Is There a Place for Theoretical Frameworks in Qualitative Research?

Casey M. Garvey and Rachel Jones

Abstract
Qualitative research proceeds from the position that there is no one observable reality. Researchers utilizing qualitative methods build findings inductively, from raw data to a conceptual understanding. Theoretical frameworks may be utilized to guide qualitative analyses by suggesting concepts and relationships to explore. The framework may provide a sense of the story emerging from the analyses. And concurrently, the rich description provided by the analyses may allow the framework to be more deeply appreciated. However, there is a risk that using a theoretical framework may stifle inductive reasoning or result in findings incongruent to the data. The following is a discussion of the application of a theoretical framework in a qualitative study. This study, guided by the Common-Sense Model, explores the choice to undergo treatment for Hepatitis C Virus among veterans. Examples from the analyses are provided to facilitate discussion on the utilization of a theoretical framework. Techniques to optimize the use of a theoretical framework, as well as mitigate risks of such use, are presented. When utilized alongside rigorous data analyses and introspection, a theoretical framework may serve as a valuable tool to navigate data in qualitative research.

Keywords
grounded theory, methods in qualitative inquiry, Straussian GT, philosophy of science, constructivist GT, theoretical frameworks

Introduction
Qualitative research follows the naturalistic paradigm, which proceeds from the premise that reality is constructed by those who live it, since perceptions about phenomena are conditioned by experience (Corbin & Strauss, 2012; Lincoln & Guba, 1985; Miles et al., 2020). Therefore, there can be no one observable reality (Lincoln & Guba, 1985). In the methodology of the naturalistic paradigm, researchers effectively become the instrument of qualitative analysis, with findings built inductively from the ground where the data are, to a more distilled, conceptual understanding (Denzin & Lincoln, 2005; Lincoln & Guba, 1985).

A theoretical framework may provide utility in qualitative analyses. Theoretical frameworks describe concepts and relationships in a given phenomenon, effectively providing a map for qualitative exploration (Miles et al., 2020). Such frameworks may have been built inductively from previous research or based upon existing theories or literature (Miles et al., 2020). A theoretical framework is useful in situations where there is an abundance of data to be explored, by helping to direct attention to a particular phenomenon of interest (Miles et al., 2020).

On the one hand, a framework may provide a sense of the story as it emerges out of the analyses, leading down paths of inquiry that may otherwise be missed (Sandelowski, 1993). In this manner, a question regarding the phenomenon becomes a gateway to the investigation, the theoretical framework suggests an orientation, and rigorous data analysis yields findings (Corbin & Strauss, 2012; Miles et al., 2020; Sandelowski, 1993). On the other hand, the theoretical framework can be more deeply appreciated because of the rich description provided by the analysis (Corbin & Strauss, 2012; Sandelowski, 1993). The framework is elaborated further by its fit to the data, and the data are comprehended in a new light. However, the use of a theoretical framework in qualitative inquiry has the potential to bias findings or stifle inductive discovery (Corbin & Strauss, 2012; Glaser & Strauss, 1999/2017; Morse, 1992). With these concerns in mind, the goal becomes one of maximizing the utility of a theoretical framework, without distorting the data into an anticipated framework (Corbin & Strauss, 2012).

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The Common-Sense Model as Applied to Hepatitis C Virus Among Veterans

The following is an example of the process of using a theoretical framework in a qualitative study. The authors conducted this study to explore how veterans with Hepatitis C Virus (HCV) infection navigate challenges and choose to undergo treatment. Open and axial coding served as the analytic approach to understand emerging concepts and relationships (Corbin & Strauss, 2012). This approach has its basis in the grounded theory methodology, which is utilized to inductively build theoretical constructs from existing data (Corbin & Strauss, 2012). Through open and axial coding, researchers break data down into parts, or codes, that are then interrelated to explain social phenomena (Corbin & Strauss, 2012).

