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How Do Professionals Regard Vulnerable People in a Portuguese Community Setting? A Qualitative Content Analysis

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Abstract: The commitment to leave no one behind is at the core of the 2030 Agenda for Sustainable Development, with special attention given to people in vulnerable situations. The present study aimed to explore the perceptions and experiences of professionals who have attended to vulnerable people in a community setting. Descriptive qualitative research was conducted using qualitative content analysis of interviews with fifteen Portuguese professionals from one community-based association, who were selected via purposive sampling. Data analysis revealed nine subcategories, which were grouped into three major categories, namely: (1) meanings of human vulnerability; (2) barriers to vulnerability mitigation; and (3) approaches to addressing vulnerability. Vulnerability manifests as a discrepancy between an individual's needs and the available resources. With the accelerated pace of globalization and the exponential rise in complexity of systems and people's needs, vulnerability is gaining visibility, but this only emphasizes the urgent need to find customized cultural, political, and institutional responses.

Keywords: vulnerability; marginalized groups; professionals; community intervention; social risk; Portugal; qualitative study



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1. Introduction

Vulnerability greatly influences an individual's physical, psychological, and emotional well-being. Vulnerable people or groups of people are often characterized by having fragile conditions and needing support and protection to fully exercise their rights as citizens (Fineman 2013; Scott et al. 2018). Vulnerable groups include individuals with physical and/or mental disabilities, children, the elderly, members of the lower social classes, and refugees (Proag 2014). At the economic level, vulnerability is related to the risk of losing access to essential services (e.g., healthcare services), losing one's job, decreasing productivity, or increasing housing rents (Proag 2014; Shi and Stevens 2005).

Vulnerability is pervasive, meaning “everyone is vulnerable” (Herring 2016). Humans are considered inherently defenseless in many situations and liable to injury or damage. In the present, this is perhaps the most typical interpretation of vulnerability. The physical vulnerability inherent to a sick body brings with it an emotional and cognitive vulnerability due to the complexity of certain health states (Boldt 2019). Therefore, vulnerability emerges

as a threat to physical and emotional well-being, in a state that is on the verge of being disturbed or destroyed due to harmful external factors (Boldt 2019; Fineman 2021).

The concept of vulnerability may be used in a more problematic way when theoretical reasons hinder rehabilitation. This second use of the concept emphasizes certain physical bodily distinctions and links them to specific social, economic, or political disadvantages. This kind of vulnerability is multitudinous and “contingent” and is theorized as specific, unique, subjective, and malleable rather than as universal, often resulting from societal pressures and prejudices and frequently imposed unfairly (Virokannas et al. 2018; Fineman 2019, 2021). According to Ten Have and Gordijn (2021), “being vulnerable is often the result of a range of social, economic and political conditions, and therefore beyond the power and control of individuals” (p. 153).

Brown (2011) highlights three key criticisms of the idea of vulnerability, drawing on the social sciences: it can be paternalistic and authoritarian; it can be used to expand social control; and it can lead to exclusion and stigmatization of groups labeled as vulnerable. Another criticism focuses on the disempowerment caused by the focus on weaknesses, dependence, and passivity rather than chances, challenges, autonomy, and self-determination (Fawcett 2009). The international policy literature contends that professionals, researchers, and decision-makers have an ethical duty both to prevent damage and attend to the needs of the vulnerable and to defend their human rights (Ten Have 2014). Early positioning of certain groups as vulnerable in research ethics guidelines—for example, the ill, the poor, or members of a minority group—suggests that vulnerability could be seen as the result of both internal and external factors, such as a limited capacity for consent and a subordinate position (Ten Have 2014).

In 2022, an estimated 21.6% of the population in the European Union was at risk of poverty or social exclusion (Eurostat 2022). The risk of poverty or social exclusion “corresponds to the sum of people who are (i) at risk of poverty (as indicated by their disposable income); and/or (ii) face severe material and social deprivation (as measured by their ability to afford a set of predefined material goods or social activities); and/or (iii) live in a household with very low work intensity” (Eurostat 2022, p. 1). Unsurprisingly, the greatest socioeconomic factor affecting the probability of poverty or social exclusion was work status (Eurostat 2022). These findings suggest that specific demographic groups—such as women, young adults, those with low levels of education, and the jobless—are more likely to experience poverty or social exclusion, implying that people from these groups are prevented (or excluded) from contributing to and benefiting from economic and social progress (Eurostat 2022; International Labour Organization 2023).

