2022

Identity Negotiations in Family Relationships: Discussing Substance Use Disorder Through the Communication Theory of Identity

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IDENTITY NEGOTIATIONS IN FAMILY RELATIONSHIPS: DISCUSSING SUBSTANCE USE DISORDER THROUGH THE COMMUNICATION THEORY OF IDENTITY

BY

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A thesis submitted in partial fulfillment of the requirements for the

Master of Arts

Major in Communication and Media Studies

South Dakota State University

2022

THESIS ACCEPTANCE PAGE

Sarah-Michele Q. Weaver

This thesis is approved as a creditable and independent investigation by a candidate for the master's degree and is acceptable for meeting the thesis requirements for this degree. Acceptance of this does not imply that the conclusions reached by the candidate are necessarily the conclusions of the major department.

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ACKNOWLEDGEMENTS

I am forever grateful for the people in my life that have made this accomplishment possible. I must first thank my thesis and academic advisor, Dr. Jenn Anderson. You saw potential in me and pushed me to reach it. Thank you for sparking my interest in research and challenging me to be a great scholar. I would not be where I am today without you. To my committee members, Dr. Karla Hunter and Dr. Alper Kayaalp, thank you for your efforts and expertise that made my study stronger. Next, I want to thank Dr. Marina Hendricks, Roxanne Lucchesi, Dr. Katy Kaduto, and Dr. Josh Westwick for allowing me to learn from them. I will always appreciate your mentorship and the opportunities I've had to work with each of you.

I would also like to thank my family for their continued support – I love you all so much. To my parents, thank you for being the foundation of my support system. To my brother, Buck, thank you for being you – you bring so much joy to my life and I'm so proud of you. I would like to express my deepest gratitude to my husband, Chase. Your unconditional love and support motivated me through the most challenging times. This would not be possible without you. Finally, to the friends I have made at SDSU - you have made this experience one to remember. Thank you for the memories.

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ABSTRACT

IDENTITY NEGOTIATIONS IN FAMILY RELATIONSHIPS: DISCUSSING SUBSTANCE USE DISORDER THROUGH THE COMMUNICATION THEORY OF IDENTITY

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Guided by the communication theory of identity (CTI), the current study explores identity negotiations among family members who have experience with substance use disorder. Semi-structured interviews were conducted with 9 participants. Personal-enacted, enacted-relational, and personal-relational identity gaps guide the scope and use of CTI. Findings mirrored 3 major themes in consideration of these identity gaps: (1) participants embraced or rejected SUD as a central aspect of personal identity, (2) participants experienced turbulence in relational identities due to SUD, and (3) personal-relational identity gaps and alignment surface in multiple contexts where interpersonal communication occurs.

CHAPTER 1: INTRODUCTION

According to the National Survey on Drug Use and Health (NSDUH), 20.7 million Americans ages twelve and over battled a substance use disorder in 2017. Of those, 8.5 million suffered co-occurring mental health disorders (American Addiction Centers [AAC], 2021). Although substance use disorder (SUD) is all too common, the rates of seeking recovery are bleak in comparison. Of this population, 4 million (19%) received treatment (AAC, 2021). Seeking treatment and recovery is dependent on whether it is considered necessary or not. Only one million (5.7%) of those who needed yet did not receive treatment truly felt they needed to. Approximately 10% of American adults (18+) claim to be in the process of recovery from an alcohol or drug use disorder. Even when individuals do find themselves in recovery, their success in terms of longevity is minimal. Over 85% of people relapse within one year of treatment (AAC, 2021). One in eight children under the age of 17 lived in a household with at least one parent in active SUD during 2017 (SAMHSA, 2017).

These statistics are alarming but may be partially attributed to the inability to properly cope with and communicate about SUD. An important site of social support and coping is within the family context (Goldsmith, 2004). Therefore, this study will explore the role of family communication in regard to substance use disorder (SUD) management. Identity negotiations between family members (with and without SUD) will be examined through the lens of identity and identity gaps, or "...discrepancies between or among the four frames of identity" (Jung & Hecht, 2004, p. 268). Utilizing Hecht's communication theory of identity (CTI) as a framework will allow for thematic analysis of identity-based messages from family members who have navigated and communicated

through SUD. For ease of the reader, family members *with* SUD will be abbreviated as "FMWSUD." Family members *without* SUD, will be referred to as functional family members, or "FFMs." Communication theory of identity offers direction toward understanding how layered frames of identity are impacted by SUD.

Substance Use Disorder

Terminology. Recovery programs such as Alcoholics Anonymous (AA) use the terminology "alcoholic" and "addict." Program participants claim to benefit from using these terms because their connotations acknowledge the need for a recovery journey (Saitz et al., 2020). Treatment centers offer the potential to unify individuals through their shared identity as "people in recovery" (White, 2012). This does not mean being labeled as an "addict" or "alcoholic" does not feel discouraging (Pickard, 2017). Plus, some argue terms like "addict" or "addiction" are stigmatizing in nature (Saitz et al., 2020; Bos et al., 2013; Pickard, 2017).

The term "substance use disorder" appears among standardized terms and definitions used in the field of psychology. Cataloged in the most recent Diagnostic and Statistical Manual (DSM-V), SUD, and its connotation, reflect a push for a more standardized, medically defined, and unstigmatized set of terms to address this topic. The emphasis on *disordered* use of substances distinguishes it from "dependency" of a substance (Saitz et al., 2020; Pickard, 2017). For example, "chemical dependency" may be used to describe opioid use disorder, but also a prescribed dose of medication intended to balance a medical condition.

Definitions. Not only are there several terms used to describe SUD, there is a long-standing debate surrounding its definition (Heyman, 2013). The fields of medicine,

philosophy, psychology, and communication have studied whether SUD should be defined as a disease, syndrome, or choice (Frank & Nagel, 2017). The American Society of Addiction Medicine's definition states, "addiction is a treatable, chronic medial disease involving complex interactions among brain circuits, genetics, the environment, and individual's life experiences" (ASAM, 2019, para. 1). Even if it takes multiple attempts, most people eventually reach permanent recovery. This is inconsistent if SUD is considered chronic (Frank & Nagel, 2017; Heyman 2013). More accurately then, SUD can be considered a highly treatable disease, and recovery is attainable (AAC, 2021). The World Health Organization (WHO) describes SUD with the words "dependence" and "syndrome" (WHO, 2010). Conversely, others argue SUD is not a disease nor a compulsion beyond conscious control, but instead a disorder of choice (Heyman, 2013).

For the purpose of the current study, the definition of SUD used will be consistent with the Diagnostic and Statistical Manual (DSM-V) which defines SUD as "patterns of symptoms resulting from the use of a substance that you continue to take, despite experiencing problems as a result" (Hartney, 2020, p. 8). This definition is broad enough to account for not only the physical attachment to SUD, but the problematic nature of the behavior as well. For the purpose of investigating diverse experiences, the type of substance will not be narrowed to one. Parameters of this research will consider SUD as destructive drugs (amphetamines, methamphetamines, opioids, etc.) and alcohol. However, this does not include "drugs" like tobacco, nicotine, caffeine, food, or other "addictive" substances that typically do not severely interfere with activities of daily living. This is harmonious with the DSM-V definition, which insists that problems are experienced as a result of the substance misuse (Hartney, 2020).

Approaches to Studying SUD

With several ways to refer to and interpret SUD, it is not a surprise that research to date reflects this. Substance use disorder has primarily been studied in two ways: (1) as a biomedical phenomenon, or physical genetic disease, and (2) as a behavior or choice (Barber, 1994; Hartney, 2020).

The Disease Model of SUD. The disease model has yielded results that amplify the understanding of biological and neural pathways, such as the mesolimbic reward system (Frank & Nagel, 2017). Viewing SUD as a biomedical phenomenon has also assisted medical professionals' success in enhancing the effectiveness of pharmaceuticals. It has especially aided in the treatment of withdrawal symptoms (Frank & Nagel, 2017). Animals are commonly used to study the physical science behind SUD (Frank & Nagel, 2017; Singer et al., 2018; Panlilio & Goldberg, 2007). However, psychological and neural processes that influence behavior are contingent on the environment in which the behavior is studied. Animal behavior does not always translate to human behavior (Singer et al., 2018). Nonetheless, the disease model offers a more demoralized view of SUD and is preferred in medical practice (Frank & Nagel, 2017; Carter et al., 2014). Knowledge of disease processes have also clarified aspects of the behavioral model. Neuroscience research has shown that mechanisms involving choice in active SUD are altered compared to controls (Frank & Nagel, 2017). Animals who are repeatedly exposed to a substance will engage in self-destructive behaviors to regain access to that substance (Frank & Nagel, 2017; Bozarth & Roy, 1985; Panlilio & Goldberg, 2007). Meaning, the physical and mental ties to SUD are arguably equally strong.

The Behavioral Model of SUD. Viewing SUD as a behavior presents its own unique challenges. Critics of this mindset interpret SUD as voluntary and feel that those who partake should be morally responsible for their actions (Frank & Nagel, 2017). Some argue this approach condones those with SUD to avoid responsibility for their actions or criminal charges that result from their behavior (Carter et al., 2014). Such moralization leads to stigmatization, blame, shame, rejection, and other divergent consequences (Frank & Nagel, 2017). Indeed, society deems SUD affected individuals as dirty, dangerous, weak, and uncaring (Corrigan et al., 2009; Crowley & Miller, 2020). To counter these stigmatizations, positive psychology takes a somewhat parallel approach to the behavioral model by offering a "responsibility without blame" framework (Pickard, 2017). This structure cultivates conversations that address personal attitudes and responses by acknowledging the truth about choice and agency in behavior. This is done while avoiding stigma and blame (Pickard, 2017).

Communication researchers (like psychologists) tend to use the behavioral model of SUD simply because behavior is a form of communication (Crowley & Miller, 2020; Duggan et al., 2008; Hecht & Choi, 2012; Horvath & Urban, 2019; Le Poire et al., 2000; Stanley & Pitts, 2019). Researchers who have used qualitative, communication-based methods have gained a well-rounded understanding of SUD (DeJonckheere & Vaughn, 2019; Stahler & Cohen, 2000; Crowley & Miller, 2020; Stanley & Pitts, 2019). Reason being, examining and describing the "social meanings that participants attach to drug use and the social processes by which such meanings are created, reinforced, and reproduced" becomes possible (Neale et al, 2005, p. 1584). Behavioral, qualitative approaches to SUD research have assisted in comprehending the nature of its

epidemiology and the lifestyle associated with its behaviors (Stahler & Cohen, 2000). Advancements such as these strive to fully grasp avenues of SUD related communication within a natural social environment (Brooks, 1994; Stahler & Cohen, 2000)

The Integrated Model of SUD. Genetics and the environment's impact on gene expression are responsible for 40%- 60% of a person's risk for developing SUD (AAC, 2021). Franken (2014, p. 13) argues, "both views of addiction, addiction as substance-centered and person-centered, emphasize addiction as a biomedical disease that is caused either by exposure or genetics." Genetics, a chaotic home environment, abuse, family members with SUD, peer influences, community attitudes, and poor academic achievement are all environmental factors that could increase risk for SUD (AAC, 2021; Menees & Segrin, 2000).

The DSM-V outlines 11 different criteria used to diagnose a person with SUD. Its definition of SUD combines aspects of behavioral implications and physical dependence (Hartney, 2020). Behavioral diagnostic criteria states that one continues to misuse substances, even when it causes problems in relationships. Biomedically, the DSM-V addresses SUD as a diseased state and attests to the development of withdrawal symptoms (Hartney, 2020). Whether SUD is viewed as a biomedical disease or behavior, the argument still stands that it is difficult to separate these two distinctions and not consider one without the other (Franken, 2014).

SUD Recovery

In relation to SUD, the term "recovery capital" can be defined as the sum of resources that a recovering person has to support them in their recovery (Laudet et al., 2006; Milios, 2019). Recovery capital is heavily reliant on the connections to family,

partners, friends, validation of new avenues, and having mentors or advocates (Milios, 2019; Laudet & White, 2008; Laudet et al., 2006). Recovery capital requires social support, which can be defined as the feeling one perceives or experiences when they are valued, cared for, and helped by others (Goldsmith, 2004). Laudet and White (2008) advise that SUD should focus on building social and personal skills such as resilience, coping skills, and increasing self-esteem.

Those who attempt sobriety in an environment that is not conducive to recovery may find themselves in high-risk, unstable situations. This makes successful long-term sobriety seem impossible. (Duggan et al., 2008; LePoire et al., 2000). People, places, or feelings that lead to substance-seeking are factors of a high-risk environment and can increase the chances of relapse (AAC, 2019). A high-risk environment, paired with, or caused by, poor coping strategies, can significantly decrease recovery progress (LePoire et al., 2000). Coping and enabling behaviors are two of the most prominent challenges to supporting family members (Platter & Kelley, 2012).

Challenges to SUD Recovery. Regardless of recovery capital, the journey to sobriety reveals a series of challenging environments within one's personal and professional lives. Inpatient facilities often refuse to admit couples or people who live together (Simmons & McMahon, 2012; Crowley & Miller, 2020). People who struggle with SUD (especially opioid use) face immense adversity. Deteriorated mental and physical well-being, stigma, and limited access to treatment are recurring barriers for many (Bos et al., 2013). These ramifications of recovery prompt high rates of relapse, shame, and employment issues (Sigmon, 2014; Crowley & Miller, 2020). Whether a

person is in active recovery or not, SUD can be one of the most difficult and confusing subjects for families to communicate about.

Family Communication

Defining a family unit can be complex since it is used to describe many different relationships. Its definition does not constrict to only those who are genetically related. Families consist of voluntary and involuntary relationships (Turner & West, 2013). The wide range of characteristics used to describe family have become commonplace as family variability has increased over the years. For example, Sharp & Thomas (2016) studied parent-child relationships in estrangement. Problematic behavior within romantic relationships has also been researched through the lens of family communication (Rhule-Louie & McMahon, 2007; Kennedy-Lightsey et al., 2015). Therefore, these relationships and family dynamics change overtime (Turner & West, 2013; Hughes, 2007). A family is a self-defined group who create and maintain themselves through their own interactions with others (Turner & West, 2013). This study will follow this definition.

Family communication research has been directed in numerous ways, even in relation to SUD. Lee and others (2011) and Horvath & Urban (2019) studied stress-coping morbidity among family members through SUD. Alcohol use disorder is commonly researched and has led to contributions in the following areas: outcomes of family involvement through treatment (McNabb et al., 1989; McCrady et al., 1986), family functioning post-recovery (Osterman & Grubic, 2000), and impact of parental SUD and family environment (Rangarajan & Kelley, 2006; Menees & Segrin, 2000; Domenico & Windle, 1993). Rohrbaugh and others (2012) studied the couple-focused intervention of communal coping in health-compromised smokers. Similarities in

drinking problems among adopted and nonadopted sons of alcoholics have also contributed to knowledge to what we know about children of alcoholics, or COAs (Goodwin et al., 1974).

Family communication concepts and theories provide alternative perspectives of family variability and how family relationships are nurtured (Wadsworth et al., 2008; Kam & Hecht, 2009). Inconsistent nurturing as control theory (INCT) gives insight as to how family members typically assist in their relatives' sobriety and the dynamics of conversations needed for support (Le Poire et al., 2000; Duggan et al., 2008). The concepts of family identification outline attachment and connectedness of a family (Phillips et al., 2018; Scharp & Thomas, 2016). Inconsistent nurturing as control theory and the idea of family identification attest to the inconsistencies (or identity gaps) of enacted behaviors expressed throughout the navigation of SUD.

Generational Patterns of SUD. Nearly 50% of adults have at least one relative that misuses alcohol in the United States (Alcoholism Statistics, 2012; Franken, 2014). The majority of those with alcohol use disorder (AUD) were raised without a father. Children of alcoholics (COAs) have a greater chance of developing a SUD themselves in their adult life. COAs who do not grow up in chaotic home environments are still vulnerable to the onset of SUD. Compared to adopted children whose biological parents did not have AUD, adopted children with biological parents who had AUD are *four times* as likely to misuse substances (Goodwin et al., 1974; Franken, 2014). These startling occurrences may be attributed to the strong link between genetic makeup and a person’s risk of developing SUD. This has been known for decades (Goodwin et al., 1974).

Families experiencing SUD are more likely to endure divorce, unemployment, financial turmoil, and damaged relationships (Menees & Segrin, 2000). Children of alcoholics are considered an at-risk population because of their genetic makeup and dysfunctional family environment, leaving them with a higher chance of experiencing a surplus of family stressors (Biederman et al., 2000). This truth remains into their adulthood. Children in these environments tend to cope with their experiences in ineffective ways. Compared to children of sober parents, COAs participate in more drug and alcohol misuse, have worse depression, agoraphobia, social phobia and generalized anxiety, less behavior control, lower self-esteem, lower scores on tests of verbal ability, and lower academic achievement (Sher et al., 1991; Menees & Segrin, 2000). When children repeat the experience of SUD just as their parents did, the environment consistent with SUD is reinforced (Rangarajan & Kelly, 2006). This becomes a generational pattern.

Communication Theory of Identity

The communication theory of identity has previously been used to research diverse groups of people. Culture (Brooks & Pitts, 2016; Hecht, 1993; Jung & Hecht, 2008; Urban & Orbe, 2010) family relationships (Colaner et al., 2014; Kam & Hecht, 2009; Phillips et al., 2018), romantic relationships (Kennedy-Lightsey et al., 2015; Merrill & Afifi, 2017) education (Brooks & Pitts, 2016; Haugh, 2008; Murray & Kennedy-Lightsey, 2013; Orbe, 2004; Scarduzio & Geist-Martin, 2008; Wadsworth, Hecht, & Jung, 2008), mental health (Jung, 2013; Jung & Hecht, 2004; Jung & Hecht, 2008; Jung, Hecht, & Wadsworth, 2007) race (Warren et al., 2010; Drummond, & Orbe,

2009), and sexuality (Faulkner & Hecht, 2011; Nuru, 2014; Scarduzio & Geist-Martin, 2008) are all topics that have been approached by CTI (Pickel, 2018).

