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"I changed, I had to realize that I was wrong": Identity gap management amidst evolving illness uncertainty

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Abstract

Doubt that a family member's health issues are real, severe, or even possible entwines some of the most challenging aspects of medical, personal, and social uncertainty. Although several studies have examined doubt, this investigation focuses on how doubt evolves and foregrounds the identity implications of uncertainty. Guided by Communication Theory of Identity (CTI), the purpose of this study was to explore the identity gaps people experience as they navigate evolving doubt about a family member's health and how they manage those identity gaps. We interviewed 33 individuals in the U.S. about a family member's health issues that they doubted but began to believe. Our analysis uncovered three identity gaps among personal, relational, and enacted layers of identity: personal-enacted, relational-enacted, and personal-relational-enacted identity gaps. Participants managed identity gaps in two primary ways: (a) closing gaps by altering personal, relational, or enacted layers of their own identity; and (b) maintaining identity gaps by putting the locus of responsibility for identity change within their family member's relational identities. This study offers theoretical implications for CTI as well as practical implications for individuals navigating doubt and evolving illness uncertainty in their family relationships.

Keywords

Uncertainty, identity, illness, family, interviews

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Introduction

When a family member has health issues, uncertainty can permeate family life, family communication, and family identity (Brashers, 2001). Others in the family may experience uncertainty surrounding the family member's health "when details of situations are ambiguous, complex, unpredictable, or probabilistic; when information is unavailable or inconsistent; and when people feel insecure in their own state of knowledge or the state of knowledge in general" (Brashers, 2001, p. 478). Uncertainty about a family member's health issues can be medical in nature and center on issues of diagnosis, symptoms, treatment, and prognosis (Brashers et al., 2003). Uncertainty can also be social and personal as individuals navigate the respective relational and identity implications of a family member's health issues (Brashers et al., 2003). The identity negotiation aspects of uncertainty management (Brashers et al., 2000) are made more challenging when individuals doubt a family member's health issues are real, severe, or even possible (Thompson & Duerringer, 2020; Thompson et al., 2020).

Doubt is a form of ontological uncertainty that entwines some of the most difficult aspects of medical, personal, and social uncertainty (see Thompson & Duerringer, 2020; Thompson et al., 2020). Concerning medical uncertainty, doubt reveals people's strong need for—and often inability to obtain—labels and diagnosis to organize their experiences of another's illness and to provide a course of action (e.g., treatment; Jutel, 2009). Individuals often wait extensively for answers to another's health issues; meanwhile, they may dismiss or attribute the symptoms to other causes (e.g., stress; McManimen et al., 2019). Doubt also increases personal uncertainty in the form of role ambiguity in managing the person's health issues (Thompson et al., 2020). Finally, doubt often exacerbates social uncertainty, contributing to the person's stigma, rejection, and isolation that accompanies not being believed or understood (Dumit, 2006). Therefore, individuals' doubt about a family member's health is multi-layered (Brashers, 2001) and its causes "extend beyond those of medical diagnosis, treatment, and recovery to personal and social aspects of daily life" (Brashers et al., 2003, p. 498).

The purpose of this study is to shift focus from medical, personal, and social *causes* of doubt (Brashers et al., 2003) to the personal and social *consequences* of doubt, which we conceptualize as personal identity and relational identity gaps and management of those gaps. Because doubt is often relationally challenging (Thompson et al., 2020), people experiencing doubt likely grapple with disconnects or gaps between how they see themselves and their relationships and how they manage illness uncertainty. For example, individuals with doubts about a family member's illness may struggle to perform the role of supportive family member (Thompson et al., 2020). How individuals negotiate identities and identity gaps has implications for adaptive uncertainty management (Brashers et al., 2000), as well as processes of coping and resilience (Afifi et al., 2020; Miller & Caughlin, 2013). We utilize the Communication Theory of Identity (CTI) (Hecht, 1993) to explore both the identity gaps people experience as they navigate evolving doubt about a family member's health and how they manage those identity gaps.

Identity gaps amidst evolving illness uncertainty

Communication Theory of Identity (CTI; Hecht, 1993) is a useful framework for exploring the identity implications—including identity conflicts—of uncertainty, particularly in personal relationships such as family. According to CTI, identity is an inherently communicative process, shaped and reshaped by social interaction (Hecht, 1993; Jung & Hecht, 2004). Therefore, "even when identity is largely symbolic, communication rituals are used to create and express" identity (Hecht, 1993, p. 78). Communication theory of identity also assumes that identities can change (Hecht, 1993). This assumption aligns with uncertainty theorizing and the evolution of uncertainty and uncertainty management (e.g., Brashers, 2001; Mishel, 1990). Although several studies have examined doubt (e.g., Thompson & Duerringer, 2020; Thompson et al., 2020), this investigation focuses on how doubt evolves and foregrounds the identity implications of uncertainty.

