

Repercussions of Internalized Stigma on the Self-Care of Homeless People



Repercussões do Estigma Internalizado no Autocuidado de Pessoas em Situação de Rua

Repercusiones del Estigma Internalizado en el Autocuidado de las Personas sin Hogar

Felicialle Pereira da Silva^a

Talita Bianca Lima da Paixão^a

Fabia Maria de Lima^a

Isla Daniela da Silva Pinto^a

Emanuela Batista Ferreira e Pereira^a

Jael Maria de Aquino^a

Simone Maria Muniz da Silva Bezerra^a

Carla Aparecida Arena Ventura^b

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ABSTRACT

Objective: to analyze the occurrence of internalized stigma among homeless people and its relationship with self-care practices.

Method: this is a descriptive and exploratory study, with a qualitative approach, carried out through semi-structured interviews. The research was conducted, between July and October 2023, at the Specialized Reference Centers for the Homeless Population in the city of Recife, Pernambuco. Data analysis was supported by the MAXQDA® software and guided by the methodological framework of thematic content analysis proposed by Bardin.

Results: a total of twenty-two users participated, with a mean age of 34.5 years. The majority were male and had been living on the streets for more than three years. The analysis of reports resulted in three thematic categories: (1) Individuals' feelings about their living conditions on the streets; (2) Perception of how society views them; (3) Perception of the homeless individual about others living in the same conditions.

Final considerations: internalized stigma compromises the homeless population's self-image and self-care, deepening social exclusion. There is a need to critically review existing intersectoral practices, promoting interventions that are more sensitive to the subjective effects of stigma.

Descriptors: Homeless People; Social Stigma; Self Care.

RESUMO

Objetivo: analisar a ocorrência do estigma internalizado em pessoas em situação de rua e sua relação com as práticas de autocuidado.

Método: estudo descritivo e exploratório, com abordagem qualitativa, realizado por meio de entrevistas semiestruturadas. A pesquisa foi conduzida entre os meses de julho e outubro de 2023 nos Centros de Referência Especializados para População em Situação de Rua no município do Recife, Pernambuco. A análise dos dados foi auxiliada pelo software MAXQDA® e orientada pelo referencial metodológico da análise de conteúdo temática proposta por Bardin.

Resultados: participaram 22 usuários, com idade média de 34,5 anos. A maioria era do sexo masculino e vivia em situação de rua há mais de três anos. A análise dos relatos resultou em três categorias temáticas: (1) Sentimento do indivíduo em relação à sua condição de vida nas ruas; (2) Percepção de como são vistas pela sociedade; (3) Percepção da própria pessoa em situação de rua sobre os que vivem nas mesmas condições.

Considerações finais: o estigma internalizado compromete a autoimagem e o autocuidado da população em situação de rua, aprofundando a exclusão social. Evidencia-se a necessidade de revisar criticamente práticas intersectoriais já existentes, promovendo intervenções mais sensíveis aos efeitos subjetivos do estigma.

Descritores: Pessoas em Situação de Rua; Estigma Social; Autocuidado.

RESUMEN

Objetivo: analizar la incidencia del estigma internalizado en personas en situación de calle y su relación con las prácticas de autocuidado.

Método: estudio descriptivo y exploratorio, con enfoque cualitativo, realizado mediante entrevistas semiestruturadas. La investigación se llevó a cabo, entre julio y octubre de 2023, en los Centros de Referencia Especializados para la Población en Situación

^a Universidade de Pernambuco, Escola de Enfermagem Nossa Senhora das Graças. Recife, Pernambuco, Brasil.

^b Universidade de São Paulo, Escola de Enfermagem de Ribeirão Preto. Ribeirão Preto, São Paulo, Brasil.

de Calle de la ciudad de Recife, Pernambuco. El análisis de datos se realizó con el *software* MAXQDA® y se guió por el marco metodológico de análisis de contenido temático propuesto por Bardin.

Resultados: participaron 22 usuarios, con una edad promedio de 34,5 años. La mayoría eran hombres y llevaban más de tres años viviendo en la calle. El análisis de los relatos arrojó tres categorías temáticas: (1) Sentimientos de la persona respecto a sus condiciones de vida en la calle; (2) Percepción de cómo la sociedad la percibe; (3) Percepción de la propia persona en situación de calle sobre quienes viven en las mismas condiciones.

Consideraciones finales: el estigma internalizado compromete la autoimagen y el autocuidado de la población sin hogar, profundizando la exclusión social. Es necesario revisar críticamente las prácticas intersectoriales existentes, promoviendo intervenciones más sensibles a los efectos subjetivos del estigma.

Descriptores: Personas sin Hogar; Estigma Social; Cuidados Personales.

■ INTRODUCTION

The homeless population (HP) is a heterogeneous group that shares common characteristics such as extreme poverty, disrupted or weakened family ties, and a absence of regular conventional housing. Therefore, they commonly use public spaces and degraded areas for temporary or permanent housing, seeking service facilities for temporary overnight stays or temporary housing⁽¹⁾.