Hepatitis C Virus (HCV) infection is chronic and largely asymptomatic but presents significant risks for hepatocellular carcinoma and cirrhosis over time (Centers for Disease Control & Prevention [CDC], 2020). Previously, treatment options were limited to less-effective injection-based regimens, such as a combination of Interferon and Ribavirin (INF-RBV; (McHutchinson et al., 2009). These treatments were associated with flu-like and psychiatric side-effects in some patients (McHutchinson et al., 2009). However, recent advances in effective and tolerable direct-acting antiviral medications (DAAs) have presented realistic options for a cure for this chronic illness (Afdahl et al., 2014; Moon et al., 2017).

Knowing the risks involved with HCV, and the availability of effective treatment, one would not be faulted for assuming that the choice to undergo treatment would be a logical one. However, choices are not always based upon careful consideration of risks and benefits, but instead may rely upon subjective experience (Jones & Oliver, 2007; Slovic, 1999). For veterans, who are disproportionately affected by HCV (Hofmeister et al., 2019; Noska et al., 2017), such experiences may include stigma and/or trauma.

Stigma in HCV largely occurs due to the association of HCV infection with injection drug use (Dowsett et al., 2017), the predominant transmission route (CDC, 2020). Stigma, in the form of perceived disrespect or stereotyping in the healthcare setting, may discourage veterans from seeking care (Rogal et al., 2016). Further, symptoms of trauma are common among veterans with HCV (Veterans Health Administration [VHA], 2014). The symptoms of dissociation, numbness, guilt or agitation borne from trauma (American Psychiatric Association [APA], 2013; van der Kolk, 2014) may result in a veteran minimizing the threat posed by HCV. In the face of such challenges, the treatment for HCV, an illness with potentially distant consequences, becomes a distant priority. How then does a veteran living with such challenges choose to undergo treatment for such an illness?

The Common-Sense Model (CSM; Leventhal et al., 2016) was selected as a theoretical framework to guide analysis in this study. This framework has also been utilized in qualitative studies among non-veterans with HCV (Safo et al., 2015), and among individuals with Human Immunodeficiency Virus (HIV; Reynolds et al., 2009). In the CSM, memories of sensations and experiences connected to illness and health form a construct known as a prototype. These prototypes activate what is described in the CSM as illness representations, which serve as mental schematics for a given illness at a given point in time (Leventhal et al., 2016). Representations of illness are constructed by individuals and are informed by these prototypes, as well as the influences of race, gender, culture, media, and interactions with others (Baumann, 2003; Leventhal et al., 2016; Martin & Suls, 2003). Together, prototypes and illness representations form one’s perception of a given illness, comprising five domains: 1) identity, or symptomatology, 2) cause, 3) controllability, 4) timeline, and, 5) consequences (Leventhal et al., 2016). The memories and sensations incorporated into prototypes are matched to illness representations along these domains to inform a construct known as an action plan (Leventhal et al., 2016). This consists of a specific action to be taken, such as taking medication, the timing of that action, and the expected outcome, such as resolution of symptoms. In this way, action plans direct the means by which to address a health threat.

For example, a person may possess a prototype of an acute illness such as viral pharyngitis based on symptoms. When this person later experiences a sore throat, the prototype activates a representation of identity that effectively states, “this pain means I have pharyngitis.” The prototype also activates and matches to a representation of controllability, which suggests that drinking cool liquids may ameliorate symptoms. Thus, an action plan is formed to rest and drink cool beverages as needed for symptom relief. The illness prototypes and representations then adjust to new information (Leventhal et al., 2011), depending on the outcome of the action plan. If this action plan results in a resolution of symptoms, then the prototype and representations may be reinforced, to be called upon again should the illness reoccur (Cameron & Leventhal, 2003). If symptoms do not improve, then there may be a mismatch between the representation of controllability and the underlying illness as originally defined by the prototype (Leventhal et al., 2016). Perhaps this person will later learn he or she actually has streptococcal pharyngitis, which may require additional clinical intervention. Should symptoms then resolve following intervention, the prototype and representations are revised (Leventhal et al., 2011), to account for the potential of either viral or streptococcal pharyngitis.