Communication theory of identity delineates four interrelated frames of identity: personal, enacted, relational, and communal (Hecht, 1993). The personal frame refers to one's self-concept, or how individuals define themselves; for example, a person's belief that they are a patient, loyal, and trustworthy sibling. The enacted frame refers to one's performed or expressed identity. For instance, a nurse might enact their identity through medical jargon. The relational frame refers to identities that are ascribed to and that emerge from an individual's relationships. Relational identity exists at four levels (Hecht, 1993). Individuals define themselves by their perception of how others see them (ascribed), through their relationships with others (e.g., brother and friend), in relation to their other identities (e.g., being a mother and a daughter), and as the relationships to which they belong (i.e., dyads, such as couples, incorporate the relationship into their own identity; Kennedy-Lightsey et al., 2015; Merrill & Afifi, 2017). Finally, the communal frame refers to identities born of group characteristics or identities ascribed by society (e.g., stigma associated with drug abuse, depression; Crowley & Miller, 2020; Hecht, 1993; Jung & Hecht, 2008). Although the four frames are distinct identity layers, as frames coexist and interpenetrate, they must be considered collectively (Jung & Hecht, 2004).

Identity gaps. As identities are shaped and reshaped through interactions, frames can align or be at odds (Hecht et al., 2005). Discrepancies among various frames produce identity gaps, meaning various identity frames coexist in contradiction (Jung & Hecht, 2004, 2008). Some of the most commonly cited gaps are among personal, enacted, and relational identity frames, especially personal-enacted and personal-relational identity gaps. A personal-enacted gap arises from discrepancies between an individual's self-concept and how they express their identity in communication with others. In some cases, individuals might perform an identity that conflicts with how they view themselves. For instance, a spouse might clutch their partner in public even when they do not see themselves as a "clingy" person (Kennedy-Lightsey et al., 2015). Other times, individuals might suppress their authentic self or manipulate their self-expression to perform a more desirable identity (Jung & Hecht, 2008; Morgan et al., 2020).

Individuals who struggle to reconcile aspects of their self-concept with their relational role might experience a personal-relational gap; for example, one's personal identity as a patient conflicting with their perceived family identity as a mother (Palmer-Wackerly et al., 2018). Furthermore, discrepancies between how one perceives they should act based on their relationship and one's expression of identity may produce a relational-enacted gap (Jung & Hecht, 2004). Personal-enacted-relational gaps may occur when expressions of personal and relational identity conflict; for instance, when individuals avoid disclosing their smoking habits to a romantic partner so as not to alter their partner's perception of them (Stanley & Pitts, 2019).

Doubting a family member's health experience could create identity gaps. For example, people who doubt another's health describe dilemmas in communicating their doubts with the person in ways that align with their own health beliefs (e.g., I would not manage my illness that way; Thompson & Duerringer, 2020) and that do not instigate conflict in the relationship by sounding insensitive or accusatory (Thompson et al., 2020). The current study extends literature on health doubts in relationship by exploring how conflicts among concerns for identity and relationship may extend beyond conversations to affect individuals' self-views and relational roles and expectations. Even when individuals move from doubt to acceptance of a family member's health experience, as is the case among participants in this study, they may wrestle with notions of who they are and what role they play in their relationships. Identities and relationships may need to be (re)constructed. To elucidate potential misalignment among individuals' identity frames as they navigate evolving uncertainty about a family member's health, we posed:

RQ1: How do people experience identity gaps as they navigate doubt about a family member's health issues?

Identity gap management. Identity gaps produce negative consequences for self and relationships. For the self, identity gaps can be a source of inner turmoil (Kam & Hecht, 2009). Colaner et al. (2014) reported participants felt distress negotiating identity in birth and adoptive families, "as though the person they viewed themselves to be was not in line with the biological family that contributed to their existence" (p. 17). Identity gaps can also be a source of relational strain as they are associated with declines in satisfaction (Kennedy-Lightsey et al., 2015; Pusateri et al., 2016), closeness, liking, commonality, and trust (Morgan et al., 2020), and decreases in intentions to enact relationally oriented behaviors in families (Phillips et al., 2018). Consequentially, people may manage identity gaps to relieve negative affect, improve communication satisfaction, attend to their relationships, and resist negative stereotypes (e.g., Crowley & Miller, 2020; Stanley & Pitts, 2019). In some situations, individuals may choose to maintain or adapt to identity gaps, such as when shared identities can harm health (e.g., enabling addiction in couples; Crowley & Miller, 2020); when identity gaps are positively valenced (e.g., projecting a socially desirable identity; Kam & Hecht, 2009; Stanley & Pitts, 2019); and when identity gaps among some identity layers preserve relational harmony and alignment among other identity frames (Stanley & Pitts, 2019).

However, less research focuses on identity negotiation explicitly as a facet of uncertainty management.

