

Article type:
Original Research

- 1 Master's Degree in Clinical Psychology, Faculty of Humanities, University of Science and Culture, Tehran, Iran.
- 2 M.A., Department of Counseling, Quchan Branch, Islamic Azad University, Quchan, Iran.
- 3 M.A., Department of Psychology, Payame Noor University, Tehran, Iran.
- 4 Department of Psychology, Tonekabon Branch, Islamic Azad University, Tonekabon, Iran.

Corresponding author email address:
hasti_mid@yahoo.com

A Thematic Narrative Analysis of Psychological Experiences in Adults Living with Chronic Hepatitis B: A Qualitative Study

Fatemesadat. Mirshafiei¹, Seyedeh Sara. Hosseini², Nadia. Khaleghi³, Marjan. Faramarzi^{4*}



Article history:

Received 12 Jul 2025
Revised 28 Jul 2025
Accepted 20 Sep 2025
Published online 01 Oct 2025

How to cite this article:

Mirshafiei, F., Hosseini, S. S., Khaleghi, N., & Faramarzi, M. (2025). A Thematic Narrative Analysis of Psychological Experiences in Adults Living with Chronic Hepatitis B: A Qualitative Study. *International Journal of Body, Mind and Culture*, 12(7), 268-274.



© 2025 the authors. This is an open access article under the terms of the Creative Commons Attribution-NonCommercial 4.0 International (CC BY-NC 4.0) License.

ABSTRACT

Objective: Chronic Hepatitis B (CHB) affects patients not only physically but also psychologically, often leading to long-term emotional distress, maladaptive coping, and social isolation. Despite its prevalence, few studies have explored the lived psychological experiences of individuals with CHB through narrative frameworks. This study aimed to analyze the life narratives of adults living with CHB to identify key psychological themes, schemas, and social factors influencing their emotional wellbeing.

Methods and Materials: A qualitative narrative analysis was conducted using McAdams' semi-structured life story interview protocol. Ten participants (aged 25–55) diagnosed with CHB were selected through purposive homogeneous sampling from a research center in Tehran. Interviews were transcribed verbatim and analyzed using Riessman's thematic model. Data were coded inductively and deductively using MAXQDA 10, and thematic saturation was reached after 10 interviews.

Findings: Six core themes emerged: (1) maladaptive early family dynamics (e.g., emotional deprivation, authoritarian parenting), (2) traumatic life events, (3) limited perceived social support, (4) negative doctor-patient experiences, (5) maladaptive emotion regulation (e.g., rumination, self-blame), and (6) cognitive inflexibility and experiential avoidance. These predisposing and reinforcing factors shaped participants' psychological responses and illness narratives.

Conclusion: Narratives revealed that family dysfunction, chronic stress, and lack of support significantly impact the psychological trajectory of individuals with CHB. Interventions targeting cognitive-emotional flexibility, social support, and narrative reconstruction may improve adaptation in this population.

Keywords: Hepatitis B, Chronic, Narrative Therapy, Emotions, Psychological Adaptation, Social Support, Qualitative Research.

Introduction

Chronic Hepatitis B (CHB) is a major global health burden, affecting over 250 million individuals worldwide, with particularly high prevalence in East Asia and the Middle East (Organization, 2023). In addition to its well-documented hepatic complications—including cirrhosis, hepatocellular carcinoma, and liver failure—CHB is increasingly recognized as a source of profound psychological distress (McMahon, 2009; Seto & Yuen, 2018). Patients often contend with stigma, social rejection, emotional dysregulation, and long-term mental health issues such as anxiety, depression, and post-traumatic stress symptoms (Patidar & Bajaj, 2016; Wang et al., 2023).

In Iran, CHB continues to be a persistent public health issue despite advances in screening and vaccination programs. Many patients experience marginalization due to a lack of public awareness and cultural misconceptions regarding disease transmission (Marjani et al., 2025). Such psychosocial challenges, coupled with the biological impact of chronic infection, can impair quality of life, treatment adherence, and psychological adaptation (Terrault et al., 2018).