The increase in the number of HP in Brazil, which surpassed 281,000 in 2023, highlights a social crisis worsened by unemployment, food insecurity, and the dismantling of public policies. In cities like Recife, Pernambuco, where more than 1,800 people live under this condition, the challenges intensify in urban centers marked by precarious access to essential services⁽²⁾.

In this context, it is observed that the HP is exposed to multiple daily vulnerabilities, including exposure to weather changes, lack of shelter and privacy, to recurring forms of discrimination, social rejection, and symbolic violence, including within public services. These conditions generate feelings of fear and insecurity, keeping individuals in a constant state of alert and subjecting them to competition for spaces and basic resources for survival.

The National Policy for the Homeless Population (*Política Nacional para a População em Situação de Rua* - PNPSR), established by Decree No.7,053 of December 23, 2009, represents a milestone in the enforcement of constitutional rights for this segment of the population, as it establishes specific guidelines and objectives aimed at ensuring broad, simplified, and safe access to public policy services and programs, including health, education, social security, social assistance, housing, safety, among others⁽³⁾.

Despite the advances driven by the PNPSR, persistent barriers still prevent the HP from fully accessing fundamental rights, such as housing, health, safety, and dignity⁽⁴⁾. This scenario makes this population vulnerable to systematic processes of exclusion and disrespect, resulting from social

invisibility in everyday life, difficulties entering the formal labor market, and the heavy burden of stigma⁽²⁻⁴⁾.

The origin of stigma date back to ancient Greece, where it was common to mark the bodies of slaves, prisoners, and criminals as public signs of social degradation, indicating that these individuals should be avoided by society. Over time, this mark ceased to be merely physical and began to take on a symbolic meaning linked to socially devalued attributes⁽⁵⁾. A systematic review study highlighted how stigma is present in public policies and society overall, affecting quality of life and access to healthcare services⁽⁶⁾.

Internalized stigma is a process by which individuals, upon becoming aware of the negative stereotypes associated with their condition, begin to agree with them, incorporating these unfavorable beliefs into their self-image and reproducing them in their behavior⁽⁷⁾. Recent studies on the theme show that the internalized stigma faced by HP affects self-esteem, mental health, and access to essential services⁽⁸⁻⁹⁾. Furthermore, internalizing stigma can lead to social isolation and a loss of motivation to seek care, compromising basic self-care practices such as personal hygiene, adequate nutrition, and adherence to health treatments, perpetuating the cycle of vulnerability and exclusion.

Self-care refers to individuals' ability to promote and maintain their own health, preventing illness and managing disease, with or without the support of healthcare professionals. This practice is essential for preserving health and quality of life, especially in adverse contexts, such as life on the streets, where universal self-care requirements are limited, such as access to healthcare services and basic hygiene. In such circumstances, self-care demands become essential strategies for survival and well-being⁽¹⁰⁾.

Internalized stigma represents a subjective dimension of social exclusion that deeply affects how HP perceive themselves and their relationship with the world^(5,8). Analyzing its occurrence in this group is essential to understanding how discriminatory discourses and social practices are absorbed by individuals, generating significant impacts on self-esteem, sense of belonging, and the pursuit of rights. By shedding

light on this process, this study contributes to the debate on the psychosocial effects of urban marginalization, offering insights for public policies and professional practices that are more sensitive to the realities of this population.

Therefore, this study aims to analyze the manifestation of internalized stigma among HP and understand its relationship with self-care, aiming to contribute to the development of more humane and effective approaches to caring for this population.

■ METHOD

Design, instruments, and data collection procedures

This is a qualitative study, descriptive and exploratory approach. The study was structured in compliance with the recommendations of the CONsolidated Criteria for Reporting Qualitative Research. Data collection was conducted through semi-structured interviews, including participants' sociodemographic, personal, and health data, followed by guiding questions adapted from the Internalized Stigma of Mental Illness (ISMI) scale, validated in Brazil. This scale was developed and validated to assess the internalized stigma perceived by the individual⁽¹¹⁾.

Recognizing that this is a qualitative study, the scale was not used as a numerical measurement tool, but rather as a reference for developing the interview questions. Three items conceptually relevant to the context of homeless people were selected, paraphrased, and recontextualized: "How do you feel about being homeless?", "How do you think people see you?", and "How do you perceive people who also live on the streets?" This adaptation allowed us to explore subjective dimensions of internalized stigma in line with the study's methodological proposal.

To ensure participant anonymity, the code "I" was adopted, referring to the word "interviewee", followed by a sequential number corresponding to the order of participation.

The study was conducted at two Specialized Reference Centers for the Homeless Population (POP Centers), located in the city of Recife, state of Pernambuco. POP Centers are shelters for people in situations of social vulnerability who use the streets as places of residence and/or survival.

