

Understanding the Shame of People with Lived Experience of Homelessness and Diabetes

Matt Larsen

matt.larsen@ucalgary.ca

University of Calgary Faculty of Medicine: University of Calgary Cumming School of Medicine

<https://orcid.org/0000-0002-9187-9422>

Shelley Raffin Bouchal

University of Calgary Faculty of Nursing

Christine A. Walsh

University of Calgary Faculty of Social Work

Aislin Mushquash

Lakehead University - Thunder Bay Campus: Lakehead University

Tucker Reed

U of C: University of Calgary

Jeremy Auger

Calgary Diabetes Advocacy Committee

Brian Bowdridge

Calgary Diabetes Advocacy Committee

Monica Nelson

Calgary Diabetes Advocacy Committee

Anna Whaley

Calgary Diabetes Advocacy Committee

David J.T. Campbell

University of Calgary Medical Centre: University of Calgary Cumming School of Medicine

<https://orcid.org/0000-0002-5570-3630>

Research Article

Keywords: diabetes, homelessness, shame, agency

Posted Date: March 18th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-9072772/v1>

License:   This work is licensed under a Creative Commons Attribution 4.0 International License.
[Read Full License](#)

Abstract

People with lived experience of homelessness and diabetes (PWLEHD) often experience intense feelings of shame. Even though shame can cause numerous and significant adverse effects, to our knowledge no study has been done that specifically explores how or why PWLEHD feel shame. We undertook a hermeneutic phenomenological study that involved seven PWLEHD. Throughout three interviews, participants were asked to describe their feelings of shame related to homelessness and diabetes. Interviews were transcribed verbatim and transcripts were analyzed using Max van Manen's hermeneutic phenomenological analysis. Five community co-researchers who were PWLEHD participated in interview guide development, data gathering, and analysis. We found four main themes related to shame experienced by PWLEHD: shame in being vulnerable; shame in having to rely on inadequate support systems; shame in being isolated and lonely; and shame in experiencing profound and/or unexpected loss. Feelings of constrained agency permeated all primary themes and was deemed to be the essential element of shame for this population. At a system level, any measures that increase the agency of PWLEHD have the potential to reduce shame. Trauma-informed models may help homeless-serving organizations build trust, reduce shame, and improve the health and well-being of their clients.

Introduction

The detrimental effects of both diabetes and homelessness have been well documented.⁽¹⁻³⁾ Individuals experiencing homelessness are often faced with circumstances where they struggle to meet their essential needs, such as finding a healthy meal or a safe place to sleep.⁽⁴⁾ Considering these acute and pressing concerns, the highly involved regime required to effectively manage one's diabetes can seem like an impossibility for people with lived experience of homelessness and diabetes (PWLEHD).^(2, 5)

In addition to increased risk for adverse health events and reduced life expectancy,⁽⁶⁾ PWLEHD often experience intense shame.⁽⁷⁻⁹⁾ The shame of living with diabetes^(9, 10) combined with the shame associated with homelessness^(8, 11) can have a cumulative negative impact on one's health.^(5, 12) Shame, or the feeling that one is flawed and unworthy of acceptance,⁽¹³⁾ is known to have a negative impact on many aspects of one's psychological well-being and results in suboptimal clinical and social outcomes for persons living with diabetes.⁽¹⁴⁾ The psychological toll of living with shame has been associated with numerous mental health conditions, such as anxiety, addiction, depression, and suicidal ideation.⁽¹⁵⁾

Education, socioeconomic status, and racial identity are pertinent factors related to shame and diabetes. A study by Inagaki et al.⁽¹⁰⁾ found that individuals with less formal education and lower socioeconomic status were more likely to experience diabetes-related shame. Additionally, Inagaki et al. found that a desire to avoid stigma and shame led to reduced engagement with healthcare professionals for this population. Results of a study by Winkley et al.⁽¹⁶⁾ revealed that African American study participants had a prevalent belief that diabetes was a personal failing. This feeling impeded participation in diabetes education/ management programs, and increased feelings of isolation and shame for this population.

Similarly, studies show that individuals with experience of homelessness often feel profound shame. Link and Cullen ^{(11)(p. 8)} found that “homelessness is associated in the public mind with other stigmatizing conditions such as mental illness and substance abuse.” Considering these stereotypes, Phelan et al. ⁽⁸⁾ described homelessness as an intensely shameful condition that prevents one from attaining full social acceptance.

In 2019, the lead author (ML) and senior author (DJTC) were part of a community-based participatory research group composed of PWLEHD (N = 8) in Toronto, Canada. Utilizing concept mapping we identified that ‘emotional wellbeing’ was one of the top three priorities for those with lived experience of homelessness and diabetes. ⁽¹⁷⁾ In 2022 the Calgary Diabetes Advocacy Committee (CDAC), a similar community-based participatory research group, conducted a nominal group technique to determine the group’s collective priorities. Co-researchers identified that raising diabetes awareness in homeless serving organizations to reduce diabetes-related stigma was their top priority. ⁽¹⁸⁾

Since emotional well-being was a topic prioritized by community co-researchers in both 2019 and 2022 advocacy groups, we sought to further understand how individuals in this circumstance understand and experience shame and stigma.