Findings from the literature suggest that some veterans perceive HCV as potentially life-threatening (Clark & Gifford, 2015; Phillips & Barnes, 2016). Such views may encompass a representation of consequences, which suggest that treatment for HCV is warranted. However, recall that representations are activated by prototypes, which are themselves often first activated by symptoms (Leventhal et al., 2016). Given that HCV is a largely asymptomatic illness (CDC, 2020), the prototype of HCV may instead default to those emotions and memories that are aroused when one is reminded of his or her infection (Garvey & Jones, 2019). In the case of injection drug use, these may involve experiences of stigma (van Boekel et al., 2013).
and/or trauma (Wisconsin et al., 2014). Such a prototype may indicate that HCV treatment is to be avoided. This may occur if a given individual experiences stigma, and comes to feel undeserving of treatment (Skeer et al., 2018), or because symptoms of trauma have desensitized this individual to a health threat (van der Kolk, 2014). Such prototypes are in conflict with representations that suggest that HCV can have significant health consequences. Since prototypes and representations must match to inform an action plan (Leventhal et al., 2016), this conflict effectively halts progression toward an action plan to initiate treatment (see Figure 1; Garvey & Jones, 2019). If such is the case, then it is possible that a veteran possessing a prototype of stigma and/or trauma might not seek treatment, even if he or she understands the consequences of such a course of action. The question then becomes, how do veterans who experience stigma and/or trauma navigate these challenges to initiate HCV treatment?

**Utilizing the Common-Sense Model to Guide Analyses**

In the present study, transcribed sections of interviews were open coded (Corbin & Strauss, 2012) and sorted into a priori categories derived from the CSM (Leventhal et al., 2016). These initial categories included the representations of illness as defined by the CSM, namely the five domains of identity, cause, controllability, consequences, and timeline. The initial categories also included experience with stigma and trauma to begin to comprehend an influence of prototypes involving stigma or trauma. The initial categories also included experiences of diagnosis, treatment, and action planning, to begin to explore how the veterans decided to initiate treatment for HCV. In this way, the CSM aided in the exploration of considerable amount of data collected in this study, consisting of nine verbatim transcripts of interviews that lasted over an hour in some cases.

As open coding progressed, codes were compared between and within veteran cases to create concepts that further defined the categories (Corbin & Strauss, 2012; Miles et al., 2020). Simultaneously, axial coding was performed to identify emerging relationships among the concepts, toward answering the research questions. These research questions were, 1) what are the illness representations concerning HCV that led to the action plan of seeking treatment? and, 2) in what ways are the illness representations of veterans with HCV affected by stigma or trauma?

The representations of consequences and experiences of trauma emerged as important themes informing the action plan to initiate treatment for HCV. The following section provides examples from the analyses to illustrate how the CSM guided analyses in this study and identified these themes.

**Matching prototypes to representations to inform an action plan.**

Consistent with the literature, most veterans in this study perceived HCV to be an asymptomatic, chronic illness, with the potential to cause severe liver damage in the years following diagnosis. “...it’s a silent killer.” one veteran explained. Another veteran offered a metaphor: “...if every day someone’s putting a grain of sand in your pocket, you don’t notice it. Now your pockets weigh ten pounds apiece...” These and similar statements, were categorized under a theme named “Adding Sand to Your Pocket” to represent the view that HCV was a slow, insidious disease. This theme encompassed a representation of consequences, which was recognized in-spite of the long and otherwise often asymptomatic course of the illness. This representation helped inform this veteran’s decision to initiate treatment for HCV. As one veteran put it: “...it’s
a positive thing towards my health to get rid (of my HCV infection), so it doesn’t . . . kill me, you know?"

The above representation of consequences suggests veterans were encouraged to seek treatment to avoid risking liver disease or death but did not explain how stigma and/or trauma may have influenced their decision. Drawing from the CSM, analyses then centered around identifying those prototypes that either 1) matched or 2) mismatched to representations of illness, to respectively 1) support or 2) not support an action plan to initiate treatment for HCV. As analyses progressed, it was found that matches were shaped by how experiences of stigma and/or trauma were framed by the veteran.