Participants

The study included users attended and registered at the study site, aged 18 years old or older, regardless of their

registration or frequency of service use. Individuals who, although registered, were not present at the POP Centers during the data collection period, thus making it impossible to contact them, and therefore were excluded.

Procedures and data analysis

Data collection was conducted between July and October 2023. The interviews were performed by a researcher who received previous training from the study advisor, a mental health specialist with extensive experience in the field of HP. The researcher's involvement in the POP Center was made possible by the advisor's prior work with the service, through regular extension and training activities with the teams working with this population, which ensured an ethical, sensitive, and technically aligned approach with the study.

Following this integration, participants were invited to participate in the study through an individual approach conducted after their appointments at the service, in compliance with ethical standards and ensuring explanation of the study's objectives. The interviews took place in a private room designed for reception, providing a private and safe environment conducive to qualified listening. Each interview lasted an average of 12 minutes, allowing participants to share their experiences in a spontaneous and safe manner.

The choice for a private space was intended to ensure the confidentiality and comfort of the interviewees, essential aspects of qualitative research, especially when involving sensitive topics or populations in vulnerable situations. This practice is in accordance with methodological guidelines, which recommend appropriate environments for data collection, ensuring the integrity and quality of the information obtained.

The first ten interviews comprised the pilot study, which aimed to evaluate and adjust the questions in the collection instrument, as well as to improve the approach with participants. Since no significant changes were needed in the script, these interviews were fully included in the final dataset for analysis. Subsequent interviews were conducted on days and times previously agreed upon with the service, so as not to interfere with their routine.

Sociodemographic data were presented descriptively. Responses to the adapted ISMI questions were recorded on a digital media device and fully transcribed to preserve the content of the statements. The data were then entered into the Qualitative Data Analysis Software (QDAS), version 2022.5 of MAXQDA®. This tool is widely used in the analysis of textual data, especially in studies based on interviews, focus groups, documents, and observations⁽¹²⁾.

The main features of a QDAS include text import, creation of hierarchical coding structures, access to coded segments, analysis of texts in their original context, and the development of notes or memos. The qualitative analysis was guided by the methodological framework of thematic content analysis, as proposed by Bardin⁽¹³⁾, a widely used approach in qualitative studies as it allows for the identification of both manifest and latent meanings in narratives.

An exhaustive reading of the digitized texts, in accordance with the first stage of content analysis proposed by Bardin⁽¹³⁾, contributed to the definition and understanding of the categories. Following the three phases of the technique - pre-analysis, material exploration, and treatment of results⁽¹³⁾, the corpus was organized and coded with the support of MAXQDA[®], software, using the "in vivo coding" function to preserve the participants' significant expressions.

The codes were organized into hierarchical structures within the MAXQDA[®], category system, allowing the visualization of frequencies, patterns, and occurrences through the "Code Matrix Browser" and "Code Relations Browser" tools. In the axial coding stage, the codes were grouped into thematic categories, allowing the construction of more comprehensive and analytically meaningful units of meaning, aligned with the research objectives.

In addition to textual coding, note-taking and analytical memo tools were used to record theoretical reflections and interpretative decisions throughout the process. The analysis was guided by the adopted theoretical framework and guided by the theoretical saturation technique, used to set the endpoint of data collection⁽¹³⁻¹⁴⁾.

Data interpretation was guided by the Dorothea Orem's concept of self-care, an American nurse and theorist, whose studies address the human functions performed by individuals to maintain functioning compatible with essential conditions for life, integrity, and personal development⁽¹⁰⁾.

Ethical considerations

This study complied with the ethical recommendations established by Resolution No. 466/2012 of the National Health Council and was approved by the Research Ethics Committee of the *Centro Universitário Maurício de Nassau*, under Opinion No.5,411,58 and Certificate of Presentation for Ethical Consideration No. 58293622,2,0000,5193.

RESULTS

The study included 22 users with a mean age of 34.5 years old (ranging from 20 to 51 years old). The majority were male (19) and had lived on the streets for more than three years. Regarding marital status, most reported being married or in a stable union, and 19 participants stated to have between one and five children. Regarding healthcare seeking, 12 participants stated seeking services between one and three times a year; six stated rarely or never; and only four stated seeking care more than three times per year.

Regarding education level, most participants reported not having completed elementary or high school (16). Only a few reported having completed elementary school (3) or higher education (3).