Existing studies approach identity gap management as various discursive strategies individuals employ to resolve discrepancies within and among frames (Nuru, 2014; Wagner et al., 2016). Relevant to this investigation, individuals with stigmatized identities have engaged in "passing" and "closeted enactment" to manage identity gaps, as well as disengagement, label changing, and hyper-engagement (Faulkner & Hecht, 2011; Nuru, 2014; Wagner et al., 2016). When relational identity is implicated, individuals may employ strategies of being considerate, concealing the act, gauging others' reactions, and deceiving close others (Stanley & Pitts, 2019). When individuals doubt a family member's illness, they may be motivated to manage potential identity gaps because doubts are associated with dilemmas in managing identity, relational, and task interaction goals, as well as negative emotions such as helplessness and relational strain (Thompson et al., 2020). Therefore, individuals may engage in identity gap management to resolve negative self and relational consequences. To learn more about participants' identity gap management amidst evolving uncertainty, we asked:

RQ2: How do people manage identity gaps while navigating doubt about a family member's health issues?

Methods

As part of a larger project on evolving uncertainty about a family member's health issues (e.g., Thompson et al., 2021), two authors conducted semi-structured interviews with 33 adults living in the U.S. about "a family member whose health you doubted, but now believe" (as stated in the study advertisement). Interviewees were ranged from age 26 to 70 (M = 39.85, SD = 11.33), and 51.5% identified as male and 48.5% as female. Most identified as White/Caucasian (69.7%), followed by African American (6.1%), Asian (6.1%), Native American (3.0%), Hispanic/Latinx (3.0%), Puerto Rican (3.0%), and other (6.1%). Interviewees reported their highest level of education as 4-year degree (36.4%), some college (30.3%), 2-year degree (21.2%), and high school diploma/GED (12.1%). Interviewee's reported annual household income was approximately $52,000 ($SD$ = $35,000).

Participants reported on siblings (33.3%), romantic partners (24.2%), parents (including stepparents and in-laws; 21.2%), cousins (9.1%), friends (9.1%), and ex-partners (3.0%). We elected to include data from participants who reported on a friend's health issues because they self-identified their friends as family members or voluntary kin (Braithwaite et al., 2010). Interviewees described a wide range of family member illnesses, including mental illnesses (e.g., depression and anxiety; 54.5%), autoimmune disorders (e.g., lupus and Type 1 diabetes; 24.3%), chronic pain (e.g., back pain and leg pain; 18.2%), alcoholism and addiction to pain pills (12.1%), and various other conditions (e.g., motion sickness and sleep apnea; 42.4%). Two participants did not know or label family members' health condition(s). Three family members were deceased at the time of the interviews.

The two author(s) recruited interviewees from Amazon's Mechanical Turk platform and conducted the interviews using Google Voice. Participants were compensated $15. The interview guide included such questions as: "What have been some of the moments or turning points when you started to believe their health issues were real or more severe than you thought?"; and "How has your change in perception affected your relationship?" Probing questions were asked when participants mentioned their identity in relation to uncertainty. Participants chose their pseudonyms. Interviews ranged from 21 to 64 min (M = 42). Interviews were professionally transcribed, yielding 473 pages for analysis. Although theoretical saturation was reached and no new insights emerged after the 25th interview, we conducted additional interviews to capture a wider range of relationships and health issues.

Within the larger project of uncertainty about a family member's health issues, this study focused on identity gaps and identity gap management, after research team members noted during interviewing and initial data immersion that identity issues were prominent. Accordingly, we analyzed the transcripts via Tracy's (2020) phronetic iterative approach; iterative referring to the alternation between emic (from the data) and etic (from existing theory and research) readings. We engaged the data sensitized to identity-related concepts of uncertainty (personal and social uncertainty; Brashers et al., 2003) and communication theory of identity (e.g., gaps, conflicts, and negotiations; Jung & Hecht, 2004) literature. Following Tracy's (2020) guidelines, our analysis unfolded in three stages: data immersion and primary-cycle coding, second-cycle coding, and synthesizing activities. We first immersed ourselves in the data and primary-cycle coded the transcripts descriptively, focusing on the "who, what, where, and when" of the data (Tracy, 2020, p. 220). Transcripts were assigned to pairs of team members in subsets of five. Team members read the five transcripts independently. Team members were encouraged to write analytic memos, ideas about the meaning of first-level descriptive codes and how they were connected (Tracy, 2020), as they read and coded. When we reconvened, we discussed codes and analytic memos in assigned pairs before convening as a larger group. Initial codes included: "big brother," "nurse," and "younger back then." We repeated this stage to ensure all transcripts were coded by at least one pair of team members.

We then turned to secondary-cycle coding to combine, condense, and organize first-level codes into second-level codes (Tracy, 2020). Again, we assigned transcripts to pairs of teams in subsets of five. Team members independently read the five transcripts and wrote analytic memos. Next, we discussed second-level codes and analytic memos in pairs and then as a larger group. Second-level codes included: "comparing identities," "feeling regretful," and "changing perspective." We repeated this stage to ensure all transcripts were second-cycle coded by at least one pair of team members. Finally, in later stages of second-cycle coding, we engaged in synthesizing activities to develop theoretically oriented themes that answered our research questions. Specifically, we created a loose analysis outline to see how our codes answered each research question (Tracy, 2020), collapsing some codes (e.g., strategies of managing identity gaps such as "changing perspective" and "seeking more information") and explicating others (e.g., how re-envisioning relational identities addressed identity gaps). To enhance validity, we

engaged in negative case analysis to locate participants whose experiences did not map onto our findings (Tracy, 2020).

