FACING ADDICTION WITH HOPE AND UNDERSTANDING

The Stigma Gap: How What We Know, What We Feel, and What We Do Shape Recovery for Families Touched by Addiction

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There is a moment many families recognize — the moment when they realize that the greatest obstacle facing their loved one isn't the substance itself. It is the wall of silence, shame, and social judgment that makes asking for help feel more dangerous than staying sick. Stigma, in addiction as in mental health broadly, is not merely an attitude problem. It is a structural barrier to care, a force that reshapes how people see themselves and whether they believe recovery is even possible. A striking new study out of South Korea offers families, clinicians, and advocates a lens through which to understand this barrier more precisely — and, crucially, a reason for hope.

Understanding the Research: Knowledge, Attitudes, and Behaviors Are Not the Same Thing

The study conducted by Han, published in the *International Journal of Mental Health Nursing*, examined 363 nursing students from four Korean universities, divided into two groups: those with clinical practicum experience (n = 175) and those without (n = 188). All participants completed an auditory hallucination simulation program — an experiential exercise designed to help students viscerally understand what it feels like to hear voices that others cannot — and then completed questionnaires measuring their knowledge, attitudes, and behaviors toward people with mental health disorders, as well as the degree of stigmatizing beliefs they held (Han).

The study's central question was elegant and practically important: among these nursing students, what *predicts* stigmatizing beliefs? And

does the answer change depending on whether students have actually worked with patients in clinical settings?

The answer, it turns out, is yes — and it matters enormously for families navigating addiction recovery.

Why the Knowledge-Attitude-Behavior Distinction Matters for Families

It is tempting to assume that stigma is simply a knowledge problem. If people only *understood* addiction as a brain disease, the thinking goes, they would stop blaming their loved ones. Advocacy organizations have spent decades working from this premise — distributing pamphlets, funding public awareness campaigns, hosting information sessions. The FAHU mission is built, in part, on this conviction: that understanding addiction more deeply changes how we respond to it.

Han's research complicates and enriches this picture in important ways. The study found that the predictive contributions of knowledge, attitudes, and behaviors to stigmatizing beliefs *differed* based on whether students had direct clinical experience with people who have mental health disorders (Han). This means that for some populations, increasing knowledge is the lever most connected to reducing stigma. For others — specifically, those who have had direct human contact — attitudes and behaviors matter more. Knowing the facts and *feeling* something compassionate about those facts are distinct psychological events. And *behaving* in accepting, non-judgmental ways is a third thing still.

For families of people with addiction, this distinction is not abstract. A parent can know, intellectually, that their child's substance use disorder is a medical condition shaped by genetics, trauma, and neurobiology. They can recite the science. And yet still feel, in a quiet corner of their heart, that their child is weak, or manipulative, or choosing this. That emotional residue — the attitude layer — does not dissolve automatically when knowledge increases. Han's research suggests it requires

something more: direct, humanizing encounter. Experience changes the equation.

The Simulation as a Bridge: What Families Can Learn from a Clinical Tool

The auditory hallucination simulation at the center of Han's study is worth pausing on. Participants wore headphones through which they heard distressing voices while attempting to complete everyday tasks — filling out forms, having conversations, navigating spaces. The purpose was not to replicate mental illness but to create an experiential bridge: to move the experience of severe psychiatric symptoms from the realm of the abstract and the *other* into something personally felt, however briefly.

This is what good family education about addiction attempts to do. Programs like Community Reinforcement and Family Training (CRAFT), Al-Anon, and family systems therapy do not simply inform families about addiction. They invite families to imaginatively inhabit their loved one's experience — to feel, even for a moment, the pull of craving, the shame of relapse, the desperation that drives use when pain becomes unbearable. This is the experiential bridge. And Han's research suggests that this kind of bridge may be more powerful than information alone in reshaping the attitudes and behaviors that ultimately determine whether a family member becomes a resource for recovery or an unintentional obstacle.

The study found that nursing students who had *already* worked with patients in clinical settings responded differently to the simulation than those who had not (Han). Their knowledge, attitudes, and behaviors predicted their stigmatizing beliefs in measurably different ways. This suggests that prior human contact with people experiencing mental illness created a different cognitive and emotional architecture — one in

which additional information was processed not in a vacuum, but against a background of real human faces and stories.