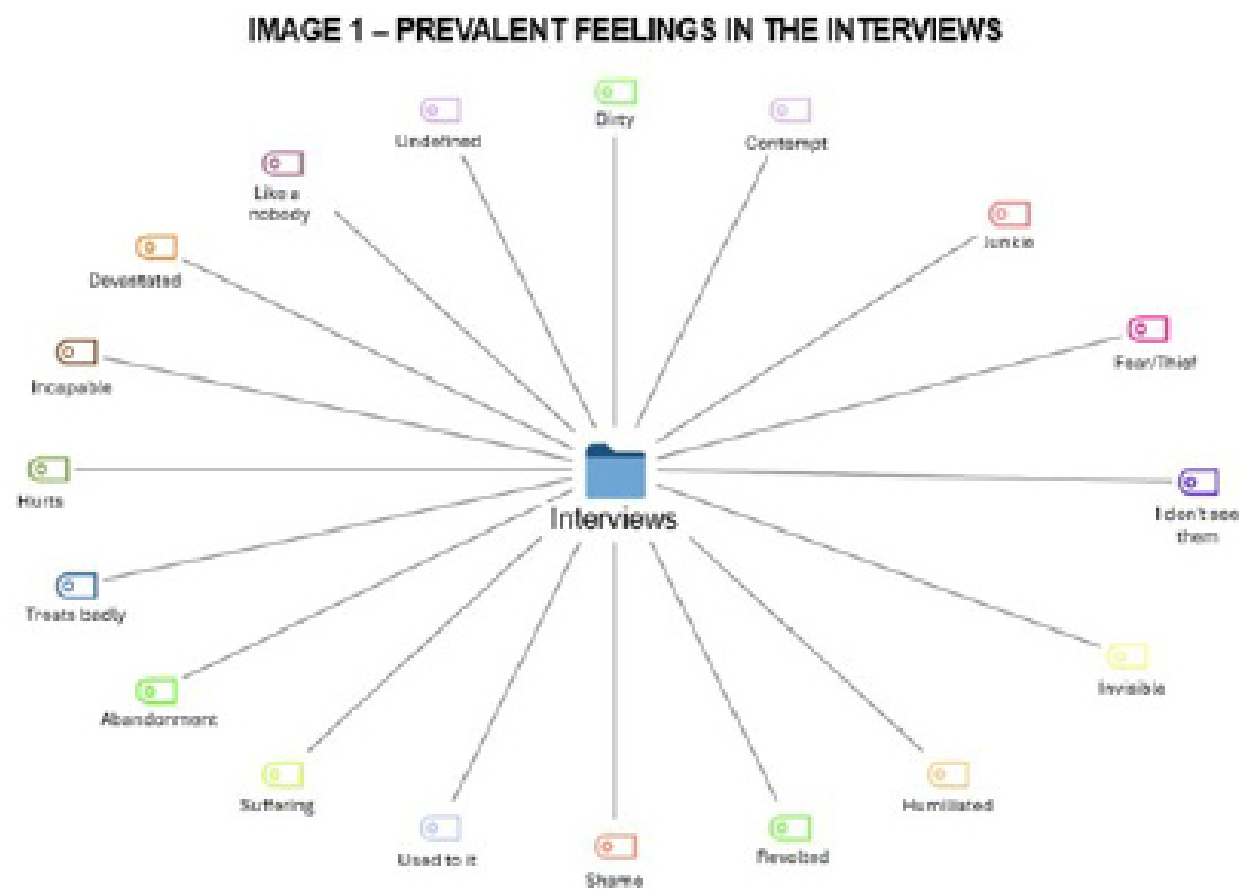
More than half of the participants' income comes from government programs (14); however, a small portion of the group stated having no source of income (5). Alcohol and other drug use, and family conflicts were the most frequently cited reasons for entering the street life. All participants reported having used some type of drug at some point in their lives. When asked about personal hygiene, almost all reported taking a daily shower (20).

The following figures present, respectively, the predominant feelings in the interviews and the most frequently used words in each category. Both images were extracted from MAXQDA[®] software. Figure 1 shows the emergence of 18 recurring feelings across the three categories analyzed. Notably, positive feelings were not among the most prevalent. In contrast, negative feelings stood out in the participants' statements, suggesting the predominance of unfavorable perceptions in their discourses.

Figure 2 illustrates the most frequently used words in each category, represented by different colors: blue for category 1; yellow for category 2; and red for category 3. These categories reflect the predominant feelings of each HP at different stages of the interview, allowing for a comparative view of the perceptions expressed throughout the process.

