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# **When the Workplace Becomes a Barrier: Stigma, Recovery, and What Families of People with Addiction Need to Know**

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# **When the Workplace Becomes a Barrier: Stigma, Recovery, and What Families of People with Addiction Need to Know**

For families living alongside a loved one's addiction or mental illness, the question of "what happens next" is rarely simple. Recovery is not a single event—it is a sustained, often nonlinear process that unfolds across homes, relationships, healthcare systems, and workplaces. And yet, much of the public conversation about recovery focuses almost exclusively on the individual: their choices, their willpower, their diagnosis. Families are left to wonder how the world their loved one must return to—the world of jobs, colleagues, and professional expectations—will receive them. A striking new study offers a sobering answer, and it demands that families, advocates, and employers pay closer attention.

**\*\*The Study the Recovery Community Needs to Read\*\***

Published in *Psychology, Health & Medicine* (2026), a qualitative study by Nkomo examines what happens when teachers in Limpopo Province, South Africa attempt to return to work following a mental illness relapse. The findings are both specific in their context and universal in their implications. Using a Social Model of Disability framework—which locates barriers not in the individual's condition, but in the social and structural environment around them—Nkomo's research reveals that sustained recovery at work is frequently undermined not by the illness itself, but by the world that refuses to accommodate it.

The study identified three core workplace barriers: unimplemented healthcare recommendations, persistent stigma, and limited organizational support. Fourteen teachers were interviewed until data saturation was reached, and their experiences were analyzed using

Tesch's open coding method. What emerged was a portrait of people trying desperately to re-enter their professional lives—only to find that the systems around them were not ready, or willing, to help.

This is, in essence, the story that millions of families of people with addiction recognize immediately.

### **\*\*Stigma Is Not a Feeling—It Is a Force\*\***

When we speak of stigma in addiction and mental health recovery, we often frame it as a matter of attitudes—the unkind thought, the whispered judgment, the averted eye. But Nkomo's research makes clear that stigma is structural. It is baked into workplaces through policies that are never enforced, accommodations that are never implemented, and cultures that punish vulnerability rather than support it.

For teachers returning after mental illness relapse, the stigma they encountered was not merely interpersonal—it was institutional. Healthcare recommendations went unimplemented. Organizational support was limited. The very systems that were supposed to ease their return to work instead exacerbated their vulnerability to relapse. This is a critical insight for families: when a loved one struggling with addiction or co-occurring mental illness attempts to return to employment, they are not simply re-entering a neutral environment. They are entering a system that, in many cases, has been structured—however unintentionally—to make sustained recovery harder.

Families often take on the exhausting and invisible labor of bridging this gap. They become case managers, advocates, schedulers, and emotional buffers, compensating for the support that workplaces fail to provide. Understanding that this gap is structural, not personal, is not merely an academic point—it is a lifeline for families who blame themselves when their loved one struggles.

### **\*\*The Social Model as a Framework for Families\*\***

The Social Model of Disability, which anchors Nkomo's study, offers something genuinely transformative for families navigating addiction recovery: a shift in focus from "what is wrong with this person" to "what is wrong with this environment." This reframing has profound implications.

In the dominant cultural narrative, addiction is understood as a failure of character or will. The recovering person is expected to prove themselves, to work harder than everyone else, to earn back trust through near-perfect performance. When they stumble—when a stressful workplace triggers a craving, when isolation intensifies a mental health crisis, when the absence of support leads to relapse—the blame falls squarely on them. The Social Model challenges this logic. It insists that when environments fail to accommodate the realities of recovery, the environment bears responsibility for the outcomes.

For families, this framework is not a way to excuse harmful behavior—it is a way to understand why recovery is so often disrupted, and to advocate more effectively for the structural changes that make sustained recovery possible. Knowing that unimplemented healthcare recommendations are a documented barrier to workplace return-to-work success (Nkomo 2026) gives families language and evidence they can bring to employers, HR departments, disability advocates, and healthcare providers.

#### **\*\*What Teachers Tell Us About Everyone in Recovery\*\***

There is something particularly poignant about teachers being at the center of this research. Teachers are caregivers by profession. They are expected to be present, patient, and emotionally available for others—often at the expense of their own wellbeing. When they experience mental illness relapse, the stigma they face is compounded by the perceived contradiction between their struggles and their professional

identity. The idea that a caregiver could be in crisis is, for many institutions, too uncomfortable to acknowledge.

This dynamic is familiar to many families of people in addiction recovery. The loved one who "should have known better"—the parent, the professional, the community pillar—faces a particularly isolating form of stigma. Their recovery is shadowed by the expectation that they perform wellness even before they have achieved it.

And yet, the teachers in Nkomo's study did not simply collapse under these pressures. They adapted. They developed coping strategies in response to the barriers they encountered. The study highlights this resilience not as a reason to accept inadequate systems, but as evidence of the extraordinary effort that people in recovery invest simply to survive within them. Families witness this effort daily. They watch loved ones navigate impossible circumstances with creativity and determination—and they understand, more than most, that this effort deserves structural support, not just personal praise.

### **\*\*The Absence of Support Is Never Neutral\*\***

Perhaps the most important insight from Nkomo's research is that the absence of support is never a neutral condition. When workplaces fail to implement healthcare recommendations, they are not simply doing nothing—they are actively increasing the risk of relapse. Limited organizational support does not simply leave people where they were; it pushes them backward. This is a critical message for families who sometimes internalize the silence or inaction of institutions as a sign that things are fine.

They are not fine. They are simply unaddressed.

For families advocating for a loved one in recovery, understanding this dynamic means moving from a posture of waiting—waiting for the workplace to step up, waiting for healthcare to coordinate, waiting for

stigma to soften on its own—to a posture of informed, compassionate advocacy. It means asking questions: Has the employer received the healthcare provider's recommendations? Has an accommodation plan been documented? Who is responsible for supporting this person's return to work, and are they actually doing it?

These are not aggressive questions. They are the questions that structural analysis demands, and that families, armed with research like Nkomo's, are now equipped to ask.

### **\*\*Hope as a Research-Grounded Position\*\***

At FAHU, we ground hope not in wishful thinking but in evidence. The evidence from Nkomo's study is clear: barriers to recovery are real, they are structural, and they are addressable. Stigma can be reduced through education and policy. Organizational support can be mandated and measured. Healthcare recommendations can be implemented with appropriate accountability mechanisms in place.

Families do not have to accept that their loved one's workplace will be a site of relapse risk. They do not have to accept that stigma is simply "how things are." They do not have to absorb, alone, the work of supporting a recovery that institutions are failing to sustain. The Social Model of Disability gives them a framework. The research gives them evidence. And the determination of people like the teachers in Limpopo Province—who developed coping strategies in the face of profound institutional failure—gives them, and all of us, a model of resilience that demands a worthy structural response.

Recovery is not just a personal journey. It is a social one. And families who understand this are better equipped to walk it—not alone, but as informed, compassionate advocates for the structural change that makes sustained recovery possible.

## Works Cited

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Nkomo. "Workplace barriers to recovery after mental illness relapse and coping strategies used: a Social Model of Disability perspective." *Psychology, Health & Medicine*, 2026. <https://pubmed.ncbi.nlm.nih.gov/42340937/>.

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