Esc Anna Nery 2025;29:e20240128

RESEARCH

www.scielo.br/EAN

Interpretations of illness and meanings attributed by people experiencing homelessness with mental disorders[a]

Interpretações da doença e significados atribuídos por pessoas em situação de rua com transtornos mentais

Interpretaciones de la enfermedad y significados atribuidos por personas en situación de calle con trastornos mentales

Letícia Passos Pereira[1]
Christine Wetzel[1]
Agnes Olschowsky[1]

1. Universidade Federal do Rio Grande do Sul, Programa de Pós-Graduação em Enfermagem. Porto Alegre, RS, Brasil.

ABSTRACT

Objective: to present how people experiencing homelessness and living with mental disorders interpret their illness process. **Method**: this qualitative study employs a theoretical-methodological approach rooted in the anthropology of health. Narrative interviews were conducted and analyzed using Fritz Schütze's framework. Interviews were carried out with five individuals experiencing homelessness and mental disorders, who were supported by a Street Outreach Clinic in capital city in southern Brazil during the second half of 2019. **Results**: perspectives emerged related to depression, self-harm, suicidal thoughts and attempts, sensory-perceptual experiences, "being nervous," psychotic episodes, and drug use. The findings revealed that participants received heterogeneous psychiatric diagnoses. Their (re)interpretations of the psychiatric explanatory system, shaped by their suffering experiences, and their unique ways of addressing, coping with, and legitimizing these experiences were influenced by cultural, social, political, and economic systems. **Final considerations and implications for practice**: the study highlights the importance of understanding illness as connected to existential suffering, as an approach solely based on symptoms limits care possibilities. It reinforces the need for care practices that consider individuals' life contexts and subjectivities, emphasizing interdisciplinary and culturally sensitive approaches.

Keywords: Medical Anthropology; Homeless Persons; Mental Health; Mental Disorders; Social Vulnerability.

RESUMO

Objetivo: apresentar como as pessoas em situação de rua com transtornos mentais interpretam seu processo de adoecimento. **Método:** consiste em um estudo qualitativo, com abordagem teórico-metodológica da antropologia da saúde. Utilizou-se entrevistas narrativas e análise com o referencial de Fritz Schütze. As entrevistas foram realizadas com cinco pessoas em situação de rua com transtornos mentais, acompanhadas por um Consultório na Rua de uma capital do sul do Brasil, no segundo semestre de 2019. **Resultados:** emergiram as perspectivas relacionadas a: depressão; autolesão, pensamentos e tentativas de morte; experiências sensoperceptivas; "ser nervosa"; surtos e uso de drogas. Evidenciou-se que os participantes recebem diagnósticos psiquiátricos heterogêneos e as (re)interpretações que fizeram do sistema explicativo da psiquiatria, a partir de suas experiências de sofrimento, e as maneiras próprias de abordar, lidar e legitimá-lo, tiveram influência de sistemas culturais, sociais, políticos e econômicos. **Considerações finais e implicações para a prática:** ressalta-se a importância de compreender a perspectiva da doença ligada a um sofrimento existencial, pois uma abordagem exclusivamente baseada em sintomas limita as possibilidades de cuidado. Reforça-se a necessidade de práticas de cuidado que considerem o contexto de vida dos sujeitos e suas subjetividades, valorizando abordagens interdisciplinares e culturalmente sensíveis.

Palavras-chave: Antropologia da Saúde; Pessoas em Situação de Rua; Saúde Mental; Transtornos Mentais; Vulnerabilidade Social.

RESUMEN

Objetivo: presentar cómo las personas en situación de calle con trastornos mentales interpretan su proceso de enfermedad. **Método**: estudio cualitativo con un enfoque teórico-metodológico de la antropología de la salud. Se utilizaron entrevistas narrativas y se realizó un análisis basado en el marco de referencia de Fritz Schütze. Las entrevistas se llevaron a cabo con cinco personas en situación de calle con trastornos mentales, atendidas por un Consultorio Callejero de una capital del sur de Brasil, durante el segundo semestre de 2019. **Resultados**: se advirtieron perspectivas relacionadas con la depresión, la autolesión, los pensamientos y tentativas de suicidio, las experiencias sensoperceptivas, "ser nerviosa", los episodios psicóticos y el consumo de drogas. Se evidenció que los participantes reciben diagnósticos psiquiátricos heterogéneos y que las (re)interpretaciones que hicieron del sistema explicativo de la psiquiatría, a partir de sus experiencias de sufrimiento, así como las maneras propias de abordarlo, enfrentarlo y legitimarlo, estuvieron influenciadas por sistemas culturales, sociales, políticos y económicos. **Consideraciones finales e implicaciones para la práctica**: se resalta la importancia de comprender la perspectiva de la enfermedad ligada al sufrimiento existencial, ya que un enfoque basado exclusivamente en los síntomas limita las posibilidades de atención. Se refuerza la necesidad de implementar prácticas de atención que consideren el contexto de vida de los sujetos y sus subjetividades, y así valorar enfoques interdisciplinarios y culturalmente sensibles.

Palabras clave: Antropología Médica; Personas con Mala Vivienda; Salud Mental; Trastornos Mentales; Vulnerabilidad Social.