Findings

Our first research question explored how individuals experienced identity gaps as they navigated doubt about a family member's health issues, and our second research question asked how interviewees managed those identity gaps. Our analysis uncovered how, earlier in their narratives, participants' doubt and doubt responses aligned with their personal and relational frames—they acted consistently with their own beliefs (i.e., personal identity), as well as their roles and expectations for their relationships (i.e., relational identities). However, as interviewees started to believe their family member's health issues were real or severe, they experienced conflict among their personal, relational, and enacted frames (RQ1). In response to the dissonance generated by these identity gaps, participants were motivated to close and/or maintain their identity gaps (RQ2). We next explain and exemplify each of the three emergent identity gaps and four identity management strategies.

Identity gap(s)

We identified identity gaps among participants' personal, relational, and enacted frames, including personal-enacted identity gaps, relational-enacted identity gaps, and personal–relational-enacted identity gaps.

Personal-enacted identity gaps. Some participants experienced a personal-enacted gap, or a discrepancy between their self-concept and their expressed identity. Upon reflection, these participants considered their communication with family members to be inconsistent with how they viewed themselves. On one hand, some participants, like Lydia, felt they acted harshly or insensitively toward their kin, despite considering themselves to be good, supportive family members: "I was angry that [my stepdad] was crumbling a little bit, and didn't really believe that he was having a hard time." Deanna shared she had "profound regrets" surrounding her brother's death and the illness that preceded it, primarily because her dismissal of his declining health—"I just blew it off...he was just being ornery"—ran counter to her self-concept as someone attentive to others' needs: "I'm a person, I like to talk. I like to try to get through to you emotionally and mentally." Some interviewees failed to act consistently with a valued personal identity. Kayla wondered how her husband's sleep apnea was "not on [her] radar," despite her nurse training. After his behavior was finally validated by diagnosis she felt guilty for "riding his butt for so long." As these participants were unable to communicate congruently with their personal views, they often experienced negative emotions such as guilt and regret when thinking about their conversations retrospectively.

On the other hand, some participants did not regret their actions, but instead were frustrated they felt pressured to act inconsistently with their self-concept out of obligation or self-protection. McKenna shared that she needed to have a "detachment with love"

approach to her sister's multiple sclerosis because, "She's been destructive and used me at times." However, this approach conflicted with her personal identity: "I am a codependent enabler, and I'm not just a little bit, honey. I will give over my entire being to you. I could wrap myself around you like an octopus." For many, personal-enacted gaps were a source of incongruence and distress.

Relational-enacted identity gaps. Other participants experienced a relational-enacted gap, or a discrepancy between the identity emerging from their relationships and their expressed identity. Consistent with Thompson et al. (2020), this gap manifested when interviewees acted in ways that misaligned with their role in the family relationship. Some participants described a gap between what a wife, husband, sibling, son, or daughter *should* do, and how they actually responded to their family member's health complaints. Specifically, some participants experienced role conflicts that negatively impacted their ability to respond to their family members in desired ways. As the "favorite" son attempting to care for his mother and a husband managing his family's expectations, Mike reflected: "I'm trying to get over there every other day, three to four times a week, which causes me issues at home. My wife… feels that I'm neglecting her and the kids which leads to a lot of friction." For others, a shared relational identity contributed to the misalignment between their ascribed relational role and the ways they expressed that identity through communication. Amanda, for example, described her close relationship with her husband as follows: "I call him my turtle shell because we turtle shell off everybody else in the world sometimes, like just keep our little bubble." As such, Amanda acknowledged how her responses to his back pain complaints countered this relational identity:

> It breaks him down for me to nag and nitpick. Do you want to build someone up or break them down? Which one is going to bring our marriage closer, you know, or which one is going to strengthen our bond? It's definitely not going to be chipping away at his ego and our bond, I guess, our trust with each other.

Additionally, Jayne said she found her mother's journey to a Graves' disease diagnosis "exasperating," which "came through in [Jayne's] attitude and tone sometimes." Despite her best efforts, Jayne admitted there was leakage:

> And I think even when you're trying really hard to be good to someone, if internally you feel like it may not be real, some of that's going to show through. No matter how well you try to hide that.

Jayne continued to elucidate how feeling "less understanding" with her mother was inconsistent with their close relationship and their family values: "If somebody in our family is sick, that's what you do. You take care of them, you know?" Overall, many interviewees shared feelings of guilt and regret with how their (in)actions toward their family member's health issues countered their valued relational identities.

Personal-relational-enacted identity gaps. In some cases, participants' gaps spanned all three frames. These personal-enacted-relational gaps prevented individuals from implementing mutually satisfying behaviors. In other words, individuals' self-concepts conflicted with their relational identities in ways that limited their ability to express one without compromising the other. Brianna, for example, desired closeness with her cousin but withheld attempts to learn more about her lupus, fearing undue stress: "It's not that I don't care…I am not a person that sits around and stresses a lot. My body just can't deal with it. I prefer not to even know about it." Chris described tension in encouraging his sister to seek professional help for her mental health. As his sister's caretaker from a young age, he wanted to push her to seek help, but as someone who also experienced anxiety, he saw value in giving her autonomy. He explained:

> It's like [I'm] constantly trying to strike a balance between making sure I say enough, but at the same time making sure that I don't say too much, because I don't want to alienate her from me, and I don't want to alienate her from her own path to figuring new things out for herself.