For example: a match between the representation of consequences and a prototype incorporating trauma occurred when a veteran sought to move on from a past that involved trauma and substance use. As one such veteran stated: “... there is a darn good reason why the windshield is so much bigger than the rear-view mirror. Because what’s important is in front of you, not behind you.” This and similar statements were categorized under a theme named “In the Rear-View Mirror,” to represent the desire to move forward with life, toward a healthy future. Framed within this prototype, the sequelae of HCV became something to be avoided for the sake of one’s future. Thus, an action plan was formulated to treat HCV. “Better deal with it now . . .” as another veteran stated.

**Mismatch between prototypes and representations.** However, for one veteran, understanding the consequences of HCV did not inform his seeking treatment. “... at the age I was at, I figured I’d just outlive it. You know, I’d probably not be here, when my liver became cirrhotic.” This position was supported by the asymptomatic nature of HCV. “... I didn’t know what I was supposed to feel ... after having this condition all of these years, I never felt any different.” Further discussion with the veteran revealed trauma stemming from early life in a gang environment, coupled with the stressors of serving as a combatant in Vietnam. “I had been a fighter since I was eight years old . . . one extreme to the next . . . you go from using your fists to using knives, eventually using pistols.” He elaborated further: “I was concerned about not getting shot and not getting stabbed in my growing-up experience.” These experiences were reflected in how he approached HCV in later life. “... when you’ve lived the kind of life I’ve lived, if there wasn’t something immediately affecting your health, your mental health . . . you didn’t give it much thought. I didn’t anyway.” Such a subdued response to injury or illness may occur in persons with histories of trauma (APA, 2013; van der Kolk, 2014). With these experiences in mind, this veteran was largely uninterested in treatment for HCV.

This veteran recognized that HCV could result in cirrhosis, reflecting a representation of consequences. However, traumatic experiences in his past appeared to have been incorporated into this veteran’s illness prototype. The illness in question, infection with HCV, presented with no symptoms, and thus the prototype was limited to experiences of trauma that suggested that those issues which do not pose an immediate threat were to be minimized. This veteran’s prototype, as it existed at the time, did not match to the representation of consequences, and so and the action plan defaulted to the experiences contained in the prototype. Thus, the potential sequelae of HCV, cirrhosis, and liver cancer, were rendered to be less important, and the action plan to seek treatment was not entertained. Other veterans contending with ongoing drug and/or alcohol addiction connected to trauma similarly minimized the consequences of HCV. Excerpts reflective of such experiences and perceptions were categorized under a theme known as “In the Grips of Trauma and Addiction,” which encompassed ways that the consequences of HCV were minimized under the weight of past experiences with trauma and substance use.

This veteran was fully prepared to live out the rest of his life without treatment, despite knowing the potential consequences. However, prototypes and representations are dynamic, and change in response to new stimuli (Leventhal et al., 2011). In this case, the veteran was eventually convinced to undergo treatment by two clinicians who took interest in his care. “If these (clinicians) were so convinced that it would be a benefit for me, it was almost like I was . . . doing it because they wanted me so much to do it.” This veteran’s original prototype that incorporated trauma was superseded by a new prototype that had incorporated the compassion of the clinicians, who felt that treating his HCV was good for his health. This new prototype activated, and was matched to, his representation of consequences, suggesting that sequelae like cirrhosis is something to be avoided. Thus, a new action plan was formed to take oral treatment for his HCV. These statements represented a shift from the prototype “In the Grips of Trauma and Addiction,” and were categorized under the veteran’s new prototype, “In the Rear-View Mirror.”