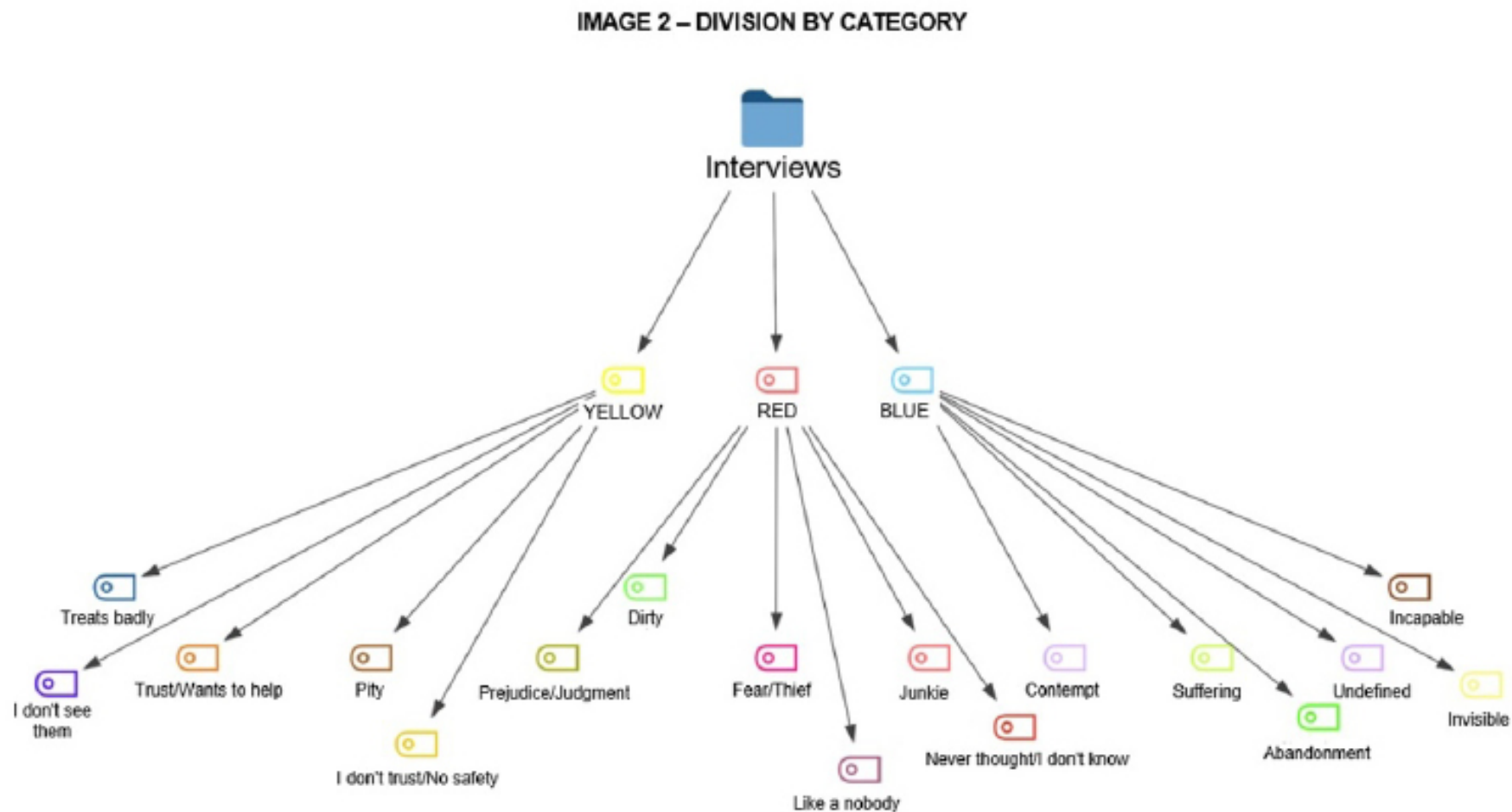
From the data analysis, using MAXQDA[®] software, three thematic categories emerged: "Negative feelings about being homeless"; "Perception of how society views them"; and "Perception of the homeless individual about others living in the same conditions". Exhaustive reading of the digitized texts, combined with content analysis as proposed by Bardin, significantly contributed to the definition and understanding of the categories, as well as to the qualitative interpretation of the data.

Figure 1. Prevalent feelings in interviews with the Homeless Population. Recife, Pernambuco, Brazil, 2023.



Source: Prepared by the authors with MAXQDA® 2022 (VERBI Software, 2022.5), 2023.

Figure 2. Division by category of the prevalent feelings among the Homeless Population. Recife, Pernambuco, Brazil, 2023.



Source: Prepared by the authors with MAXQDA® 2022 (VERBI Software, 2022.5), 2023.

Category 1: Negative feelings about being homeless

This category highlighted the feelings expressed by participants regarding their experience of homelessness. It was observed that most reported predominantly negative feelings, such as sadness and guilt, associated with the experience. Additionally, they highlighted the perception of a lack of concrete alternatives to change this reality, as illustrated by the interview excerpts presented below:

Sad. It's all very difficult! (I7)

Humiliated, angry, I didn't want to be like this, I feel ashamed too... (I11)

It's bad, my aunt, the person becomes worthless, but God knows everything! (I17)

Worry about children and family members appeared in the reports of some participants, who expressed feelings of discouragement and guilt due to their living conditions:

Devastated! Not for me, but for him (my son), because sometimes, when I don't have a shelter, like, in my family's house. Then, if I'm under a supermarket, and everyone sees me with him, then I feel downcast, old, devastated. It's like an old rag. (I3)

I feel sad, hurt. I just don't feel desperate, don't feel crazy, you know, but I feel very dejected, very sad and tired of this horrible thing, this ugly thing... I get sad... that there are people going through things because of me, you know, like my mother, my son [...] (I22)

Only one participant reported that living on the streets wasn't exclusively negative, stating that he felt good most of the time:

I feel good. Sometimes I'm feeling hurt and want to leave, want to go home, because that's the situation on the street. But the street isn't bad, man. It's not bad, it's good! It has everything! (I1)

Category 2: Perception of how society views them

This category highlighted how participants perceive society's view of them. According to their reports, there is a recurring concern about how they are observed and judged,

a perception that manifests especially in the way people look at them in everyday life.