In these narratives, participants' expressed identity was discrepant with either their personal or their relational frame, posing what seemed to be a no win situation. As Mike explained: "Damned if you do and damned if you don't," as privileging one frame in their enactments potentially compromised another. To the extent that identity gaps were distressing and caused dissonance, and because identities are a source of expectations and motivations (Hecht, 1993), participants managed their identity gaps by attempting to close them or by maintaining them over time.

Closing or bridging the gap(s)

Participants motivated to close gaps among their personal, relational, and enacted frames often shared feelings of guilt and regret that they did not act in accordance with what they knew and wanted themselves to be because they had responded unsupportively toward their family members. These interviewees typically rationalized their identity gaps and attributed their doubt to external causes, including missed diagnoses, as they simply were unaware of the person's condition and its severity. This sensemaking was illustrated by Flowers about her brother's diabetes that went untreated for much of his childhood, leading to his premature death:

> Well, when we were growing up, every once in a while he would start to throw up, when he would get too hot and stuff. I started to worry and that's when mama and daddy did, too. That's why they were taking him to the doctor and stuff. But they were saying that he had anxiety problems and that they think that's why he couldn't handle the work on the farm. But it turned out to be something totally different...It was scary for me. Because I felt guilty because I had doubted him.

In response to their identity gaps and associated feelings of guilt and regret, these participants described engaging in identity negotiation to reconcile or align their identities

with their valued identities in support of the family member and their health issues. Interviewees closed identity gaps by attending to one or a combination of personal, relational, and enacted layers by: (a) changing their belief system or self-concept (personal), (b) re-envisioning their relationships (relational), and/or (c) increasing supportive responses (enacted).

Changing their belief system or self-concept. Some participants managed their identity gaps by attending to the personal identity frame, particularly when they perceived they needed to revise their own belief system or self-concept. For instance, after initially doubting his younger sister's trauma, which contradicted his identity as a kind, supportive brother, Manny grew into a "protector" role with his female family members: "I've kind of determined that part of my job is to protect them, at least to give them some sort of support, knowing that there's at least someone here who will help them with anything." Similarly, after initially questioning the legitimacy of his cousin's mental health issues, Jake ultimately drew on his own experience as a person with depression and anxiety to relate to his cousin and express empathy, thereby altering his belief system and becoming more understanding. As Jake shared: "I can understand the whole locking yourself in your room and not wanting to do anything… And if he's even close to what I was feeling, I just act like how I would treat myself…" Eric also spoke to the importance of perspective-taking, reflecting:

> Empathy isn't, I'll still say isn't, isn't something I have. I'm not able to empathize with people. But the fact that we are so close made me stop and think, you know, "What is she going through? How must that feel?"

Here, Eric illustrated how identity change can be difficult, as he did not view himself as an empathic person, despite the empathy he felt for his wife. At the same time, and like many interviewees, Eric spoke to how strong shared relational identities prompted him to want to change aspects of himself to manage identity gaps and ultimately better support his wife and her health issues.

Re-envisioning the relationship. When individuals prioritized their relational identities to manage the identity gap, they typically sought to bridge understandings of their family member's health issues and what the health issues meant for their relationship. Such interviewees changed expectations of the relationship by embracing caregiver roles, adopting communal coping approaches, and increasing the saliency of desired relational identities (i.e., priding themselves on acting like a "big brother"). For example, Ashley attended to her relational-enacted gap by "taking the initiative" to contact her sister with depression, giving her time and space to open up about her experiences. Eric redefined his relationship with his wife after realizing that what he perceived as weakness was really his wife's severe anxiety. He consequently went from being annoyed to taking an active role and partnership in managing her anxiety: "It's not her problem, there are no her problems and my problems. There are only our problems."

Similarly, Robert described a major shift in his relational identity—"I've kind of joined his team, so to speak, of anything we do in our relationship we do together"—wherein he normalized his partner's health issues as a part of the relationship: "I look at it as just a different checkbox that we have to check off when we're doing things, if it's going to be compatible with what we're looking for." As these examples illustrate, interviewees who re-envisioned their relationships no longer let the family member's health condition negatively affect them or the relationship, creating a relational culture where imperfections or differences were not just tolerated but mutually embraced. Interviewees said these identity shifts ultimately strengthened bonds and helped them communally cope with health issues in their relationships (Afifi et al., 2020).

Increasing supportive responses. Some participants altered their enacted identity to align with their relational identity by providing support. For example, Kayla described coaching her husband ahead of doctors' visits, drawing upon her identity as a nurse to enact the role of supportive wife. Similarly, Tom sought to support his girlfriend physically and emotionally by giving her massages and taking time to actively listen to and empathize with her back pain complaints, reinforcing his identity as a caring and considerate person. Additionally, Robert regularly attended his partner's doctor appointments with him and strove to accommodate his motion sickness as much as possible, viewing it not as a "hinderance that he has or something" and suggesting activities they both could enjoy, which helped manage the motion sickness while reifying his identity and strengthening their partnership.