Psychological adaptation to chronic illness involves not only coping with medical symptoms but also meaning-making—how individuals interpret, narrate, and integrate their illness into their identity (Bury, 1982; Frank, 2022). In this context, narrative approaches offer a unique lens for exploring lived experiences. Narrative psychology posits that people construct their identities through internalized life stories that give coherence to past experiences and help them navigate present challenges (McAdams, 2018). These stories are shaped by cultural norms, family dynamics, emotional regulation patterns, and interpersonal interactions, all of which are often disrupted in patients with stigmatized conditions like CHB (Murray, 2017).

Despite the relevance of narrative frameworks to understanding chronic illness, few studies have applied rigorous narrative analysis to the psychological experiences of individuals with CHB. Most prior research has focused on biomedical markers or health behaviors, neglecting the subjective and sociocultural dimensions of illness experience (Adoboi & Mohammadnezhad, 2025; Seto & Yuen, 2018).

Given this gap, the present study aimed to conduct a thematic narrative analysis of life stories told by adults living with CHB. The goal was to identify psychological themes—such as trauma, social support, coping patterns, and maladaptive schemas—that contribute to emotional distress and resilience. By doing so, we seek to inform culturally sensitive, psychologically attuned interventions for this often-overlooked population.

Methods and Materials

Research Design

This study employed a qualitative design using thematic narrative analysis, guided by Riessman, (2008) model, within a constructivist paradigm. Although earlier sections of the manuscript refer to a "mixed-methods" framework, the present research is purely qualitative in nature, focused on eliciting and analyzing personal illness narratives of individuals diagnosed with chronic hepatitis B (CHB). No quantitative instrument was designed or validated during this phase. Therefore, all descriptions of "instrument development" or "exploratory sequential design" were excluded from the final research protocol due to conceptual inconsistency.

Participants and Sampling

The target population included all adult patients diagnosed with CHB who had been referred to the Middle East Research Center for Liver and Gastroenterology in Tehran between March and December 2019. Purposive homogeneous sampling was employed to select participants who met the following inclusion criteria: Confirmed diagnosis of chronic hepatitis B by a hepatologist (minimum 6 months persistence of HBsAg); Age range between 25 to 60 years; Ability to articulate their life experiences in Persian; No comorbid severe psychiatric disorders (as assessed by a consulting psychologist). Exclusion criteria included: recent history of major surgery, advanced decompensated cirrhosis, or refusal to participate in audio-recorded interviews. Data saturation was achieved with 10 participants (6 male, 4 female), as no new codes or categories emerged after the tenth interview, in accordance with qualitative research standards (Dyson et al., 2014). Although the sample size is limited, in-depth qualitative methods prioritize information richness over quantity.

Procedure

The primary tool for data collection was the semi-structured life story interview protocol developed by (McAdams, 2018). This method is particularly suitable for exploring psychological identity, coping processes, and personal meaning-making in chronically ill populations. Each participant was interviewed once in a private room at the research center. Interview durations ranged from 60 to 90 minutes, depending on participant engagement. With informed consent, all interviews were audio-recorded and later transcribed verbatim for analysis. The interview guide included questions across the following dimensions: Life chapters and turning points; Major emotional highs and lows; Key interpersonal relationships; Coping with illness and stigma; Reflections on the future and personal meaning. All interviews were conducted by the first author, a trained clinical psychologist with prior experience in qualitative interviewing and narrative analysis. Participants were assured of complete confidentiality and the right to withdraw at any stage without consequence.

Data Analysis

The interviews were analyzed using Riessman's thematic narrative analysis framework, which emphasizes both content and structure of personal narratives (Riessman, 2008). The process followed five stages: Transcription and familiarization: Audio recordings were transcribed verbatim. The researcher reviewed transcripts repeatedly to identify core narrative segments. Initial coding: Open coding was performed inductively, labeling meaningful narrative units line-by-line. Theme development: Related codes were grouped into categories and subthemes using both participant language and interpretive labels. Axial synthesis: Themes were linked to theoretical constructs such as maladaptive schemas, social support, and motivational structure. Contextualization: Narratives were interpreted in light of cultural, familial, and psychological contexts relevant to Iranian society.