Prejudice and Judgment. People think we're here because we want to be, but no one wants to be on the streets, risking death at any moment, unable to sleep properly, or doing anything for fear of others. (I11)

Participants reported feeling that society views them as useless, dangerous, or associated with drug use. This form of social discrimination and prejudice is perceived even when not explicitly verbalized, evidenced by attitudes such as fear, indifference, and avoidance of close contact, as most interviewees reported:

They're afraid, they think we're going to steal, I just beg, nothing else! (I12);

Like a junkie, right? A homeless person is useless [...] (I2) [...] sometimes, we see it in people's eyes, right? For example, sometimes we're lying down like "crazy," people walk by, and sometimes we're even using drugs, right? People pass by, and that look there, man, I don't know [...] (I8)

They must see us as terrible, because if someone steps off a sidewalk—this is what I saw. The person is here. The sidewalk is clean, but they'd rather walk through the mud than walk on the sidewalk or next to you. So, that means you're dirtier than that mud they're walking through. Isn't that it? (I6)

Two participants said they didn't know how to answer the question, mentioning that they had never thought about how society views them:

Man... I don't know how to answer! Now I want to find out! One of these days, I'll ask. (I9)

I never even thought about it. I never even stopped to think about that! (I1)

Category 3: Perception of the homeless individual about others living in the same conditions

This category analyzed how participants perceived each other within their own group. Although they acknowledge that they shared experiences of suffering, their reports revealed a marked lack of mutual trust. There was also a highlighted perception that drug use contributes to an

increased sense of insecurity among individuals experiencing homelessness themselves:

[...] I trust while distrusting... people who use drugs can't be trusted, I don't trust them at all [...]. (I21)

I felt sorry, but I couldn't do anything, and I couldn't trust anyone. (I11)

I don't feel safe! I don't trust anyone! (I17)

I don't feel safe, there's too much trickery. (I5)

Only one participant stated that they trust the people they live with in the same places, even demonstrating feelings of affection toward them:

They don't like it either, it's really bad, but I trust them because I always see the same people in the same places. (I13)

■ DISCUSSION

The sociodemographic characteristics of the participants in this study corroborate findings from other studies on homeless people, especially regarding the predominance of males, living with partners, and having children^(2,15). It is observed that the predominant age group corresponds to the productive age, and most participants have some source of income, usually from informal work.

In the context of capitalism, a significant portion of the population is unable to enter the formal labor market. In this model, where an individual's value tends to be measured by their productivity and consumption capacity, those who do not fit to these standards are often relegated to invisibility and marginalization. This process is directly reflected in the living conditions of homeless people, reinforcing mechanisms of social exclusion and the reproduction of structural inequalities.

When considering the principle of universality of the Unified Health System (*Sistema Único de Saúde*), which provides for equal access to healthcare services for all citizens, it becomes necessary to question the extent to which this principle is implemented in the care of HP. Although guaranteed by law, this population's access to healthcare services is marked by material, symbolic, and institutional barriers that compromise universality. The meritocratic and exclusionary logic that permeates the social system widens the gap between the constitutional ideal of a universal system and the concrete experiences of historically marginalized groups⁽¹⁶⁾.

Regarding education, most participants reported not having completed elementary school. From this perspective, it is observed that lower educational levels may predispose individuals to deficits in self-care, since the ability to perform self-care practices is acquired throughout life and is subject to conditioning factors, such as education level⁽¹⁷⁾. However, it is noteworthy that a small percentage reported having completed higher education. In this context, it is understood that, regardless of education level, other variables can overlap, leading individuals to homelessness, such as the use and abuse of psychoactive substances.

Studies point out that the use and abuse of psychoactive substances are among the main factors associated with homelessness, as this practice is often related to family conflicts, unemployment, involvement in illicit activities, and chemical dependency. Excessive consumption of these substances leads to several physiological and behavioral consequences, such as increased morbidity and mortality associated with diseases, compromised self-care, and worsening mental health^(18–20).

Psychoactive substances have physical and chemical properties capable of interfering with vital functions, causing progressive damage to the body, and leading to chemical and psychological dependence. In this context, withdrawal becomes a significant obstacle for HP, even though overcoming it is essential for their own survival⁽²¹⁾. From another perspective, the perception of social exclusion can undermine self-care actions due to difficulties in adhering to necessary practices. Therefore, it is understood that the entire context experienced on the streets directly impacts self-care deficits, as it represents a condition of vulnerability associated with continuous exposure to physical and psycho-emotional harm resulting from the daily struggle to meet basic human needs⁽²²⁾.