Corresponding author:
Letícia Passos Pereira.
letipassos23@gmail.com

Submitted on 01/13/2025.
Accepted on 04/16/2025.

DOI:https://doi.org/10.1590/2177-9465-EAN-2024-0128en

INTRODUCTION

This article explores how individuals experiencing homelessness and living with mental disorders, assisted by a *Consultório na Rua* (Street Outreach Clinic) team, understand their illness process.

Grounded in medical anthropology, the theoretical framework supports the articulation of participants' own perspectives on illness and care. This approach enables analysis of how they interpret these experiences based on the ways illness affects their behavior, relationships, care-seeking pathways, and responses, resulting in individualized and subjective meanings.[1]

Explanatory models for a single illness episode can vary significantly depending on context, speaker, and audience. Illness may be interpreted through a biological lens, focusing on physiological or psychological symptoms (disease), as well as through the subjective experience of the affected person (illness). The concept also involves communication and interpersonal interaction, particularly within family and social networks.[1]

Therefore, in addressing illness interpretations within a specific group, individuals experiencing homelessness and living with mental disorders, it is essential to consider the specific vulnerabilities and contextual conditions to which these individuals are exposed.

The relevance of this perspective aligns with a paradigmatic shift in the theoretical and practical field of mental health, oriented toward overcoming the asylum-based model.[2] Inspired by the principles of the Psychiatric Reform, this shift aims to break away from a paradigm exclusively centered on disease, recognizing that decoupling mental health care from the disease itself and focusing on the person who suffers, perceives, and feels what is being experienced can transform established practices.

Accordingly, understanding the cultural construction of illness as a psychosocial experience from the perspective of the affected person enables access to alternative interpretative frameworks. Mental health care, often shaped by psychiatry's explanatory models, tends to overlook or delegitimize other understandings of illness.

This article thus aims to present how individuals experiencing homelessness and living with mental disorders interpret their illness processes.

METHOD

This is a qualitative study based on the perspective of medical anthropology.[1] The research was conducted within a *Consultório na Rua* (CR) program located in a capital city in southern Brazil. Empirical data were collected through narrative interviews conducted between July and October 2019, supplemented by a review of electronic medical records from the E-SUS system. These records were used to identify health professionals' assessments, documented diagnoses, and clinical impressions, allowing for the inclusion of multiple professional perspectives.

The interviews were conducted by a researcher trained in Nursing, with experience in qualitative research and prior involvement with vulnerable populations. The researcher had no previous relationship with participants, and their role in the study was clearly explained at the start of each interview to ensure transparency regarding the research objectives.

Participants were selected through purposive sampling based on the following inclusion criteria: living in homelessness for at least six months, having a diagnosed mental disorder, and possessing sufficient cognitive and communication abilities to comprehend and participate in the research. The exclusion criterion was the inability to establish dialogue, which rendered interviews unfeasible.

Recruiting participants posed a significant methodological challenge due to the characteristics of the target population. Many individuals experiencing homelessness initially expressed mistrust toward the study, requiring sustained effort from the researcher to establish a minimal rapport necessary for conducting the interview. To reduce this barrier, direct and respectful approaches were adopted, prioritizing accessible explanations of the study's purpose. In certain cases, prior informal interactions were needed before participants felt comfortable enough to share their stories. Additionally, recruitment was not immediate: multiple attempts were necessary to ensure that participants met the inclusion criteria. Therefore, the final sample was drawn from a broader group, including only those who qualified and agreed to participate.

The methodological perspective sought to deepen the understanding of how individuals experiencing homelessness and mental disorders interpret and assign meaning to their condition, considering their life histories. For this purpose, the narrative interview method was employed, a valuable tool for understanding how individuals construct identities through life storytelling.[3] Narratives allow for subjective expression and the emergence of new meanings around experiences, positioning the narrator as central and active in the care process.[4] Considering individuals experiencing homelessness as informants also presents the advantage of enabling their voices to be heard, as these individuals are often stigmatized, excluded from research, and have their stories disregarded.

Interviews were conducted in person, in a private room within the CR facility, ensuring privacy and safety. Initial contact was made directly at the facility, where potential participants were invited to take part in the study. Those who agreed received detailed information about the research and signed an Informed Consent Form (ICF).

Interviews were audio-recorded and lasted a mean of 50 minutes. The interview protocol followed the structure of narrative interviews: initial contact and negotiation, main story, questioning phase, and conclusion.[5,6]

The initial phase involved inviting the participant and explaining procedures via the ICF. Upon initiating the narrative, participants were encouraged to share their life stories, marking the beginning of the main story phase. Notes were taken during this stage to guide later clarifying questions. The questioning phase followed, exploring sub-stories and expanding on earlier notes. The interview concluded with a brief closure to avoid ending immediately after the narration of traumatic or distressing episodes.[7] Each participant was interviewed individually and only once.