To enhance analytical rigor, the coding process was conducted using MAXQDA version 10. Two independent reviewers (clinical psychology faculty) audited the codebook and provided peer debriefing to ensure thematic credibility and minimize interpretive bias. Disagreements in coding were resolved via consensus. Member checking—a common validation technique—was limited due to difficulties in re-contacting participants. However, the research team conducted iterative reviews of audio recordings to ensure alignment between narrative tone and coded content.

Ethical Considerations

All participants signed written informed consent forms prior to participation. Confidentiality was maintained by anonymizing all identifiers and storing digital data on encrypted devices. No compensation was provided to participants beyond verbal appreciation. The study was conducted in full compliance with the ethical principles of the Declaration of Helsinki (Association, 2013).

Findings and Results

Participant Characteristics

The final sample consisted of 10 participants (6 men, 4 women) with a confirmed diagnosis of chronic hepatitis B (CHB). The participants ranged in age from 25 to 55 years. Educational levels varied from primary school to master's degree. Seven participants were married, and three were single. All individuals had been living with CHB for at least two years.

Thematic narrative analysis of the interviews yielded six overarching themes and fourteen subthemes, which reflect participants' psychological experiences, emotional responses, and coping strategies in relation to their illness. The table 1 shows the hierarchical relationship between initial codes (raw data units), axial codes (subthemes), and selective themes (core constructs) derived from narrative data.

Table 1*Detailed Coding Framework*

Selective Theme	Axial Code (Subtheme)	Initial Codes (Examples)
Family Dynamics	Emotional deprivation	"No one listened to me at home"; "I was invisible to my parents"
	Conditional affection	"Love was always earned, not given"
	Parent–sibling inversion	"I raised my siblings after my mom died"
Traumatic Life Events	Cumulative loss	"I lost my sister and then my job—all within a year"
	Childhood violence	"My father beat me every day... I stopped crying eventually"
	Emotional abandonment	"Even when I was sick, my mother didn't come to the hospital"
Perceived Social Support	Secrecy and concealment	"I hide the disease from my husband"; "No one at work knows"
	Instrumental support from siblings	"My sister paid for my tests when I couldn't afford them"
Emotion Regulation	Rumination and guilt	"I keep replaying everything I did wrong"; "I blame myself"
	Experiential avoidance	"I avoid anyone who asks questions"; "I shut down emotionally"
Doctor–Patient Relationship	Diagnostic trauma	"The doctor didn't even look me in the eye"; "He just said: 'You're sick'"
	Lack of guidance	"They gave me a prescription and nothing else"
Motivational Conflict	Suppressed autonomy	"I wanted to study, they made me marry at 13"
	Identity incoherence	"I don't know who I am anymore"

Theme 1: Family Dynamics

Participants reported chronic emotional deprivation, often rooted in parental neglect, loss, or inconsistent caregiving. Many were forced to assume adult roles prematurely. *"When I was 10, my mother passed away. After that, my father said: 'You're the woman of the house now.' I raised my brothers like a mother. No time to cry."* (P3). This relational void produced persistent internal schemas of unworthiness and emotional self-suppression. *"Nothing I ever did was good enough for my father. He'd smile only when guests came."* (P7)

Theme 2: Traumatic Life Events

Most narratives included traumatic turning points, including sibling deaths, physical abuse, and life-threatening situations—often untreated or unresolved. *"I was sexually abused by my uncle when I was 9. I never told anyone. Sometimes I think the illness is my punishment."* (P2). This unresolved trauma often shaped illness interpretation as retribution or karmic justice. *"I feel like I've been carrying a curse since childhood. Hepatitis is just another burden."* (P5)

Theme 3: Social Support and Stigma

A large subset described isolation, shame, and stigma, with minimal access to emotional validation. *"No one must know. If they do, they'll say I'm impure. My aunt already told people I'm dying."* (P4). In contrast, participants who had access to nonjudgmental siblings or spouses coped better. *"My husband looked me in the*

eyes and said, 'We'll deal with this together.' That night, I cried for the first time in years." (P10)