In parallel, the emergence of the COVID-19 pandemic had a strong impact on various social, economic, and cultural contexts. Vulnerable populations faced greater difficulties in accessing fundamental rights, such as education and rehabilitation for people with disabilities, mental health monitoring, and equal opportunities regardless of ethnicity and race (Lewis et al. 2022a). In addition, the need to comply with isolation caused individuals to lose their jobs, homes, and family and social support, which had serious implications for their mental health (Lewis et al. 2022a). According to Mezzina et al. (2022), COVID-19 is a “syndemic, i.e., the consequences of the disease are exacerbated by social and economic disparity” (p. 1).

In Portugal, the pandemic was also responsible for worsening inequalities in access to health and social care (Direção Geral de Saúde 2021). Conversely, COVID-19 infections, hospitalizations, and mortality rates were magnified by social factors, which overlapped with biological risks, according to the report presented by the World Health Organization (2021). The report concluded that the population groups with increased rates of mortality and morbidity included poorer people, ethnic minorities such as indigenous communities, migrants, low-paid essential workers, prisoners, homeless people, and populations affected by emergencies (Direção Geral de Saúde 2021).

Around 17.9% of the resident population in Portugal in 2011 was in a condition of greater deprivation (Ribeiro et al. 2018), as measured by the European Deprivation Index (EDI).

This study also found that EDI was positively associated with the mortality rate from any cause. The southern region of Portugal revealed higher deprivation than the northern region, meaning it had a more deprived population, with greater social vulnerability. The specific social determinants responsible for such inequalities are related to poverty and deprivation; overcrowded housing; lack of social protection; lack of protection at work; low occupational health standards; precarious employment; stigmatization; and inequality in access to health information, public healthcare, treatment, prevention, and vaccination ([Direção Geral de Saúde 2021](#)).

Employing the 2030 Agenda for Sustainable Development—centered on the needs of the poorest and most vulnerable and based on a spirit of strengthened global solidarity—is crucial ([UNESCO 2021](#)). Only with this perspective can we develop “an equitable, tolerant, and socially inclusive world where the needs of the most vulnerable can be met” ([United Nations 2015](#), p. 1).

To the best of our knowledge, there is no prior research in Portugal about what professionals attending to those in vulnerable situations think about the vulnerability concept. As expressions of vulnerability are strongly influenced by cultural factors ([Galindo et al. 2018](#)), this study aimed to explore the perceptions and experiences of professionals who have attended to vulnerable people in a community setting. We hope this study offers a detailed picture of the vulnerability of socially excluded people who live in the community through the eyes of their carers.

2. Materials and Methods

2.1. Study Design

This qualitative descriptive study used a conventional content analysis method. This methodology allowed for flexibility in data collection and processing in order to gain rich information and offer a thorough overview of the general insights among the research participants ([Kim et al. 2017](#)). The authors followed the Consolidated Criteria for Reporting Qualitative Research (COREQ), which are intended to promote transparent and thorough reporting of qualitative research ([Tong et al. 2007](#)).

2.2. Setting, Participants, and Recruitment

The study population consisted of professionals working for a non-governmental organization (InPulsar—Association for Community Development) in a central Portugal location that supports the social and economic inclusion of disadvantaged people (e.g., people with low incomes, uninsured people, homeless people, racial or ethnic minorities, migrants and refugees). While not replacing the State, they provide public services involving the different members of a community without receiving any financial gain (not-for-profit); everything they receive is destined for the welfare of the communities where they intervene. This association comprises 24 professionals from diverse backgrounds.

Participants were recruited voluntarily using a purposive sampling procedure. The inclusion criteria were as follows: (1) being an adult (>18 years old); (2) working directly with vulnerable people; and (3) having more than 3 months of experience with the organization. The exclusion criteria were as follows: (1) being absent at the time of data collection due to vacation or illness, and (2) not being able to communicate in Portuguese. In total, 15 people took part in our research.

2.3. Data Collection

The data were collected in March 2023 (post-pandemic period), through a semi-structured interview. The interview guide was developed by reviewing the relevant literature ([Häfliger et al. 2023](#); [Laranjeira et al. 2022](#)) and considering the study's context. All interviews began with open questions to help researchers understand the concept of vulnerability and its promoting factors and to identify barriers to vulnerability mitigation and which mitigation strategies were used. Probing techniques were used to ensure depth and clarify the information.