Dyadic examination of SUD related identities has primarily focused on specific relationships such as romantic partners (Merrill & Afifi, 2017; Crowley & Miller, 2020). Crowley & Miller (2020) studied the negotiated exchanges between romantic partners struggling with opioid use disorder through the context of coping. Identity gaps in family relationships, romantic partners, and authority figures have been examined in young adult smokers (Stanley, 2016; Stanley & Pitts, 2019). Communication theory of identity has also been used to analyze the expression of individuals' recovery through Alcoholics Anonymous (Franken, 2014). Identity migrations within living practices, social involvement, and social support, have also been studied (Hughes, 2007).

Identity. Identity has traditionally been examined through the contexts of social roles, group memberships, and personal attributes. It has served as a central construct in social and behavioral sciences. Psychology conceptualizes identity as an aspect of the self and self-concept. It assigns meaning to individuals (Hogg, 1993; Tajfel & Turner, 1979; Jung & Hecht, 2004). This view of identity considers aspects of identity as personal properties. Unfortunately, this has left minimal consideration of its communicative aspects (Hecht, 1993; Jung & Hecht, 2004). New and developing research has shifted its attention to focus on how identity shapes the way messages are produced, enacted, and interpreted (Hecht, 1993; Hecht et al., 2003). In more recent years research has also aimed to connect individuals and society. In order to accomplish this, scholars have focused on the direct relationship between identity and communication (Jung & Hecht, 2004). Before Jung & Hecht (2004) CTI research focused on one frame of identity at a

time. How frames relate to each other was not well articulated or understood prior to this. Thus, research avoided how frames act jointly. Romantic couples, adversity of COAs, and individual identity development through SUD recovery is well represented in the literature. More research needs to focus on the evolution of SUD and family relationships over time. It is common for research to narrow in on one type of SUD (opioids, alcoholism). Less research accounts for multi-substance use or consider support for SUD with varying family identification.

Summary

This study aims to understand the identity negotiations between family members in the presence of SUD. The prevalence of SUD is a critical point of concern. The sections thus far have outlined terminology, definitions, and research approaches tied to SUD. More so, the importance of effective support should not be underestimated. Recovery is challenging and complex. Family support is often at the forefront of successful SUD interventions (Goldsmith, 2004). While this is sought after, generational patterns of SUD source obstacles within family dynamics. FFMs and children experience tribulation at the expense of disruptive environments (Lee et al., 2011; Horvath & Urban, 2019). This can make it difficult to be supportive and communicate effectively.

CHAPTER 2: LITERATURE REVIEW

Chapter two is a literature review that details CTI, its four frames (personal, enacted, relational, communal), identity gaps, and identity pathways. Personal-enacted, personal-relational, and enacted-relational identity gaps will be highlighted in this study. Factors that exacerbate identity gaps such as relational uncertainty, codependency, and enabling exhibit varying levels of relationship functioning and ability to communicate

constructively (Merrill & Afifi, 2017). In addition to the communication theory of identity, the following chapter briefly expands on family identification (Phillips et al., 2018; Scharp & Thomas, 2016), and inconsistent nurturing as control theory (Le Poire et al., 2000; Duggan et al., 2008). These provide alternate ways to interpret avenues of communication satisfaction and identity gaps through family interactions. This chapter also touches on the importance of effective coping strategies such as communal coping. This "we based" approach strengthens relational identities and the notion of social support.

Communication Theory of Identity

Communication theory of identity has a wide scope of application within mutual influences between identity and communication. The theory explains that social relations and roles are internalized by individuals as identities through communication (Jung & Hecht, 2004). As a result, individual identities are acted out as social behavior through the means of communication. Identity is a marker of self-definition (Hecht, 1993). It also mirrors social interactions and relationships through communication (Hecht et al., 2003). Meaning, behavior as it is expressed is a function of identity through communication (Jung & Hecht, 2004).

Communication Satisfaction. A long-standing key outcome and goal of effective communication is communication satisfaction (Spitzberg & Hecht, 1984; Jung & Hecht, 2004). Communication satisfaction can refer to the emotional response when inner standards are reinforced in communication (Hecht, 1993; Jung & Hecht, 2004). Hecht & Hopfer (2010) reached a turning point in CTI's way of thinking about communication satisfaction. By conceptualizing identity as communication rather than seeing identity

simply as a product of communication, people are better able to articulate and set goals towards communication satisfaction (Jung, 2011; Hecht, 1993; Hecht et al., 2003; Jung & Hecht, 2004). In other words, identity is not separate from communication (Braithwaite & Schrodt, 2015). Goals towards communication satisfaction are developed when one can recognize that current communication is ineffective. When frames align, satisfaction is possible. In contrast, dissatisfaction occurs through maladaptive identity gaps (Jung, 2011).

CTI utilizes four frames, or layers, to explain the structure and complexity of identity. These four frames are personal, enacted, relational, and communal (Hecht, 1993). Each frame can be considered a perspective of a whole, holistic, and integrated identity (Jung & Hecht, 2004). The personal identity infiltrates into the enacted, relational, and communal (Jung & Hecht, 2004).

Personal Frame. The personal frame focuses on how people view themselves. Personal identity is an individual's self-concept or self-image (Jung, 2011; Jung & Hecht, 2004; Wadsworth et al., 2008). The individual is the locus, or frame, of identity. It also connects to self-cognitions, self-esteem, and a spiritual sense of being (Jung & Hecht, 2004). Articulation of a personal identity may be communicated as, "I am smart" "I am shy" or "I am competitive" (Hecht & Choi, 2012). While others may influence self-concept, an individual's personal expectations and motivations are found within this frame (Hecht, 1993; Pickel, 2018).

Enacted Frame. The frame of enactment is displayed through messages and represented through behavior. Enacted identity is performed and expressed outward. These acts of identity are exchanged through communication with others. Disclosures and

dialogue within social interactions are not only expressions of identity, but identity itself that becomes part of a relationship (Jung & Hecht, 2004; Hecht, 1993; Wadsworth et al., 2008).

Relational Frame. The relational frame explains how our identity emerges through relations with others (Hecht, 1993; Jung, 2011; Jung & Hecht, 2004). Relational identity is composed of four levels. The first level reveals that humans develop and shape identity by internalizing how others view them. This partially explains why behavior changes in the presence of different individuals or groups (Wadsworth et al., 2008). Individuals negotiate identity by controlling communication with others, based on how they think they are being perceived (Jung & Hecht, 2004; Hecht, 1993; Stanley & Pitts, 2019). Next, people identify themselves through relationships with others. These identities, such as being a spouse, sibling, or friend to someone, constructs a sense of self. Third, identities co-exist with one another as everyone has a unique combination of relationships. For instance, one can be a parent and a spouse, or a teacher and a student. The final level examines how relationships themselves take on identities. A married couple becomes an entity composed of two separate identities. Identity is negotiated and becomes a characteristic of the relationship. The relationship's identity is expressed through communication (Jung & Hecht, 2004).

Communal Frame. Lastly, communal identity is defined by collectives (Jung & Hecht, 2004). This frame highlights identity that is held or formed by groups. It does not account for the individual identities of group members. Group or communal identity is learned by other members of the same group and differentiated by groups that are unrelated (Hecht, 1993; Orbe, 2004; Jung, 2011). Since communal identities operate on a

collective level, a collective level of observation is required to study this frame (Jung & Hecht, 2004).

Interpenetration & Identity Gaps. Frames of identity are examined two, three, or four at a time, but not individually (Hecht, 2004; Wadsworth et al., 2008). Each frame cannot exist solely on its own and provide an accurate description of identity. Frames layer to serve a purpose: to make different aspects of life work together simultaneously and allow for the possibility to adapt within those diverse roles (Braithwaite & Schrodt, 2015). Identity is both fluid and habitual due to the interpenetration of frames. Interpenetration can also be referred to as juxtapositions or mutual interdependence (Jung & Hecht, 2004).

Identity and the four frames outlined in this theory reveal that no part of identity is concrete. Identity as a whole and in different contexts may be interpreted through the concept of layering (Hecht, 1993). Fluidity of identity inevitably causes dialectical interpenetration, or contradiction between frames. Substance use disorder does not allow for sustainable identity satisfaction because it does not play a harmonious role in managing a typical lifestyle. Communication can never be objectively or subjectively perfect. People rarely experience or internalize their interactions with one another in the same way. Therefore, identity gaps will always accompany communication and appear to some degree in all relationships. This is normal but causes distress and tension if not managed effectively (Jung & Hecht, 2004).

If approached correctly, the strain of identity gaps can fortunately be used as leverage to motivate behavior change. Dissonance pushes people to adapt alternative health behaviors (Hecht & Choi, 2012). When an individual's SUD identity creates

extreme tension and disproportion within other areas of their life, identity gaps get to a point where coexisting is no longer manageable (McIntosh and McKeganey, 2000; McIntosh and McKeganey, 2001). It is important to consider that as one identity gap closes, another opens through the formation of a new personal identity (Jung, 2011).

When conceptualizing identity as a means of communication, perhaps it is not the identity itself that is so complex, but the communication required to express it is not efficient. Frames of identity are not equally developed. Positive and negative experiences collectively misalign layers of identity. In turn, attempts to reach identity alignment are found within undesirable dissonance and negative communicative and psychological outcomes (Braithwaite & Schrodt, 2015). These stressors and identity gaps have a unique relationship. Meaning, a stressful event such as divorce may also be considered an identity gap that affects previously cohesively layered parts of identity. Getting a divorce would affect more than just the relational frame of identity. Starting a new job, new relationship, or becoming a parent are much different motivations than experiencing health problems, losing a friend to SUD, overdosing, or being convicted of criminal charges (Waldorf and Biernacki, 1981; Stall and Biernacki, 1986).

Negative outcomes are more severe as identity gaps become larger. Also then, resolving identity gaps emanates productive, positive outcomes (Jung & Hecht, 2004; Jung, 2011). Psychological consequences such as depression and behavioral inconsistencies arise when identity misalignment is left untreated (Jung & Hecht, 2008). Therefore, measuring identity gaps is a good way to indicate the severity of a problem (Jung & Hecht, 2004).

Identity Pathways. The self is integral to our understanding of communication and identity transformation. Having a strong sense of self fuels coping mechanisms for stressors in life (Mann et al., 2004). McIntosh and McKeganey (2000) studied shifts in identity narratives within the process of recovery. Successful recovery requires parts of identity to reposition in order to fit within a non-SUD identity. Over the course of the recovery process, construction of a non-SUD identity provides desirable narratives that aid success. Results provided distinction between three narratives: (1) the individual's sense of self before SUD became a central part of their life, (2) The individual's sense of the person they had become as a result of their SUD, and (3) The individual's sense of the person they aspired to be (McIntosh & McKeganey, 2000).

As narratives for identity provide value and comprehension of self-concept, social identities influence how a relationship gives value to self-concept. There are two distinctive identity-related pathways that lead in and out of SUD (Dingle et al., 2015; Hughes, 2007; McIntosh & McKeganey, 2000). First, identity loss is consistent with the predominantly known progression of SUD identities (McIntosh & McKeganey, 2000). Narratives in the literature traditionally describe the disorder as an identity loss. Individuals who fit this pathway experience a loss of valued identities as a result of SUD. In this light, recovery is a process of identity "redemption." Identity reconstruction shifts from a "SUD identity" to a "recovery identity." Similarly, Hughes (2007) highlighted that one must believe in their ability to become sober and buy into a non-misusing identity. This is consistent with identity repair narratives (McIntosh & McKeganey, 2000). These are later recovered through recovery when participants have the desire to renew their pre-SUD identities (Dingle et al., 2015).

The second pathway, identity gain, reveals further discernment of social identities and motivations behind SUD. Individuals redeem value from new relationships that support the enactment of SUD. SUD identity and behavior is valued due to improved social interaction, belongingness, and communication satisfaction (Dingle et al., 2015). Hughes (2007) addressed the identity gain pathway by advising that, in order to stay on a path of recovery, relationships gained through SUD should be discontinued. Living practices and social involvement among different webs of people must be closely regulated (Hughes, 2007).

Identity Gaps

Since the four frames of identity provide 11 possible combinations of identity gaps, there are numerous ways to study CTI. Personal-enacted and personal-relational gaps were first studied by Jung and Hecht (2004). Since then, these gaps have remained most prevalent in the literature along with enacted-relational gaps (Drummond & Orbe, 2009; Nuru, 2014; Wadsworth et al., 2008; Stanley, 2016; Stanley & Pitts, 2019; Jung, 2011). Personal-enacted identity gaps must be articulated first due to its ability to predict personal-relational and enacted-relational gaps. When personal-enacted identity gaps are present, personal-relational and enacted-relational identity gaps are more likely to emerge alongside (Jung, 2011). Relational identity gaps commonly result from negative communication outcomes consistent with personal-enacted identity gaps. It may take longer for personal-relational identity gaps to emerge as the perception of someone is influenced by enacted behavior (Jung & Hecht, 2004) Enacted-relational gaps appear from communicative identities and have a stronger effect on communication outcomes compared to personal-relational and personal-enacted gaps (Jung, 2011).

This study will address personal-enacted identity gaps due to its predictive nature, but will focus on personal-relational and enacted-relational gaps. Reason being, in order to gain knowledge of family relationships, the relational layer must be a priority. SUD influences and is influenced by relationships and the communication that defines those relationships (Franken, 2014).

Personal-enacted Identity Gaps. A personal-enacted identity gap can be defined as a disconnect or dissonance between self-concept and identities expressed through behavior. For example, enacting the behavior of substance use while not claiming or understanding to have a SUD lays a discrepancy between thoughts and actions. Becoming sober is a drastic change in behavior, but even post recovery, people may view themselves as a person with SUD (Stanley, 2016; Stanley & Pitts, 2019). Other theories have provided parallel ways of viewing the nuances between personal and enacted identities. The "front stage" and "backstage" explain behavior negotiations through self-presentation (Goffman, 1959; Jung & Hecht, 2004; Hecht et al., 1993). Communication Boundary Management Theory implies the separation as disclosed and undisclosed parts of self that contain boundaries between them. Similarly, the Silencing the Self Theory claims expressed and suppressed parts of self (Jack, 1991, 1999; Jung & Hecht, 2004).

Assertive people tend to have smaller personal-enacted identity gaps. This is consistent with the idea of engaged coping, which is done partially through assertiveness (Horvath & Urban, 2019). Communication apprehension creates larger personal-enacted identity gaps (Jung, 2011). Implementing aspects of healthy coping constitutes smaller personal-enacted identity gaps. This is especially important because personal-enacted gaps predict gaps at the relational level (Jung, 2011).

Personal-relational Identity Gaps. Assignments developed in relationships do not always follow the self-concepts of those involved or reflect their role in the relationship at hand. Personal-relational identity gaps occur when an individual's self-concept does not match with other people's perceptions of them, or their relationship to them. The perception each person has about the relationship itself is also an important factor in personal-relational identity gaps (Jung, 2011; Jung & Hecht, 2004; Jung & Hecht, 2008; Kam & Hecht, 2009; Crowley & Miller, 2020).

It is not unusual for an individual's self-view to differ from the ways in which others perceive them (Jung & Hecht, 2004). This becomes a problem for relationships affected by SUD. The discernment of these relationships is most often questioned through turmoil. Functional family members may accuse their relatives of having a SUD, but they argue they are sober. Similarly, those with SUD may be fully aware of their behavior but other people either do not know of their SUD or do not account for it in their assigned identity of that person (Stanley, 2016; Stanley & Pitts, 2019). Ultimately, these mismatched opinions of personal relationships and individual behaviors create tension through several ways.

Uncertainty, Perception, & Involvement. Personal-relational identity gaps occur in light of having doubts or concerns about the other party's level of involvement. Relational uncertainty is associated with negative experiences and adverse relational behaviors (Merrill & Afifi, 2017). Recognizing problems (such as SUD) at varied levels of perception and involvement elicits hindrance in conflict management and the recovery process (Horvath & Urban, 2019). Increased negativity, bias against the other partner,

and topic avoidance are all consequences of personal-relational identity gaps (Merrill & Afifi, 2017; Horvath & Urban, 2019).

Relationships are formed and reformed through continual identity formation. Just as identity evolves in other layers of CTI, relational identities fluctuate overtime and relationships change (Hughes, 2007; Jung & Hecht, 2004). Sharing strong, similar views of relationship identity is important in predicting overall relationship functioning (Merrill & Afifi, 2017). In families, this is essentially family identification (Phillips et al., 2018; Wadsworth et al., 2008; Kam & Hecht, 2009). When "who I think we are" does not match with "who you think we are," a personal-relational identity gap appears. Irregularities in relational standards and expectations link to communication dissatisfaction, decreased partner dependency, and withdrawals from relationships (Merrill & Afifi, 2017; Wadsworth et al., 2008; Kam & Hecht, 2009). This is a supporting argument behind communal coping. If "we-talk" is implemented, issues surrounding personal-relational identity gaps have a platform to productively dissolve (Rohrbaugh et al., 2012; Kennedy-Lightsey et al., 2015). In families, this can become a generational problem. Children of alcoholics are more depressed, less likely to be satisfied with their marriages, and have a higher chance of utilizing alcohol as a coping mechanism (Domenico & Windle, 1993; Menees & Segrin 2000). Other struggles present as the dynamic changes. For instance, young adult smokers reported hiding their SUD because they anticipated and feared their families' disappointment and disapproval (Stanley & Pitts, 2019).

Personal-relational identity gaps appear in the presence of stigma and judgement at the interpersonal level. It is common to experience judgement and stigmatization from

others' presumptions of SUD. Feeling as if a functional family member, friend, or partner is "better than," superior, or judgmental of them damages personal identity. No matter if this judgement is real or assumed, it causes tension between self-concept and the relationships held with others (Stanley & Pitts, 2019).