After full transcription, the interviews were analyzed following the stages proposed by Fritz Schütze[5] for narrative interviews. The first stage, formal text analysis, involved organizing the text and identifying life trajectories in chronological order. Next, structural description of the content examined each trajectory in detail, identifying various processual structures throughout life. Analytical abstraction enabled the reconstruction of the overall biography, emphasizing the participants' argumentative theoretical contributions concerning their life stories, identities, and paths during the knowledge analysis phase. Contrastive comparison grouped and analyzed the interview set, identifying similarities and differences.[7]

Participants did not review or validate the transcripts of their interviews, which was considered a study limitation. Data were analyzed based on three categories established during the exploratory phase: conceptions of care, interpretation of illness, and therapeutic itineraries. This article discusses findings related to the "interpretation of illness" category.

To minimize interpretation bias, a structured analytical approach was adopted and reviewed by more than one researcher. Findings were triangulated through consultation of the electronic records in the E-SUS system, allowing for comparison between participants' narratives and clinical documentation. Diversity of voices was prioritized to ensure that various perspectives were included in the final analysis.

The study complied with all ethical and legal principles governing research involving human subjects, in accordance with Resolution No. 466/2012 and Resolution No. 510/2016, which establishes specific guidelines for research in the Human and Social Sciences. To ensure participant anonymity, fictitious names were used, and no identifying information was included. The study received approval from the Ethics Committee of the Federal University of Rio Grande do Sul (UFRGS), approval no. 3.272.312/2019, and from the Research Committee of the Municipal Government of Porto Alegre, approval no. 3.336/2019.

RESULTS

Findings indicate that all study participants had multiple psychiatric disorder diagnoses, which were grouped into four categories according to the International Classification of Diseases (ICD-11):[8] Anxiety Disorders, Mood Disorders, Psychotic Disorders, and Substance Use Disorders.

Anxiety disorders were identified in Elza and Luiz. Mood disorders appeared in the records of five all participants – namely, Elza, Luiz, Pablo, Rita, and Sarita. Substance use disorders were documented for Elza, Luiz, and Pablo, while psychotic disorders were diagnosed in Luiz, Pablo, and Rita.

The results reveal how participants recognize, explain, and reinterpret their mental health conditions, their manifestations, and related aspects, drawing upon Arthur Kleinman's (1980) explanatory models of disease and illness.

Their interpretations reflect dynamic, multifaceted understandings of mental illness. Although some narratives adopt medical terminology, the meanings assigned to these terms shift when interpreted through the lens of lived experience.

To enhance clarity and highlight participants' perspectives, these interpretations were organized into three main categories: Mood Disorders and Self-Injurious Behaviors, Sensory-Perceptual Experiences, and Behaviors and Expressions of Distress. These categories are presented in Charts 1, 2, and 3, respectively, along with narrative excerpts. This structure supports a more nuanced understanding of how participants experience and re-signify mental illness.

DISCUSSION

The variety of diagnoses found in the participants' medical records may be related to several factors, including possible changes over time in the various assessments conducted by different professionals, and the inherent difficulty of establishing accurate diagnoses in non-specialized services.

The presence of multiple, overlapping diagnoses underscores the complexity of psychiatric conditions affecting this population. It reinforces the need for interdisciplinary and integrated approaches, particularly in contexts of extreme social vulnerability, such as among individuals experiencing homelessness and assisted by CR teams.

These diagnoses follow psychiatric classification systems that often do not align neatly with a single disorder, revealing internal inconsistencies within these frameworks.[9] Participants' interpretations of illness, and the meanings they assign to their suffering, may reflect either a reinterpretation of the diagnosis or entirely alternative frameworks of understanding.

On one hand, institutionalized illness follows nosographic classifications created by the professional sector. On the other, lay interpretations are dynamic and, even when linked to psychiatric symptoms, tend to be expressed in culturally meaningful and socially accepted ways.[10]

One interpretation observed involved depression, which participants often described as related to difficult life circumstances rather than as a strictly medical condition. Depression was associated with emotional fluctuations and linked to life events that intensified feelings of helplessness. In many cases, these emotions were not experienced as pathological, but rather as part of the intrinsic distress of their social condition.

Labeling these feelings—such as sadness, hopelessness, and discouragement—as "depression" allowed individuals to find a socially recognized explanation for their suffering.[11] In this sense, the psychiatric label offers a way to communicate subjective pain and gain legitimacy in the face of ongoing adversity.

In a society marked by narcissism, fluidity, and a lack of stable reference points, where suffering is often silenced, individuals who cannot meet cultural expectations are blamed for their failures.[11] Consequently, existential distress becomes internalized as illness, demanding strategies for management and survival.

Chart 1. Mood Disorders and Self-Injurious Behaviors.

Interpretation	Characteristics	Narrative fragments
1. Depression	1.1. Feeling "low-spirited"; weakness and prostration; prolonged periods of loss of appetite and excessive sleep.	*I was feeling down, in a deep depression. (Sarita).* *I fell into depression. I went forty days without eating, just sleeping. [...] I couldn't get up, I felt weak. (Pablo)*
	1.2. Described as suffering, in contexts of violence, deprivation and hardship.	*I fell into depression, I was assaulted. I went through a lot of hardship. (Luiz)*
2. Self-injury, thoughts and attempts to kill	2.1 Dimensions: - Health problem; - Relief from suffering; - Religious belief.	*I started having health problems, started cutting myself [...] Every time I took medication, I took it all at once. (Pablo)* *When the alcohol, the drugs, and the medication run out, then it leads to depression, and I start cutting myself. I feel relief, pleasure, euphoria. [...] It's not to end my life, it's as if it gives me strength to go on. [...] [cutting] It's kind of an obligation. The more I fulfill my obligation, the more things will get better. Because how is he* [Exu] *going to give me the things I'm asking for, if I'm not able to give him what he wants? (Luiz)* *I don't know how I haven't killed myself* [referring to her living conditions], *because you're not supposed to do that, it's in the Bible. (Rita)*

Chart 2. Self-Injurious Behaviors.