Theme 4: Emotion Regulation and Cognitive Style

Participants engaged in rumination, self-blame, and catastrophic thinking, particularly around diagnosis or perceived failure. *"I play scenes in my head—what if I didn't go to that clinic? What if I had used gloves? It drives me crazy."* (P1). They often avoided emotional exposure or disclosure as a way to manage internal tension. *"I keep everything inside. If I talk, I'll collapse."* (P6)

Theme 5: Doctor–Patient Communication

Many participants described their diagnosis disclosure as a psychologically scarring moment. *"He said: 'You're infected. Live carefully.' And then handed me pills. That's all. No emotion, no support."* (P8). This lack of empathetic communication led to lasting mistrust in the healthcare system and reinforced self-stigma.

Theme 6: Motivational Structure and Identity Conflict

Participants expressed deep regret about abandoned goals and internal conflict between family-imposed expectations and personal dreams. *"I wanted to be a nurse. But my father said I should get married. Now, I change my kids' diapers and wonder who I could have been."* (P5). These conflicting narratives produced identity fragmentation and chronic dissatisfaction.

Participants frequently used metaphoric language to express complex emotional states. This suggests a symbolic processing of trauma and illness.

Table 2

Narrative Imagery and Metaphors

Metaphor Used	Interpretation
"I carry this disease like a silent bomb"	Constant anxiety, fear of social exposure
"My life feels like an unfinished book"	Unresolved identity, blocked life trajectory
"It's like drowning without water"	Emotional suffocation and helplessness
"A locked room inside me"	Repressed trauma, emotional inaccessibility

These metaphors reveal symbolic strategies participants use to frame and contain psychological pain.

Discussion and Conclusion

The present study explored the lived psychological experiences of adults living with chronic hepatitis B (CHB) through thematic narrative analysis. The findings reveal a complex interplay of emotional deprivation, trauma, stigma, and internal motivational conflict that shapes how individuals perceive, narrate, and cope with their illness. These results resonate with and extend prior work in chronic illness psychology, narrative identity theory, and trauma-informed care.

The central theme of family-based emotional deprivation and authoritarian parenting reflects broader sociocultural norms in many non-Western contexts, where emotional expression is suppressed and intergenerational hierarchies are rigid (Marjani et al., 2025). These early relational schemas align with Young's schema theory, particularly domains of "emotional deprivation" and "defectiveness/shame" (Young et al., 2006). Participants' narratives revealed how unresolved childhood experiences formed internalized models of unworthiness and self-silencing—factors that may amplify disease-related shame and reduce help-seeking behaviors (Adoboi & Mohammadnezhad, 2025).

Cumulative trauma, particularly in the form of bereavement and abuse, emerged as a key feature in participants' biographies. These experiences mirror what Herman & Kallivayalil (2018) describes as "chronic interpersonal trauma," which reshapes self-narratives and identity continuity. Illness, in this context, was not merely a biomedical condition but a symbolic continuation of past adversity—what Frank (2022) terms "the wounded storyteller." Several participants interpreted CHB as divine punishment or karmic justice, which may reflect culturally embedded fatalistic beliefs and religious coping styles (Deng et al., 2025; Pargament, 2011).

The imagery was predominantly passive, tragic, or burden-focused, consistent with trauma narratives.

The theme of limited social support and fear of stigma is consistent with global literature on hepatitis B (Patidar & Bajaj, 2016; Wang et al., 2023). CHB is often shrouded in misinformation about transmission, leading patients to conceal their diagnosis, even from close family members. This concealment reinforces social isolation and may contribute to chronic emotional suppression. The presence of a supportive sibling or spouse, as observed in a few narratives, functioned as a critical buffer against psychological collapse, echoing the protective role of social bonds identified in attachment theory (Mikulincer & Shaver, 2010).