Contrary to the common belief that HP do not maintain hygiene, most participants reported bathing daily, a practice that represents a relevant self-care action, as it contributes to improving self-esteem, health, and well-being. According to an analysis conducted in a study, self-care aims to encourage behaviors that specifically promote the integrity of vital functions and human development⁽¹⁰⁾.

The capacity for self-care can be influenced by various factors, such as culture, life experiences, socioeconomic conditions, family structure, age, gender, and education. According to self-care theory, a person who has the potential to meet their own health needs is considered a self-care agent. Otherwise, they become dependent on the support of others to meet these needs, as they are unable to autonomously fulfill all the demands required for adequate self-care⁽¹⁰⁾.

This context involves not only a lack of individual resources but also a lack of adequate assistance from professionals and public policies to ensure the rights to citizenship and health. The feelings identified through analysis using the MAXQDA® software⁽¹²⁾ demonstrated a predominance of negative perceptions among participants, influenced both by their experience on the streets and by how they are viewed by society and how they perceive other homeless people.

The negative feelings associated with street life, cited by most participants, reaffirm that stigma constitutes a social marker that assigns negative value to the stigmatized individual. The relationship between stigma and the stigmatized person involves moral disqualification and feelings of humiliation on the part of the stigmatized person⁽²³⁾. HP express feelings of hopelessness regarding the possibility of changing their living conditions, reporting shame in front of others and their families. From this perspective, self-care ceases to be a daily practice, and is often neglected.

It is observed that many homeless individuals feel guilty for not being able to maintain self-care, ensure survival with dignity, and provide care for their family members. The lack of qualified assistance and the limited prospect of improving living conditions contribute to the perception that this group is neglected, both socially and by the government⁽²⁴⁾. It is important to highlight that these factors impact the lives of HP in different ways and degrees, as they not only interrelate but also feed off each other, hindering the adoption of self-care practices.

Healthcare institutions have as fundamental principles the promotion of citizenship and respect for the choices of all patients. However, they often adopt welfare-based actions that tend to view HP as individuals lacking autonomy, culture, and values. From this perspective, the denial of rights reinforces the perception that the events in their lives do not trigger social interest. Such symbolic markers contribute to the individual's distance from access to material and symbolic goods of society, including healthcare services, which they often avoid out of shame, fear of rejection, or mistreatment⁽²⁵⁾. Consequently, practices aimed at preserving life, health, development, and well-being fail to be executed.

The existence of HP represents a counterpoint to the social order, as they are neither fully integrated into society nor able to detach from it. Stigma, in this context, refers to the preconceptions that transform normative expectations into rigid and exclusionary demands. There are three distinct types of stigma: bodily abominations, related to physical deformities; perceived character flaws, related to criminal history, drug addiction, unemployment, sexual orientation, political activism, and mental disorders; and tribal stigmas, linked to race, nationality, or religion, which can be inherited

through family line and attributed to all its members⁽⁵⁾. These socially constructed stereotypes contribute to individuals distancing themselves from self-care practices, as they reinforce feelings of exclusion and personal devaluation.

Socially directed attitudes toward stigmatized individuals and the behaviors adopted to them are widely recognized, as it is assumed that stigmatized individuals are not fully human. Stigma, in this sense, encompasses two complementary aspects: the moral mark and the supposed character deformity. The use of derogatory terms to classify stigmatized groups is common and negatively impacts the encouragement of positive health practices⁽²⁶⁾. In the interviews, expressions such as "junkie", "thief", and "outlaw" were identified, reflecting internalized social prejudice. Based on this behavior, Goffman highlights the existence of multiple forms of discrimination, through which the chances of life and dignity of stigmatized individuals are often reduced⁽⁵⁾.

The presence of perceived stigma was evident, as HP recognize the social judgment they are subjected to, especially through behaviors of avoidance, fear, and rejection directed at them. In this context, participants reported situations where passersby crossed the street or even stepped in puddles to avoid being near them. Such episodes highlight the presence of prejudices that attribute exclusive responsibility to the HP for their living conditions, as if these were the result of a personal choice.

In category 3, the presence of internalized stigma was strongly evident in the participants' statements, reflecting the process of internalizing stigma, which becomes central to their psychological conditions. This process leads to decreased self-esteem and self-efficacy, a perception of discredit, as well as feelings of shame, guilt, anguish, anger, and self-blame. Furthermore, internalized stigma generates several practical implications, such as limited prospects for recovery and restricted social support networks⁽²⁷⁾.

The feelings of self-rejection and low self-esteem expressed in the interviews are directly related to the stigmatizing and discriminatory practices experienced by the participants. This context hinders the establishment of interpersonal bonds, including with others in similar situations, highlighting the presence of internalized stigma. Thus, the prejudiced and negative view directed at HP compromises both access to and continuity of healthcare.