Methods

Study Design

Hermeneutic phenomenology was chosen as the philosophical and methodological foundation of this research project. Phenomenology is the study of lived experience with the goal of being able to uncover the essential characteristic of a particular phenomenon. ⁽¹⁹⁾ As hermeneutics refers to the study of interpretation, the aim of hermeneutic phenomenology is for the researcher to describe and interpret the essential meaning of the phenomenon reported by study participants. ⁽¹⁹⁾

Setting

Calgary, a major metropolitan city in Western Canada, is home to approximately 1.4 million residents. ⁽²⁰⁾ Being a major city and hub for services, there are many people experiencing homelessness in the city. In the 2024 point-in-time count, the city counted approximately 3,100 individuals experiencing homelessness on a given night. ⁽²¹⁾

Lived Experience Involvement and Oversight

The CDAC, described above, played numerous critical roles in the development and conduct of this project, given that the ideas were born out of their collective experiences and priorities. CDAC co-

researchers (n = 5) participated in all phases of the research, including interview guide creation, data collection, and data analysis and interpretation.

The lead investigator (ML), senior investigator (DJTC), and research staff (TR) organized and led 16 meetings with CDAC co-researchers from November 2023 – April 2024 held at the Calgary Central Public library. CDAC co-researchers took part in training sessions on key principles of qualitative data collection and analysis (e.g., what constitutes a code, how to make field notes, etc.).

Study Participants and Recruitment

Our goal was to recruit 5–7 adult PWLEHD using convenience sampling approaches. As individuals with type 1 diabetes make up 5–10% of Canadians living with diabetes,⁽²²⁾ we sought to recruit at least one participant who had type 1 diabetes. Additionally, we also sought to include individuals of diverse gender, age, race, and ethnic identities in our sample.

To aid in recruitment, we put up fliers for the study in several homeless-serving community agencies in downtown Calgary. In addition to recruiting through traditional means (i.e., word of mouth from shelter staff and health care workers), CDAC co-researchers were invited to help recruit members of their social network who had relevant lived experience. Former CDAC co-researchers who had not been actively participating in the group at the time of the study were also invited to be participants.

Eligibility for the study were adults (18–85 years) who had been diagnosed with any form of diabetes prior to or while experiencing a period of homelessness of one month or longer. All participants signed the written informed consent to participate in the study and agreed to have their names pseudonymized in subsequent reports.

As an honorarium, study participants received \$20 for every hour of interview they completed. Light refreshments and transit tickets were provided for in person interviews.

This research study was reviewed and approved by the University of Calgary Conjoint Health Ethics Board (ethics certificate: REB23-1250).

Data Collection

Interviews were conducted in person at the Calgary Central Public Library and over Zoom® teleconferencing software. In most cases, a CDAC member was present during each interview. During interviews, co-researchers shared some of their lived experiences, asked interviewees additional probing questions, and debriefed with the lead investigator after interviews were completed.

Study participants were involved in interpretive conversations (interviews) aiming to uncover the deep shared meanings of lived experiences, on three separate occasions between January 2024 April 2024. The focus of each interview was distinct:

Interview #1: Shame and stigma related to diabetes.

Interview #2: Shame and stigma related to homelessness.

Interview #3: Coping with stigma and shame and ways of developing shame resilience.

Building upon the identified priorities of CDAC co-researchers, the specific questions in the interview guides evolved through input from the research team and the lead investigator's own experience: ML having experienced homelessness from May 2018 to August 2019 while living with diabetes during this time.

Interview audio was recorded digitally and transcribed verbatim using human-verified AI transcription (Rev.com©). All transcripts were read over by the lead author to ensure authenticity.

Data analysis

Debrief sessions with the lead author (ML) and the co-researcher assisting in the interview were held immediately after each participant interview to discuss what they had found particularly interesting, possible questions to ask in future interviews, or issues to discuss at upcoming CDAC meetings.

At group meetings, the study team and CDAC co-researchers read abridged transcripts aloud and discussed them. Appealing to the CDAC's lived experience of homelessness and diabetes as well as their feelings related to these experiences, discussions focused on interpreting how, and why a participant felt shame based on what they had shared.

After CDAC meetings concluded, ML began coding interview transcripts using NVivo14© software (Lumivero, Denver CO). Using Max van Manen's selective approach to hermeneutic phenomenological analysis, ⁽¹⁹⁾ participant quotes that seemed indicative of shameful feelings were assigned preliminary sub-theme titles (e.g., "impossible situation," "powerless," etc.). As additional transcripts were analysed quotes particularly indicative of emotions related to shame were grouped under higher order themes (e.g., "frustration with support systems," "sadness due to perceived rejection from others"). At this point, ML began to search for a shared feature running through these themes that would be indicative of the essence of the phenomenon of shame for PWLEHD.

Rigour

The study team conducted a member checking session with three of the study participants on April 26, 2024. This process revealed that the interpretations concerning how and why PWLEHD feel shame were largely congruent between the study team and ML. On February 20, 2025, ML conducted a peer debriefing session with CDAC co-researchers and two study participants who had joined CDAC towards the end of the study. During this session, ML presented the four primary themes for their review. Both CDAC co-researchers and study participants expressed a high degree of agreement with these themes.