**Utilizing Theoretical Frameworks**

Elaborating on the analogy of theoretical frameworks as maps (Miles et al., 2020), consider data in a qualitative study to be represented by an island. We know that on this island there is a treasure (findings). It is certainly possible to roam the island (without a framework) looking for signs of the treasure, but for every lead there may be a dozen dead ends. Thus, it may be helpful to bring along a treasure map, or in this case, a theoretical framework, to aid in navigation (Miles et al., 2020). We know that it was made by someone who knows where the treasure is hidden based on their own experience (evidence from literature; Miles et al., 2020). It provides landmarks (theoretical orientation, concepts and constructs) and suggested paths (processes and relationships) through the island (Corbin & Strauss, 2012; Sandelowski, 1993). However, in trying too hard to stick to the map (warping data to fit the framework, or rote positioning of the data into a priori categories) one might lose sight of the actual goal (answering the research question; Corbin & Strauss, 2012; Morse, 1992; Sandelowski, 1993), or return home with an empty chest (producing findings that are incongruent to the phenomenon). In using the map, one must
still use one’s skills and instincts to navigate the island (Corbin & Strauss, 2012; methodical coding, reflection, and writing; Morse, 1992). Keeping that in mind, however, a treasure map may prove to be a valuable tool.

The risks in utilizing a framework may be mitigated by exploring the fit between the data and the framework, and thoughtfully questioning when and how it will be used (MacFarlane & O’Reilly-de-Brún, 2012; Sandelowski, 1993). The researcher, at each stage of inquiry, asks whether the research would be benefited or detracted by use of the theoretical framework (Sandelowski, 1993). In this way, the researcher maintains a stance of uncertainty, and remains open to the possibility that the data may not fit the chosen framework, and if so, its use should be abandoned (Corbin & Strauss, 2012). If it turns out that the map isn’t leading to the treasure, then it becomes a discussion among shipmates (research team members). Together, they might decide to use a different map (a new framework) or decide to rely on one’s own skills to find the treasure (analyze without a framework to discover emergent themes; Lincoln & Guba, 1985).

Researchers concerned about unduly fitting data to their chosen model, may wish to explore the use of their model at every stage of a given study, to be sure that it is contributing to analyses (MacFarlane & O’Reilly-de-Brún, 2012). Further means of mitigating bias include maintaining memos, a process of keeping records of thoughts, feelings and discoveries related to research (Corbin & Strauss, 2012; Guba & Lincoln, 1981). In this way, memos provide an audit trail and provide evidence for coding decisions, and a means of tracing back steps should one encounter a dead end. Collaboration with other researchers well-versed in the phenomenon or population (Patton, 1999) can also provide a fresh set of eyes to a researcher who may be leaning too far in one direction or another. In this way, the risk of presenting findings that are incongruent to the context of the phenomenon can be reduced.

Lastly, it is important to consider the qualitative analytic approach that one is utilizing, and the appropriateness of using a theoretical framework with that approach. For example, the authors’ reflected on whether utilizing the CSM to guide open and axial coding would be appropriate in the present study. In discussing open and axial coding, Corbin and Strauss (2012) emphasize a preference for conducting qualitative analyses without a theoretical framework and warn against warping the data to fit a preconceived framework. However, they also note that a theoretical framework may have utility in providing initial orientation or concepts for individuals building upon an existing program of research or seeking to develop mid-range theory (Corbin & Strauss, 2012). However, researchers should also maintain a reflexive stance, and be prepared to revisit the use of the framework as findings emerge (Corbin & Strauss, 2012). With this in mind, it was determined by the authors that the use of the CSM in this study was appropriate. The following section presents a challenge the authors encountered in utilizing a theoretical framework.

Course-Correction in the Use of a Theoretical Framework

The CSM provided the initial categories for open coding for the study of HCV treatment initiation among veterans. Following the map laid out by the CSM, those data and relationships that pointed to the action plan were prioritized. The initial attempt was to build a story of each veteran’s experiences with stigma and trauma, as well as individual representations of identity, cause, timeline, consequences, and controllability. Given the amount of data to explore, the CSM was relied upon heavily in the early stages of analyses to sort and code excerpts. The end result, however, was a miasma of excerpts that described perceptions of HCV, and experiences of stigma and trauma, but little of how these answered the research questions. There were hints of a larger story, as evidenced by the emerging importance of consequences and trauma, but these seemed to be lost in the description. The treasure map was followed too closely, and thus the explorer lost sight of the treasure itself.

