narrowing the diversity of perspectives included.

Future research could build upon these findings in several comprehensive and transformative ways. Expanding the participant pool would provide a more inclusive picture of STI-related negotiation practices. Longitudinal studies could track how strategies and protective behaviours evolve across different stages of relationships, yielding insights into both continuity and change. Incorporating mixed methods could complement self-reported narratives with behavioural evidence and strengthen the overall validity of the findings. Comparative studies across cultural contexts could also illuminate both universal and culturally specific barriers to STI communication among lesbian women. Future work should also examine the role of digital communities and health education campaigns in shaping discourse, as online platforms increasingly function as safe spaces where marginalised groups construct shared vocabularies for sexual health.

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