Some participants attempted to close identity gaps by acting like the relational partner they were normatively expected to be, or at least refraining from making unsupportive comments. Interviewees recognized that their expressions of doubt violated U.S. values of openness and supportiveness in relationships (Goldsmith & Domann-Scholz, 2013; Thompson et al., 2020). For instance, regarding her husband's health concerns, Jes told herself not to "'immediately dismiss him verbally or blow him off.' I have to stop my brain and just listen and think differently than I have for a long time about the situation." Additionally, over time Jenifer said she changed her behavior toward her sister from being unsupportive to providing tangible support: "In the beginning I might've just said, 'Do some research,' but I have been more active in that area, in bringing up stuff and asking her questions about changing her lifestyle."

Several participants simultaneously attended to personal, relational, and enacted layers. Such participants seemed to experience the best outcomes of identity gap management. As Horatio said: "I changed, I had to realize that I was wrong." He also described being more attentive to his wife's health needs and that he was "happy to do the job of a husband." However, as many participants reflected, it took years to achieve desired outcomes. Ten years after struggling to "understand how [his step-father] could go through such a profound personality change in a short period of time," Todd accepted his step-father's mental health issues and adopted a caregiving role:

> We spend a lot of time together and we talk a lot, so as far as mapping out his personality, it's pretty much down. I pretty much have it down. He's come back quite a bit. He's just a little different than he was before, but that's going to happen. People change as they get older.

Todd and other interviewees attributed improved relationships to changes in the layers of their identity in response to their identity gaps. As Todd stated: "Well, it's tough for me to say if it's my change in perspective or if it's my engagement of my parents more. But we've all become a lot closer."

Maintaining identity gap(s)

Unlike those who rationalized their identity gaps and felt guilty, some participants were motivated to maintain identity gaps, typically justifying them out of prolonged feelings of resentment, frustration, anger, and fatigue. It was often the case that these interviewees did not have a strong relational identity with which to align their personal and enacted identity layers. Hence, these participants shifted the locus of responsibility to family members, attributing their doubt and identity gaps to the family member's identities. Next, we describe how participants maintained identity gaps by reinscribing negative identities upon family members within the layers of family members' relational identities.

Reinscribing negative relational identities

Family member's poor character. Some participants maintained their identity gaps by ascribing negative character traits to family members (see also Crowley & Miller, 2020). Ascriptions ranged from suspicions and beliefs about malingering and substance abuse to attacks on the family member's character. For example, Jason said his sister's complaints of headaches "went in one ear and out the other" because "She always had all these excuses. 'Oh, the doctor said I could die at any time.' I've never met a drug addict that didn't have an excuse. They blame it all on doctors." Moreover, participants defended their position by labeling family members as "black sheep" (John of his brother), "lazy" (Tom of his girlfriend), and "manipulative" (McKenna of her sister). Participants commonly described family members as being "known to exaggerate stuff and make up stuff" (Jenifer of her sister).

Embedded within many participants' ascriptions were social comparisons that typically characterized the family member as a deviant. Jennifer's doubt about her brother's alleged multiple sclerosis aligned with her perception that she and her family enacted a relational identity to which her brother did not adhere: "We're kind of all social justice people except for him." Instead, her brother was "kind of a selfish non-contributing member of society." She reasoned that alleging a multiple sclerosis diagnosis would be consistent with his penchant for "making stories up." Conversely, Miya doubted her sister's Lyme disease was legitimate, although she did believe her sister had a mental illness underlying her "crazy":

> She's got horrible anger problems, which she's always had, and she got from my father. And then, me and my mom have always gotten along. We're kind of the chill ones and her and my dad were the loud obnoxious ones.

As these examples suggest, participants' perceptions that they and their family members differed in terms of personality, values, and ideals created distance between themselves and their family members. Specifically, ascribing family members as having negative character traits not only justified participants' doubt and doubt responses, but also positioned participants as superior in the relationship. Consequently, as "good" family members, participants' identity gaps were justified; rather, the locus of turmoil associated with identity gaps was located within their family member's "bad" personal identity, effectively casting family members as (un)deserving of participants' support and empathy (Crowley & Miller, 2020; Thompson & Duerringer, 2020).

Family member's failed relational role(s). Some participants maintained identity gaps by pointing to the family member's roles and failures to meet role expectations as reasons why they doubted and responded to the family member's health issues in normatively unsupportive ways (i.e., their own personal-enacted gap). For example, Miya intimated that her sister was not a good mother, sharing her beliefs that her sister was malingering and "taking advantage of being a single mom with two kids" by having their mother care for her sister's children. As another example, Jake described his prior relationship with his cousin as so close that he considered his cousin the closest "brother." However, over the years his cousin's anxiety and depression had "[stopped] him from doing anything." Jake described an interaction made memorable for its disappointment:

> "You were supposed to"—he was trying to teach me guitar and stuff like that and he just wasn't up for it. And kind of almost to the point of being rude. And I was like, "All right man, whatever you can just do you, and I'll hopefully...you come back and we can be friends again." But it just never really happened.