1. Sensory-perceptual experiences	1.1. Listening to voices: - Present since childhood trajectories; - Feelings: fright, acceptance, comfort, a sense of welcome; - - Communication with deities; - Warning of dangers. -	*At first, I was scared, but now I've accepted him* [Exu] *as a guide, as a father. He is important, he's giving me strength to get up. (Luiz)* *It was nice talking to people, even if they didn't exist. At least there was someone who listened to me, who understood what I was saying. (Pablo)* *Voices like: "That one wants to kill you!" (Rita)*
	1.2. Visions: - Involved people, images, lights and religious beings such as saints and angels; - Recourse to divine help in times of despair. -	*I saw a hand, like a fig gesture [...] in the yard, there were some benches and there was a statue of a saint. I looked inside that statue and saw a light coming out of its eyes. (Sarita)* *They looked like angels, but they were people with fluorescent lights, walking on the ceiling. People who didn't exist. (Pablo)* *God gives me the vision. I can even see the street where he is, and I can see what he looks like* [referring to her missing husband]. *(Elza)*
	1.3. Olfactory manifestations: - Contact with significant people who are already dead.	*He* [her deceased husband] *used to give me a tiny perfume bottle, like the kind you find in mansions. [...] It was a way of saying he was there. That rose scent would invade my whole body, and I felt he was right there next to me. (Elza)*

Chart 3. Behaviors and Expressions of Distress.

1. "Being nervous"	1.1. Differentiating between "being nervous" and "being crazy".	*I'm short-tempered! Crazy is one thing – crazy kills – and being short-tempered is another. [...] Just say 'calm down' and that works, but crazy, crazy has to scream. (Rita)*
	1.2. It manifests itself through phobias, mistrust, disorganization and infantilization.	*I'm phobic, all messed up. I'm not a child anymore, but my mind... Did you see the papers?* [referring to wet, torn, disorganized documents] *It looked like a child's. (Rita)*
	1.3. Related to the negative effects of life and situations of sadness, exhaustion and suffering.	*I'm short-tempered because life only gives me no, and that's exhausting. [...] It's too much sadness for one person [...] But up here* [points to her head]*, it's tired, it's exhausted. (Rita)*
	1.4. Related to trauma and violence.	*They raped me and I don't remember anymore. [...] I died that day [...] I think that's why I got a bit crazier in the nerves. (Rita)*
2. Episodes	2.1. Behaviors associated with head or brain problems.	*I started having health problems, having episodes, started having some attacks. [...] My mind would black out. (Pablo)* *I had a breakdown, ended up in a psychiatric prison hospital. [...] My daughter got sick in the head too, started having episodes. (Elza)*
	2.2. Intense, unpredictable, aggressive behavior related to lack of control.	*At the clinic I started having episodes, breaking beds, breaking windows, confronting the nurses, throwing food at the walls. (Pablo)*
	2.3. Triggering factors: - Related to conflicts, fears and insecurities; - Related to unfavorable conditions in everyday life;	*I started having* [episodes] *because of the psychologist. She would put things in my head, saying I had problems when I didn't. I started attacking everyone, thinking they were going to hurt me. I was afraid of people. I felt insecure. (Pablo)*
	- Related to communication problems. -	*Then Heitor* [owner of the workshop where she and her husband sleep] *said 'Don't come.' That's why I had an episode. (Rita)* [Referring to the reason her daughter had a breakdown] *I didn't say it right* [about the father's death]. *I didn't speak with care, didn't know how to explain. (Elza)*
	2.4. Forms of Treatment: Understanding Attitudes from Close Individuals, Medication.	*He* [husband] *had several breakdowns and now we're trying to get him treatment. He's going to start taking medication for his mind and I'm going to try to help, so he can get better. Medication, friendship, affection. (Elza)*
3. Substance use	3.1 Perceived as an addiction.	*I started using drugs. I thought it was good because I saw everyone doing it. I didn't feel withdrawal. [...] Then the addiction hit, I started craving it more. Like people say, an addict? Who just wants more and more. (Pablo)* *I wasn't that addicted, but I had other friends who were worse. I sniffed* [inhalants] *just to keep them company. (Elza)* *I had my drug habits, but I was okay. After I moved on to another drug, I lost everything. (Luiz)*
	3.2 As a resource for discomfort.	*I drink* [wine] *because I'm sad, unhappy without my daughter, I'm in a miserable place and waiting for food that never came. (Rita)* *I go back to drugs because something disappoints me. Someone who's not good for me. [...] I was there* [in prison]*, drugged on meds. [...] Because it's not easy spending Christmas, New Year's, and your birthday with no family around. Alone, in four walls. I just slept. Didn't even get up to eat. (Pablo)*
	3.3 Associated with violence.	*My mom beat me a lot when I was a kid, because of drinking, and a person with alcoholism is rebellious, angry, I don't know, sad. She still drinks and comes at me. (Elza)* *He used to beat me, drunk, high [...] Just to show how messed up it was, he came at me with a punch, but then he fell back. (Sarita)*
	3.4 Obstacles to life projects.	[Referring to when she tried to start a new life in São Paulo] *Too many drugs, and I ended up failing. [...] Getting involved with people who use, it's even harder. [...] I failed, used drugs in the shelter, and ended up losing my spot. I got kicked out and went back to the streets. (Luiz)*