Romantic couples who reported differing substance-related habits reported labeling and stereotyping toward each other. Relationship quality shifted with varying substance use, such as, people were treated better while attempting and maintaining recovery. When in active SUD, more tension, fights, and name calling occurred (Crowley & Miller, 2020; Duggan et al., 2008). Whereas instances like these hindered dyadic communal coping, others argue their partner's support was crucial to repairing a damaged personal SUD identity. Functional partners affirmed desirable traits that improved feelings of worthlessness. In this case, personal-relational gaps promoted couples to cope with SUD's negative effects on self-esteem (Crowley & Miller, 2020).

Enacted-relational Identity Gaps. Enacted identity is an expressed, communicative behavior, while a relational identity presumes a person's connection to whom they communicate with. Unlike personal identity, these two frames inherently depend on communication (Jung, 2011). Engaging in competent communication about one's self-concept and feeling understood in those conversations link to positive mental health (Kelly, 2000). In turn, barriers to communicating about the self and feeling misunderstood can produce undesired mental health outcomes (Jack, 1999; Jung & Hecht, 2008).

Enacted-relational identity gaps occur when there is a disconnect between a dyad's joint identity and the performance of their identity (Kennedy-Lightsey et al., 2015;

Crowley & Miller, 2020). In efforts to influence perceptions in a variety of relationships, people communicate accordingly. For example, a person may not disclose that they are misusing drugs or alcohol with the intention that others will not perceive them as having SUD. Young adult smokers have admitted to lying about smoking, hiding the behavior, and evaluating others' behavior before disclosing smoking status or enacting the behavior of smoking (Stanley, 2016; Stanley & Pitts, 2019). This inconsistency in appraisal can be recognized by those taking part in the relationship (Jung, 2011). In contrast, this can be fluid and influenced by the immediate environment. Young adult smokers reported identity alignment when in the presence of other smokers and people their age (Stanley, 2016). This puts strain and delay on intervention. In this context, the identity gain pathway reinforces SUD related behavior through certain relationships (Dingle et al., 2015; Hughes, 2007).

The consistency between intended self-presentations and public images is a continual, conscience concern for many (Goffman, 1959; Jung, 2011). Due to these identity gaps, the practice of non-self-disclosure is used to protect self-image and project normalcy (Schrodt & Afifi, 2018). "Patterns of self-disclosure vary across relationships that display differences in definition, including family relationships" (Schrodt & Afifi, 2018, para. 5). One may hide SUD or not address the topic of SUD in their relationships (Dailey & Palomares, 2004). Identity gaps lead to topic avoidance (Jung & Hecht, 2004; Jung & Hecht, 2008; Schrodt & Afifi, 2018). Functional family members also avoid engaging in difficult communication when relational uncertainty is felt. Individuals who feel their partner is not meeting their standards enact avoidance behaviors and lessen their dependence on that partner (Merrill & Afifi, 2017).

For many people with SUD, misuse of substances is a central focal point of relational life. Yet, couples who misuse substances together do not necessarily perceive their use as a representation of who they are as a couple (Crowley & Miller, 2020). So, SUD as an enactment can be inconsistent with a perceived relational identity. As far as defining relationship identity, some couples did not feel that substance abuse was a contributor. Dyads chose to define their relationship based on positive aspects outside of SUD. In this sense, the role and severity of SUD is downplayed. In contrast, the strength of a romantic relationship can be consistently irritated by substance withdrawals. Withdrawals cause individuals to become aggressive and irritable. These withdrawal induced behaviors struggle to fit within an ideal relational identity (Crowley & Miller, 2020). While some minimize the role of SUD within relationships, others revealed that consistent SUD behavior highlights the correlation between substance misuse and relational identity. Being that, recognizing heavy substance misuse can act as an unfortunate reminder of the inability to cope and reach recovery (Phillips et al., 2018). Repeating relapses are a discouraging and disappointing endeavor for people with SUD and their supporting functional family members.

Identity transformation and relational repair have better outcomes when social support is enacted by sober parties (Milios, 2019; Platter & Kelley, 2012). If change is required for relational-identity repair, those participating in the relationship must be present so that a person attempting recovery can prove what they can and are willing to do in the context of the support they have (Hughes, 2007).

Codependency & Enabling. Inconsistent nurturing as control theory brings clarity to what can be considered a pivotal dynamic of enacted-relational identity gaps (Duggan

et al., 2008; Le Poire et al., 2000). Negotiations and communication patterns that embrace, repair, or resist SUD-related identities manifest in many variations. A typical relational dynamic presents competing goals to nurture the relationship (Duggan et al., 2008; Le Poire et al., 2000). This nurturing can either reinforce or discourage SUD related behavior (Crowley & Miller, 2020).

Co-dependent relationships are defined as a dyad in which one member is burdened with SUD while the other is identified as the functional partner (Duggan et al., 2008). At first, the functional member may gain satisfaction and enjoyment from being a caretaker. After a while, the non-functional member with SUD assumes a comfortable role in receiving this treatment and has more control than the functional partner. Control is regained through sacrifice and submission (Duggan et al., 2008). This causes strain on the functional partner and abstaining from further care becomes best practice (Horvath & Urban, 2019). An identity gap appears as a result of tolerant-inactive coping by the functional partner. Functional partners endure self-sacrificial behaviors by intermittently communicating reinforcement and punishment (Horvath & Urban, 2019; Lee et al., 2011). Imbalance of nurturing results in ineffective, unclear communication patterns that reinforce undesired SUD related behaviors (Le Poire et al., 2000; Duggan et al., 2008; Franken, 2014).

Family Identification

According to Phillips and others, “Families serve as a relational culture with unique communicative behavioral, and attitudinal dimensions that are key for the socialization and development- or hindrance- of individual, relational, and psychosocial outcomes for family members” (2018, p. 2). The degree and direction of family influence

is dependent on the perception of family identification, or, the extent to which one feels a sense of connection with their family group (Phillips et al., 2018).

Family identification is a factor in altering relational identity gaps and improving familial relationships. For example, when family identification is low, it does not buffer or improve the negative effect of relational identity gaps. A high family identification intensifies the negative effects of identity gaps (Phillips et al., 2018). Identity gaps have been tied to several negative individual and relational effects, including family relationships. So, when family identification is damaged and identity gaps are present, members are less inclined to nurture familial relationships in the future (Wadsworth et al., 2008; Kam & Hecht, 2009). People who gain and reinforce relational identities through SUD may deplete family identification due to the new, valued relationships found outside the family (Dingle et al., 2015; McIntosh & McKeganey, 2000; Hughes, 2007).

Transforming identities, including family identities, are socio-historically bound (Hughes, 2007). Families are constantly compared to other families (Phillips et al., 2018). This is something to consider, especially in rural areas. When a family does not conform to society's expectations, they struggle to navigate what it means to be a “good” family and question what is effective for the family unit (Phillips et al., 2018). Communal identity gaps may be shared among families and stunt motivation to seek treatment.

A lack of family identification may serve as a benefit for those who belong to families with high rates of SUD (Scharp & Thomas, 2016). Family support is not an ideal addition to recovery capital in all situations. If the family dynamics are not conducive to SUD recovery, social support needs to be sourced elsewhere. Family members who

experience SUD together can pose a risk and benefit as far as being a source of support. Substance use disorder is often introduced and reinforced by people we are close with (Rhule-Louie & McMahon, 2007; Scharp & Thomas, 2016; Crowley & Miller, 2020; Hughes, 2007). Substance use disorders and the coping mechanisms used to mediate them provide many avenues that lead to disrupted family dynamics and relationships (Platter & Kelley, 2012).

Coping

When looking at SUD, family relationships, and identity, it is important to examine how one's actions affect the identities of those around them. Substance-related problems cause chronic stress for relatives, putting a significant strain on their psychological well-being. Functional family members, compared to controls, experience more severe depression, stress, and psychiatric morbidity (Lee et al., 2011). According to the stress-strain-coping-support (SSCS) model, relatives respond to high amounts of stress with varying coping styles that can be divided into three categories: engaged, tolerant-inactive, and withdrawal coping (Lee et al., 2011; Horvath & Urban, 2019). Engaged coping entails an attempt to control and protect family structure with assertiveness, support, or emotional reactions. Tolerant-inactive coping promotes acts of self-sacrificing behavior on behalf of the person with SUD's benefit through acceptance or support of the disorder. Lastly, withdrawal coping is carried out through focusing on individual needs while distancing away from FMWSUD (Horvath & Urban, 2019).

Communal coping is an adaptive and effective way to alleviate ineffective coping styles and take a family-based approach to SUD management. Communal coping can be considered a dyadic process that involves categorizing a stressor, such as a chronic health

condition, as “our” problem in contrast to “yours” or “mine” (Lyons et al., 1998; Rohrbaugh et al., 2012). This strategy is only effective when a dyad’s sensemaking and problem-solving actions facilitate outcomes that adapt to each party. When adaptability is accounted for and coping strategies promote flexibility, successful outcomes are more likely (Kato, 2012).

“We-talk” or, a “we” based approach to treatment is an indicator of successful cessation outcomes (Rohrbaugh et al., 2012). Communal coping needs to be studied across different dyad-focused interventions. This is challenging to conceptualize because each individual and relationship has unique problems. In married couples, identity gaps affect relationship satisfaction and dynamics of public performances (Kennedy-Lightsey et al., 2015). There is a lack of “we-talk” and communal coping literature in the context of family relationships (cousins, siblings, grandparents, parents, aunts, uncles, etc.) as they all communicate differently than romantic partners.

A functional family member’s support is extremely desirable for successful intervention, as there are promising ties between adequate social support and successful SUD recovery (Goldsmith, 2004). Greater family involvement in SUD treatment has been associated with substance abstinence, better relationships, and positive feelings about self (McCrady et al., 1986; McNabb et al., 1989; LePoire et al., 2000). Distancing oneself from another’s SUD is an adaptive response, commonly done when control over a stressful event is lost. Those who distance away from another’s SUD may be doing so as an act of self-care (Platter & Kelley, 2012).

Summary

For families to achieve communication satisfaction, identity gain and loss pathways need to be mediated (McIntosh & McKeganey, 2000; Dingle et al., 2015; Hughes, 2007). FMWSUD misalign personal and relational identities throughout the course of SUD (Hughes, 2007; Dingle et al., 2015). They also gain relational identities through enacting SUD related behaviors with others (Merrill & Afifi, 2017). This presents its own unique challenges as the drastically varied relational identity gaps are no longer deemed as manageable.

Family members and couples who co-exist in the same household have significant influence on one another's behavior. As a result, they experience excessive barriers within their daily life and communication (Simmons & McMahon, 2012; Crowley & Miller, 2020). Families also experience a separation or distance from their community as they tackle the unique issue of SUD. This can lead to shared communal gaps and prevent family focused prevention from happening in locally sourced areas (Bos et al., 2013; Crowley & Miller, 2020).

Social support is needed with the consideration of effective coping strategies. Communal coping is preferable in order to ensure that social support is in place and that identity gaps can be recognized and managed in an effective way (Lyons et al., 1998; Rohrbaugh et al., 2012). By examining the personal-relational and enacted-relational identity gaps, we can further articulate how a family maintains their relationships through the experience of SUD and address the coping required to do so. The complicated and overlapping dynamics of family communication patterns, family identification, coping styles, and risk factors intertwine through identity gaps.

FFMs play a crucial role in how identity repair, recovery, and relational mediation come together (Goldsmith, 2004). They also walk a fine line between enabling and helping through the enactment of inconsistent nurturing (Platter & Kelley, 2012; Le Poire et al., 2000; Duggan et al., 2008). Identity gaps appear through stigma reinforcement, damaged identities, ineffective coping, enabling, and codependency (Bos et al., 2013; Menees & Segrin, 2000; Lyons et al., 1998; Rohrbaugh et al., 2012).

The literature has depicted relational identity gaps through varied levels of involvement, coping, and support. Identity pathways in and out of SUD highlight the flaws and strengths of negotiating this involvement, coping, and support. Each family is unique, so baseline communication of shared relational identities varies in the levels of conversation orientation, conformity orientation, family identification, and nurturing.

The current study has been designed with the intent of investigating how family members manage their relationships in the context of SUD. More specifically, it aims to make connections between personal, enacted, and relational identities. Since personal-enacted identity gaps predict gaps at the relational level (Jung, 2011), regard for personal identity was embedded into the research question. In most cases, personal-relational and enacted-relational identity gaps occur in family relationships simultaneously. Identity gaps of similar nature may appear through dramatically different communication. Therefore, I present the following research question as a means of guiding this study.

> RQ: How do family members (with and without SUD) perceive, enact, and negotiate their personal and relational identities as they navigate the presence of SUD within their family?

CHAPTER 3: METHODOLOGY

The following chapter outlines the study's methodology. It provides an explanation of recruitment, the sample, procedures, and compensation. Confidentiality and validity are also clarified. Finally, data was translated through six steps of thematic analysis (Nowell et al.,2017).

Recruitment

After receiving IRB approval in August 2021, I began to recruit participants in three main ways. First, I reached out to the Freedom Inn His Grace Ministry via email. This is a Christian ministry that provides up to eighteen months of transitional housing and comprehensive programming for those experiencing SUD. Secondly, I utilized social media platforms including Facebook, Twitter, Instagram, and Snapchat. These posts included my contact information so that potential participants could easily and confidentially inquire about the study. Third, I promoted recruitment through word of mouth and snowball sampling. Snowball sampling was critical in the success of recruitment.

I had an original goal to interview ten participants. There were nine participants in this study. I was able to reach saturation with this sample size. Participants were compensated with a $30.00 e-gift card to their choice of Amazon or Walmart. This was sent via email. All participants chose an Amazon gift card. It is possible that Amazon was preferred over Walmart due to the compensation being in a digital, paperless format, which is more consistent with purchasing methods of Amazon.

Sample

In addition to age and gender, qualifying participants self-disclosed that they met one or both of the following criteria: (1) is or was a FMWSUD (2) is or was a FFM. Four participants were FFMs, and five participants were FMWSUD. No participants were in active SUD. All five FMWSUD had reached full recovery. An interesting characteristic of these five participants lies in the fact that they also possessed the identity of a FFM. Therefore, all nine participants share the experience of being a FFM.

Criteria was not limited to the type of family relationship (such as parent-child). By welcoming all family perspectives, the results were able to expose multifaceted identity negotiations amongst multiple generations, and within both immediate and extended families. Participants spoke about the following shared relational identities: parent-child, grandparent-grandchild, sibling-sibling, aunt/uncle-niece/nephew, husband-wife, and boyfriend-girlfriend. To qualify for an interview, individuals had to be 18 years of age or older. Ages ranged from 20-60 years old, and the average age was 38. Gender of participants was imbalanced, totaling 7 females and 2 males. Table one organizes these characteristics of the sample.

Table 1
Participant Characteristics

Name of participant	**Gender**	**Age**	**Qualifying criteria for participating**	**Additional family members and their relationship to participant**
Mike*	M	48	FFM FMWSUD (has recovered)	Jennifer (daughter)
Jennifer*	F	20	FFM	Mike (father)
Emily	F	60	FFM FMWSUD (has recovered)	Lucas (stepson)
Lilly	F	21	FFM	Olivia (aunt) David (father)
Sophia	F	23	FFM	Noah (brother) John (father)
Alice**	F	34	FFM FMWSUD (has recovered)	Thomas (husband) Ava (sister) Kyle (nephew/ Ava's son)
Thomas**	M	34	FFM FMWSUD (has recovered)	Judy (mother)
Kayla	F	49	FFM FMWSUD (has recovered)	
Brooke	F	50	FFM	Ben (husband) Dylan (brother) Jesse (brother) Gloria (sister) Henry (father)

Note. *Mike and Jennifer interviewed as a pair (father-daughter)
**Thomas and Alice interviewed as a pair (husband-wife)

Procedures

Participants participated in semi-structured interviews that averaged 36 minutes in length. Semi-structured interviews are the most common method of qualitative data collection within the field of health services research (DeJonckheere & Vaughn, 2019). Participants had the option to interview alone or with 1-2 additional family members. No interviews held three or more participants. Out of nine participants, five interviewed individually, and the remaining four interviewed in pairs of two. Length fluctuated since interviews were conducted both individually and in pairs. Each participant was only interviewed once, regardless of if they interviewed alone or with another family member. Through acknowledging variances within qualifying criteria (being a FFM vs FMWSUD) and 1-3 person interviews, three versions of the interview protocol were created. Interview protocol A was intended for FFMs, interview protocol B was intended for FMWSUD, and interview protocol C was catered to interview 2-3 participants at once, regardless of their qualifying criteria.

Regardless of these considerations, there was still overlap in which interview protocols applied. Those who met both criteria of being a FFM and FMWSUD technically could have used interview protocol A or B. In these cases, interview protocol B was used to account for their direct experiences of having SUD. To combat this, I diligently asked follow-up questions that addressed their experiences as both a FMWSUD and FFM. Participants who met both criteria *and* interviewed in pairs responded to all questions from interview protocol C.

Participants chose between virtual and in-person interviews. Zoom was used to record and transcribe data collection. The location of in-person interviews was decided

by participants and took place in both their homes and public places. Giving the option to participate through remote interviewing provides a couple advantages. Due to the sensitivity of the topic, some participants expressed feeling more comfortable speaking from home. In our current days of COVID-19, this ensured accessible and safe participation. Virtual interviews geographically expanded the pool of potential participants by eliminating the barriers of travel and physical location. Additionally, I was able to conduct a two-person interview with one participant in-person, and the other on Zoom. Out of nine participants, five chose virtual Zoom interviews. Considering this is a hard-to-reach population and difficult subject to discuss, this eased recruitment efforts.

Confidentiality

Each participant obtained a copy of, and signed, an informed consent form prior to participating. A short QuestionPro survey was distributed before interviews. It asked questions about basic demographics (name, age, gender), qualifying criteria, and contact information. This also confirmed the email address in which compensation was received.

I took precautions to protect participant confidentiality. Interviews were held in a private space. I am the only one with access to interview recordings, notes, and transcripts. All personal identifiers were omitted from the study and switched with an alias name. Results were reported in such a way that cannot be traced back to individual participants.