Families who have loved someone through addiction carry this same architecture. They have *already* had the clinical practicum, so to speak. They have sat at 2 a.m. waiting for a call. They have driven to emergency rooms. They have held hands shaking with withdrawal. The question Han's research implicitly raises is: how do we design support and education for these families that meets them where they actually are — in the *attitude* and *behavior* dimensions, not merely the knowledge dimension?

Stigma Impedes Treatment-Seeking: The Stakes Are Real

Han's study opens with a premise that must not pass without emphasis: "Stigmatising beliefs towards people with mental health disorders impede treatment-seeking and recovery" (Han). This is not a background platitude. It is the core clinical and ethical problem.

When a person with a substance use disorder internalizes stigma — when they come to believe the messages society sends about being weak, broken, or morally deficient — they are less likely to seek treatment, less likely to disclose their condition to healthcare providers, and more likely to experience the shame-driven isolation that research consistently associates with worse outcomes. Self-stigma is a treatment barrier that operates from the inside.

But stigma within families functions as a treatment barrier too, in ways that are often invisible to the families themselves. A parent who responds to a child's disclosure with anger rather than curiosity, a spouse who frames every relapse as a choice and a betrayal, a sibling who refuses to attend family therapy — these responses are not simply interpersonal failures. They are downstream consequences of stigmatizing beliefs that were never examined or challenged. Han's research matters here because it points toward a mechanism: when we understand *how*

stigma forms — through the particular interplay of knowledge, attitudes, and experiential history — we gain leverage over it.

Hope Is Not Naivety: It Is a Clinical and Ethical Stance

One of the insights embedded in Han's research design is that simulation and experiential learning can measurably alter the predictors of stigma — even among people who may already hold entrenched beliefs. This is hopeful not because it implies change is easy, but because it implies change is *possible*. The architecture of stigma is not immutable. It is built from knowledge, attitudes, and behaviors — and all three are teachable, trainable, revisable.

For FAHU, this is the heart of the matter. Facing addiction with hope and understanding is not a soft or sentimental stance. It is a position grounded in the emerging science of how stigma functions and how it can be dismantled. It acknowledges that families come to this work with their own histories, their own pain, and their own well-worn attitudes that may be doing harm even as they come from love. It does not shame those families. It offers them the same experiential bridge — the simulation, the encounter, the imaginative inhabitation of another person's suffering — that Han's nursing students received.

What would it mean to take seriously the finding that knowledge, attitudes, and behaviors operate as *distinct* levers? It would mean designing family programs that don't simply deliver information but create structured opportunities for emotional and attitudinal work. It would mean helping families not just to *know* that addiction is a disease, but to *feel* it in their bodies, to revise the quiet blame they may carry, and then to *practice* new behaviors — responses that convey that their loved one is worth fighting for, and that recovery is not a miracle but a process that compassionate presence can support.

Conclusion: The Family as a Site of Recovery

Han's study was conducted in nursing schools, among young professionals learning to care for strangers. But its implications extend far beyond clinical training. The dynamics it illuminates — the gap between knowing and feeling, between feeling and doing, the role of direct human encounter in bridging that gap — are the dynamics of every family living with addiction.

Families are not simply bystanders to addiction. They are, in the language of family systems research, part of the ecology in which recovery either takes root or fails to. The attitudes they carry, the behaviors they enact, the degree to which they can move from stigmatizing responses toward compassionate engagement — all of this shapes the environment that their loved one wakes up in every day.

The most important intervention may not be the next medication or the next treatment protocol, though both matter. It may be the conversation a mother has in a support group, where she realizes for the first time that her anger at her son is partly shame she has absorbed from a culture that still, in too many ways, regards addiction as a moral failure. It may be the moment a husband stops rehearsing ultimatums and starts asking, with genuine curiosity, what his wife is actually feeling. These moments — small, private, unglamorous — are where the real work of recovery begins.

Understanding how stigma is built, as Han's research helps us do, is how we begin to take it apart.

Works Cited

Han. “Auditory Hallucination Simulation and Mental Health Stigma Among Nursing Students: How Clinical Practicum Experience Differentiates the Predictive Contributions of Knowledge, Attitudes, and Behaviours.” International Journal of Mental Health Nursing, 2026. https://pubmed.ncbi.nlm.nih.gov/42495816/.