In the attempt to manage the large quantities of data, it was determined that excerpts were merely being placed into the various a priori categories (Corbin & Strauss, 2012; Morse, 1992). In doing so, the CSM was inadvertently favored over the research question. Returning to the research question (getting back on course to the treasure) was a process that unfolded in stages. This first required a re-affirmation that theoretical frameworks provide orientation and guidance for analyses, rather than a prescribed direction. Reflection, and review of the theory and the data, created space to recognize that an action plan resulted from a match between illness representations and prototypes (Garvey & Jones, 2019). From there, the process moved toward exploration of how representations and prototypes informed the specific action plan to initiate HCV treatment. The memos generated throughout analysis aided tremendously, facilitating following the trail back to the beginning. The process continued to advance toward reconceptualizing the codes, concepts and categories. Thus, as axial coding progressed, the a priori categories derived from the CSM in open coding were confirmed, revised, or eliminated, with new categories formulated to respond to the emerging findings. These became the themes that served to answer the research questions. These themes and supporting data were explored with study co-investigators to ensure that emerging findings were answering the research questions and were not unduly contorted to fit the CSM.

Conclusion

Qualitative research is a process of discovery, with new knowledge being a product of the researcher’s interpretation of the story depicted by the data (Lincoln & Guba, 1985). Depending on one’s qualitative approach, a theoretical framework may be useful to guide analysis and suggest avenues of exploration (Corbin & Strauss, 2012; Miles et al., 2020; Sandelowski, 1993). In the present study, understanding the concepts of prototypes and illness representations provided an orientation to explore veterans’ decision to initiate treatment for HCV. A
priori categories from the CSM provided organization to analyze the rich data collected from interviews with veterans. Further exploration of the framework and the data led to the understanding that it was the match between prototypes and representations of illness that informed action plans. A representation of consequences that recognized the risks of HCV infection, when matched to a prototype that reframed experiences of trauma toward personal wellness and recovery, informed veterans’ decision to initiate treatment.

However, the application of a framework in qualitative research depends upon methodical analysis, as well as thoughtful reflection of the applicability of the framework (MacFarlane & O’Reilly-de-Brün, 2012; Sandelowski, 1993). Over-reliance on a framework runs the risk of telling a story that is not true to the phenomenon under study (Morse, 1992). In such cases, it may be beneficial to return to the research questions and reflect upon how the framework may contribute to answering these questions. This may be accomplished by revisiting codes and concepts to explore their applicability. From there, existing categories drawn from a theoretical framework can be revised as needed to reflect emergent findings. Should one keep a navigator’s sight, and thoughtfully question the meaning behind data, a theoretical framework can serve as a valuable map on the way to meaningful discovery.

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Authors’ Note

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Ethics Statement

Participants provided written informed consent to participate in the study discussed in this article. This study was approved by the institutional review boards at the Edith Nourse Rogers Memorial Veterans Hospital, where the study was conducted (Project ID: 1192875; Project Number 0014), as well Northeastern University, the authors’ academic institution (IRB Number 16-09-07).

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References

Afiohal, N., Zeuzem, S., Kwo, P., Chojkier, M., Gitlin, N., Puoti, M., Romero-Gomez, M., Zarski, J. P., Agarwal, K., Buggisch, P., Foster, G. R., Bräu, N., Buti, M., Jacobson, I. M., Subramanian, G. M., Ding, X., Mo, H., Yang, J. C., Pang, P. S., . . . Marcellin, P. (2014). Ledipasvir and sofosbuvir for untreated HCV genotype 1 infection. The New England Journal of Medicine, 370(20), 1889–1898. https://doi.org/10.1056/NEJMoa1316366

American Psychiatric Association. (2013). Trauma- and stressor-related disorders. In Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.dsm07

Baumann, L. C. (2003). Culture and illness representation. In L. D. Cameron & H. Leventhal (Eds.), The self-regulation of health and illness behavior [Kindle edition]. Routledge.

Cameron, L. D., & Leventhal, H. (2003). Self-regulation, health, and illness: An overview. In L.D. Cameron & H. Leventhal (Eds.), The self-regulation of health and illness behavior [Kindle edition]. Routledge.