Validity

In qualitative research, it is common for the researcher to act as both the data collector and analyst. This poses a higher risk for bias (Miles & Huberman, 1994). Since

I embodied both of these roles, validity was prioritized in a number of ways. While conducting thematic analysis I diligently separated my own experiences from results in order to present objectively neutral results (Miles & Huberman, 1994). Internal validity was reached through the process of member checking (Birt, et al., 2016). Participants were asked to validate the correctness of my interpretations.

Data Analysis

This study followed thematic analysis to review interview transcripts. Thematic analysis can be used for a range of subjects and research questions (Nowell et al., 2017). It is a useful method for examining similarities and differences among research participants (Braun & Clarke, 2006; Nowell et al., 2017). Themes are not valued by quantifiable measures, but instead depend on whether they capture importance related to the research questions (Braun & Clarke, 2006). Working with a smaller sample size allowed for deeper examination of the family experience. Due to the complexity of it, a larger sample size may have been inhibiting towards the goal of discovering these themes organically.

Nowell and others (2017) developed six phases of thematic analysis: (1) familiarize yourself with the data (2) generate initial codes (3) search for themes (4) review themes (5) define and name themes, and (6) produce the report. To follow this process, I listened and re-listened to audio recordings. As I listened, I made notes and highlighted quotes in a separate document. Next, I grouped quotes and the associated findings of them to generate initial codes. My search for themes began through these groupings. At first it was difficult to categorize themes that were consistent with CTI. Consequently, my review of themes became organized topically, rather than theoretically.

To give an example, a few of my initial themes read as: *sympathy and empathy, generational patterns, caregiver roles, romantic partners, risk for relapse, etc.* Topical findings revealed specific contexts where identity was negotiated, but not how. While I had originally thought of this as a setback, it proved to be a necessary scaffolding in revealing patterns of identity. I translated data to meet the needs of CTI's framework with the mindset of, "*how do these categories involve the personal, relational, and enacted frames of identity?"* Thematic analysis revealed three main themes that parallel each of the three identity gaps highlighted in chapter two (personal-enacted, personal-relational, and enacted-relational). The following chapter presents the results of this process.

CHAPTER 4: RESULTS

Overview of Themes

Chapter four is structured by three major themes. Theme one emerged from participants embracing or rejecting SUD as a central aspect of their personal identity. Personal-enacted identity gaps were developed through one's connection to SUD, and the decision to embrace or reject it. Theme two found that participants experienced turbulence in relational identities due to SUD. Quality and quantity of communication was greatly impacted, but not always dependent on, levels of sobriety. SUD ultimately influenced the relationships both FFMs and FMWSUD's chose to maintain. Family members struggled to reach communication satisfaction due to the enacted barriers of enabling, topic avoidance, lying, and deception. Finally, these challenges often lead to disruptions in family responsibilities and roles. Theme three states that personal-relational identity gaps surface in multiple contexts where interpersonal communication occurs. Perceptiveness of the relationship, each other, and oneself ultimately develop

from the personal negotiations outlined in theme 1, and the relational experiences associated with SUD in theme 2. Therefore, there is much overlap in this theme as it articulates motivations behind enactment, and the personal reservations that take place along with it. Results further enhance the understanding of personal-enacted, personal-relational, and enacted-relational identity negotiations. For ease of the reader, the research question has been restated below:

> RQ: How do family members (with and without SUD) perceive, enact, and negotiate their personal and relational identities as they navigate the presence of SUD within their family?

Theme 1: Participants embraced or rejected SUD as a central aspect of personal identity.

Personal negotiations provide structure for all forms of relational communication (Jung & Hecht, 2004). Personal identity was developed through family experiences and generational involvement with SUD. This further supports that personal-enacted identity gaps predict and cause gaps on relational levels (Jung, 2011). When one member of the family changes their behavior, this affects the family dynamic (Lander et al., 2013). Theme one observes personal-enacted identity through the following subthemes: (1) involvement with SUD (2) rejecting SUD, and (3) embracing SUD. Due to the invasiveness of SUD, individuals were faced with the decision to accept or reject it from their personal identity in order to reach identity alignment (Dingle et al., 2015).

Personal-enacted identity gaps and alignment occur due to one's personal involvement with SUD. In the presence of SUD, participants subsequently embraced or rejected SUD as a central aspect of personal identity. For both FMWSUDs and FFMs,

motivations and reasoning behind each identity pathway varied. SUD's involvement with personal identity inevitably stemmed from the generational patterns that arise in this context. "*It goes back generations*" (Kayla). Family communication patterns are highly connected to how personal identity is intrinsically and extrinsically developed (Schrodt et al., 2008; Rangarajan & Kelley, 2006).

Brooke's brother Jesse, "*was definitely just like my dad, cut from the same cloth.*" Individuals who belong to families with high rates of SUD are more likely to develop the disorder themselves (Biederman et al., 2000). Additionally, even though FFMs reject the enactment of SUD, they still have affiliations with it due to their family environment. This directly affects personal identity and self-esteem (Rangarajan & Kelley, 2006). *"It kind of messes you up when you're younger*" (Sophia).

All participants reported having more than one person in their family with SUD. "*Both mom and dad did it*" (Jennifer). Sophia, Thomas, Alice, Brooke, Jennifer, Lilly, and Kayla report having adult relatives with SUD during their childhood. "*I blame a lot on my dad for leaving us when we were young*" (Brooke). While genetics are a factor (Goodwin et al., 1974), families may experience generational cycles of maladaptive SUD management due to adverse behaviors that are enacted, modeled, and reinforced through communication (Domenico & Windle, 1993; Menees & Segrin 2000).

Kayla's mom, "*grew up in an abusive and unstable home.*" Poor inhibitory control and parenting processes (such as ineffective discipline) impact the development of personal identity and characteristics of temperament (Pears et al., 2007). "*A doctor would tell you I was born to be an alcoholic, it's in both sides of my family"* (Kayla). These generational patterns of SUD have consequences on relational roles, personal

identity, dynamics of family interaction, and paint a complex picture. Kayla is starting to see the generation under her develop similar habits, *"I now have adult children questioning their own addiction issues."*

Individuals found themselves in a position where SUD was not embraced, nor rejected, but involuntarily attached to their identity. Kayla wishes people knew that, *"These people are people. They are not the disease; they are separate from the disease. There are real people inside there screaming to get out.*" For FMWSUD, the personal identity became overwhelmed by the addictive nature it presents. "*It consumed me for a long time*" (Mike). In turn, this intensified the personal-enacted identity gap that is SUD, and negatively impacted regard for self and decision making (Chen et al., 2020). "*I didn't really care that I put myself in dangerous situations*" (Kayla). Personal expectations and motivation stem from the personal identity (Hecht, 1993; Pickel, 2018).

By virtue of the overwhelming hold that SUD has, outside sources often must disrupt this pattern in order to induce any sort of improvement. "*If it's continued active addition and nothing is changing, there's going to have to be another impact from someplace else*" (Emily). This outlines why FMWSUD must fully buy into rejecting their SUD identity (Hughes, 2007).

Even after recovery, FMWSUD reported lingering negative self-views. "*I look at myself differently after the things that I've done after being addicted to certain things*" (Thomas). It is common for those in this position to report feelings of guilt and shame (Snoek et al., 2021). For FFMs, personal-enacted identity gaps surface due to displaying vastly different versions of identity to various outlets of their life. This becomes damaging to the view and function of self. "*It affects your finances, work life,*

relationships with other people, and you start becoming very isolated. I'm this professional person at work, but yet, at home I've got this sick thing going on. You just feel crazy when you're trying to maintain yourself, and it starts to erode you" (Emily).

Personal-enacted identity gaps and alignment occur by rejecting SUD as a central aspect of personal identity. By bearing witness to the SUD, FFMs warrant the negotiation between accepting the presence of SUD in their family environment, while rejecting it on a personal level. FFMs articulate their own identification away from it with the consideration of what they are willing and not willing to repeat. "It *showed me what I don't want to do and what I don't want to get into*" (Jennifer). FFMs reinforced their personal and enacted identities by evolving strong feelings against SUD. "*I will not touch any pills, and I am very cautious around people that do that*" (Lilly). These identity affirmations are helpful in shaping personal boundaries and avoiding generational patterns of SUD. "*It's taught me a lot of lessons and the person that I don't want to become*" (Thomas). However, we must consider that while rejecting SUD is obviously beneficial for FFMs, some participants unfortunately reach this conclusion out of fear or resentment. Sophia's brother, Noah, "*will not drink, he's super afraid of the consequences.*" Jennifer "*never wanted to become a heavy drinker and start to like it.*" As a couple, Alice says that, "*we wanted to be better, we didn't want to become our parents.*" FMWSUD also found rejecting that identity to be valuable. "*That's not really who I wanted to be or what I wanted to do*" (Emily).

Personal-enacted identity gaps and alignment occur by embracing SUD as a central aspect of personal identity. Some FMWSUD found embracing SUD as part of their personal identity holistic for their recovery. Thus, considering SUD as part of

identity, yet not enacting it, is a demonstration of a personal-enacted identity gap. Ironically, this identity-gap mirrors the opposite of an individual in active SUD. When in active SUD, the personal identity usually rejects SUD with dissonance, yet enacts behaviors that do not align with self. *"It's important to make sure it's somewhere in my view because if I forget about it, I may lose my recovery"* (Kayla). In this way, identity gaps are shown to flip in order to gain identity alignment, but not necessarily close. Even after 20 years of recovery, Kayla explains, *"It's part of my recovery, remembering that it is something that could potentially kill me."* While the enactment of SUD remains dormant, viewing oneself as a person with SUD post recovery is a way of controlling the personal-enacted identity gap that *is and was* SUD. "*I have an addiction forever, but it's going great, and I don't have cravings*" (Mike). Storing an SUD identity could be beneficial because through recovery, individuals take control of that aspect of themselves. When impaired, the personal identity suffers cognitively. "*I don't remember any of it, that's the sick part.*" (Mike). The psychological consequence of removing it from the personal identity would be to remove self-control over it. "*Now that I have everything under control, I don't feel one bit of pressure from it*" (Mike). Thomas stated that it "*100% defines the person that I am*" (Thomas).

Theme 2: Participants experienced turbulence in relational identities due to SUD.

Enacted-relational identity gaps and alignment were articulated through the fluctuations of (1) the connectedness of the relationship (2) family roles and responsibilities, and (3) ineffective methods of identity management. Families experienced and avoided turbulence for varying periods of time. This caused family

communication patterns to change considering relational behaviors and individual well-being (Schrodt et al., 2008).

Family members resorted to managing their interactions with enabling, topic avoidance, lying, and deception. Motivations behind utilizing these barriers of communication stem from relational uncertainty and the desire to maintain communication satisfaction (Golish, 2000). Avoiding the discussion about SUD further worsened enacted-relational identity gaps (Caughlin & Afifi, 2004; Schrodt & Afifi, 2018). Even when SUD was addressed, the productivity of those conversations was heavily weighted by lying and deception (Mahon, 2016; Stanley & Pitts, 2019).

Inconsistent enactment and nurturing of relationships originated from fluctuations in relational connectedness and sobriety (Duggan et al., 2008; Le Poire et al., 2000). FFMs who addressed SUD with tolerant-inactive coping strategies, such as enabling, experienced enacted-relational identity gaps by simultaneously reinforcing and discouraging their relative's SUD (Horvath & Urban, 2019; Lee et al., 2011). Relationship functioning is known to vary due to enabling, ability to communicate, and codependent tendencies (Merrill & Afifi, 2017).

Turbulence stemmed from imbalances in family roles and responsibilities. FFMs took on additional caretaker roles as FMWSUD neglected them. These fluctuations in performance and expectations between shared relational identities forcibly created enacted relational identity gaps (Kennedy-Lightsey et al., 2015; Crowley & Miller, 2020).

Participants found identity alignment within relationships that followed their desired affiliation of accepting or rejecting SUD. Ultimately, one's personal view of SUD

impacts what is considered available for social support and influences the relationships we seek and maintain (Stanley, 2016). Despite the challenges, participants reiterated that family support is critical for successful intervention and identity alignment (Goldsmith, 2004). The connections between social involvement and SUD confirm that relationships among different aspects of a FMWSUD's life are closely interconnected in composing enacted identity (Hughes, 2007).

Enacted-relational identity gaps and alignment occur by fluctuations in the connectedness of family relationships. There are parallel fluctuations between the quality of family relationships and sobriety (Osterman & Grubic, 2000). "*I wish my brother Dylan was clean, I feel like we were closer when he was*" (Brooke). Participants indicated that SUD was a prominent factor in the productivity and frequency of communication. "*With the drinking and stuff, we definitely grew apart a little bit*" (Sophia). Mike reports a "*major*" change in the way his family interacted with him. "*It was bad, it was just the drinking that caused that*" (Mike). FFMS and FMWSUD both recall having the inability to sustain a healthy relationship when SUD is present. "*I just basically pushed everybody away for a long time, but everybody came back*" (Mike).

Regardless of a FMWSUD's level of sobriety, the damages these relationships face can cause them to disconnect for extended periods of time (Caughlin & Afifi, 2004). Enacted-relational identity gaps are created and sustained by avoiding interaction all together. This translates as a form of withdrawal coping (Horvath & Urban, 2019). Brooke has gone six months without talking to Gloria, Thomas' immediate family did not speak to Judy for five years, and Sophia did not see her dad for a year. "*Dealing with the dysfunction in my family meant, for a long time, I kept my distance. But I did miss my*

family" (Brooke). Enacted-relational identity gaps surface when family members feel the loss of discontinued interactions, making it difficult for relationships to repair, or in some cases, begin. Referring to her younger sister, "*Our relationship didn't start 'till after I got sober*" (Kayla).

Successful SUD recovery alleviated enacted-relational identity gaps. "*Since my mother and my sister have moved away from certain things, I do believe our relationship has gotten better and we communicate better*" (Alice). By rejecting SUD identity and improving personal and enacted identities, FMWSUD are further capable of restoring relational identity gaps (McIntosh & McKeganey, 2000). "*I've made amends with all of my family members*" (Kayla).

Sobriety does not guarantee the improvement of damaged relationships, "*He wasn't there for the first 13 years of my life because of drugs, and he's not here now, even though he's not on drugs, so the communication still isn't there*" (Thomas). Enacted-relational identity gaps can remain unchanged despite recovery. Olivia is now sober, and yet Lilly and her family, "*haven't talked to her in years.*" Damages led by SUD fabricate into patterns of relational stagnation and the unwillingness to repair it (Wadsworth et al., 2008; Kam & Hecht, 2009). When asked about her and Olivia's relationship, Lilly stated, "*we don't have one."*

As outlined in theme one, individuals found tension and alignment when faced with the decision to embrace or reject SUD. The same patterns of tension and alignment occurred within the context of relationships, which changed avenues and effectiveness of social support (Rhule-Louie & McMahon, 2007; Scharp & Thomas, 2016; Crowley & Miller, 2020; Hughes, 2007). Both FFMS and FMWSUD report seeking and maintaining

relationships that align with their existing or desired affiliations with SUD (Goldsmith, 2004). In this way, SUD influences the relationships (both romantic and non-romantic) that individuals seek by providing a reason for sustaining that relationship.

Romantic and non-romantic relationships serve as important outlets for support and SUD recovery (Crowley & Miller, 2020; Goldsmith, 2004). Inversely then, these relationships have the power to produce equally negative influences and delays toward recovery (Dingle et al., 2015). When SUD is expressed comfortably it becomes an aligned and shared enactment between a shared relational identity (Stanley, 2016). "*You connect in unhealthy way*s" (Emily). Dylan's girlfriend has SUD and encourages his relapse. Due to the relationships gained through SUD, there is a resistance to recovery and the discontinuing of these relationships. *"It ruined some of my enjoyment because I enjoyed going out and hanging out with people, but I just don't anymore, new playgrounds*" (Mike).

Individuals may choose to discontinue a relationship in order to begin or continue recovery. "We *got divorced because he couldn't quit drinking and kept bringing alcohol into the home*" (Kayla). When two people disagree on embracing or rejecting SUD, it misaligns the formerly shared enactment of that SUD. The desire to seek or maintain recovery becomes one-sided. The person who continues to embrace SUD is now providing a dissonant angle of support (Osterman & Grubic, 2000; Braithwaite & Schrodt, 2015). The relationship may not survive due to the enacted-relational strain this initiates. Enacted-relational identity gaps remain permanently unresolved when communal coping is not appropriately adaptable (Kato, 2012). Separation of SUD alignment is consistent with separation of shared relational identities. This supports the

effectiveness that communal coping has shown in successful identity repair and alignment (Lyons et al., 1998; Rohrbaugh et al., 2012).

In contrast, Ava negotiated the rejection of SUD through the motivation of a new romantic relationship. *"She fell in love and didn't want to be that type of person anymore*" (Alice). Some FMWSUD found it beneficial to surround themselves with people who hold opposing views of SUD. The experience of someone else's recovery creates a desire to attempt identity reformation within oneself. Kayla's recovery journey "*had a lot to do with the guy I was with,"* and "*it just sparked my interest.*" She remembers "*seeing a glimpse of something positive when he was in recovery.*" By having SUD and being with a sober partner, Ava and Kayla experienced enacted-relational identity gaps. Reaching a sober identity negotiates alignment of this identity gap.

Understanding and experiencing the identity of a FFM was taken into consideration when seeking and maintaining friendships. For FFMs, relational identity alignment translates as finding others who share the same personal-enacted positions that reject yet understand SUD. Jennifer states, "*I always click better with the ones that have gone through that because I've also gone through it.*" Awareness of SUD magnetizes relationships due to the support that can be interchangeably given and received. "*My roommate and I always talked about it"* (Jennifer). Brooke's best friend, "*knows about it all and stuff so it's nice to have somebody who knows my siblings and what we've gone through.*" This speaks volumes to the importance of empathy (Cox, 2011). Those who are going through an extremely stressful situation may have a decreased tolerance for those who are perceived to not understand (Petronio, 2002).