This is a case of incorporating and reinterpreting a psychiatric diagnosis as an explanatory basis for feelings and behaviors related to experiences of adversity, which are not, in themselves, indicative of psychopathology. The broad and often trivialized use of the term “depression” in contemporary discourse has contributed to its adoption as a common label for various forms of discomfort.

Self-harm, along with suicidal thoughts and attempts, was interpreted as a health issue, where the act such as cutting were seen not only as symptoms—alongside psychotic episodes, seizures, and depressive states—but also as coping strategies in the absence of other resources, such as medication, alcohol, or illicit drugs.

As such, it replaces substances that generate pleasure, well-being, and euphoria, and assumes a similar function. Understanding it from this perspective means viewing it as a manifestation of distress.

In this view, self-harm serves a function similar to substance use, providing momentary relief, pleasure, or even a euphoric state. It is a manifestation of psychological distress, transforming internal psychic pain into external physical pain. This transformation often provides temporary relief and functions as an emotional release.[12] Additionally, self-harm can induce a sense of pleasure or of “high,” similar to what certain substances produce.[13]

Other reported sensations – such as “strength to carry on” and “obligation” – suggest a religious interpretation of self-harm. In this view, self-harm is a form of exchange with a spiritual entity, which, in return for the act, grants favors or improved life conditions. Thus, beyond the positive sensations caused by self-harm, religious belief also offers hopeful expectations, framing the act as auspicious.

It is also important to consider another perspective on this issue, by understanding the reasons participants gave for self-harming – lack of medication, absence of emotional support, and limited life prospects. This failure of various sectors leads individuals to seek and find relief in such practices. It prompts the professional sector to reconsider whether merely repressing self-harm as a symptom is enough, given its links to multiple other factors.

Suicidal thoughts were frequently connected to depressive symptoms and failed pharmacological treatment and were often seen as a response to the desire to escape daily suffering.

Contexts of distress, sadness, hopelessness, and depression relate to suicidal behavior, while religious belief and access to treatment were described as protective factors. In this sense, life satisfaction, depression, and religious commitment can be considered components within the risk-protection spectrum regarding suicidal ideation, a phenomenon that requires a multidimensional explanatory model.

In contexts marked by intense suffering, deprivation, and limited coping resources, suicide attempts may be perceived as the only way to interrupt emotional pain. These responses highlight the multifactorial nature of suicidal behavior, shaped by individual, social, and structural factors.[14] Therefore, even if not explicitly interpreted in the narratives, suicide attempts reveal that, for some, ending one’s life was a response to being overwhelmed by suffering.

Being in a situation of homelessness may represent a risk factor for suicidal ideation, especially when combined with other issues such as substance use, socioeconomic hardship, and psychological distress, creating a complex feedback loop. In this context of vulnerability, basic human needs are impacted, and there is exposure to health-damaging behaviors that demand attention. It becomes evident that individuals experiencing homelessness are subject to numerous conditions that may contribute to suicidal behavior.[15]

The interpretation of sensory-perceptual experiences was related to hearing voices, seeing visions, and experiencing olfactory manifestations that others do not hear/see/sense. These sensory experiences, interpreted in the professional sector as hallucinations, acquire alternative explanatory bases in the participants’ experiences and are manifested as positive, offering comfort, support, and the possibility of contact with deceased individuals. Thus, they are understood as truly human experiences, legitimized as non-deviant, non-pathological, in contrast to the traditional biomedical model that pathologizes them.

Both hearing voices and seeing visions appeared as forms of communication with deities, in a positive relationship, characterized by exchange and support, and as a resource for problem-solving. Although each individual interprets their experiences according to their religious cultural background, communication with powerful entities assumes an important role and assists them significantly. In this way, each person understands the voices based on their content, origin, and impact on their lives, assigning them meanings that hold value for them, according to their life history, bringing this experience into the realm of subjectivity.[16]

Seeking to understand the meaning attributed to the voices and the relationship with them aligns with the perspective of the International Hearing Voices Movement, which constitutes a counter-discourse to the classical psychiatric knowledge about the term “hearing voices” and the experience it symbolizes. Thus, hearing voices is no longer seen as a symptom but as a human experience, diverse and unique for each hearer, capable of encompassing various meanings, including interpretations that deviate from the hegemonic discourse of psychiatry.[16]

The interpretation of “being nervous” is related to a differentiation from madness to feelings of fear, to a disorganized and childish experience, and to suffering.