Finally, several spouses described how early unmet relational expectations contributed to a negative shared relational identity that perpetuated identity gaps. For instance, Jes explained how her husband's inability to meet "demands" about "everyday things" in their marriage contributed to her lingering doubt about her husband's digestive issues and stomach pains. She wondered aloud: "'How can you do these other things, but you can't do that applied to the relationship?' So you're not really sick. You're simply trying to get out of something again." Across interviews, some participants described how they did not feel obligated to fulfill expectations in their role(s) or resolve their relational-enacted identity gaps if family members did not fulfill their role expectations.

Negative shared relational history. Finally, participants maintained their identity gaps by citing no or poor shared relational identity as a reason why they were unwilling or unable to change aspects of their own identity. For some, as Miya voiced, the general sentiment was: "We were never that close. We don't really have much in common." Thus,

interviewees perceived efforts to change their identity frames as futile. Other participants acknowledged that family circumstances out of their and their family member's control made it difficult to have a close relationship with their family member that would influence them to feel and act differently. Participants reproduced such negative relations in their talk. For instance, McKenna shared how coming "from a pretty dysfunctional family" continued to affect how the family responded to one another's health needs:

> I think sometimes, the cost of believing someone or focusing on their illness or empathy was to let go of your needs being met somehow. A lot of times in my family of origin. We're not very good at helping each other validate each other.

As this example suggests, and contrary to interviewees motivated to close identity gaps by re-envisioning the relationship, participants such as McKenna characterized their relationships as immutable—negative in the past, present, and likely the future.

Some participants maintained identity gaps over an extended period by placing responsibility for the shared relational identity on the family member; if the relationship was going to improve, then it was up to the family member to change. For instance, FJ maintained he was willing to spend more time with his friend with several mental illnesses provided she attended long-term therapy:

> But I don't want to put the normalcy back into it when I know that she's like three weeks removed from starting new therapy and, I mean, regimented stuff and actually gets that, "Oh man, we're just hanging out and everything's back to normal." I don't want her to just stop all the progress or something like that, you know?

Overall, reinscribing negative relational identities upon family members served to symbolically distance family members from participants and other relatives. It seemed that if participants could not and did not want to change the conflicts among their own identities (e.g., change their beliefs and act more supportively), they needed to shift responsibility to their family member and attribute the turmoil associated with identity gaps to the family member's poor character, the family member's failed relational role(s), and the negative shared relational history between them.

Discussion

This study's purpose was to shed light on the identity implications of uncertainty management, particularly over time as people doubted and started to believe a family member's illness. Our analysis uncovered three identity gaps among interviewees' personal, relational, and enacted identity frames. Interviewees articulated personal-enacted gaps, such as when their self-views (e.g., beliefs about health broadly and how health should be managed) conflicted with how they communicated with their family member about their health (e.g., expressed irritation, "nagging," and dismissiveness). Participants also described relational-enacted gaps, including discrepancies among their ascribed identities, roles, and shared relational identities and their communication with

family members about family members' health. Participants commonly described a gap among all three frames, such as when their self-view conflicted with their family roles, limiting how they expressed their identity in communication with family members' about family members' health.

All three identity gaps involved the enacted layer because, as most interviewees recognized, doubt through dismissal, denial, minimization, or unawareness of family members' health issues are normatively unsupportive communication behaviors (Thompson & Duerringer, 2020; Thompson et al., 2020). As identity gaps represent a form of dissonance that is relatively distressing (Bergquist et al., 2019; Wagner et al., 2016), interviewees shared how they managed their identity gaps by closing them or maintaining them, although many participants engaged in both closing and maintaining identity gaps over the course of their family member's health issues. Granting our findings are consistent with other CTI research illustrating the central influence of relational roles and expectations on individuals' identity gaps and subsequent management of those gaps (Nuru, 2014; Rubinsky, 2021; Stanley & Pitts, 2019), the present study offers a unique perspective on the influence of shared relational identities in identity gap management.

Theoretical and practical implications

From a theoretical perspective, our findings contribute to literature in at least three ways. First, although most CTI research focuses on gaps among one's own identity frames (e.g., one's own personal-enacted identity gap), we found that participants perceived identity gaps between themselves and their family member's identity frames. Some interviewees used these perceived identity differences to manage their own identity gaps, distancing themselves and their family members. Indeed, individuals whose partners had opioid use disorders made similar ascriptions about their partners as our interviewees did about their family members, suggesting that they are "weak, untrustworthy, and lacked the willpower necessary to overcome [their health issues]" (Crowley & Miller, 2020, p. 1647).