Enacted-relational identity gaps and alignment occur by fluctuations of family responsibilities. The fluctuations mentioned above ultimately lead to shifts in family responsibility, roles, and involvement. According to Phillips and others (2016), identity gaps are not designated to specific family forms or relationships but emerge from family interaction. In order to maintain family balance and needs, FFMs take on multiple (sometimes competing) family roles that FMWSUD neglect to maintain. "*Your addiction becomes our addiction because now we're addicted to being worried about you and what you're going to do next*" (Alice). Relational roles, such as a father, mother, grandparent, sibling, nephew, etc., become disrupted, inconsistent, or discontinued (Lander, 2013). Children lack relational roles in their life as adults neglect to nurture them (Levitt, 2013). In many cases, other family members step in to fill these roles. This is not always by choice but done so out of the best interest of the family at large and children involved. Not having SUD inherently brought on added responsibility and stress. "*I'm the black sheet of the family. I'm the one that doesn't have those issues, and everything falls on me and I hate it. It's frustrating and extremely exhausting, hence the reason I go to therapy*" (Brooke). Alice similarly stated, "*Her responsibilities became me and my husband's responsibilities.*"

When parents have SUD, this causes intense shifts in traditional family expectations (Coulombe et al., 2018). Relational roles reversed or shifted in a manner that was not required before SUD. "*She's supposed to be the parent and help us, and here we are parenting her, the roles were reversed*" (Alice). Thomas, *"felt she was a child that I had to take care of.*" The parent-child relationship strained as the responsibilities

traditionally held by the parents are being required by the child. The parent is unable to display an identity consistent with parenting.

In this absence of engaging in a parent identity, children took on parent identities over their siblings. "*Timothy's dad was a drunk and my mom was a drug addict and, I mean, I changed his diapers, fed him, I did everything at seven years old. Seven-year-olds shouldn't have to do that*" (Thomas). Overlapping sibling and parent relational identities created tension. Such as, a parent identity is supposed to be responsible for, and have authority over a child. When siblings fulfilled this responsibility, there was not only added demands from them, but confusion in their ability to enact as siblings.

Participants reported having parents who left or played a minimal part in their life. This contributed to childcare custody changes, legal issues, and instability. When FMWSUD were unable to be adequate parents, FFMs took on an additional parent identity. Alice and Thomas raised their nephew Kyle for six years, and claimed Ava, "*didn't have to worry about being a mother*" (Alice). As they were enacting as parents and aunt/uncle toward Kyle, relational identities overlapped. This eliminated opportunities within their shared marriage identity and added stress to their family environment. Alice explained, *"We were just new parents ourselves*" and "*we never got to be that young married couple with a fresh start."* Supporting various family members "*caused a lot of strain on our marriage*" (Thomas). Despite limitations experienced early in their marriage due to added FFM responsibilities, Thomas was willing to raise Kyle because, "*I grew up in that as a child, with a screwed-up family, and I didn't want him to have to grow up seeing the same kind of things.*" Kyle's personal identity was at risk, and they did what they could to preserve it from a young age. Children learn to adapt to the

absence of a parental figure, and experience confusion during relational diffusion. Taking care of Kyle was done with the intention of preventing further generational patterns of SUD. However, by doing this, it changes the dynamics of their relationship and family unit.

When FMWSUD experienced loss of their parent identity this (sometimes irrationally) motivated attempts to regain possession of their children. By doing so, this caused conflict with FFMs taking over said parent identity. Brooke's niece and nephew "*would just go missing*" because their parents would take them despite not having custody. "*My parents had decided that we can't keep them safe here and ended up going into foster care.*" Enacted-relational identity gaps originate in the idea that, as their grandparents, they should be able to keep the children safe, but ultimately could not (Kam & Hecht, 2009). Parents attempt to reach an identity alignment of being a parent, but their route of doing so is damaged and unsafe due to their SUD. Other FMWSUD reached recovery with motivation from their parent identity. Jennifer remembers Mike going to treatment for his kids, "*He was like, yes, I will do this for you kids, and he did it."*

As a result of an imbalance in caregiver roles and responsibility, *FFMs* shared multiple instances of bringing children into the topic of conversation as a means of leverage and motivation for sobriety (Waldorf & Biernacki, 1981; Stall and Biernacki, 1986). Brooke recalled telling Gloria, "*you need to get back here for your daughter, and you're just out doing what you want, drinking, and being with whoever."* Sophia said that her Aunt Ruth was the person to "*remind my dad that he does have two young children that do need a father right now.*" FFMs are also tasked with the responsibility to shelter

children from FMWSUD, but this proved to be a productive means of leverage. Alice says that Judy, "*wasn't able to see the grandkids. That was a reason for her to want to actually try.*" Alice also believes that Judy lived longer because of her grandchildren. For many, losing important parts of their social network induces motivation to recover (Dingle et al., 2015).

Enacted-relational identity gaps and alignment occur by using ineffective methods of communication and SUD management. Communication competence is a prerequisite for increasing communication satisfaction and decreasing relational identity gaps (Jung, 2011). Participants recalled negative occurrences of enabling, topic avoidance, lying, and deception. Ironically, these very enactments were used to maintain identity satisfaction and minimize the damages of SUD. The intentions an individual has for communication is going to alter their definition of a positive outcome. Differences in these intentions have little to no regard for the other person's communication satisfaction.

It was previously established that relational identity alignment and support is found through mutually embracing or rejecting SUD. However, this does not always happen, and family dynamics inevitably demand equilibrium in its absence. Some FFMs unintentionally adapted patterns of enactment consistent with enabling and took over caregiver roles. Judy, "*knew that I would always take her in*" (Thomas). FFMs participated in enabling behaviors in efforts to maintain the identities of their FMWSUD, the relationship, and overall family unit. By attempting to reject or minimize aspects of their relative's SUD identity, FFMs articulated personal battles between the desire to provide support and balancing the threshold of support and enabling (Platter & Kelley, 2012). "*I try to be supportive and not enable*" (Kayla). FFMs found it difficult to

discontinue enabling behaviors, despite becoming aware of them (Horvath & Urban, 2019; Lee et al., 2011). "*There were times where my mom needed money, she said for her bills, and I knew that she was going to use it for drugs, but I still sent it to her*" (Thomas).

There is a learning curve within the contexts of boundaries and support. "*I struggle with, well if it's not me, then who's it going to be?*" yet, "*I'm not as bad of an enabler as I used to be*" (Emily). FFMs shared inner struggles between their personal identity (wanting to be good people), and enacted identity (giving). "*It's hard too because we have been taken advantage of so many times and it's hard to be a good person and want to give give give*" (Alice). Those who discontinued enabling felt as if they were abandoning their FMWSUD. "*I care about this person, I want to help them, but yet I'm abandoning them in a way*" (Emily).

While Brooke has let her siblings live with her in the past, "*I wish I could do more, but I know that I can't let him live with me because I'd only be enabling his drug addiction*." Enabling also manifests in the form of bargaining with FMWSUD. "*This is the last time I'm giving you any money unless I see some changes in your life*" (Emily). The problem being, these negotiations are paired with enabling behaviors, such as giving money, and reinforce the ability to continue to have SUD.

Both FFMS and FMWSUD managed SUD induced enacted-relational identity gaps by avoiding the topic altogether (Jung & Hecht, 2004; Jung & Hecht, 2008; Schrodt & Afifi, 2018). Participants experienced topic avoidance both during active SUD and post recovery. While in active SUD Kayla recalled, "*I don't remember any of my family members trying to talk to me about stopping. I avoided them enough that I never heard that.*" Kayla limited the opportunity for communication with FFMs to take place. Topic

avoidance nonverbally implied the discouragement of having that discussion (Kam & Hecht, 2009).

Even when family members communicated frequently, conversations did not commonly intend to address or resolve issues surrounding SUD. FMWSUD intentionally avoided discussing their SUD in order to maintain relationships and minimize FFMs awareness of it. Even though Brooke and her sister talk, "*about every other day*," she "*found out she was drinking last week*." When topic avoidance occurs, this does not mean communication is limited. FFMs also chose avoidance during periods of impairment. "*I can't talk to you right now; I'm just not going to talk to you when you're messed up*" (Emily).

When family relationships stabilized, triggering subjects and past occurrences rooted in SUD still created underlining enacted-relational identity gaps. These are managed with topic avoidance (Dailey & Palomares, 2004; Caughlin & Afifi, 2004; Kam & Hecht, 2009). Alice avoids bringing up the past to avoid fights with Ava. "*I think she is close to apologizing and thanking me for all those years but chickens out every time*" (Alice). Relationships repaired out of SUD nonverbally established shared boundaries of what is and what is not considered available for communication. "*I can't really put my finger on any one time that we've really ever sat down and talked about it,*" and, "*we don't really reflect*" (Sophia). Avoiding these topics is done so in order to maintain reformed identities, even if there are things left unsaid. "We *don't talk about it much today*" (Kayla).

Topic avoidance is a productive form of identity management for some family relationships, but not others. Brooke stated, "*we've never really talked about it with my*

brother Jesse." yet, "*I will talk about it with my sister."* It is critical to remember that topic avoidance also occurs amongst FFMs. Brooke doesn't perpetually see the point of discussing her siblings' SUD with her parents because "*it's not like we're going to do anything.*" Brooke's intentions of wanting her siblings to reach recovery is not being addressed productively. To such a degree, the conversation's benefit is not eminent, and would rather be avoided.

When SUD was a topic of conversation, discussions were directed by negotiations of lying and deception. Participants reported inconsistencies between what was being communicated to them and observable factors such as demeanor, living situation, friends, and employment status. FMWSUD categorized their deceptive behaviors as part of their SUD identity. "*I did all the classic things that alcoholics and addicts do. I lied, I took stuff, it was volatile*" (Kayla). These behaviors start to negatively impact FFMs. This explains how and why SUD induced enacted-relational identity gaps appear among presumably functioning families.

FMWSUD achieved communication satisfaction of FFMs in individual interactions through lies and deception yet continued to maintain SUD identity outside of those interactions (Brodbeck et al., 2007). Judy would tell the family that she was "*getting better*" and "*lied to me all the time about it*" (Thomas). Deceptive narratives established themselves through repetition, even if they were foundationally ineffective in negotiating identity. "*It was the same story every time"* (Thomas). Depending on relational intentions, these narratives become either more or less effective when reused. For FMWSUD, deception was effective at the expense of FFMs. Judy gave her family *"false hopes" (Alice).* Emily's stepson Lucas, "*pretends like he's clean and sober but his*

behavior doesn't align with what he's saying." By attempting to deceive or minimize SUD related behavior, FMWSUD channeled their communication to meet the needs of FFM's expectations and alignment of that relationship's identity. This became straining to the relationship, and caused emotional damage (Mohon, 2016). "*She definitely played on Thomas's heart*" (Alice).

Enacted-relational identity gaps derived from these behaviors, leading FFMs constantly questioning the sincerity of interactions held with FMWSUD. "*You're always on the alert. I'm always looking, are they sober? Are they using? Are they being honest? Can you trust what they're saying? Are they being sincere? Is it safe to be around them right now?*" (Emily). This created breakdowns in trust. Despite experiencing this, FFMs also participated in deceptive behaviors in efforts to maintain the identities of themselves, FMWSUD, and overall family unit. "*You just start to be more isolated, fold secrets, and you don't tell people what's really going on, because they don't really understand*" (Emily). Meaning that, lying and deception are not always ill intended, but a means of maintaining relationships in the presence of SUD. This reinforces that some relationships would rather reach agreement than the truth (Mahon, 2016).

Despite communication challenges, participants emphasized the importance in engaging in conversations about SUD related issues as a way of resolving them (Goldsmith & MacGeorge, 2000). "*Just being able to talk through things helps a lot*" (Sophia). "*Communication is one of the biggest ways to help, I think that helps us cope with it*" (Thomas). For Thomas and Alice, being consistent supporters and caretakers presented a learning curve of communicating and their enactment as a couple. "*Looking back, me and Thomas could have communicated a little bit better, but we were so young*

and dealing with so much stuff. As we've gotten older, I think we do a very good job talking about it" (Alice).

Considering topic avoidance, lies, deception, and changing caregiver roles, having these conversations is easier said than done. "We *talked about it a lot of different times, and nothing had ever changed*" (Thomas). Sophia described herself as "*easy to get along with,*" yet found visitation with her dad to be difficult. For Thomas, talking to Judy felt like an "*accomplishment.*" FFMs attempted these conversations in order to maintain their own presence within that relationship, despite giving up on expectations of identity reformation. *"I would think, maybe my words are going to help. It would make me have a sense of feeling better about the situation, but at the same time, knowing that in the back of my mind, that it was never going to get better*" (Thomas).

Theme 3: Personal-relational identity gaps and alignment surface in multiple contexts where interpersonal communication occurs.

An important factor in gauging personal-relational identity gaps is knowing how each person perceives the relationship itself (Jung, 2011; Jung & Hecht, 2004; Jung & Hecht, 2008; Kam & Hecht, 2009; Crowley & Miller, 2020). While there are no subthemes in this final section, it collectively displays how personal-enacted and enacted-relational identity negotiations share results through personal-relational identity. The frame of enactment is accounted for in the first two themes. Enacted identity, or behavior, produces changes in perceptions of self and relationships. Sharing strong and similar views of a shared relational identity improves the functioning of that relationship (Merrill & Afifi, 2017). Overall functions of the family unit greatly impact family identification (Phillips et al., 2018; Scharp & Thomas, 2016). Communication is self-regulated based

on how one feels they are being perceived (Jung & Hecht, 2004; Hecht, 1993; Stanley & Pitts, 2019). Therefore, the final theme focuses on the perceptions of SUD, family members, and what happens when these perceptions are internalized via personal identity.

SUD has been researched through the lens of behavior and disease (Barber, 1994; Hartney, 2020). Results reinforced that it is difficult to explicitly categorize SUD as one or the other. Declaring SUD as a disease or behavior is arguably more consistent with theme one and personal-enacted identity. However, participants favored aspects of these definitions as they aligned with personal-relational identity. Brooke did not always view SUD as a disease. This changed as her experiences surrounding SUD changed, "*I do get it's a disease.*" FFMs who reject their FMWSUD's disorder dissociate their view of that person from it. *"That's the disease, that's not really them doing it*" (Emily). Those who view SUD as a behavioral choice emphasized that a strong sense of self is required for recovery (Mann et al., 2004). "*I was always told that it's a disease, I don't feel it's a disease*" (Thomas).

While sympathy and empathy more so align with personal-enacted identity, it can only be obtained through experiences and communication. Sympathy and empathy were recognized as part of personal identity when properly and genuinely channeled towards others (Cox, 2011). Thus, we can explain these negotiations through personal-relational identity. Personal-relational identity gaps were alleviated through an increased understanding and involvement of SUD. This impacted FFMs ability to perceive SUD identities. Lilly recalled judging Olivia in the past, but has learned that, "*addiction isn't a choice, it's just something that happens.*" FFMs experienced alignment through

negotiations in how they define, interact with, and ultimately perceive SUD. "*I did judge them before I started learning more about it,"* but is*, "nowhere near as judgmental as I used to be*" (Brooke). When FFMs do not possess a full understanding of SUD or adequate capacities of empathy, it minimizes the effectiveness of communication satisfaction. "*My mom has never drank, smoked, nothing. She doesn't know what it is to be drunk or anything like that*" (Brooke).

FMWSUD naturally developed sympathy and empathy for the disorder through direct involvement. "*I have a lot more sympathy for them. They are not a laughing stock to me because I was there*" (Mike). Recovered individuals found it easier to see others in a positive light due to having empathy for a shared SUD identity. Emily and Kayla say they have "*compassion*" for those with SUD. "*I did it so I can forgive that kind of stuff*" (Emily). Alignment of an SUD identity may provide a solid foundation for providing support "*The best help is somebody who's gone through it*" (Emily).

Despite gaining an increased awareness for SUD, FFMs developed personal-relational identity gaps by internalizing the contradicting displays of identity FMWSUD enacted. FFMs emphasized and mourned the loss of FMWSUD's positive identities that were prominent pre-SUD. It is impossible to ignore the differences between SUD identity, and pre-SUD identities. While these identities still exist, they become muted or deformed due behavior conducive to SUD. FFMs apprehensively formed negative perceptions of their FMWSUD. "*I hate seeing him like that"* (Brooke). Personal-relational identity gaps are revealed in how FFMs want to see their relatives versus how they are actually seen in active SUD. "*I don't feel like they have a good life.*" Brooke views Jesse as *"super smart"* and is disappointed that, *"he could have done anything he*

wanted but he chose to be a drunk." She then stated that her other brother, Dylan is, *"a good person and I wish he could fight this addiction, but he can't, and it just hurts my heart*." By describing her FMWSUD as "*smart"* and a "*good person"* Brooke showed how FFMs account for positive aspects of pre-SUD identities during active SUD. Personal-relational identity gaps surface out of disappointment, loss, and desire for change.

FFMs develop new perceptions of FMWSUD in order to properly describe identities consistent with SUD. "*My younger sister saw me as this crazy person in the house that was always causing chaos*" (Kayla). Unfortunately, these are usually not positive in nature due to the turbulence experienced in theme two. John was "*kind of unreliable most of my life*" (Sophia). Participants struggled with communication exchanges as a result of personal-relational identity gaps. Seeing Jesse was described as *"weird*" and "*it's almost like saying hi to a stranger because we don't have a relationship at all*" (Brooke).

Strong negative emotions such as resentment, frustration, and anger fed into personal-relational identity conflict. FFMs expressed anger toward FMWSUD for neglecting family responsibilities and relationships. "*I was just mad at her because she chose drugs and drinking over her kids*" (Brooke). Personal-relational identity gaps lie within how FMWSUD are perceived to mismanage these relational identities in active SUD. "*I don't understand, like you have this amazing little angel to live for and you need to figure it out*" (Brooke). In some cases, views towards FMWSUD were severe and cohesively enforced topic avoidance. "*It made me absolutely hate the person she was. I wanted absolutely nothing to do with her*" (Thomas). Even so, FMWSUD were able to

maintain some relational identities better than others. This left unequal balances in enacted-relational gaps. FFMs inconsistently assigned perceptions to separate relational identities. "*She was a great grandma, terrible mom, but great grandma*" (Alice). Personal-relational internalizations become skewed as some family relationships are deemed as aligned while others are not.