Results

Study Participants

We recruited seven PWLEHD to participate in this study (Table 1). All participants completed the three interviews between January and April 2024. Duration of individual interviews ranged from 43 to 157 minutes. Out of the 21 interviews conducted, 17 were completed with a CDAC member present.

Table 1
Study Participant Information

Pseudonym	Age/ Gender	Ethnicity/ background	Housing status (as of interview #1)	Diabetes type	Length of time lived with diabetes	Complications from diabetes / Comorbidities
Diana	55 Female	White/ European	Homeless shelter	Type 2	6.5 years	• Burning, tingling, numbness in toes and feet • High blood pressure • Obesity • Sleep apnea
Henry	60 Male	White/ Canadian	Homeless shelter	Type 2	1 year	• Diabetes eye problems (retinopathy) • Depression • Anxiety (panic attacks, general anxiety, phobias) • Hepatitis
Caleb	66 Male	Black/ African	Supportive living facility	Type 2	10 years	• Kidney problems (nephropathy) • Diabetes eye problems (retinopathy) • High blood pressure • High cholesterol • Depression
Natasha	55 Female	White/ Canadian	Independent accommodations	Type 2	Not disclosed	• Heart disease/ heart attacks • Burning, tingling, numbness in toes and feet

Pseudonym	Age/ Gender	Ethnicity/ background	Housing status (as of interview #1)	Diabetes type	Length of time lived with diabetes	Complications from diabetes / Comorbidities
						• High cholesterol • Obesity • Sleep apnea • Depression • Drug addiction
Frank	63 Male	White/ Canadian	Supportive living facility	Type 2	15 years	• Diabetes eye problems • Burning, tingling, numbness in toes and feet • High blood pressure • Alcohol addiction
Jake	54 Male	White/ European	Independent accommodations	Type 2	6 years	• Heart disease, heart attacks, • Foot ulcers (wounds), gangrene, or amputations • Kidney problems (nephropathy) • Diabetic neuropathy • Obesity • Sleep apnea • Depression • Anxiety (panic attacks, general anxiety, phobias)

Pseudonym	Age/ Gender	Ethnicity/ background	Housing status (as of interview #1)	Diabetes type	Length of time lived with diabetes	Complications from diabetes / Comorbidities
Melissa	40 Female	White/ Canadian	Independent accommodations	Type 1	27 years	● Foot ulcers (wounds), gangrene, or amputations ● Diabetes eye problems (retinopathy) ● Burning, tingling, numbness in toes and feet ● Depression ● Anxiety (panic attacks, general anxiety, phobias) ● Drug addiction

Through the data analysis process, four primary themes were identified that illuminate the experience of shame experienced by study participants:

- Shame in being vulnerable
- Shame in having to rely on inadequate support systems
- Shame in being isolated and lonely; and
- Shame in experiencing profound and/or unexpected loss

Illustrative quotes are provided in the following section with additional supporting quotes provided in Table 2.

Table 2

Quotes from study participants

Shame in Being Vulnerable

Vulnerability to others.	Vulnerability to oneself.
Floor number 3 [at the homeless shelter] is not fun. Everything's stolen at least once. I've had my clothes, everything that I own, stolen at least three times... Then, I got beat up... The staff there just doesn't give a shit. (Henry, interview 1).	There'll be the time when I'm... in my sixties and I won't be able to move as fast, and I won't be able to make money, and I'll be just miserable... And I'll say [to myself] ... "You could have took care of yourself so good. You could have set yourself up so sweet if... but no." Then I'll give myself shit. (Diana, interview 3)

Shame in Having to Rely on Inadequate Support Systems

Inadequacies in homeless shelters and supportive living facilities.	Inadequacies in medical and housing support systems.
Why not allow the diabetic patients to take some of the medications to [their] room? ... If you are on an extreme high [i.e., high blood sugar], and you have to walk all the way around, and then down a bunch of stairs [to get your medication from staff at the front desk] ... that person could fall down the stairs and break his neck, the way the blood sugar is. (Jake, interview 1)	There's other medications out there that I could be taking, and I can't because I have to pay for it. I could be taking two pills instead of all them f***ing pills that are killing my f***ing insides. (Natasha, interview 2)

Shame in Experiencing Profound and/or Unexpected Loss

Loss of money or material possessions	Loss of physical appearance or bodily health	Loss in the emotional realm	Loss of a valued identity
I was embarrassed to say that I didn't have an actual physical address, and then to ask for help for food and stuff on top of it... it was hard. I knew I had to eat. If I didn't eat, it was going to give me a whirlwind of problems. (Melissa, interview 3)	You walk in somewhere and you can see the reception desk, and you can see the receptionist with a big smile on her face while she's talking to the customer. Then she looks at you and the smile wipes right off her face... I don't walk around with holes in my clothes, but I am walking around toothless. I'm toothless, therefore I'm stupid. (Natasha, interview 2)	I haven't talked to my family in a very long time... My ex got a hold of them and [told them] I'm the baddest man on the planet, I think. (Henry, interview 2)	It is very shameful... when you were somebody before and now you are nobody. (Caleb, interview 1)