Centers for Disease Control and Prevention. (2020). Hepatitis C questions and answers for health professionals. Retrieved February 25, 2020, from http://www.cdc.gov/hepatitis/HCV/HCVfaq.html-

Clark, J. A., & Gifford, A. L. (2015). Resolute efforts to cure Hepatitis C: Understanding patients’ reasons for completing antiviral treatment. Health, 19(5), 473–489. https://doi.org/10.1177/1363459314555237

Corbin, J., & Strauss, A. (2012). Basics of qualitative research (3rd ed.): Techniques and procedures for developing grounded theory. Sage.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), The SAGE handbook of qualitative research (3rd ed., pp. 1–32). Sage.

Dowsett, L. E., Coward, S., Lorenzetti, D. L., MacKean, G., & Clement, F. (2017). Living with Hepatitis C Virus: A systematic review and narrative synthesis of qualitative literature. Canadian Journal of Gastroenterology and Hepatology, 2017, 1–11. https://doi.org/10.1155/2017/3268650

Garvey, C. M. & Jones, R. (2019). The role of stigma and trauma in Hepatitis C virus treatment: Applying the common-sense model. Public Health Nursing, 36(6), 829–835. https://doi.org/10.1111/phn.12665

Glaser, B. G., & Strauss, A. L. (2017). The discovery of grounded theory. In B. G. Glaser & A. L. Strauss, The discovery of grounded theory: Strategies for qualitative research [Kindle edition]. Routledge. (Original work published 1999)

Guba, E. G., & Lincoln, Y. S. (1981). Effective evaluation. Jossey-Bass Publishers.
Hofmeister, M. G., Rosenthal, E. M., Barker, L. K., Rosenberg, E. S., Barranco, M. A., Hall, E. W., Edlin, B. R., Mermin, J., Ward, J. W., & Ryerson, A. B. (2019). Estimating prevalence of Hepatitis C virus infection in the United States, 2013-2016. Hepatology, 69(3), 1020–1031. https://doi.org/10.1002/hep.30297

Jones, R., & Oliver, M. (2007). Young urban women's patterns of unprotected sex with men engaging in HIV risk behaviors. AIDS and Behavior, 11, 812–821. https://doi.org/10.1007/s10461-006-9194-3

Leventhal, H., Leventhal, E. A., & Breland, J. Y. (2011). Cognitive science speaks to the “common-sense” of chronic illness management. Annals of Behavioral Medicine, 41, 152–163. https://doi.org/10.1007/s12160-010-9246-9

Leventhal, H., Phillips, L. A., & Burns, E. (2016). The common-sense model of self-regulation (CSM): A dynamic framework for understanding illness self-management. Journal of Behavioral Medicine, 39, 935–946. https://doi.org/10.1007/s10865-016-9782-2

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. Sage.

MacFarlane, A., & O'Reilly-de Brún, M. (2012). Using a theory-driven conceptual framework in qualitative health research. Qualitative Health Research, 22(5), 607–618. https://doi.org/10.1177/1049732311431898

Martin, M., & Suls, J. (2003). How gender stereotypes influence self-regulation of cardiac health care-seeking and adaptation. In L. D. Cameron & H. Leventhal (Eds.), The self-regulation of health and illness behavior [Kindle edition]. Routledge.

McHutchison, J. G., Lawitz, E. J., Shiffman, M. L., Muir, A. J., Galler, G. W., McConne, J., Nyberg, L. M., Lee, W. M., Ghalib, R. H., Schiff, E. R., Galati, J. S., Bacon, B. R., Davis, M. N., Mukhopadhyay, P., Koury, K., Noviello, S., Pedicone, L. D., Brass, C. A., Albrecht, J. K., & Sulkowski, M. S. (2009). Peginterferon Alfa-2b or Alfa-2a with Ribavirin for treatment of Hepatitis C infection. The New England Journal of Medicine, 361(6), 580–593. https://doi.org/10.1056/NEJmoa0808010

Miles, M. B., Huberman, A. M., & Saldaná, J. (2020). Qualitative data analysis: A methods sourcebook (4th ed.) [Kindle edition]. Sage.