A particularly striking finding was the prevalence of maladaptive emotion regulation, including rumination, experiential avoidance, and catastrophic thinking. These cognitive patterns align with core processes identified in Acceptance and Commitment Therapy (ACT), particularly "cognitive fusion" and "experiential avoidance" (Hayes et al., 2011). Participants often narrated an inability to disengage from guilt-laden thoughts or future-oriented anxiety, leading to emotional paralysis. This points to the potential relevance of third-wave behavioral interventions in supporting this population.

The doctor-patient relationship, especially around diagnostic disclosure, emerged as a pivotal moment in shaping illness narrative. Participants' recollections of receiving their diagnosis often involved language of shock, abandonment, or fear. As found in previous studies (Wang et al., 2023), non-empathic disclosure can act as a secondary trauma, reinforcing internalized stigma and triggering long-lasting mistrust in the healthcare system. This underscores the urgent need for training clinicians in trauma-sensitive, patient-centered communication.

Finally, motivational conflict and blocked goal pursuit were prevalent, particularly among women who were denied educational or professional opportunities due to

patriarchal norms. Their narratives reflected internalized role expectations and fractured identities, resonating with McAdams (2018) theory of narrative identity, where identity is formed through coherence between one's remembered past and imagined future. When societal or familial constraints disrupt this coherence, individuals experience identity diffusion and psychological stagnation.

Together, these themes offer a portrait of how CHB is not only a viral illness but a deeply biographical and psychosocial event, refracted through past trauma, cultural narratives, and internal belief systems.

Limitations

Despite its contributions, this study has several limitations. First, the sample was limited to ten individuals from a single urban center in Iran, potentially limiting generalizability. Second, although data saturation was achieved, gender balance and socioeconomic diversity were not optimal. Third, member checking was only partially possible due to challenges in participant follow-up. Additionally, the absence of triangulation with other data sources (e.g., clinical records, family interviews) may have narrowed interpretation.

This study illustrates how individuals living with chronic hepatitis B construct their illness narratives around a core of emotional loss, trauma, and relational rupture. Their psychological responses are shaped not only by the disease itself but by deeply embedded schemas, social stigmas, and cultural beliefs. The findings underscore the need for integrated psychosocial care, incorporating narrative reconstruction, trauma-informed approaches, and emotion regulation strategies. Clinical protocols must be attuned not just to virological outcomes, but to how patients live with, interpret, and internalize their diagnosis. Future research should explore culturally sensitive interventions that address both psychological healing and identity reformation.

Acknowledgments

The authors express their gratitude and appreciation to all participants.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Helsinki Declaration, which provides guidelines for ethical research involving human participants. Ethical considerations in this study were that participation was entirely optional.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

Authors' Contributions

All authors equally contribute to this study.

References

- Adoboi, F., & Mohammadnezhad, M. (2025). A Systematic Review Study on Lived Experiences of People Living with Hepatitis B (PLHB). *Global Journal of Health Science*, 17(1). <https://doi.org/10.5539/gjhs.v17n1p63>
- Association, W. M. (2013). World Medical Association Declaration of Helsinki: ethical principles for medical research involving human subjects. *Jama*, 310(20), 2191-2194. <https://doi.org/10.1001/jama.2013.281053>
- Bury, M. (1982). Chronic illness as biographical disruption. *Sociology of health & illness*, 4(2), 167-182. <https://doi.org/10.1111/1467-9566.ep11339939>
- Deng, Q., Wu, S., & Liu, W. (2025). Effect of social influence on antiviral therapy behavior among chronic hepatitis B patients with different disease knowledge levels. *BMC Public Health*, 25(1), 1-11. <https://doi.org/10.1186/s12889-025-22683-7>
- Dyson, J. K., Waller, J., Turley, A., Michael, E., Moses, S., Valappil, M., Hudson, M., Bassendine, M., & McPherson, S. (2014). Hepatitis B in pregnancy. *Frontline gastroenterology*, 5(2), 111-117. <https://doi.org/10.1136/flgastro-2013-100361>
- Frank, A. W. (2022). *The wounded storyteller: Body, illness & ethics*. University of Chicago press. <https://press.uchicago.edu/ucp/books/book/chicago/W/bo14674212.html>
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2011). *Acceptance and commitment therapy: The process and practice of mindful change*. Guilford press. <https://psycnet.apa.org/record/2012-00755-000>
- Herman, J. L., & Kallivayalil, D. (2018). *Group trauma treatment in early recovery*. Guilford Publications. <https://www.guilford.com/books/Group-Trauma-Treatment-in-Early-Recovery/Herman-Kallivayalil-Program/9781462537440?srsId=AfmBOoqKQ4K8P0Gsl7ANJxEqf05nO-KwHmMb5IagV7i4KOAsA3oTbauQ>