Shame in Being Isolated and Lonely

The experience of disconnection	The experience of rejection
The one night that I got fired from my job... I thought no one didn't want me. I felt isolated. I was alone... I couldn't turn to the family because, at that time, I wasn't talking to 'em for years and years... I was afraid wouldn't survive the night... I just talked to myself. I wondered why this happened to me... I know I had a struggle against me. A real struggle. (Frank, interview 3)	They'd be right happy if I just went back to being a 24/7 drug addict, because I'd die pretty soon. It's easy to just [say], "We don't need to help them, pretty soon, they'll be dead anyway." ... Most heroin addicts don't come out of it. They die. (Natasha, interview 2)

Shame in Being Vulnerable

Participants described being vulnerable in a myriad of ways throughout their interviews. As participants expressed that harm could originate from both the external environment or from within one's own mind, the theme of vulnerability was divided into two categories: vulnerability to others and vulnerability to oneself.

Vulnerability to others.

Several participants cited examples where they believed professionals in support roles had abused the power of their position, as Diana shared in the following anecdote about an interaction with her psychiatrist:

I got mad at him... I said, "Why the f*** did you give me pills that put me out for a whole day?" He looked at me and he said... "You see this pen? This pen is very powerful... this pen can keep you here for many years." ... All we did after that was talk about the weather. (Diana, interview 2)

Diana's portrayal of the doctor during her outburst illustrates how secure he is in his knowledge that she is powerless. In addition to her outrage at being heavily tranquilized, Diana's shame comes from her inability to redress the perceived wrong done to her.

Vulnerability to oneself.

One way in which participants revealed vulnerability to themselves was by expressing negative self-judgment. This judgment was expressed by participants being resentful of themselves for not meeting personal expectations and/or believing that others who shared a similar background were much better off than they were. Caleb mentioned that:

You may think that, because of where you are [supportive living facility], you are not worth even to rent your own accommodation... When you think back, you think about your friends and say, "Oh my God" ...

You think about your present situation and think about, "Oh, I have a friend. We came to Canada together. Look at me now. Look at them. (Caleb, interview 3)

This passage embodies the idea of being 'put to shame' by finding oneself lacking in comparison to others. Caleb's words express his mortification at his failure to match the accomplishments of his peers.

Shame in Having to Rely on Inadequate Support Systems

For our study, systemic inadequacies were conceived of as formal policies or regular actions taken within a system that worked to counteract the system's apparent purpose. Along with the shame that came from being unable to support oneself, study participants' shame was exacerbated due to having no option other than to rely on systems they felt to be inadequate.

Inadequacies in homeless shelters and supportive living facilities.

Not being able to easily access supplies to test glucose levels and treat high or low blood sugars in shelters led to participants feeling disempowered and dependent on shelter staff. Diana expressed her frustration at not having access to a glucometer, saying "Every day is a gamble. I don't know where the f*** I'm at [with my blood sugar levels]. And I've seen someone go into a diabetic coma" (Diana, interview 1). In many Calgary shelters clients are not allowed to keep their lancets and insulin pens on them as shelter policies deem these as potential weapons. The fact that this policy works to endanger clients with diabetes speaks to an inadequacy within the system. Diana's shame comes from having to stay in an environment where her needs conflict with what is permitted.

Inadequacies in medical and housing support systems.

Several participants reported feeling that the shelter system fails to ensure individuals could retain housing for any length of time. Rather, it seemed to Henry that the housing system was set up to ensure a return to homelessness.

In these places [homeless shelters], what they do is they try to get you out of there. "Oh, we'll pay first and last month [rent] and we'll get you a place." So, what happens is they get out of there, they get their own place, but you can't pay the rent on a temp job at 17 bucks an hour. So, it doesn't take them long before they're back there, and so totally defeating all the purpose of it, right? (Henry, interview 2)

Henry's shame comes from being forced to contend with a housing system he feels is not designed to do what it purports to.

Shame in Experiencing Profound and/or Unexpected Loss

The losses suffered by PWLEHD are often numerous, traumatic, and unexpected. Study participants expressed losses regarding money or material possessions, loss of physical appearance or bodily health, loss in the emotional realm, and loss of a valued identity.

Loss of money or material possessions.

Jake explains the sequence of events that led up to him experiencing homelessness:

After my mother passed away... the house that I inherited... burned down... the insurance company said, "Well, since you're not on the insurance for the house, we don't have to pay you." ... I told them, "Actually, my mother's last will and testament..." And they said, "That doesn't mean anything to us." ... I never got paid out. And the property, well, I just walked away from it all. (Jake, interview 1)

Jake's flat retelling of how he accepted the insurance company's disregard of his mother's will shows him as someone that could not bear to face another challenge. Jake's profound and consecutive losses overwhelmed his capacity to cope and shook him to his very core.

Loss of physical appearance or bodily health.

Every participant in the study reported extensive loss related to bodily health and physical ability. Melissa explained "I'm dealing with a severe wound on my foot right now and a broken heel... because of my diabetes... I have gastroparesis, I have neuropathy, I have retinopathy," (Melissa, interview 1). Melissa latter added, "I'm broken and can't do anything," (Melissa, interview 1). In referring to herself as "broken" it appeared that this did not solely refer to her broken heel. Due to the incurable and debilitating nature of her diabetes, Melissa believed her body and her life were beyond repair.