FMWSUD experienced personal-relational identity gaps in terms of considering who and what was available for support within the family unit (Laudet et al., 2006; Milios, 2019). "*Depending on the day,*" Kayla felt she could ask her family for support. Other FMWSUD felt confident reaching out for support and experienced identity alignment by doing so. This alignment and perception of support made it easier to reject SUD identity. "*I got lucky to have the support line I did"* (Mike). However, Mike still experienced hesitancy and uncertainty through worrying about how FFMs viewed him because he internalized his family's resentment. "*There was maybe a lot of resentment, and I was worried that not everybody was happy with our relationship.*" If Mike's perceptions of FFM's are correct, he is also becoming aware of their personal-relational identity gaps towards him. Resentment is a personal-enacted identity gap felt by both FFMs and FMWSUD.

Families who embraced positive change and perceptions of FMWSUD were proficient at sustaining new personal-relational and enacted-relational identity alignment. *"The way I see him now is who he is, and who he was, was back then"* (Sophia). Perceptions consistent with repaired relational identities reject SUD. "*It's gone, it's in the past*" (Mike). Sophia said something very similar. "*I kind of see it as a thing of the past.*" FMWSUD maintained a new ascribed identity in the eyes of FFMs through

consistent, positive enactments. Through recovery, FMWSUD are able to negotiate new perceptions of themselves until SUD identity is no longer observable. *"I've had people that have come into my life and have met my dad and I'll explain who he was when I was younger, and they don't see it"* (Sophia).

The experience of SUD reinforced the strength of family relationships (Osterman & Grubic, 2000). This was often recognized post-recovery. Multiple participants reported viewing their relationships as "*strong"* as a result of the enacted-relational identity gaps outlined in theme two. "*I think that we are such a strong couple because we've been through so much" (Alice).* Mike perceives his current relationship with Jennifer as "*solid*" and believes their relationship is "*stronger because of what happened.*" Even amongst FFMs, SUD is a factor in how those relationships are valued. Sophia and Noah's childhood "*has made us closer and more honest with each other*."

Personal-relational identity gaps remained after death and became a factor in the amount of time surviving FFMs spent in one of the five stages of grief. Fatal overdoses affect bereavement (Templeton, 2015). Thinking that Judy was sober, "*that changed my perspective, like wow, she's getting it this time.*" When they got the phone call that she had passed, "*That changed my perspective to being so angry*" (Alice). She went on to admit, "*I'm still angry to this day*." This is a display of how detrimental negotiations of topic avoidance and deception can be.

The presence of SUD inherently changes how the family unit is perceived (Phillips et al., 2018; Scharp & Thomas, 2016). Lily remembers this time period as "*very chaotic*." FFMs felt that they are perceived differently outside the family unit as a result of the SUD that exists in their family. "*There's a lot of people that think less of people*

who have alcoholic fathers" (Sophia). When SUD highlights family dynamics that go against societal norms, members may question what it means to be a "good" family (Phillips et al., 2018). FMWSUD's unpredictability can lead to FFMs feeling hesitant to engage with them due to fear of how they will be perceived. "*You were almost embarrassed to have them around*" (Alice).

Summary

Led by CTI, the current study identifies negotiations of personal, relational, and enacted identity in the contexts of family and SUD. Findings reinforce the importance of identity alignment, repairing damaged relationships, and understanding ways SUD is experienced generationally. Theme one provided a foundation of understanding towards personal negotiations. Personal identity was developed through family experiences and generational involvement with SUD. Due to the invasiveness of SUD, individuals were faced with the decision to accept or reject it from their personal identity in order to reach identity alignment. Enacted-relational identity gaps surfaced through the inability to achieve communication satisfaction. Negotiations were challenged by fluctuations in family relationships, communication barriers, support, and family responsibilities. Finally, personal-relational identity gaps appear where interpersonal communication occurs. As interactions within a relationship change, perceptions of that relationship also change. These are internalized and motivate enacted-relational negotiations.

CHAPTER 5: DISCUSSION

Communication theory of identity holds value for examining how SUD changes the dynamics of communication and ways in which identity is considered to be effectively and ineffectively managed. Frames of identity provide a flexible outline in

which the positive, negative, and unavoidably complex negotiations amidst family relationships can be revealed. These findings expand the work on CTI, its application to family communication, and SUD. The following and final chapter includes a discussion of major findings related to the literature on CTI, SUD, family relationships, future research directions, and limitations.

Summary of Findings

Participants revealed two main goals of identity negotiation (1) to achieve identity alignment within personal identity, and (2) to achieve identity alignment within relational identities. No matter how identities were perceived, enacted, or negotiated, implementing goals of identity alignment caused conflict. Participants generally focused their answers on 1-2 people, yet most implied having multiple FMWSUD. It can be assumed that family members mentioned in their answers had the biggest impact on them and were most involved in their lives. This indicates that the strongest and most immediate family relational identities have a stronger impact on one another compared to weaker, extended family relational identities. Some may translate this distinction as immediate family versus extended family. When relational identities are altered, extended family members may be ascribed as immediate family, and vice versa. Enacted-relational identity gaps transcendently occur in these relationships and are often intense.

Personal Identity

Personal-enacted Identity. Results suggest that the experience of SUD could be considered a personal-enacted identity gap. SUD was a strong indicator of personal-relational and enacted-relational identity gaps (Franken, 2014). Tension between personal identity and the urge to enact in misusing substances ultimately alters behavior (Frank &

Nagel, 2017; Chen et al., 2020; Panlilio & Goldberg, 2007). Enactment cannot always be maintained (Braithwaite & Schrodt, 2015). Therefore, personal-enacted identity gaps leak into relational identities (Jung, 2011). When SUD is reviewed in the lens of a personal-enacted identity gap it further organizes how that affects family relationships.

Not only do personal-enacted identity gaps predict gaps at the relational level, (Jung, 2011), the opposite may also be true. Personal identity is developed through family experiences and environment. Identity negotiations originating from the relational frame (i.e., family relationships) presented personal-enacted identity gaps. FFMs primarily rejected SUD identity to avoid developing the disorder and embraced its presence due to its prominence within the family. FMWSUD rejected SUD identity to continue or begin recovery. While this is seemingly parallel to the identity pathways in and out of SUD, recovered FMWSUD reported contradicting ideals as far as the importance and benefit of leaving their "SUD identity" behind (McIntosh & McKeganey, 2000; Dingle et al., 2015). FMWSUD embraced their SUD identity both pre and post recovery. Recovered FMWSUD continued to embrace SUD identity within the personal frame in order to maintain control over the personal-enacted identity gap that is SUD. This sheds light on the flexibility of coping styles and reinforces that recovery narratives depend on what the personal identity inherently needs (Kato, 2012).

Generational Patterns. Generational patterns of SUD impact development of personal identity and coping strategies (Domenico & Windle, 1993; Menees & Segrin 2000). Relational tensions within a household are complicated and children face identity gaps without choice, control, or full understanding. Reservations of adult relatives and their inability to explain the experience in an age-appropriate way negatively impacts the

experience children have of a changing family dynamic. In other words, adult problems become another's childhood traumas (Sher et al., 1991). Relationships that dissolve can feel like abandonment (Osterman & Grubic, 2000).

SUD changes what is modeled to the family and instills confusing messages of what is viewed as acceptable behavior (Menees & Segrin, 2000). Furthermore, patterns of communication and enactment are what frame unhealthy coping mechanisms, friendships, and romantic relationships. When unhealthy patterns of communication are displayed generationally, family members find difficulty in the ability to cope with that exposure (McCrady et al., 1986; McNabb et al., 1989). This could be a large contributor in why children are at higher risk for developing SUD in their adult life (Menees & Segrin, 2000). The ability to recognize, properly process, and manage identity-gaps rooted in childhood may increase with age (Arnett, 2007). Regardless of maturity, a child's level of involvement is 100% by default. A child's level of comprehension is restricted by the factors of age and information disclosed by adults (i.e., topic avoidance) (Kam & Hecht, 2009). Developmental stages are going to dictate the questions children discover and ask, and how adults are willing to answer those questions.

First born and/ or older children, such as Thomas, Noah or Jesse, established intense personal-enacted identity negotiation that narrated boundaries against SUD. Thomas had the responsibilities of a parent at age 7. Jesse and Thomas went on to have SUD in their adult lives. Noah avoids alcohol at all costs. It is surprising that identity pathways of FFMs are not profound in the literature alongside the research on children of those with SUD (Goodwin et al., 1974; Franken, 2014), social support (Goldsmith, 2004; Hughes, 2007) and involvement in communal coping (Lyons et al., 1998; Rohrbaugh et

al., 2012). Participants who only identified as functional family members also indicated strong affirmations that embraced and/ or rejected SUD identity.

Relational Identity.

All participants reported relational identity gaps to some degree. Individuals created and initiated relational identity gaps in order to maintain family relationships. Quality and frequency of communication fluctuated with levels of sobriety and relational damage (Braithwaite & Schrodt, 2015). Recovery is often a prerequisite to repairing areas of identity affected by it. Participants showed positive correlations between sobriety and improved relationships, and negative fluctuations during active SUD (Dingle et al., 2015). Identity reformation is the process of how people reach SUD recovery and improve damaged family relationships. Identity is known to be fluid and habitual (Jung & Hecht, 2004). This further reinforces that identity reformation out of SUD balances out relationships. Through this, the personal identity of the two parties become more aligned, and therefore, able to enact those alignments within the relationship (Merrill & Afifi, 2017). This is not always the case. Damage to shared identities can cause them to permanently dissolve, despite sobriety and recovery status (Crowley & Miller, 2020; Osterman & Grubic, 2000).

Personal-relational Identity. Personal-relational identity challenges resulted from internalizing interpersonal communications (Jung & Hecht, 2004). Participants upheld positive and negative views of themselves and others in the presence of SUD. Definitions of SUD were favored through the relationships that connected participants to the experience. Results reinforced that both the disease and behavioral models of SUD hold value in contributing to its understanding (Barber, 1994; Hartney, 2020; Heyman, 2013;

Frank & Nagel, 2017). Perceptions of FMWSUD improved overtime through personal attainment of sympathy and empathy. Empathy has shown to be a requirement for implementing person-centered health interventions (Cox, 2011). Families who embraced positive aspects post recovery affirmed the strength of their relationship. This aided in aligning a new reformed relational identity.

Personal-relational identity gaps occur when perceptions of sobriety and overall well-being are skewed through lies, masking a sober identity, or when priorities of those conversations are met with different expectations of communication satisfaction. Responsibilities assumed within shared relational identities become altered and/or neglected. Personal-relational identity gaps help and hinder SUD recovery (Stanley, 2016; Stanley & Pitts, 2019). FFMs who focus on their FMWSUD pre-SUD identities and dissociate SUD from their relationship may delay recognition of the need for support. However, when FFMs focus on their FMWSUD SUD identity, this could be a motivational factor for providing support.

Enacted-relational Identity. Enacted-relational identity gaps have the strongest impact on communication satisfaction (Jung, 2011). With this in mind, the current study outlines how SUD influences the relationships individuals seek and maintain (Crowley & Miller, 2020; Goldsmith, 2004; Dingle et al., 2015). Seeking and maintaining relationships and support was motivated by the desire to mutually embrace or reject SUD. This applied to both FFMs and FMWSUD. Having conflicting positions towards SUD created dissonance for recovery capital (Laudet et al., 2006; Milios, 2019). Yet, some FMWSUD found success in embracing relational identities with individuals that rejected SUD. This made it easier to reject SUD within their own personal identity (White, 2012).

FFMs found alignment in relationships outside the family unit due to their source of support. They also found it easier to support FMWSUD when their relational identities were in good standing.

Enabling is a complicated display of enactment, and usually does not lead to good outcomes (Horvath & Urban, 2019; Lee et al., 2011). The intention of being helpful connects aspects of support and enabling (Platter & Kelly, 2012). Identity gaps lie between enabling and providing support. While FFMs do not want to intentionally enable, they may intentionally make sure relatives with SUD are not homeless, have bills paid, etc. Personal-relational identity gaps occur when social support is seen as enabling, and/or enabling is seen as social support. This adds to what we know about high-risk environments and barriers to recovery (LePoire et al., 2000). Multiple FFMs admitted to supporting FMWSUD in ways that made it easier to continue the disorder. Enabling behaviors may strengthen, weaken, or vary overtime. This is consistent with elements of inconsistent nurturing as control theory (Duggan et al., 2008; Le Poire et al., 2000). Emily and Brooke reflect on the learning process to discontinue enabling behaviors, all while becoming empathetic and supportive.

Changes in family roles and responsibilities occurred as enacted-relational identities fell short. This strained existing relational identities and caused overlap (Coulombe et al., 2018). Grandparents, children, siblings, aunts, and uncles, all reported taking over a parental role. In some cases, the parent identity was negotiated back and forth between two parties. This would not have been necessary in the absence of SUD. Therefore, SUD changes the performance of shared identities (Braithwaite & Schrodt,

2015). FFMs are left to fulfill relational expectations that FMWSUD fail to meet in order to maintain balance within the family unit.

There is evidence throughout that shows the ramifications that SUD has on children, the relational identity of being a parent, and the difficulty of maintaining stable parent-child relationships (Rangarajan & Kelly, 2006; Lander, 2013; Pears et al., 2007). However, there are also indications that children have a positive impact on SUD recovery. This suggests that children may pull more weight in leveraging positive decision making compared to inputs from adult relationships. The strain of identity gaps has shown to motivate behavior change (Hecht & Choi, 2012).

Lying, Deception, & Topic Avoidance. Lying, deception, and topic avoidance are traditionally considered barriers to communication satisfaction (Jung & Hecht, 2008; Schrodt & Afifi, 2018). However, participants utilized these functions of communication to preserve relationships, personal identities, or both. Moderate selective disclosure can be healthy and beneficial for relationships (Golish, 2000). Intentions behind using ineffective methods of communication diversified as SUD became less compatible within the relationship (Braithwaite & Schrodt, 2015). While these behaviors are undesirable, they serve as outlets for identity negotiation. To conclude, lying, deception, and topic avoidance are not always malicious in their intent.

Relationships are repairable, yet still experience limitations in what is discussed. Sophia, Kayla, Alice, Thomas, Lilly and Brooke, all report some degree of current avoidance with their families. Topic avoidance is a gatekeeper for privacy (Petronio, 2002). Analyzing what is and what is not discussed affects one’s impression of their relationship (Caughlin & Afifi, 2004). Limitations in communication often establish

silently and occur between two or more family members. Topic avoidance is a means of achieving communication satisfaction (Jung & Hecht, 2004). Avoiding difficult discussions is a mechanism of both productive and unproductive coping. Families naturally choose to avoid the topic of SUD if it is not satisfying to discuss. This made it harder to resolve dormant issues (Caughlin & Afifi, 2004).

Non-verbal communication reveals just as much about identity as words do. Lack of family communication should be equally accounted for when studying observable enactment. To give an analogy, verbal communication may be considered the positive space, while non-verbal communication is the negative space. Identity gaps occur in this negative space, but only become visible by recognizable patterns in the positive space. What is discussed also reveals what is not discussed, and vice versa. Whether topic avoidance occurs due to tension in the relationship, out of respect, or to avoid conflict, it may be necessary for repairing relational identities and identity reformation.

FFMs report inconsistencies between what was being communicated to them, and observable factors such as demeanor, living situation, friends, and employment status. By attempting to hide or minimize their behavior, they are communicating what meets their FFM's expectations of them. Results on lying and deception expand what we know about their intent. Research on negotiation bias reveals that people would rather reach consensus over the truth (Brodbeck et al., 2007). Complex deception articulates that lying is asserted with the intent to deceive. Communication patterns of lying and deception should be studied together (Mahon, 2016). There is no one size fits all solution to managing identity gaps. Results highlight the successes, failures, and reservations of the attempts to preserve or close them.

Theoretical Implications

Relational Frame of Identity. Due to the four levels within the relational frame, identity gaps connected to relational identity are hard to articulate. Identity gaps involving the relational frame may emphasize a particular level within it, yet simultaneously affect all four. This is lacking in the literature. The current study finds evidence of how identity gaps and the levels with the relational frame change the way we consider their context. Highlighting the differences within the relational frame further complicates the already complex layering of each of the four frames. However, future research on the relational frame may be able to hone in on the layers within it and further define their impact on communication and relational identity struggles. The first level explains that we shape identity by internalizing how others see us (Hecht, 1993; Jung, 2011; Jung & Hecht, 2004). This essentially the definition of a personal-relational identity gap. The second level allows people to identify themselves through relationships (Jung & Hecht, 2004; Hecht, 1993; Stanley & Pitts, 2019). Participants who added to their list of identifiable relational identities (such as a parent) consider this through the second layer of the relational frame. Personal-relational identity gaps occur here as well. If a FFM is overtaking a parent role, that does not mean they feel like a parent. Nor does the child consider that person their parent. The third layer explains that these relational identities co-exist (Jung & Hecht, 2004). Each individual has a unique combination of relationships. As relational identities overlap, vary in expectations, and functioning, enacted-relational identity gaps are emphasized. Finally, identity becomes a shared characteristic of the relationship (Jung & Hecht, 2004; Hecht, 1993; Stanley & Pitts, 2019). Because the fourth level is expressed through communication, we can isolate this

frame to examine communication patterns such as topic avoidance, lying, and deception. Research on relational identity should be approached dyadically since individuals share it.

Sustaining Identity Gaps & Identity Alignment. Identity gaps are not always intended to be resolved. In fact, participants intentionally sustained identity gaps as a way to reach identity alignment. Severity of relational identity gaps cannot be measured by the quality or quantity of communication, but by the circumstances of the relationship's identity. Multiple participants went long periods of time without speaking to relatives. The intent was to create boundaries and prevent further damage to personal and relational identities. However, these periods without communication also proved to be damaging when prolonged.