The distinction between being mad and nervous reproduces the social imaginary of the madness-associated dangerousness, linking it to people who commit violence and murder, contributing to the production of a social attitude of fear and discrimination toward those identified as such.[17] This differentiation also occurs in relation to treatment, which includes medication and restraint, distinguishing it from that offered to the mad – to the “nervous”, it is enough to ask them to calm down, whereas with the mad, one must shout.

People living on the streets, due to their constant exposure to vulnerability and precarious living conditions, are more susceptible to the development and worsening of mental health problems.[18] In this context, the repetition of rejections throughout life – whether by individuals, services, or the public system itself – accumulates in a way that intensifies psychic suffering, surpassing the limits an individual can bear, resulting in mental illness.

Thus, this perception of illness is related to profound suffering, corresponding to suffering understood in the psychosocial dimension, such as suffering from lack of recognition, exclusion, being harmed in their rights, dignity, or frustrated in their vital needs.[19] Understanding "being nervous" cannot be restricted to fixed diagnostic categories, grounded exclusively in modern medical and psychological knowledge. Psychosocial attention, by proposing expanded and territorialized care, breaks with the reductionist view of the biomedical model, which interprets psychic suffering in a one-cause approach centered on nosological diagnoses.[20] Therefore, it is essential to question these lenses and adopt practices that consider the singularity of each individual, their life trajectory, and the conditions in which they are inserted.

In relation to the interpretation of psychotic outbreaks, they are characterized as a disease of the head/brain, manifested through specific behaviors related to loss of control, conflicts, and impulsivity; unfavorable conditions of daily life; communication problems; and requiring medication and understanding/caring attitudes.

In this interpretation, we see, in some aspects, a re-signification of the biomedical discourse, especially the organicist psychiatry perspective, where the "deviations" of thought and behavior are seen as evidence of brain disorders.

Overcoming the organicity means understanding that psychic life, as well as its reflection in the function of the body's organs and tissues, is the mirror of an individual's history – how they have lived, disappointments and gratifications, their social dimension, and the significant experiences that marked their existence.[21]

The manifestations of psychotic outbreaks are often interpreted in popular imagination through a stigmatizing view of madness, historically associating people with mental disorders to dangerousness, aggressiveness, and incapacity. Over time, these people have been treated as alienated, transgressive, and violent, becoming targets of prejudice and social exclusion. Even with advances in deinstitutionalization, society still maintains a representation of madness that reinforces the alienation and depersonalization of these individuals.[22]

The manifestation of psychotic outbreaks occurred in a context perceived as violent, frightening, causing fear and insecurity, being a reaction, a defense mechanism, to this scenario, interpreted as iatrogenic. Aggression, in many cases, appears to be a reaction to states of fear, suffering, and unbearable tension.[21]

The suffering caused by the hostile conditions of daily life can trigger an outbreak as a consequence of life's problems. Thus, "going mad" refers to having reached the limit of bearing difficulties; it is the final expression of someone who can no longer cope with the struggles of daily life.

It is considered that, as with the triggering factors, there is a biologicist perspective related to medication; and another relational perspective, linked to understanding and willingness to help. The latter considers a more integral and expanded locus of care, which, in some ways, refers to new ways of looking at mental health crises.

However, when it comes to people living on the streets with mental disorders, we are still far from some proposals being discussed in mental health. It is necessary to advance in this sense so that, in experiences like outbreaks, these individuals can have their care guaranteed in the most dialogical and networked way possible.

The interpretation of illness concerning drug use is part of the personal and family experience of participants, manifested in the use of both illicit and licit drugs, such as alcohol and medications.

The ideas and beliefs associated with substance use influence not only the subjective perception of those who use them but also the way these individuals interpret the effects and deal with the consequences of their consumption.[23] As an addiction, substance use is often described as a transition from controlled, social use to a problematic pattern, marked by continuous consumption or experimentation with other substances. This process can occur at various levels, sometimes leading to withdrawal syndrome. Although the concept of addiction carries a negative connotation, it does not always imply a problem for the user.

However, social discourses that criminalize or stigmatize certain substances and their users may reinforce negative perceptions, shaping how individuals identify with their use.[23] Thus, those who experience problematic substance use often associate it with unfavorable consequences in their lives.

Substance use can be understood as a coping mechanism to deal with distress, functioning as a strategy to alleviate sadness, disappointment, and other forms of suffering. In contexts marked by precariousness, such as the prison system and homelessness, this practice emerges as a survival mechanism, providing temporary relief in the face of unbearable experiences.

In this scenario, substance use can be interpreted not merely as an individual symptom but as a reflection of the difficulties imposed by contemporary life, highlighting the fragility of social relationships and conditions. For many people experiencing homelessness, substance use becomes intertwined with their very mode of existence in this context, serving as a means of sociability, a way to cope with hunger, and a method of dealing with psychosocial hardships.[23] Thus, substances take on a role beyond mere consumption, representing an attempt to mitigate suffering and sustain existence amid adversity.

Substance use associated with violence appears mainly in relation to experiences of aggression, in which close individuals exhibited altered behavior, with substance use being the explanatory basis for such conduct.