Loss in the emotional realm.

A loss in the emotional realm was conceived of as a loss of valued social connections that caused intense distress to participants. For Caleb, this distress was caused by his diminished ability to support his family, as he explained:

I had my own house and then all of a sudden ended up nowhere... [I went] from jail to the [supportive housing facility] ... I've lost my family. They can't stay with me. I can't stay with them in their one room they rented for school. (Caleb, interview 3)

Losing his house and his role as his family's provider did more than alter Caleb's relationship with them, this loss made him feel that what meaningful connections he had with his family were now severed. After losing his house he "ended up nowhere," emphasizing the meaninglessness of his new place in the world without that which bound him to what really mattered.

Loss of a valued identity.

Becoming unemployed and subsequently losing housing can impose on one a new, highly devalued identity. When one loses a valued identity/professional role, its loss and subsequent replacement with a contrasting devalued identity can cause extraordinary shame. Regarding this pain, Natasha wept as she recounted how she was fired from her job as a truck driver:

I used to get paid \$2,500 every Friday... When I came out of jail, he [my boss] was my one phone call... I said, "I can come to work tomorrow." He said, "You're a f***ing loser. You're not coming to work." (Natasha,

interview 2)

Natasha later remarked, "I don't worry about people judging me. I don't care. If you can back up a trailer like I can, then we can talk." (Natasha, interview 2). That said, for her to go from feeling proud of her skills as a truck driver and being seen as a valued employee to then being insulted and dismissed, the loss of status continues to be a great source of shame for her.

Shame in Being Isolated and Lonely

All participants frequently expressed feeling lonely and isolated throughout their journeys. These feelings were brought about by the belief that something kept them disconnected from others or believing that others actively rejected them.

The experience of disconnection.

Feeling different or disconnected from those who did not have diabetes was expressed by most study participants. In his second interview, Caleb described the shame that arose when those living with diabetes compared themselves to "normal" people who did not have the illness:

Normal is... you eat whatever you want to eat... He [person with diabetes] feels that he is not like other people. They can go about their day without any problem, without having to test themselves [i.e., test blood glucose]. That will make them feel very unusual compared with the other type of human beings. And that will give you a lot of emotional stress. (Caleb, interview 2)

In addition to the added challenges those with diabetes deal with, Caleb believed those who do not have the illness make those with diabetes feel "unusual" by comparison. While the word 'unusual' does not always carry a negative connotation, for Caleb, emotional stress comes from feeling less than "normal," a different "type of human being."

The experience of rejection.

As Jake explained, internalizing the stigma of homelessness led to the belief that one can never again be truly accepted:

Living on the street is a mindset that makes it harder for the homeless to integrate back into society. And, at the same time, it's also society that makes it harder for the person to integrate... Some people would refer to them as, "Those are the people that are throwaways." That's no way to live. (Jake, interview 3)

Jake explains how experiencing homelessness is so unlike being housed that it is difficult to adapt to the vastly different circumstances and responsibilities when one secures housing. More so, Jake asserted that, even when housed, those who had experienced homelessness are still made to feel like they can never escape the stigma of having been on the fringes of society. As such, they can never be truly accepted.

Constrained Agency as the Essential Characteristic of the Shame Experienced by PWLEHD in this Study

Lacking the ability to bring about a desired situation or to prevent an undesired situation from occurring was ubiquitous amongst study participants. As illustrated in Fig. 1, constrained agency, the perception that one's available actions are unduly limited and that control over one's life is fundamentally reduced, permeated all four primary themes.

Since the main concepts contained within the four primary themes all directly relate to an aspect of constrained agency, it is impossible to fully conceive of the shame experienced by those interviewed without also thinking of how their agency is constrained. As the essence of a phenomenon is that overriding characteristic which, if removed, would fundamentally alter the nature of the phenomenon, constrained agency was found to be the essence of the phenomenon of shame for the PWLEHD in this study.

Discussion

In their study on the self-management of type 2 diabetes, Wilson et al. ⁽²³⁾ found that study participants with a strong sense of self-efficacy were better at self-managing their diabetes than participants who exhibited lower self-efficacy. Self-efficacy has been closely linked to agency, ⁽²⁴⁾ both pertaining to one's ability to bring about a desired outcome. Hope is necessary for self-efficacy, however, due to the oppressive nature of homelessness in conjunction with the many challenges of managing diabetes, participants in our study often described a sense of hopelessness about changing many aspects of their lives.

In their study on barriers and facilitators to diabetes self-management for PWLEHD, Manser et al. defined personal autonomy and security as "individual agency and choice when making decisions related to one's health and well-being." ^{(25)(p3120)} Further to this, Manser et al. noted that shelter clients lacked autonomy regarding "access, choice, and timing of meals," ^{(24)(p.3123)} which then negatively affected their well-being. In addition to the lack of agency in being able to control their meals at homeless shelters, participants in our study reported being unable to retain their diabetes management supplies and, in some cases, prevent theft or physical abuse.