Mike and Kayla said that SUD is a part of who they are. Maintaining that identity gap between having SUD and not enacting it acts as a reminder of their success without SUD. Focusing on the positive aspects of a FMWSUD (even if SUD is negatively impacting their behavior) promotes resilience in FFMs' ability to provide support (Johansen et al., 2013). When relationships improve, sustaining enacted-relational identity gaps can minimize conflict. Alice and Ava engage in topic avoidance. This allows for more positive conversation to take place. Especially in emerging adulthood, individuals often establish dissonance between personal and family identity (Arnett, 2007). Children who reject SUD from a young age have a better chance of breaking generational cycles.

Practical Implications

Family Relationships. Biologically speaking, family relationships are not necessarily chosen and occur without control. We don't choose our parents, sister, children, grandparents, etc. However, individuals choose romantic partners. This difference in choice alone may reveal nuances of relational intentions and motivations for enactment. Due to these considerations, examining identity negotiations of genetically related individuals separate from romantic couples is justifiably productive. Variations in how relational identity gaps manifest are anticipated as they require very different demands. For example, the daily requirements of living with a spouse are very different from maintaining a sibling relationship. If a married couple gets divorce, that relational identity can dissolve and remain that way through the absence of enactment. This becomes more complicated with immediate and extended family members. Interactions may be inevitable at times, such as during family gatherings (weddings, funerals, celebrations, etc.) It is hard to examine one without the other (Turner & West, 2013). Romantic and genetic family relationships compose one's identity and measurement of family identification (Phillips et al., 2018; Wadsworth et al., 2008; Kam & Hecht, 2009). For example, when a parent leaves their spouse, there is a possibility that they are also leaving their children or altering that visitation. Identity gaps related to this are going to be different in that person's attitude of separating from a spouse vs. children. Both romantic partners and genetic relatives have the power to lower family identification, alter personal and relational identities, and guide behavior based on how family is defined and prioritized.

Constructing Recovery Capital. Recovery capital is referred to as the total scope of supportive resources one has for SUD recovery (Laudet et al., 2006). Social support and coping are not the same thing. Social support can be a form of coping (Platter & Kelly, 2012). Coping requires personal identity, but not relational identities. The relational frame of identity assists in social support and communal coping (Laudet & White, 2008). Findings on social support suggest that an individual's recovery capital is best constructed of diverse relational identities (Milios, 2019; Laudet et al., 2006; Lyons et al., 1998). Participants highlighted multifaceted approaches to coping and support inside and outside the family unit. Inputs from recovery centers, treatment programs, therapy, spiritual/religious practice, and discussions with friends and family all aided in reaching long term sobriety.

Recovery capital, motivational causes for seeking it, and how those methods and people are chosen reveal a lot about the attempt to align personal, relational, and enacted identities (Laudet, et al., 2006; Laudet & White, 2008). Weaknesses in this baseline level of support reveals predispositional challenges an individual may face and allow them to strategize necessary resources accordingly.

High family identification magnifies identity gaps (Phillips et al., 2018). An individual's strongest family relationships are at highest risk for the most damage. Consequently, these relationships are also most ideal for building a recovery capital and successful communal coping (Laudet & White, 2008). Individuals must recognize that family members who compose their support system are the same people that need support from them in return. This inability to nurture family relationships creates many versions of enacted-relational identity gaps.

Generational patterns of SUD help and hinder the process of building recovery capital (Rhule-Louie & McMahon, 2007; Scharp & Thomas, 2016; Crowley & Miller, 2020; Hughes, 2007). This becomes more challenging when there are multiple members with SUD, and they are not able to support one another while going through the same problems. In this case, individuals may need to rely on more people outside the family unit. When relationships go dormant for long periods of time during active SUD there are discrepancies between support, empathy, and the reports of such. These are the people that ideally provide supportive interaction but are not present. FFMS, even with reports of periodically dormant relationships, express the presence of empathy and efforts of support. Meaning that, availability to enact support and activity status of relationships have a positive relationship. On the other hand, empathy does not require support or necessarily lead to observable behavior.

Nature vs. Nurture. When thinking about generational patterns of SUD, it is appropriate to address the nature versus nurture argument. It has been established that genetics are a factor in SUD (Goodwin et al., 1974; AAC, 2021). The nurturing element accounts for how individuals experience this during their formative years and impacts on adulthood (Levitt, 2013). The results of this study conclude that the presence of SUD in families factors into account both elements of nature (genetics) and nurture (patterns of communication and behavior). CTI acknowledges identity as communication (Jung & Hecht, 2004). Therefore, all nurturing appears through communication and identity negotiation. The nature vs. nurture argument mirrors the disease vs. behavior definition argument of SUD. A disease model is more digestible when genetic factors are understood (Frank & Nagel, 2017). Correspondingly, recognizing SUD as a behavior is

to account for one's foundational environment and experiences of nurturing (Carter, et al., 2014; Heyman, 2013). Families with high rates of SUD are then at higher risk both genetically and behaviorally. Not only this, but results indicate inconsistent nurturing through the experience of SUD (Le Poire et al., 2000; Duggan et al., 2008).

Limitations

There are areas of limitation that could be addressed in future research. With a relatively small sample size of 9, future studies could benefit from a greater number of interviews. Another limitation of this sample lies within geographical limits. This study was not intended to be rural based, but all participants were recruited from rural areas. Nuances between rural and urban SUD are complicated. Therefore, it is important to consider these differences while expanding research on identity negotiation. Rural areas see greater rates of alcohol abuse, while urban areas struggle with illicit drugs. Urban areas offer more access to prevention and treatment centers. Rural areas struggle to provide these services (Hoeg, 2021). Data collection was not restricted to focus on one specific type of family relationship, such as children of alcoholics (Domenico & Windle, 1993; Menees & Segrin 2000). The sample possesses a gender imbalance with 7 women and 2 men. Interestingly, compared to women, men are more likely to use illicit drugs (NIDA, 2022). I would be curious to see how gender balances out with a larger scale of participants. However, this topic reveals a blind spot if more women come forward with their experiences, yet men carry higher rates of SUD. This parallels with the current findings regarding topic avoidance. If more men have SUD, then more men are avoiding communication around that experience. Finally, the topic of SUD can be very

uncomfortable to discuss. It is impossible to know what participants left out, or how complete their answers were.

Future Research Directions

CTI's flexibility and universal application leaves room for many avenues of research to stem from the current study. To start, repeating a similar process with more participants may be beneficial. Narrowing down the parameters for qualifying criteria would isolate specific family experiences. Separately examining genetic versus romantic relationships, siblings, blended families, or strictly those who have vs. have not directly had SUD are just a few examples of how this sample could be divided. Even though the communal frame of identity was not emphasized in my research question, understanding the personal, relational, and enacted identity gaps acts as a scaffolding for further research focused on the communal frame. The four frames of identity produce 11 possible combinations of identity gaps (Jung & Hecht, 2004). This study only covered three frames of identity and three identity gaps. If repeated, I would consider examining the personal, enacted, and relational frames as a tri-layered identity gap. However, I do not regret selecting identity gaps limited to two frames. It allowed results to breathe and highlighted the predictive nature that two frames can have on a 3rd or 4th. Observations three frames of identity at a time may blur the significance of those results

This study observes a gray area in how family units should be defined in terms of CTI. It begs the question, is the family unit a shared relational identity, and to be explored from the relational lens? Or is the family unit a shared communal identity, composed of relational identities? Identity gaps that are widespread amongst family units plant diverse identity gaps within individual members. However, communal identity does

not account for group member's individual identity (Hecht, 1993; Orbe, 2004; Jung, 2011). Family characteristics separate and distinct themselves from other family units. Therefore, families share a "family" group identity across multiple generations. The family unit could be defined as a shared relational identity *or* a group communal identity, depending on the lens of research.

While navigated with CTI, this study assists in understanding the applicability of existing theories mentioned in chapters one and two. These include inconsistent nurturing as control theory (Le Poire et al., 2000; Duggan et al., 2008), family identification (Phillips et al., 2018; Scharp & Thomas, 2016), and the concepts of recovery capital (Laudet et al., 2006; Milios, 2019), and communal coping (Rohrbaugh et al., 2012). Because CTI is so broad, its weakness lies in the ability to articulate identity gaps with consistent clarity. The theory is able to explain *how* identity is challenged, changed, and negotiated. Theories mentioned above support CTI in expanding the *why* and interpreting motivations behind communication with different measures. Regardless of how communication in this context is organized, these theories share parallels and exist in harmony. Thus, opportunities to layer theories together offer strengthened answers, and detail how these experiences are interpreted.

This study was not meant to specifically measure strength of relationships prior to experiencing SUD. Results indicate high fluctuations in family relationships. Knowing more about the baseline relationship would be beneficial. The concept of family identification studies the connectedness of a family, and individual members' attachment to that connection (Phillips et al., 2018; Scharp & Thomas, 2016). Generational patterns of SUD greatly influence foundations of communication and family dynamics. Family

identification offers a basis of measuring the strength and quality of relationships pre-SUD. A relationship's baseline functionality points to challenges that are exacerbated by SUD vs. created by SUD. This distinction is important. If communication satisfaction is not generally achieved before SUD is a factor in that relationship, achieving it after the fact becomes even more difficult. Those who hold value to family relationships are going to be more willing to provide and receive social support and engage in conversation. However, research on family identification shows that high family identification intensifies negative stressors (Phillips et al., 2018).

Using methods of virtual data collection, such as Zoom, has proven to be very beneficial. In a rural area, public places are limited. The chances of running into someone you know is also fairly high. By offering virtual interviews, participants have a safer option. There is no need to commute to a location. It also allows those who don't feel comfortable going out to participate. Participants may also feel more comfortable sharing and answering questions in their own space, with the added distance of a computer screen. Using virtual methods makes studies more accessible and can reach a wider audience. We have adapted to using more technology in this way since the start of the COVID-19 pandemic. There is an increased familiarity with it, and this could very well mean there will be an increased interest in collecting qualitative data this way. Covid-19 has also made it more difficult to meet in public places, especially if it is not deemed a necessity.

Summary

SUD is a common and challenging disorder. Through semi-structured interviews, the current study explored identity negotiations within family relationships. Provoking

and sustaining identity gaps differed among unique family contexts. Participants articulated personal negotiations with accepting or rejecting SUD. Family relationships suffered in several ways. Quality and quantity of communication correlated with levels of sobriety and disruptive family experiences. Fluctuations in relationship functioning, responsibilities, and roles shifted the way shared relational identities were enacted and perceived. Personal and relational identities were effectively and ineffectively managed through communicable means of topic avoidance, lying, and deception. Internalizations of family members, SUD, and interactions led to personal-enacted gaps and alignment. These occurred simultaneously with personal-enacted and enacted-relational identity negotiations rooted in SUD. I expected to find negotiations of identity gaps. However, I did not expect to discover identity alignment as an equally important measure of communication satisfaction. Sustaining identity gaps can be considered a means of identity alignment. Communication research heavily depends on the understanding of relationships. Therefore, this study offers future research directions towards the relational and communal frames of CTI, family variability, support, and nurturing.

REFERENCES

American Society of Addiction Medicine Board of Directors. (2019, September). *Definition of addiction*. https://www.asam.org/Quality-Science/definition-of-addiction

American Addiction Centers. (2021). *Addiction statistics: Drug & substance abuse statistics.* https://americanaddictioncenters.org/rehab-guide/addiction-statistics

Arnett, J. J. (2007). Emerging adulthood: What is it, and what is it good for? *Child Development Perspectives, 1*(2), 68–73. https://doi.org/10.1111/j.1750-8606.2007.00016.x

Barber, J. G. (1994). Social work with addictions. *New York: New York University Press 41*(5), 571-572. https://doi.org/10.1093/sw/41.5.571

Biederman, J., Faraone, S. V., Monuteaux, M. C., & Feighner, J. A. (2000). Patterns of alcohol and drug use in adolescents can be predicted by parental substance use disorders. *Pediatrics, 106*(4), 792–797. https://doi.org/10.1542/peds.106.4.792

Bos, A. E. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology*, *35*(1), 1–9. http://doi.org/10.1080/01973533. 2012.746147r

Braithwaite, & Schrodt, P. (2015). *Engaging theories in interpersonal communication : multiple perspectives* (Second edition.). SAGE.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. http://doi.org/10.1191/1478088706qp063oa

Brodbeck, F., Kerschreiter, R., Mojzisch, A., & Schulz-Hardt, S. (2007). Group decision making under conditions of distributed knowledge: The information asymmetries model. *Academy of Management Review, 32*(2), 459-479. https://doi.org/10.5465/AMR.2007.24351441

Brooks, C., & Pitts, M. (2016). Communication and identity management in a globally connected classroom: An online international and intercultural learning experience. *Journal of International and Intercultural Communication, 9*(1), 52-68. http://doi.org/10.1080/17513057.2016.1120849

Brooks, C. R. (1994). Using ethnography in the evaluation of drug prevention and intervention programs. *The International Journal of the Addictions, 29*(6), 791-801. http://doi.org/10.3109/10826089409047910

Carter, A., Mathews, R., Bell, S. (2014). Control and responsibility in addicted individuals: What do addiction neuroscientists and clinicians think? *Neuroethics 7*(2), 205–214. https://doi.org/10.1007/s12152-013-9196-6

Caughlin, J. P., & Afifi, T. D. (2004). When is topic avoidance unsatisfying? Examining moderators of the association between avoidance and dissatisfaction. *Human Communication Research, 30*(4), 479-513. https://doi.org/10.1093/hcr/30.4.479

Chen, S., Yang, P., Chen, T., Su, H., Jiang, H., & Zhao, M. (2020). Risky decision-making in individuals with substance use disorder: A meta-analysis and meta-regression review. *Psychopharmacology, 237*(7), 1893–1908. https://doi.org/10.1007/s00213-020-05506-y

Colaner, C., Halliwell, D., & Guignon, P. (2014). "What do you say to your mother when your mother's standing beside you?" Birth and adoptive family contributions to

adoptive identity via relational identity and relational-relational identity gaps. *Communication Monographs, 81*(4), 469-494. https://doi.org/10.1080/03637751.2014.955808

Corrigan, P. W., Kuwabara, S. A., & O'Shaughnessy, J. (2009). The public stigma of mental illness and drug addiction: Findings from a stratified random sample. *Journal of Social Work: JSW, 9*(2), 139–147. http://doi.org/10.1177/1468017308101818

Cox, J. (2011). Empathy, identity and engagement in person-centered medicine: the sociocultural context: Empathy and a body-mind-spirit paradigm. *Journal of Evaluation in Clinical Practice, 17*(2), 350–353. https://doi.org/10.1111/j.1365-2753.2010.01580.x

Crowley, J., & Miller, L. (2020). "Who's gonna love a junkie? But he does": Exploring couples' identity negotiations and dyadic coping in the context of opioid use disorder. *Journal of Social and Personal Relationships, 37*(5), 1634-1652. https://doi.org/10.1177/0265407520903385

Dailey, R. M., & Palomares, N. A. (2004). Strategic topic avoidance: An investigation of topic avoidance frequency, strategies used, and relational correlates. *Communication Monographs, 71*(4), 471–496. https://doi.org/10.1080/0363452042000307443

DeJonckheere, M., & Vaughn, L. M. (2019). Semi-structured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health, 7*(2), e000057. https://doi.org/10.1136/fmch-2018-000057

Dingle, G. A., Cruwys, T., & Frings, D. (2015). Social identities as pathways into and out of addiction. *Frontiers in Psychology, 6,* 1795-1796. http://doi.org/10.3389/fpsyg.2015.01795

Domenico, D., & Windle, M. (1993). Intrapersonal and interpersonal functioning among middle-aged female adult children of alcoholics. *Journal of Consulting and Clinical Psychology 61*(4), 659–666. https://doi.org/10.1037/0022-006X.61.4.659

Drummond, D. K., & Orbe, M. P. (2009). "Who are you trying to be?": Identity gaps within interracial encounters. *Qualitative Research Reports in Communication, 10*(1), 81-87. https://doi.org/10.1080/17459430903236098

Duggan, A. P., Dailey, R. M., & Le Poire, B. A. (2008). Reinforcement and punishment of substance abuse during ongoing interactions: A conversational test of inconsistent nurturing as control theory. *Journal of Health Communication, 13*(5), 417–433. http://doi.org/10.1080/ 10810730802198722

Faulkner, S. L., & Hecht, M. L. (2011). The negotiation of closetable identities: A narrative analysis of lesbian, gay, bisexual, transgendered queer Jewish identity. *Journal of Social and Personal Relationships, 28*(6), 829-847. https://doi.org/10.1177/0265407510391338

Franken, N. (2014). *Applying the communication theory of identity to members of alcoholics anonymous: A phenomenological analysis of the expression of the recovery experience.* [Doctoral dissertation, University of Missouri-Columbia]. MOspace. https://doi.org/10.32469/10355/44464

Frank, L. E., & Nagel, S. K. (2017). Addiction and moralization: the role of the underlying model of addiction. *Neuroethics 10*(1), 129–139. https://doi.org/10.1007/s12152-017-9307-x

Goffman, E. (1959). *The presentation of self in everyday life.* Anchor Books.

Golish, T. D. (2000). Is openness always better? Exploring the role of topic avoidance, satisfaction, and parenting styles of stepparents. *Communication Quarterly, 48*(2), 137-158. https://doi.org/10.1080/01463370009385587

Goldsmith, D. J. (2004). *Communicating social support*. Cambridge University Press.

Goodwin, D. W., Schulsinger, F., Moller, N., Hermansen, L., Winokur, G., & Guze, S. B. (1974). Drinking problems in adopted and nonadopted sons of alcoholics. *Archives of General Psychiatry, 31*(2), 164. https://doi.org/10.1001/archpsyc.1974.01760140022003

Hartney, E. (2020, March 21). *DSM 5 criteria for substance use disorders.* Verywell Mind. https://www.verywellmind.com/dsm-5-criteria-for-substance-use-disorders-21926

Haugh, M. (2008). The discursive negotiation of international student identities. *Discourse: Studies in the Cultural Politics of Education, 29*(2), 207-222. https://doi.org/10.1080/01596300801966849

Heyman, G. M. (2013). Addiction and choice: Theory and new data. *Frontiers in Psychiatry, 4*, 31-31. https://doi.org/10.3389/fpsyt.2013.00031

Hecht, M. L. (1993). 2002--A research odyssey toward the development of a communication theory of identity. *Communication Monographs, 60*(1), 76–82. https://doi.org/10.1080/036377593093762973

Hecht, M. L., Marsiglia, F. F., Elek-Fisk, E., Wagstaff, D. A., Kulis, S., & Dustman, P. (2003) Culturally-grounded substance use prevention: An evaluation of the Keeping it R.E.A.L. curriculum. *Prevention Science, 4*(4), 233-248. https://doi.org/10.1023/A:1026016131401

Hecht, M. L., & Choi, H. J. (2012). The communication theory of identity as a framework for health message design. In H. Cho (Eds.), *Health communication message design: Theory and practice* (pp. 137-152). Thousand Oaks, CA: Sage.