Moon, A. M., Green, P. K., Berry, K., & Ioannou, G. N. (2017). Transformation of Hepatitis C antiviral treatment in a national healthcare system following the introduction of direct antiviral agents. Alimentary Pharmacology and Therapeutics, 45, 1201–1212. https://doi.org/10.1111/apt.14021

Morse, J. M. (1992). The power of induction. Qualitative Health Research, 2(1), 3–6.

Noska, A. J., Belperio, P. S., Loomis, T. P., O'Toole, T. P., & Backus, L. I. (2017). Prevalence of human immunodeficiency virus, hepatitis C Virus, and Hepatitis B Virus among homeless and nonhomeless United States Veterans. Clinical Infectious Diseases, 65, 252–258. https://doi.org/10.1093/cid/cix295

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. Health Services Research, 34(S), 1189–1208.

Phillips, F. H., & Barnes, D. M. (2016). Meaning of adherence in Hepatitis C-infected military veterans. Gastroenterology Nursing, 39(1), 17–23. https://doi.org/10.1097/SGA.0000000000000199

Reynolds, N. R., Sanzenero Eller, L., Nicholas, P. K., Corless, I. B., Kirksey, K., Hamilton, M. J., Kemppainen, J. K., Bunch, E., Dole, P., Wantland, D., Sefcik, E., Nokes, K. M., Coleman, C. L., Rivero, M., Canaval, G. E., Tsai, Y. F., & Holzemer, W. L. (2009). HIV illness representation as predictor of self-care management and health outcomes: A multi-site, cross-cultural study. AIDS and Behavior, 13, 258–267. https://doi.org/10.1007/s10461-007-9297-5

Rogal, S. S., Arnold, R. M., Chapko, M., Hanusa, B. V., Youk, A., Switzer, G. E., Sevick, M. A., Bayliss, N. K., Zook, C. L., Chidi, A., Obrosky, D. S., & Zickmund, S. L. (2016). The patient-provider relationship is associated with Hepatitis C treatment eligibility: A prospective mixed-methods cohort study. PLoS One, 11(2), e0148596. https://doi.org/10.1371/journal.pone.0148596

Safo, S. A., Batchelder, A., Peyser, D., & Litwin, A. H. (2015). The common-sense model applied to Hepatitis C: A qualitative analysis of the impact of disease comparison and witnessed death on Hepatitis C illness perception. Harm Reduction Journal, 12:20. https://doi.org/10.1186/s12954-015-0054-1

Sandelski, M. (1993). Theory unmasked: The uses and guises of theory in qualitative research. Research in Nursing and Health, 16, 213–218.

Skeer, M. R., Ladin, K., Wilkins, L. E., Landy, D. M., & Stopka, T. J. (2018). ‘Hep C’s like the common cold’: Understanding barriers along the HCV care continuum among young people who inject drugs. Drug and Alcohol Dependence, 190, 246–254. https://doi.org/10.1016/j.drugalcdep.2018.06.013

Slovic, P. (1999). Trust, emotion, sex, politics, and science: Surveying the risk-assessment battlefield. Risk analysis, 19(4), 689–701.

van Boekel, L. C., Brouwers, E., van Wegen, J., & Garretsen, H. F. L. (2013). Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence, 131(1-2), 23–35. https://doi.org/10.1016/j.drugalcdep.2013.02.018

van der Kolk, B. A. (2014). The body keeps the score: Brain, mind and body in the healing of trauma [Kindle edition]. Penguin Books.

Veterans Health Administration. (2014). State of care for veterans with Hepatitis C 2014. United States Department of Veterans Affairs.

Wisco, B. E., Marx, B. P., Wolf, E. J., Miller, M. W., Southwick, S. M., & Pietrzak, R. H. (2014). Posttraumatic stress disorder in the US veteran population: Results from the national health and resilience in veterans study. Journal of Clinical Psychiatry, 75(12), 1338–1346. https://doi.org/10.4088/JCP.14m09328