Consequently, our second contribution has implications for stigma in families. To the extent that participants continued to emphasize and act upon differences between themselves and their family members, casting the family member as abnormal could stigmatize family members (Crowley & Miller, 2020; Thompson & Parsloe, 2019) as well as justify unsupportive responses to their health issues (Thompson & Duerringer, 2020). Future research may pair stigma management (Meisenbach, 2010) with CTI to elucidate how individuals with doubted health conditions respond to "damaged identities" ascribed to them (Crowley & Miller, 2020), and how stigma management can mitigate the negative effects of such ascriptions.

A third theoretical implication of this study concerns the centrality of shared relational identities on identity gap management. Previous scholars have shown that experiences navigating illnesses such as cancer can shape family members' shared relational identities (e.g., couple identity; Miller & Caughlin, 2013). Our investigation further reveals how existing shared relational identities can shape how people manage emergent identity gaps, depending on the strength of the relationship. When shared relational identities were strong, participants often described aligning their personal and enacted frames with the

shared relational frame. Those with weak or no shared identity often described maintaining their own identity gaps by justifying them and placing the responsibility for identity change on family members. Doing so defended interviewees' refusal to adopt views, conform to relational expectations, and enact communication to which they did not identify.

This study suggests that aligning personal, relational, and enacted identities (i.e., closing identity gaps) may help individuals cope with uncertainty surrounding a family member's illness. Generally, participants described how changing their self-concept and beliefs, communication, and relationship expectations functioned to resolve identity gaps and promoted relational growth and repair. According to CTI research and our study's findings, individuals struggling with doubt and subsequent turmoil should reflect on the interconnectedness of their communication, self-concept, and relational identity, and how inconsistencies among these frames may be contributing to negative consequences for themselves and the relationship (Crowley & Miller, 2020). Interviewees often described long processes of coming to these realizations and the difficulties living with persistent gaps, including emotional leakage (relational-enacted gap), and feelings of inauthenticity in their relationship (personal-enacted gap). Participants often experienced deep regret that they harbored resentment for their family members' health issues they did not fully understand and expressed remorse that they did not act before their family members' health deteriorated. When family members were deceased, interviewees expressed guilt and remorse in ways that suggest that their identity gap management remains incomplete. At the same time, such realizations may necessitate extended time horizons, as identity negotiation amidst illness uncertainty is influenced by other processes, including individual development and illness progression, that can vary and intersect in complex ways (Brashers et al., 2000; Miller & Caughlin, 2013; Thompson et al., 2021).

Communication theory of identity suggests with increased awareness of how various identities can interpenetrate in more or less satisfying ways, individuals should consider how their communicative identity management can be directed toward fostering strong, close relationships (Hecht, 1993). This prescription also aligns with theories of resilience (Afifi et al., 2016; Buzzanell, 2010) and how communication and affirming identities—whether individual or relational—can foster relational environments in which partners turn toward instead of away from one another during times of stress and change (Afifi et al., 2016). Importantly, many participants needed to maintain gaps for self-protection, particularly when relationships were inequitable, harmful, abusive, and even enabling (Crowley & Miller, 2020). Although maintaining identity gaps may be necessary, participants described how such gaps may continue to be sources of stress. As these interviewees recognized, and as previous literature demonstrates (e.g., Thompson et al., 2020), ignoring, dismissing, and denying others' health issues violates normative expectations of support in relationships and (re)produces relational-enacted identity gaps. Individuals who accept these identity gaps are inherent in their relationship may have the added burden of defending their doubt and related communication choices because others in the family or social network may view them as "bad" siblings, spouses, sons or daughters, and the like. Future research may consider the discursive strategies doubters

employ with others to maintain identity gaps, and the effects of this communication work over time (e.g., increased stress and stigma).

Limitations

This study's implications should be considered alongside its limitations. First, we recruited participants through Amazon's Mechanical Turk platform. This procedure allowed us to interview adults across the U.S.; however, individuals on the platform tend to be younger and more educated than the overall U.S. population (Walters et al., 2018). Future research should recruit participants from more diverse sampling pools. A second study limitation concerns its reliance on perspectives of one family member. Collecting data from dyads or multiple family members would expand understanding of how identities are negotiated at different levels within families (i.e., individuals, dyads, and family), particularly given the saliency of shared relational identities in this study. Similarly, a third limitation is we did not collect demographic information about participants' gender identity, sexual orientation, employment, and their own health status. In particular, individuals' identification with illness and disability may influence how they perceive and respond to their family member's health (e.g., Thompson & Parsloe, 2019). Last, we only relied on people's reflections at one data point. A forthcoming study could examine the evolution of identities and identity gap management via interviewing people over time.

Conclusion

This study's findings illustrate the complexity and fluidity of identity negotiation alongside managing chronic illness and chronic illness uncertainty in relationships (Mishel, 1990). Participants described experiencing identity gaps among their personal, relational, and enacted layers of identity, namely, because doubting their family member's health issues and expressing that doubt contradicted their self-views and violated relational expectations. In response, interviewees closed identity gaps and aligned personal, relational, and enacted frames; they also maintained identity gaps by placing responsibility for identity change on family members. This research adds to a rich and growing literature exploring the intersection of identity and health in family relationships over time (e.g., Crowley & Miller, 2020).

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