Stigma has significant consequences for individuals, such as social isolation, deterioration in quality of life, and loss of self-esteem. This context contributes to the distancing of users from social and healthcare services, further worsening their living conditions⁽⁸⁾. Self-care deficit is identified by the discrepancy between self-care demands and the individual's ability to meet them. According to Orem's theory⁽¹⁰⁾, the term

does not refer to a “human disorder” but may be associated with functional or structural dysfunctions of the human being. In this sense, internalized stigma significantly compromises the maintenance of health care.

To address such difficulties, Orem⁽¹⁰⁾ identified five methods of support that aim to promote self-care in individuals: (1) acting for or doing for another; (2) guiding another; (3) offering physical or psychological support; (4) providing an environment that promotes personal development, enabling individuals to meet current and future needs; and (5) teaching another. From this perspective, professionals working with HP can support individuals in initiating and maintaining self-care, as well as prescribing, providing, and regulating direct forms of assistance in daily living activities and social, educational, and health needs.

The guarantee of comprehensive health care is a right of the HP, just like other citizenship rights. Therefore, priority should be given to adapting existing actions and services to ensure equity and universal access within the Unified Health System (*Sistema Único de Saúde*) through interdisciplinary and multiprofessional care. Strengthening health promotion actions, with an emphasis on the Street Clinic Program (*Programa Consultório na Rua*), has the potential to expand access to prevention, promotion, and treatment of high-incidence conditions in this population, such as sexually transmitted infections/AIDS, tuberculosis, leprosy, mental disorders, and conditions resulting from alcohol and other drug use, among others⁽²⁸⁾. Additionally, such strategies contribute to encouraging self-care practices among the HP.

The PNPSR is the result of an institutional effort aimed at defining guidelines that enable full access to the rights guaranteed to all Brazilian citizens, as well as opportunities for full social development. This policy considers the specificities of living in public spaces and the meanings constructed by experiences of living on the streets. In this sense, it aims to strengthen and reestablish family and community networks⁽³⁾. However, analysis of the interviews reveals that these objectives have not yet been fully achieved and that the presence of social stigma directly influences how this group perceives and identifies itself.

Thus, HP need to constantly reaffirm their status as human beings and citizens to access fundamental rights, as well as to cope with prejudice and social judgments. Society has historically constructed a negative image of this group, based on stereotypes that hinder access to opportunities for change and social reintegration.

The limitations of this study include the fact that data collection was conducted exclusively with HP who attend the POP Center, which may limit the representativeness of the findings, considering the growth and dispersion of this

population across different regions of the city. Furthermore, the average interview duration of approximately 12 minutes may have limited the depth of the narratives, as it was not possible to conduct follow-up interviews. Given these limitations, it is recommended further studies with larger samples and expanded methodological approaches allowing a deeper understanding of the effects of internalized stigma on this population.

Another limitation concerns the use of Dorothea Orem's concept of self-care. Developed in a different context, this framework may not encompass the complexities of HP. It is necessary to reflect on the adequacy of nursing theories in contexts of vulnerability, considering interdisciplinary approaches that broaden and reframe the analytical categories.

■ FINAL CONSIDERATIONS

This study reaffirms the social stigmatization of HP and advances by highlighting mechanisms of internalization of stigma, such as self-blaming for their own condition and the adoption of socially constructed negative perceptions. These mechanisms generate significant subjective consequences, such as shame, guilt, and low self-esteem. It is also observed that participants' views of their own group reproduce social stigmas, reflecting distrust and, at times, contempt.

Internalized stigma reduces an individual's ability to seek help, while socially imposed stigma undermines compliance with intersectoral guarantees designed to ensure the rights of HP. Orem's theory identifies possibilities for supporting self-care that involve guaranteeing rights, providing ethical and effective care, and implementing public policies aimed at this population group.

It is recommended to invest in actions that promote the dissemination of norms and practices to address social stigmatization processes and reduce internalized stigma, through inclusive care and humanized access to health promotion actions and social programs. Such changes require collective engagement, political mobilization, and concrete actions to cope with inequalities.

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■ Data and material availability

Access to the dataset is available upon request from the corresponding author.

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■ Authorship contributions

Project administration: Fabia Maria de Lima
Conceptualization: Felicialle Pereira da Silva
Formal analysis: Emanuela Batista Ferreira e Pereira
Investigation: Carla Aparecida Arena Ventura
Methodology: Talita Bianca Lima da Paixão
Supervision: Felicialle Pereira da Silva
Data presentation design: Isla Daniela da Silva Pinto
Data presentation design: Jael Maria de Aquino
Writing-original draft: Talita Bianca Lima da Paixão
Writing-review & editing: Simone Maria Muniz da Silva Bezerra

The authors declare that there is no conflict of interest.

■ Corresponding author:

Talita Bianca Lima da Paixão
Email: talitabianca28@gmail.com

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Deise Lisboa Riquinho

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