The research team organized and conducted the interviews, and two co-researchers (C.L. and A.Q.) oversaw and supervised all interviewers (senior undergraduate nursing students). For the interviews, the researchers (C.C., C.F., M.P., and M.I.R.) received proper preparation, ensuring that during the interview, certain questions and/or ambiguous details could be adequately clarified. This training was important to prepare researchers to understand and respect certain silences, giving the interviewee time to formulate ideas and thoughts.

Individual interviews were scheduled by an InPulsar institutional facilitator (L.C.), with a day and time according to the availability of the institution's professionals and considering its activities. The interviewers sought to offer a calm, private, and safe environment to guarantee confidentiality. Thus, all interviews took place in a private room provided by InPulsar, where contact with the outside world was minimal and the interviewees could concentrate on the questions.

All interviews were recorded using an audio recorder, and consent for recording was requested through verbal and written consent, underlining that only researchers would have access to the collected data. The duration of each interview ranged from 20 min to 40 min, with an average of approximately 30 min. No interviews were repeated.

To facilitate the identification of each interview, these were designated by the letter "P" and identified with a number indicating the order of interviews. Thus, "P1" refers to the first participant's interview and "P15" to participant 15's interview.

2.4. Data Analysis

A conventional qualitative content analysis was used ([Graneheim and Lundman 2004](#); [Lindgren et al. 2020](#)) to identify, analyze, and report patterns or themes in the interview material. This inductive content analysis included the following steps: (1) reading and identifying units of meaning in the speeches; (2) obtaining condensed meaning units; (3) extracting initial codes; (4) identifying emerging categories and subcategories; and (5) synthesizing and interpreting results ([Graneheim et al. 2017](#)). For data analysis, we used the WebQDA software (Universidade de Aveiro, Aveiro, Portugal) created to clearly and intuitively assist in the management of qualitative data. With the support of this software, data were organized, and a tree analysis system was created (all codes and subcodes were ordered hierarchically) to encode all the information ([Souza and Souza 2021](#)).

2.5. Study Rigor

To ensure data reliability and rigor, the Guba and Lincoln criteria of credibility, transferability, dependability, and confirmability were considered ([Amin et al. 2020](#); [Tolley et al. 2005](#)). The researchers examined the first-level data and then conducted participant member checks to boost trustworthiness. Participants were requested to evaluate the results, comment on the correctness of the interpretations, and validate descriptions as part of the final member verification process. Peer debriefing was also used to assess credibility. The researchers worked with two scholars in nursing and qualitative research (C.L. and A.Q.) to exchange text summaries, identify themes, carry out constitutive processes (to find patterns of meaning), and create final drafts of findings. A thorough analytical description of the context, methods, and sample was developed to maximize variety in age and job experience to attain transferability. Additionally, individuals were cited directly, and the entire research method and background were thoroughly described. The researchers then worked together to organize the data definitively to attain dependability and confirmability. There were no significant disagreements, although ambiguous words and sentences were reviewed and clarified. Code, subcategory, and category disagreements were addressed until a consensus was found. Participants were recruited until the research team members mutually agreed that the data were well saturated. After the 12th interview, additional participants added little information to that collected in the previous interviews. Thus, the researchers agreed to close the sample with 15 participants.

2.6. Ethics

This research project was submitted to the Local Ethics Committee and obtained a favorable opinion (CE/IPLEIRIA/02/2022). All participants gave both written and verbal permission, as required by the Helsinki Declaration, for the recording of their interviews. The study's participants voluntarily signed up to participate, and they were given the option to leave at any time. They were also told they would be informed of the study's general results if they so wished and might be contacted again to complete the discussion, if necessary. The gathered information was stored and used following privacy laws and current legislation governing the protection of sensitive data.

In order to protect the identity of research respondents, we only included relevant background information to assure confidentiality.

3. Results

3.1. Demographics

The study sample comprised a total of fifteen participants who were mostly female, with only two males (Table 1). Ages ranged from 22 to 58, with an average age of 36.7 ± 9.91 years. Their durations of professional activity in the InPulsar Association varied between 9 months and 11 years. Most participants ($n = 12$) had an academic background in social sciences (e.g., social workers, social mediators, and psychologists).

Table 1. Participant description ($n = 15$).