- Marjani, A., Alavian, S. M., Nassiri Toosi, M., Alavian, S. H., Abazari, M. F., Khamseh, A., & Jazayeri, S. M. (2025). Hepatitis B virus infection after immunization: How serious it is? An updated review. *Clinical and Experimental Medicine*, 25(1), 113. <https://doi.org/10.1007/s10238-025-01645-8>
- McAdams, D. P. (2018). Narrative identity: What is it? What does it do? How do you measure it? *Imagination, cognition and personality*, 37(3), 359-372. <https://doi.org/10.1177/0276236618756704>
- McMahon, B. J. (2009). The influence of hepatitis B virus genotype and subgenotype on the natural history of chronic hepatitis B. *Hepatology international*, 3(2), 334-342. <https://doi.org/10.1007/s12072-008-9112-z>
- Mikulincer, M., & Shaver, P. R. (2010). *Attachment in adulthood: Structure, dynamics, and change*. Guilford Publications. https://www.guilford.com/books/Attachment-in-Adulthood/Mikulincer-Shaver/9781462533817?srsId=AfmBOooO6qwpJZ26hjxx357B8J3DPy_g7yxa-S7fxL_RhFxPnjiD50NI
- Murray, M. (2017). *Critical health psychology*. Bloomsbury Publishing. <https://www.bloomsbury.com/uk/critical-health-psychology-9781137282644/>
- Organization, W. H. (2023). *Tracking universal health coverage: 2023 global monitoring report*. World Health Organization. <https://www.who.int/publications/i/item/9789240080379>
- Pargament, K. I. (2011). Religion and coping: The current state of knowledge. *The Oxford handbook of stress, health, and coping*, 269-288. <https://doi.org/10.1093/oxfordhb/9780195375343.013.0014>
- Patidar, K. R., & Bajaj, J. S. (2016). Tired of hepatitis B? *Digestive diseases and sciences*, 61(4), 953-954. <https://doi.org/10.1007/s10620-016-4067-8>
- Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage. <https://psycnet.apa.org/record/2008-05683-000>
- Seto, W.-K., & Yuen, M.-F. (2018). Hepatitis B Virus: Asian Perspective. In *Clinical Epidemiology of Chronic Liver Diseases* (pp. 99-116). Springer. https://doi.org/10.1007/978-3-319-94355-8_8
- Terrault, N. A., Lok, A. S., McMahon, B. J., Chang, K. M., Hwang, J. P., Jonas, M. M., Brown Jr, R. S., Bzowej, N. H., & Wong, J. B. (2018). Update on prevention, diagnosis, and treatment of chronic hepatitis B: AASLD 2018 hepatitis B guidance. *Hepatology*, 67(4), 1560-1599. <https://doi.org/10.1002/hep.29800>
- Wang, T., Kong, L.-N., Yao, Y., & Li, L. (2023). Self-efficacy, coping strategies and quality of life among patients with chronic hepatitis B. *Western Journal of Nursing Research*, 45(9), 800-806. <https://doi.org/10.1177/01939459231184714>
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2006). *Schema therapy: A practitioner's guide*. Guilford Press. <https://www.guilford.com/books/Schema-Therapy/Young-Klosko-Weishaar/9781593853723?srsId=AfmBOoqYIHWeCUC22AzW7jkr3Qxbk35cLcWVxAI9ZNynXitaQ9YPBh0U>