Many participants reported psychological distress related to their experiences of homelessness and diabetes. These experiences echo findings from a recent meta-aggregation of qualitative studies ⁽²⁶⁾ indicating that individuals who have experienced homelessness often display signs of significant trauma. Additionally, Kelly et al. ⁽²⁷⁾ found that, due to the anxiety associated with the chronic disease, many individuals living with diabetes would appreciate more focus on their mental/emotional health from their health care team. Given the psychological burden of both diabetes and homelessness, implementing trauma informed care practices is likely to be of significant benefit for PWLEHD.

Strengths of the Study

Due to lead author's own lived experience of homelessness and diabetes participants likely viewed him as an insider and provided more honest answers and a thicker, richer description ⁽²⁸⁾ of their feelings of shame than they would to a researcher without an experiential overlap. Having access to the combined knowledge of CDAC co-researchers provided unique insight that aided in understanding the lived experience of study participants. The input of CDAC co-researchers on study participants' emotional states and interpretations on their rationale for saying/ doing certain things were often more illuminating than those informed by the academic literature alone. Discussions with CDAC co-researchers often caused the lead author to recalibrate his initial interpretations and views of the narrations of study participants from a novel perspective.

Limitations of the Study

The original goal for our study was to recruit a purposive sample of study participants representative of people with diabetes in Canada. ⁽²²⁾ However, due to the difficulty of recruitment, we instead relied on convenience sampling. As such our study lacked participants of Indigenous background and participants who identified as 2SLGBTQIA+. The lack of diverse identities and lived experiences amongst our study participants negatively impacts the transferability of our study findings, even within the unique health, social and shelter supports available in our physical location. Further research with other populations and in other jurisdictions may help to confirm that these themes apply more broadly.

Conclusion

Suffering the indignities of homelessness while attempting to manage one's diabetes can lead to a loss of agency. Our study reveals that this sense of constrained agency lies at the heart of the phenomenon of shame for PWLEHD. At a system level, any measures implemented that increase the agency of PWLEHD, including within the health and social support systems, have potential to reduce shame. In addition, trauma-informed models may help homeless serving organizations build trust, reduce shame, and improve the health and well-being of their clients.

Declarations

Acknowledgements

ChatGPT (OpenAI, GPT-5.2; web interface; accessed February 2026) was used to generate preliminary summaries of published literature and to support drafting portions of the discussion section. All content generated by the tool was critically reviewed, edited, and verified by the authors. The authors accept full responsibility for the content and integrity of the manuscript.

Research reported in this publication was supported by the Social Sciences and Humanities Research Council, the Alberta Strategy for Patient Oriented Research Support Unit, and the Libin Cardiovascular

Institute.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributors

Matt Larsen, BEd, MSc, has been involved in research since January 2019 when he joined a community based participatory research group as a person with lived experience of homelessness and diabetes. In June 2025 he completed his studies as a master's student in Community Health Sciences at the University of Calgary.

Shelley Raffin Bouchal, RN, PhD, is an Associate Professor in the Faculty of Nursing, at the University of Calgary. Her scholarship and research program is in the areas of palliative care, advance care planning and psychosocial/spiritual care at the end of life.

Christine A. Walsh, MSc, MSW, PhD, RSW, is a professor at the Faculty of Social Work, University of Calgary. Her research centres the voices of marginalized populations including older adults with histories of abuse, social exclusion, poverty, and homelessness.

Aislin Mushquash, PhD, is a Clinical Psychologist and an Associate Professor in the Department of Psychology at Lakehead University. Her research focuses on understanding maladaptive coping and innovative approaches to foster adaptive coping.

Tucker Reed, BSc, is a PhD student in Community Health Science, specializing in Health Services Research at the University of Calgary. His research focuses on how to improve access to diabetes-specific care among structurally vulnerable individuals.

Jeremy Auger has been a part of the CDAC for about two years and has been a strong supporter for people with diabetes who are experiencing homelessness. Jeremy's creativity and thoughtfulness have contributed significantly to CDAC arts-based projects.

Brian Bowdridge has been with the CDAC since 2022 and has been a passionate advocate for improving access to diabetes-appropriate foods in shelters. Brian hopes to inspire others to take action and address the challenges of living with diabetes while experiencing homelessness.

Monica Nelson has been a co-researcher and member of the CDAC since 2023. Monica actively engages with the CDAC with the aim of providing care and support for others in her community.

Anna Whaley has been a part of the CDAC since the very beginning of the committee in 2021. Her favorite thing about the CDAC is that she feels like she finally has a place and voice in a diabetes group as someone living with type 1 diabetes.

David Campbell, MD, PhD, MSc, FRCPC, is a medical specialist in Endocrinology & Metabolism and is an Associate Professor in the Department of Medicine at the University of Calgary in the field of Health Services Research. His area of research is social disparities and their impacts on clinical outcomes of metabolic diseases.