Participant	Age (Years)	Sex	Professional Activity in InPulsar
1	25	Female	9 months
2	46	Female	2 years
3	42	Female	11 years
4	27	Female	1.5 years
5	40	Female	7 years
6	28	Male	6 years
7	30	Female	2 years
8	58	Male	5 years
9	22	Female	2 years
10	44	Female	4 years
11	38	Female	10 years
12	44	Female	1.5 years
13	44	Female	4 years and 3 months
14	30	Female	3 years and 2 months
15	32	Female	7 years

3.2. Findings from Interviews

The study's results were distilled into three main categories and nine subcategories, as outlined below (Figure 1). The findings are detailed for each theme, along with meaningful quotations.

3.2.1. Meanings of Human Vulnerability

This theme revealed the meanings attributed to vulnerability based on the participants' experiences with people at risk for social, economic, environmental, or other reasons, therefore making them more exposed to vulnerability risk factors. Based on the responses, three sub-themes emerged. The first refers to vulnerability due to deprivation of fundamental rights.

Three participants considered this to be a fragile condition, whereby citizens are prevented from accessing their basic rights.

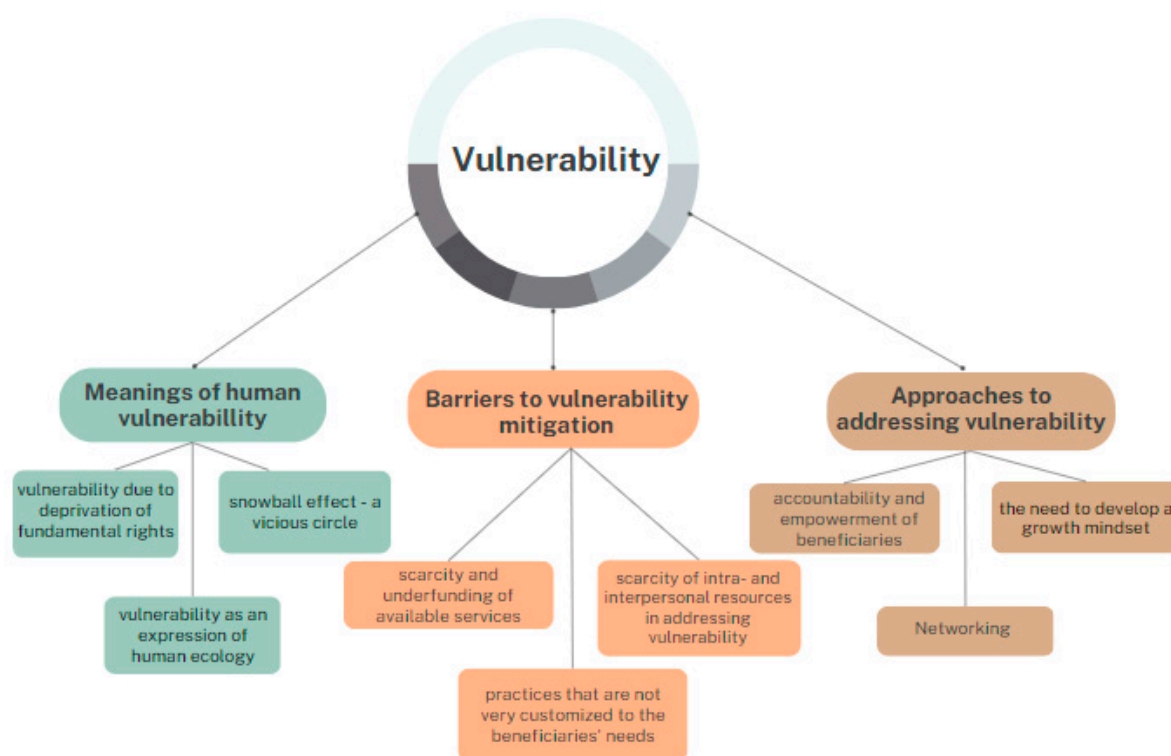


Figure 1. Content analysis map: an overview of findings.

P5 stated that all people who are in some kind of more fragile situation or who are prevented from being citizens in the full exercise of their rights due to a wide range of issues, namely social, financial, and cultural matters, are vulnerable. Likewise, P2 and P9 also highlighted the deprivation of rights to health, food, and education.

In parallel, P11 focused on migrant populations who, in addition to their previous condition of greater fragility, encounter obstacles at the bureaucratic level, emphasizing that “migrants [...] do not have a family doctor, they do not have referrals [...] it is a very painful, very tense process, and people are already in such a fragile situation”.

For P12, framing certain populations in the category of “vulnerable” may represent, paradoxically and ambiguously, a way of agreeing with their condition as non-subjects who lack rights, whether they are “migrant groups, poor populations, homeless people, or LGBTQIA+ groups”.