Hecht, M. L., & Hopfer, S. (2010). The communication theory of identity. In R.L. Jackson (Eds.), *Encyclopedia of identity* (pp. 115-119) Thousand Oaks, CA: Sage.

Hughes, K. (2007, June 6). Migrating identities: The relational constitution of drug use and addiction. *Sociology of Health and Illness, 29*(5), 673-691. https://doi.org/10.1111/j.1467-9566.2007.01018.x

Hoeg, N. (2022). *Substance Abuse in Rural Vs. Urban Areas*. Addiction Center. https://www.addictioncenter.com/community/substance-abuse-rural-vs-urban/

Hogg, M. (1993). Group cohesiveness: A critical review and some new direction. *European Review of Social Psychology, 4*(1), 85-111. https://doi.org/10.1080/14792779343000031

Horvath, Z., & Urban, R. (2019). Testing the stress-strain-coping-support (SSCS) model among family members of an alcohol misusing relative: The mediated effect of burden and tolerant-inactive coping. *Addictive Behaviors, 89*, 200-205. https://doi.org/10.1016/j.addbeh.2018.10.010

Jack, D. C. (1991). *Silencing the self: Women and depression*. Harvard University Press.

Jack, D. C. (1999). *Silencing the self: Inner dialogue and outer realities*. In T. Joiner & J. C. Coyne. (Eds.), *Interaction nature of depression: Advances in interpersonal approaches* (pp. 221-246). American Psychological Association. https://doi.org/10.1037/10311-008

Johansen, A. B., Brendryen, H., Darnell, F. J., & Wennesland, D. K. (2013). Practical support aids addiction recovery: the positive identity model of change. BMC *Psychiatry, 13*(1), 201-201. https://doi.org/10.1186/1471-244X-13-201

Jung, E., & Hecht, M. (2004). Elaborating the communication theory of identity: Identity gaps and communication outcomes. *Communication Quarterly, 52*(3), 265-283. http://dx.doi.org/10.1080/01463370409370197

Jung, E., & Hecht, M. L. (2008, August). Identity gaps and level of depression among Korean immigrants. *Health Communication, 23*(4), 313–325. https://doi.org/10.1080/10410230802229688

Jung, E. (2013). Delineation of a threefold relationship among communication input variables, identity gaps, and depressive symptoms. *The Southern Communication Journal, 78*(2), 163-184. https://doi.org/10.1080/1041794X.2012.741652

Jung, E. (2011). Identity gap: Mediator between communication input and outcome variables. *Communication Quarterly, 59*(3), 315–338. http://doi.org/10.1080/01463373.2011.583501

Jung, E., Hecht, M., & Wadsworth, B. (2007). The role of identity in international 106 students' psychological well-being in the United States: A model of depression level, identity gaps, discrimination, and acculturation. *International Journal of*

Intercultural Relations, 31(5), 605-624. https://doi.org/10.1016/j.ijintrel.2007.04.001

Kato, T. (2012). Development of the coping flexibility scale: Evidence for the coping flexibility hypothesis. *Journal of Counseling Psychology, 59*(2), 262-273. http://dx.doi.org/10.1037/a0027770

Kam, J., & Hecht, M. (2009). Investigating the role of identity gaps among communicative and relational outcomes within the grandparent–grandchild relationship: The young-adult grandchildren's perspective. *Western Journal of Communication, 73*(4), 456-480. https://doi.org/10.1080/10570310903279067

Kelly, A. E. (2000). Helping construct desirable identities: A self-presentational view of psychotherapy. *Psychological Bulletin, 126*(4), 475–494. https://doi.org/10.1037/0033-2909.126.4.475

Kennedy-Lightsey, C. D., Martin, M. M., LaBelle, S., & Weber, K. (2015, June 19). Attachment, identity gaps, and communication and relational outcomes in marital couples' public performances. *Journal of Family Communication, 15*(3), 232–248. https://doi.org/10.1080/15267431.2015.1043430

Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: From theory to practice. *Social Work in Public Health, 28*(3-4), 194–205. https://doi.org/10.1080/19371918.2013.759005

Laudet, A. B., Morgen, K., & White, W. L. (2006). The role of social supports, spirituality, religiousness, life meaning and affiliation with 12-step fellowships in quality of life satisfaction among individuals in recovery from alcohol and drug

problems. *Alcohol Treat Quarterly, 24*(1-2), 33–73. http://doi.org/10.1300/J020v24n01_04

Laudet, A. B., & White, W. L. (2008). Recovery capital as prospective predictor of sustained recovery, life satisfaction, and stress among former poly-substance users. *Substance Use & Misuse, 43*(1), 27–54. https://doi.org/10.1080/10826080701681473

Lee, K. M. T., Manning, V., Teoh, H. C., Winslow, M., Lee, A., Subramaniam, M., Guo, S., & Wong, K. E., (2011, July 4) Stress-coping morbidity among family members of addiction patients in Singapore. *Drug and Alcohol Review, 30*(4), 441-447. https://doi.org/10.1111/j.1465-3362.2011.00301.x

Le Poire, B. A., Hallett, J. S., & Erlandson, K. T. (2000, July). An initial test of inconsistent nurturing as control theory: How partners of drug abusers assist their partners' sobriety. *Human Communication Research, 26*(3), 432–457. http://doi.org/10.1111/j.1468-2958.2000.tb00764.x

Levitt, M. (2013). Perceptions of nature, nurture and behavior. *Life Sciences, Society and Policy 9*(1), 13-13. https://doi.org/10.1186/2195-7819-9-13

Lyons, R. F., Mickelson, K., Sullivan, J. L., & Coyne, J. C. (1998, October 1). Coping as a communal process. *Journal of Social and Personal Relationships, 15*(5), 579–605. http://doi.org/10.1177/0265407598155001

Mahon, J. E. (2016). *The definition of lying and deception*. Stanford Encyclopedia of Philosophy. https://plato.stanford.edu/archives/win2016/entries/lying-definition

Mann, M., Hosman, C. M. H., Schaalma, H. P., & De Vries, N. K. (2004, June 15). Self-esteem in broad-spectrum approach for mental health promotion. *Health Education Research, 19*(4), 357–372. https://doi.org/10.1093/her/cyg041

McCrady, B. S., Noel, N. E., Abrams, D. B., Stout, R. L., Nelson, H. F., & Hay, W. M. (1986). Comparative effectiveness of three types of spouse involvement in outpatient behavioral alcoholism treatment. *Journal of Studies on Alcohol, 47*(6), 459-465. http://doi.org/10.15288/jsa.1986.47.459

McIntosh, J., & McKeganey, N. (2000, May). Addicts' narratives of recovery from drug use: Constructing a non-addict identity. *Social Science and Medicine, 50*(10), 1501-1510. https://doi.org/10.1016/s0277-9536(99)00409-8

McIntosh, J., & McKeganey, N. (2001, February). Identity and recovery from dependent drug use: The addict's perspective. *Drugs: Education, Prevention, and Policy, 8*(1), 47-59. https://doi.org/10.1080/09687630124064

McNabb, J., Der-Karabetian, A., & Rhoads, J. (1989, December). Family involvement and outcome in treatment of alcoholism. *Psychological Reports, 65*(3 Pt. 2), 1327-1330. https://doi.org/10.2466/pr0.1989.65.3f.1327

Menees, M. M., & Segrin, C. (2000, July 1). The specificity of disrupted processes in families of adult children of alcoholics. *Alcohol and Alcoholism, 35*(4), 361-367. https://doi.org/10.1093/alcalc/35.4.361

Merrill, A. F., & Afifi, T. D. (2017, July 1). Couple identity gaps, the management of conflict, and biological and self-reported stress in romantic relationships. *Human Communication Research, 43*(3), 363-396. https://doi.org/10.1111/hcre.12110

Milios, R. (2019, November 4). *How social connections affect recovery.* American Addiction Centers: National Rehabs Directory. https://www.rehabs.com/pro-talk/how-social-connections-affect-recovery/

Murray, C., & Kennedy-Lightsey, C. (2013). Should I stay or go?: Student identity gaps, feelings, and intent to leave. *Communication Research Reports, 30*(2), 96-105. https://doi.org/10.1080/08824096.2012.762894

Neale, J., Allen, D., & Coombs, L. (2005, September 9). Qualitative research methods within addictions. *Addiction, 100*(11), 1584-1593. https://doi.org/10.1111/j.1360-0443.2005.01230.x

National Institute on Drug Abuse. (2022, April). *Sex and Gender Differences in Substance Use*. https://nida.nih.gov/publications/research-reports/substance-use-in-women/sex-gender-differences-in-substance-use on 2022, April 25

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods*, *16*(1), 1-13. https://doi.org/10.1177/1609406917733847

Nuru, A. (2014). Between layers: Understanding the communicative negotiation of conflicting identities by transgender individuals. *Communication Studies, 65*(3), 281-297. https://doi.org/10.1080/10510974.2013.833527

Orbe, M. (2004). Negotiating multiple identities within multiple frames: An analysis of first generation college students. *Communication Education, 53*(2), 131-149. https://doi.org/10.1080/0363452041000168240

Osterman, F., & Grubic, V. N. (2000, December). Family functioning of recovered alcohol-addicted patients. A comparative study. *Journal of Substance Abuse Treatment, 19*(4), 475–479. https://doi.org/10.1016/S0740-5472(00)00126-4

Panlilio, L. V., & Goldberg, S. R. (2007). Self-administration of drugs in animals and humans as a model and an investigative tool. *Addiction, 102*(12), 1863–1870. https://doi.org/10.1111/j.1360-0443.2007.02011.x

Pears, K., Capaldi, D. M., & Owen, L. D. (2007). Substance use risk across three generations: The roles of parent discipline practices and inhibitory control. *Psychology of Addictive Behaviors, 21*(3), 373–386. https://doi.org/10.1037/0893-164x.21.3.373

Petronio, S. (2002). *Boundaries of privacy: Dialectics of disclosure.* Albany: State University of New York Press.

Phillips, K., Ledbetter, A., Soliz, J., & Bergquist, G. (2018, April 26). Investigating the interplay between identity gaps and communication patterns in predicting relational intentions in families in the United States. *Journal of communication*, *68*(3), 590-611. https://doi.org/10.1093/joc/jqy016

Pickard, H. (2017). Responsibility without Blame for Addiction. *Neuroethics, 10*(1), 169–180. https://doi.org/10.1007/s12152-016-9295-2

Pikel, A. (2018). *Framed by sexuality: An examination of identity - messages in "purity culture" reflections*. [Open Prairie: Open Public Research Access Institutional Repository and Information Exchange]. https://openprairie.sdstate.edu/etd/2662?utm_source=openprairie.sdstate.edu%2Fetd%2F2662&utm_medium=PDF&utm_campaign=PDFCoverPages

Platter, A. J., & Kelley, M. L. (2012). Effectiveness of an educational and support program for family members of a substance abuser. *The American Journal of Family Therapy*, *40*(3), 208–213. https://doi.org/10.1080/01926187.2011.585308

Rangarajan, S., & Kelley, L. (2006, August 1). Family communication patterns, family environment, and the impact of parental alcoholism on offspring self-esteem. *Journal of Social and Personal Relationships, 23*(4), 655-671. https://doi.org/10.1177%2F0265407506065990

Rohrbaugh, M. J., Shoham, V., Skoyen, J. A., Jensen, M., & Mehl, M. R. (2012, March 16). We-talk, communal coping, and cessation success in a couple-focused intervention for health-compromised smokers. *Family Process, 51*(1), 107–121. http://doi.org/10.1111/j.1545-5300.2012.01388.x

Rhule-Louie, D. M., & McMahon, R. J. (2007, February 21). Problem behavior and romantic relationships: Assortative mating, behavior contagion, and desistance. *Clinical Child and Family Psychology Review, 10*(1), 53–100. http://doi.org/10.1007/s10567-006-0016-y

Saitz, R., Miller, S. C., Fiellin, D.A., & Rosenthal, R.N. (2020). Recommended use of terminology in addiction medicine. *Journal of Addiction Medicine, 15*(1), 3-7. https://doi.org/10.1097/adm.0000000000000673

Scarduzio, J., & Geist-Martin, P. (2008). Making sense of fractured identities: Male professors' narratives of sexual harassment. *Communication Monographs*, *75*(4), 369-395. https://doi.org/10.1080/03637750802512363

Scharp, K. M., & Thomas, L. J. (2016). Family “bonds”: Making meaning of parent–child relationships in estrangement narratives. *Journal of Family Communication, 16*(1), 32–50. https://doi.org/10.1080/15267431.2015.1111215

Schrodt, P., & Afifi, T. D. (2018). A social relations model of negative relational disclosures and closeness in families. *Journal of Social and Personal Relationships*, *35*(2), 180–201. https://doi.org/10.1177/0265407516680304

Schrodt, P., Witt, P. L., & Messersmith, A. S. (2008). A meta-analytical review of family communication patterns and their associations with information processing, behavioral, and psychosocial outcomes. *Communication Monographs, 75*(3), 248–269. https://doi.org/10.1080/03637750802256318

Sher, K. J., Walitzer, K. S., Wood, P. K., & Brent, E. E. (1991). Characteristics of children of alcoholics: Putative risk factors, substance use and abuse, and psychopathology. *Journal of Abnormal Psychology 100*(4), 427–448. https://doi.org/10.1037/0021-843X.100.4.427

Sigmon, S. C. (2014). Access to treatment for opioid dependence in rural America. *JAMA Psychiatry, 71*(4), 359–360. http://doi.org/10.1001/jamapsychiatry.2013.4450

Simmons, J., & McMahon, J. M. (2012, August 9). Barriers to drug treatment for IDU couples: The need for couple-based approaches. *Journal of Addictive Diseases, 31*(3), 242–257. http://doi.org/10.1080/10550887.2012.702985

Singer, B. F., Fadanelli, M., Kawa, A. B., & Robinson, T. E. (2018). Are cocaine-seeking "habits" necessary for the development of addiction-like behavior in rats? *The Journal of Neuroscience, 38*(1), 60–73. https://doi.org/10.1523/jneurosci.2458-17.2017

Stall, R., & Biernacki, P. (1986). Spontaneous remission from the problematic use of substances: an inductive model derived from a comparative analysis of the alcohol, opiate, tobacco and food/obesity literatures. *The International Journal of The Addictions, 21*(1), 1-23. https://doi.org/10.3109/10826088609063434

Stahler, G. J., & Cohen, E. (2000). Using ethnographic methodology in substance abuse treatment outcome research, *Journal of Substance Abuse Treatment, 18*(1), 1-8. https://doi.org/10.1016/S0740-5472(99)00029-X.

Stanley, S. (2016). *Targeting young adult smoker's multiple identity gaps and identity management strategies for behavior change: An application of the communication theory of identity*. [The University of Arizona, ProQuest Dissertations Publishing]. http://hdl.handle.net/10150/612611

Stanley, S., & Pitts, M. J. (2019). "I'm scared of the disappointment": Young adult smokers' relational identity gaps and management strategies as sites of communication intervention. *Health Communication, 34*(8), 904-911. https://doi.org/10.1080/10410236.2018.1440507

Spitzberg, B. H., & Hecht, M. L. (1984). A component model of relational competence. *Human Communication Research, 10*(4), 575-599. https://doi.org/10.1111/j.1468-2958.1984.tb00033.x

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. Austin & S. Worchel (Eds.). *The social psychology of intergroup relations* (pp. 33-47). Monterey, CA: Brooks/Cole

Templeton, L., Valentine, C., McKell, J., Ford, A., Velleman, R., Walter, T., Hay, G., Bauld, L., & Hollywood, J. (2017). Bereavement following a fatal overdose: The

experiences of adults in England and Scotland. *Drugs: Education, Prevention and Policy, 24*(1), 58–66. https://doi-org.excelsior.sdstate.edu/10.3109/09687637.2015.1127328

Turner, L. H., & West, R. L. (2013). *Perspectives on family communication*. McGraw-Hill Education.

Urban, E., & Orbe, M. (2010). Identity gaps of contemporary U.S. immigrants: Acknowledging divergent communicative experiences. *Communication Studies, 61*(3), 304-320. https://doi.org/10.1080/10510971003757147

Wadsworth, B., Hecht, M., & Jung, E. (2008). The role of identity gaps, discrimination, and acculturation in international students' educational satisfaction in American classrooms. *Communication Education, 57*(1), 64-87. https://doi.org/10.1080/03634520701668407

Waldorf & Biernacki, P. (1981). The natural recovery from opiate addiction: Some preliminary findings. *Journal of Drug Issues, 11*(1), 61-74. https://doi.org/10.1177/002204268101100104

Warren, J., Hecht, M., Jung, E., Kvasny, L., & Henderson, M. (2010). African American ethnic and class-based identities on the world wide web: Moderating the effects of self-perceived information seeking/finding and web self-efficacy. *Communication Research, 37*(5), 674-702. https://doi.org/10.1177/0093650210374005

White, W. L. (2012). *Recovery/remission from substance use disorders: An analysis of reported outcomes in 415 scientific reports, 1868–2011*. Department of Behavioral Health and Intellectual Disability Services & Great Lakes Addiction Technology Transfer Center.

https://www.naadac.org/assets/2416/whitewl2012_recoveryremission_from_substance_abuse_disorders.pdf

World Health Organization. (2010, December 9). *Dependence syndrome.* http://www.who.int/substance_abuse/terminology/definition1/en/