References

1. Bowen E, Anderson AJ, Capozziello N, Hewner S. Managing Health Without Stable Housing: Dimensions of Treatment Burden and Patient Capacity for People With Chronic Health Conditions Experiencing Homelessness. *Qual Health Res*. 2025;35(13):1450–63. 10.1177/10497323241302673.
2. Campbell RB, Larsen M, DiGiandomenico A, et al. The challenges of managing diabetes while homeless: a qualitative study using photovoice methodology. *Can Med Assoc J*. 2021;193(27):E1034–41. 10.1503/cmaj.202537.
3. Hwang SW, Bugeja AL. Barriers to appropriate diabetes management among homeless people in Toronto. *CMAJ Can Med Assoc J J Assoc Medicale Can*. 2000;163(2):161–5.
4. Hwang SW. Homelessness and health. *Can Med Assoc J*. 2001;164(2):229.
5. Tariq S, Grewal EK, Campbell RB, Campbell DJT. Exploring the role of psychological factors in diabetes management for people experiencing housing instability: a qualitative descriptive study of providers' perspectives across Canada. *J Soc Distress Homelessness* Published online May 13, 2024:1–12. 10.1080/10530789.2024.2352293
6. Sharan R, Wiens K, Ronksley PE, et al. The Association of Homelessness With Rates of Diabetes Complications: A Population-Based Cohort Study. *Diabetes Care*. 2023;46(8):1469–76. 10.2337/dc23-0211.
7. Browne JL, Ventura A, Mosely K, Speight J. I call it the blame and shame disease': a qualitative study about perceptions of social stigma surrounding type 2 diabetes. *BMJ Open*. 2013;3(11):e003384. 10.1136/bmjopen-2013-003384.
8. Phelan J, Link BG, Moore RE, Stueve A. The Stigma of Homelessness: The Impact of the Label Homeless on Attitudes Toward Poor Persons. *Soc Psychol Q*. 1997;60(4):323. 10.2307/2787093.
9. Shaban C. Psychological themes that influence self-management of type 1 diabetes. *World J Diabetes*. 2015;6(4):621. 10.4239/wjd.v6.i4.621.
10. Inagaki S, Matsuda T, Muramae N, Abe K, Kato K. Diabetes-related shame among people with type 2 diabetes: an internet-based cross-sectional study. *BMJ Open Diabetes Res Care*. 2022;10(6):e003001. 10.1136/bmjdr-2022-003001.
11. Link BG, Cullen FT. Reconsidering the social rejection of ex-mental patients: Levels of attitudinal response. *Am J Community Psychol*. 1983;11(3):261–73. 10.1007/BF00893367.
12. Sekar P, Ward M, Gust S, et al. Disseminating Community-Engaged Research Involving People Experiencing Homelessness and Diabetes Using Participatory Theater. *Health Promot Pract*. 2025;26(3):463–74. 10.1177/15248399231221731.

13. Brown B. Shame Resilience Theory: A Grounded Theory Study on Women and Shame. *Fam Soc J Contemp Soc Serv*. 2006;87(1):43–52. 10.1606/1044-3894.3483.
14. Schabert J, Browne JL, Mosely K, Speight J. Social Stigma in Diabetes: A Framework to Understand a Growing Problem for an Increasing Epidemic. *Patient - Patient-Centered Outcomes Res*. 2013;6(1):1–10. 10.1007/s40271-012-0001-0.
15. Goffnett J, Liechty JM, Kidder E. Interventions to reduce shame: A systematic review. *J Behav Cogn Ther*. 2020;30(2):141–60. 10.1016/j.jbct.2020.03.001.
16. Winkley K, Ewrierhoma C, Amiel SA, Lempp HK, Ismail K, Forbes A. Patient explanations for non-attendance at structured diabetes education sessions for newly diagnosed Type 2 diabetes: a qualitative study. *Diabet Med*. 2015;32(1):120–8. 10.1111/dme.12556.
17. Grewal EK, Campbell RB, Booth GL, et al. Using concept mapping to prioritize barriers to diabetes care and self-management for those who experience homelessness. *Int J Equity Health*. 2021;20(1):158. 10.1186/s12939-021-01494-3.
18. Tariq S, Grewal EK, Booth R, et al. Lessons learned from a virtual Community-Based Participatory Research project: prioritizing needs of people who have diabetes and experiences of homelessness to co-design a participatory action project. *Res Involv Engagem*. 2023;9(1):46. 10.1186/s40900-023-00456-z.
19. van Manen M. *Researching Lived Experience, Second Edition: Human Science for an Action Sensitive Pedagogy*. 2nd ed. Taylor and Francis; 1997.
20. Government of Canada SC. Population and dwelling counts: Canada and census subdivisions (municipalities). February 9, 2022. Accessed December 15, 2025. <https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=9810000201>
21. Calgary Homeless Foundation. Point-in-Time Count reports – Calgary Homeless Foundation. 2025. Accessed December 17, 2025. <https://www.calgaryhomeless.com/learn/point-in-time-count-reports/>
22. Diabetes Canada. National and provincial backgrounders 2024 - Diabetes Canada. *DiabetesCanadaWebsite*. 2024. Accessed May 9, 2025. [https://www.diabetes.ca/research-\(1\)/advocacy-reports/national-and-provincial-backgrounders](https://www.diabetes.ca/research-(1)/advocacy-reports/national-and-provincial-backgrounders)
23. Wilson AL, McNaughton D, Meyer SB, Ward PR. Understanding the links between resilience and type-2 diabetes self-management: a qualitative study in South Australia. *Arch Public Health*. 2017;75(1):56. 10.1186/s13690-017-0222-8.
24. Bandura A. *Social Foundations of Thought and Action: A Social Cognitive Theory*. Prentice-Hall; 1986.
25. Manser ST, Sekar P, Bonilla Z, et al. Homelessness and Type 2 Diabetes: A Qualitative Study of Facilitators and Barriers to Self-Management and Medication Adherence. *J Gen Intern Med*. 2024;39(16):3120–8. 10.1007/s11606-024-09030-z.
26. Goldszmidt R, Chen SP, Gewurtz R, Hand C, Ward B, Marshall CA. Experiences of Trauma for Older Adults With Lived and Living Experiences of Homelessness in Middle to High Income Countries: A Systematic Review and Meta-Aggregation. Heyn PC, ed. *The Gerontologist*. 2025;65(6):gnaf099. 10.1093/geront/gnaf099