Alongside this, a dual interpretation arises: while substance use is seen as justifying certain behaviors, it is also interpreted through a moral lens, using morally charged terms such as "drunk," "addict," "shameless," "unruly," and "disgraceful." In this perspective, substance use is positioned both as an explanation for violent behavior and as an intentional moral failing.

This moralizing construction surrounding substance use directly affects how society perceives individuals who use these substances, making it difficult to recognize them as social subjects within a context. Popular imagination plays a significant role in perpetuating these stigmas, as collective discourses tend to place sole responsibility on the user, disregarding structural and contextual factors that shape their lives.[24] In this way, maintaining a moralizing view of substance use not only reinforces social exclusion but also hinders the development of more humanized and effective approaches to address the related issues.

Substance use was also understood as an obstacle to life projects, leading to failures in achieving goals and in relationships. Relationships with others who also used substances contributed to the context of difficulty.

Thus, it becomes clear that substance use, within a context of social vulnerability, is associated with difficulty in achieving fulfillment, reaching personal goals, and developing life plans. In this sense, substance use brings with it the consequence of life disorganization and becomes a barrier to personal development.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

The participants interpreted their illness processes in ways that gave diagnostic labels meanings grounded in their personal experiences. Thus, depression was understood as a malaise of modern times, self-injury as a search for relief from suffering, sensory-perceptual experiences as manifestations of comfort, “being nervous” as distinct from being dangerous, mental crises as illnesses of the mind and as the threshold for enduring hardship, and substance use as both a coping strategy and a barrier to life goals.

In light of these illness interpretations, the psychiatric explanatory model was reinterpreted by participants based on their lived experiences and how these meanings were translated into practice. Subjective experiences of suffering and individualized ways of understanding, addressing, and legitimizing experiences associated with one’s own and others’ illnesses were considered, recognizing that these are embedded not only in biological systems but also in cultural, social, political, and economic contexts. Therefore, approaching the experience through the lens of illness made it possible to acknowledge important dimensions of suffering and care that go beyond a diagnostic/cure logic.

This presents a challenge for the professional health sector to integrate diverse forms of knowledge and practice that embrace these interpretations and are capable of providing care that accounts for illness, not only disease. Some initiatives have demonstrated that such a perspective is possible; however, this approach must be extended to include people experiencing homelessness with mental health conditions.

Given that participants were contacted through a professional health service, it is acknowledged that this may represent a limitation of the study, as other individuals experiencing homelessness with mental disorders who do not access this service were not included. Future studies should consider strategies to recruit participants through additional means beyond the professional sector.

Another limitation concerns the time required to establish rapport and build trust with participants, which made it impossible to conduct more than one interview per individual. This constraint prevented the researchers from revisiting certain gaps that emerged during the analysis of the initial interviews.

Accordingly, the importance of understanding illness as an existential experience is reinforced, recognizing that the disease-oriented approach based solely on symptoms has restricted interpretative and care possibilities.

ACKNOWLEDGMENTS

None.

FINANCIAL SUPPORT

None.

DATA AVAILABILITY RESEARCH

The data is available on demand to authors.

CONFLICT OF INTEREST

None.

REFERENCES

1. Kleinman A. Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry. Berkeley/Los Angeles: University of California Press; 1980. http://doi.org/10.1525/9780520340848.
2. Costa-Rosa A. O modo psicossocial: um paradigma das práticas substitutivas ao modo asilar. In: Amarante P, organizador. Ensaios: subjetividade, saúde mental, sociedade. Rio de Janeiro: Editora Fiocruz; 2000. p. 141-168.
3. Jovchelovich S, Bauer MW. Entrevista narrativa. In: Bauer MW, Gaskell G, editores. Pesquisa qualitativa com texto, imagem e som: um manual prático. 13ª ed. Petrópolis: Vozes; 2017. p. 90-113.
4. Artioli G, Cosentino C, Taffurelli C, Ferri P, Foà C. The narrative interview for the assessment of the assisted person: structure, method and data analysis. Acta Biomed. 2019;90(6-S):7-16. http://doi.org/10.23750/abm.v90i6-S.8640. PMid:31292409.
5. Schütze F. Pesquisa biográfica e entrevista narrativa. In: Weller W, Pfaff N, organizadores. Metodologias da pesquisa qualitativa em educação: teoria e prática. 3ª ed. Petrópolis: Vozes; 2013. p. 211-22.
6. Rosenthal G. Pesquisa social interpretativa: uma introdução. 5ª ed. Porto Alegre: Edipucrs; 2014. 576 p.
7. Pereira LP, Wetzel C, Pavani FM, Olschowsky A, Moraes BM, Klein E. Entrevista narrativa com pessoas em situação de rua com transtornos mentais: relato de experiência. Esc Anna Nery. 2021;25(3):e20200017. http://doi.org/10.1590/2177-9465-ean-2020-0017.
8. World Health Organization. ICD-11 implementation or transition guide [Internet]. Geneva: WHO; 2019 [citado 2025 Jan 13]. Disponível em: https://icd.who.int/docs/ICD-11%20Implementation%20or%20Transition%20Guide_v105.pdf