The second sub-theme referred to vulnerability as an expression of human ecology. The concept of vulnerability emerged as the subject’s constitutive reality, naturally being in need of help, reflecting a permanent state of being or danger or exposure to potential harm. In this regard, P5 commented “that vulnerability arises associated with generational poverty, of families that are unable to break the cycle of poverty”. Then “belonging to an ethnic minority [...] not having enough school qualifications to find a more competitive job” pushes people into situations of enormous fragility.

Invisibility also appeared as a symptom of vulnerability and is therefore assumed as a central element in the work of social and community support organizations. For P4, “people who are part of the social fringes have little ability to believe in relationships, much less in services”. Therefore, uncovering these realities and preventing vulnerability from deflating humanity’s social support practices is imperative, as is reflecting on the complex connectivity inherent in sociocultural contexts through a human ecological lens.

The COVID-19 pandemic reinforced the integral dimension of vulnerability resulting from social inequalities and aggravated by economic processes and public policies that often disregarded care for the most impacted populations. Access to many social support services was constrained, constituting a form of vulnerability:

P11: *“Nowadays access to many services is practically only done online. [...] some services stopped working in person [...] it is also a vulnerability”.*

During the pandemic’s contingency period, InPulsar was their exclusive service provider. Thus, P10 pointed out that its support was essential to ensure the community’s access to schooling and provide means to access online classes. These were particularly relevant because access was largely only digital, by e-mail or phone, and by appointment.

In the post-pandemic period, the impact of the previous isolation on interpersonal and human relationships was visible, namely in children and adolescents:

P12: *“[...] we are in a post-pandemic period and in which human relationships existed, but they existed in a completely different way [...] and we feel in these children [...] this difficulty in dealing with themselves and with the other”.*

The third and last sub-theme concerns the snowball effect—a vicious circle. Participants commented that one vulnerability can imply consequences that generate another type of vulnerability at the most varied levels. P3 mentioned that people’s loss of income often makes it impossible to purchase food and maintain housing, increasing their vulnerability.

P6 and P7 agreed that consumption of psychoactive substances has been increasing in the poorest populations, constituting either a cause or a consequence of other situations, such as mental illness. Vulnerable people are more susceptible to disease and have fewer personal and societal resources to deal with its effects on mental health:

P6: *“the easiest refuge is through consumption [...] an easier and more immediate escape. Then there are its effects linked to the consumption of illicit substances”.*

P7 indicated the impact on mental health, commenting that understanding *“whether consumption led to mental illness or, on the other hand, mental illness led to consumption”* is complex.

3.2.2. Barriers to Vulnerability Mitigation

This theme contains the main challenges and barriers to vulnerability mitigation that were identified by the participants. It was divided into three sub-themes: scarcity and underfunding of available services; practices that are poorly customized to meet the beneficiaries’ needs; and scarcity of intra- and interpersonal resources in addressing vulnerability.

The first difficulty corresponds to the scarcity and underfunding of the available services. Participants referred to the lack of answers, for example, as P12 stated, *“a specialty consultation, a dental medicine consultation, a psychiatry consultation, a child psychiatry consultation [...]. There are not enough resources to respond to these requests”.*

At the same time, P15 highlighted the lack of support and solutions for homeless people:

P15: *Homeless people should not be on the street for more than 24 h, but then in practice, this does not materialize, because there are no effective responses on the ground [...] we do not have enough means or resources [...] we call the social emergency line and they don’t respond immediately, so the whole structure itself is not working.*

P4 confirmed this gap in responses from those with the power to decide these issues, stating that *“we are aware of the problem, and we know the solutions, but we have difficulty producing effective answers”.*

Another challenge for mitigating vulnerability stems from practices that are poorly customized to meet beneficiaries’ needs. The participants again pointed out the difficulty in obtaining the necessary referrals to support services, either due to the excessive associated bureaucracy or the lack of preparation by the responsible professionals:

P5: “[...] the bureaucratic burden and the complexity associated with these processes are great [...] there is also a lack of sensitivity on the part of the services themselves and a great lack of preparation of professionals in this area [...]”.

However, these services often do not meet the needs of their beneficiaries. As mentioned by P10, “sometimes there is an answer to a certain question, but it does not suit all the people who need it”. Sometimes professionals build inappropriate interventions because they do not involve service users, simultaneously acting as targets and partners of care:

P14: “[...] Sometimes we want to develop skills with people who can’t develop them at all, and this limits the effectiveness of interventions”.