27. Kelly RC, Holt RIG, Desborough L, et al. The psychosocial burdens of living with diabetes. Diabet Med. 2024;41(3):e15219. 10.1111/dme.15219.

28. Geertz C. The Interpretation of Cultures: Selected Essays. Repr. Basic Books; 2009.

Figures

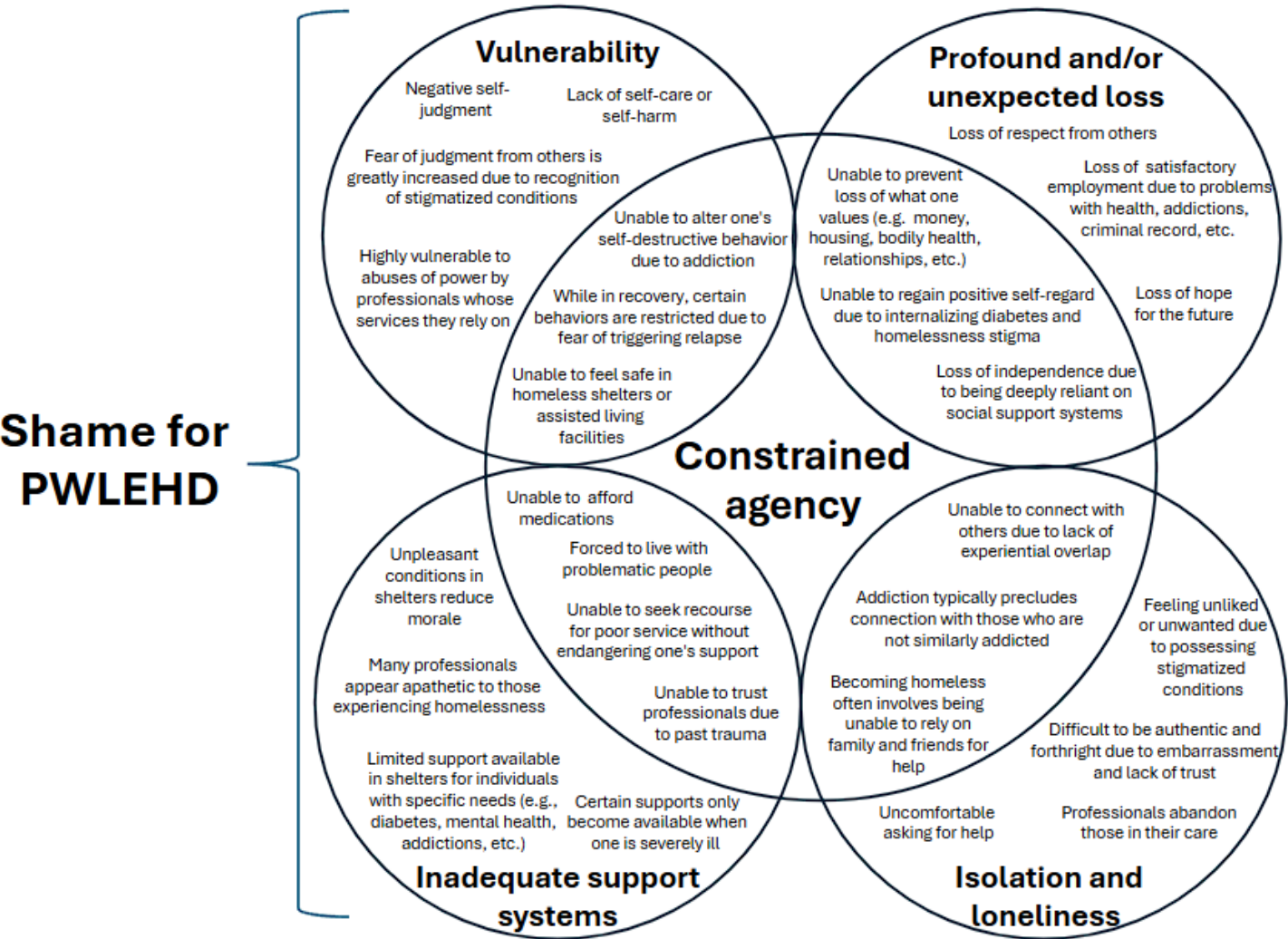


Figure 1

Shame for PWLEHD