9. Allsopp K, Read J, Corcoran R, Kinderman P. Heterogeneity in psychiatric diagnostic classification. Psychiatry Res. 2019;279:15-22. http://doi.org/10.1016/j.psychres.2019.07.005. PMid:31279246.
10. Rabelo MC, Alves PCB, Souza IMA. Signos, significados e práticas relativos à doença mental. In: Rabelo MC, Alves PCB, Souza IMA, editores. Experiência de doença e narrativa. Rio de Janeiro: Editora Fiocruz; 1999. p. 43-73. http://doi.org/10.7476/9788575412664.
11. Praxedes LCMA, Souza MAG, Azevedo MO, Vale LR. Depressão: um sintoma social caracterizado como mal do século. Epitaya. 2023;1(31):124-37. http://doi.org/10.47879/ed.ep.2023717p124.
12. Özen-Dursun B, Kaptan SK, Giles S, Husain N, Panagioti M. Understanding self-harm and suicidal behaviours in South Asian communities in the UK: systematic review and meta-synthesis. BJPsych Open. 2023;9(3):e82. http://doi.org/10.1192/bjo.2023.63. PMid:37183676.
13. Câmara L, Canavêz F. Contribuições de Sándor Ferenczi para o fenômeno da autolesão. Rev Latinoam Psicopatol Fundam. 2020;23(1):57-76. http://doi.org/10.1590/1415-4714.2020v23n1p57.5.
14. Silva DA, Marcolan JF. A reincidência de tentativa de suicídio associada a severidade da sintomatologia depressiva. Res Soc Dev. 2021;10(16):e299101623843. http://doi.org/10.33448/rsd-v10i16.23843.
15. Fernandes MA, Pillon SC, Reis MDC, Barbosa NS, Ibiapina JPB, Costa APC. Ideação suicida, uso de substâncias psicoativas e sofrimento mental entre a população em situação de rua de um município brasileiro. SMAD Rev Eletrônica Saúde Mental Álcool Drog. 2024;20:e-214319. http://doi.org/10.11606/issn.1806-6976.smad.2024.214319.
16. Machado RA, Souza TT, Ubessi LD, Lopes IF, Kantorski LPK, Guedes AC. Programa ouvidores de vozes: visibilidade da experiência de ouvir vozes. Rev Recien. 2023;13(41):502-10. http://doi.org/10.24276/rrecien2023.13.41.502-510.
17. Amarante P. Saúde mental e atenção psicossocial. 1ª ed. Rio de Janeiro: Editora Fiocruz; 2007.
18. Oliveira EC. Mental health of homeless adults in the city of Feira de Santana: from living to getting sick. RSD. 2021;10(6):e44810616055. http://doi.org/10.33448/rsd-v10i6.16055.
19. Barus-Michel J, Camps C. Sofrimento e perda de sentido: considerações psicossociais e clínicas. Psic Rev Vetor Ed [Internet]. 2003; [citado 2025 Jan 13];4(1):54-71. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1676-73142003000100007&lng=pt&nrm=iso
20. Jafelice GT, Silva DA, Marcolan JF. Potencialidades e desafios do trabalho multiprofissional nos Centros de Atenção Psicossocial. SMAD Rev Eletrônica Saúde Mental Álcool Drog. 2022;18(1):17-25. http://doi.org/10.11606/issn.1806-6976.smad.2022.172106.
21. Piccione R, Cesare G. Guida alla salute mentale: per la conoscenza delle cure e dei servizi. Meran: Edizioni Alphabeta Verlag; 2018.
22. Lira NDCS, Silva MA, Silva RCS, Andrade CHS, Silva VC. Representação social acerca da doença mental: uma revisão integrativa. Braz J Dev. 2021;7(11):103113-30. http://doi.org/10.34117/bjdv7n11-096.
23. Marques LS, Costa JHM, Gomes MM, Silva MM. Saberes, territórios e uso de drogas: modos de vida na rua e reinvenção do cuidado. Cien Saude Colet. 2022;27(1):123-32. http://doi.org/10.1590/1413-81232022271.19542021. PMid:35043892.
24. Silva VAM, Pinho LB, Nasi C, Siniak DS, Santos EO, Ávila MB et al. Care for drug users in a family health strategy: potentials and challenges. Cogitare Enferm. 2024;29:e93351. http://doi.org/10.1590/ce.v29i0.95454.

AUTHOR'S CONTRIBUTIONS

Study design. Letícia Passos Pereira.

Data collection. Letícia Passos Pereira.

Data analysis and interpretation of results. Letícia Passos Pereira. Christine Wetzel. Agnes Olschowsky.

Writing and critical review of the manuscript. Letícia Passos Pereira. Christine Wetzel. Agnes Olschowsky.

Approval of the final version of the manuscript. Letícia Passos Pereira. Christine Wetzel. Agnes Olschowsky.

Responsibility for all aspects of the content and integrity of the published article. Letícia Passos Pereira. Christine Wetzel. Agnes Olschowsky.

ASSOCIATED EDITOR

Marta Sauthier

SCIENTIFIC EDITOR

Marcelle Miranda da Silva

---

[a] Excerpted from the dissertation "In the world of the street: therapeutic itineraries of homeless people with mental disorders in the search for care", presented to the Postgraduate Program in Nursing, at the *Universidade Federal do Rio Grande do Sul,* in 2020.