On the other hand, participants also claimed that people need not only social support but a multi-service approach, which often does not happen:

P13: “[...] People need other types of support (especially in the health area), psychological support, and other responses that allow us to refer people”.

The scarcity of intra- and interpersonal resources in addressing vulnerability also constitutes a barrier, since, as mentioned by some participants, professionals need to acquire emotional skills and self-knowledge concerning the process of supporting their users:

P4: [...] the biggest difficulty, deep down, is for us to understand what the other person sometimes wants [...] This leads us to disappointments [...] and disappointment is created because we create expectations [...]. It’s hard to go home knowing the problems we all deal with daily [...] sometimes it’s hard to dissociate their problems from ours.

Each person invites a unique interpersonal relationship, opening up an opportunity for personal growth. Thus, it is essential to acquire the aptitude to meet others while preserving one’s individuality, which implies relating without dissolving:

P15: “I feel that sometimes there is a feeling of ingratitude towards our work [...] but our mission is to create empathetic relationships. But sometimes we get too involved and find it difficult to distance ourselves”.

Some participants also mentioned difficulties in managing expectations regarding the success of interventions, which sometimes generated frustration and suffering:

P6: “[...] many questions make me think and reflect [...] in professional terms [...] we think we know the right path for people, but that doesn’t always happen [...]”.

P10: “Many times, we set expectations that will be good for them, but then they don’t meet our expectations”.

P3: “[...] Sometimes we believe more in people than they believe in themselves”.

P14 emphasized the importance of self-care and adaptive strategies to deal with the complexity of some users’ existential situations. In this regard, she said: “[...] it is very important to have some personal care that allows us to effectively tackle the daily challenges [...]”.

3.2.3. Approaches to Addressing Vulnerability

This theme suggests a set of strategies to deal with vulnerability that is indicated by the participants. Based on the data obtained, three sub-themes were identified: (1) accountability and empowerment of beneficiaries; (2) networking; and (3) the need to develop a growth mindset.

The first strategy stresses the importance of accountability and empowering beneficiaries. In this perspective, some participants revealed that professionals seek to train and reintegrate people or groups through practice in-place:

P4: “[...] it is very important. The person is focused and the interest emerges from them to emancipate and reintegrate in society”.

P3: I think that [...] putting the person at the center of the intervention is fundamental, considering that each person is a person. We here at InPulsar have a principle, which is

the principle of humanism: treating all people with respect. All people are human beings who deserve to be heard and this is an essential point [...].

As a complement to this proximity approach, P7 referred to providing beneficiaries with communication strategies and socioemotional regulation, as this provides resources to access educational and training opportunities and to develop an entrepreneurial attitude to approach the labor market:

P7: *“It is good practice to provide our users with some strategies for emotional management, communication, and how to communicate more assertively [...] this helps them integrate into the community”.*

The importance of networking emerged as a second strategy. According to P9 and P3, professionals adopt this method to meet the different needs of people or groups that use the association:

P9: *“[...] Whenever there is a request for help, we try to respond as best we can; and when we don’t succeed, we look for other partners [...] answers in terms of clothing and food”.*

P3: *“[...] we mobilize all the support that exists, in terms of economic support, training that exists [...] to fill the identified needs and often access to services they can take advantage of”.*

P4 mentioned that the available resources and social partners are insufficient, given the increase in requests for help in recent years. In this sense, this underlines the impossibility of responding quickly to all the requests and needs that arise daily:

P4: *“[...] our resources, more and more, we have a network of beneficial resources [...] nobody should be on the street more than 24 h, right? And, unfortunately, we haven’t been able to bridge that yet. And, therefore, there is this lack of resources here [...] to give that immediate response.*

On the other hand, P2 and P13 recognized that periodic meetings with community agents are fundamental exercises that provide foresight into possible solutions, thus making the whole community responsible:

P2: *“[...] meetings are important moments that help us make more informed and enlightened decisions”.*

P13: *“[...] engagements with stakeholders are crucial for our purposes”.*

Finally, the need to develop a growth mindset emerged from the participants, i.e., the ability to view challenges positively, considering them as an opportunity to improve their knowledge. P1 revealed that she admired how vulnerable people or groups can see their difficulties as learning opportunities while being aware that professionals are there to support them:

P1: *“[...] it is an enriching experience because every day we learn from them [...] they manage to deal with what they have and want to change [...] they realize that we are here for them [...]”.*

P8 indicated that he used his experience and life path to deal with vulnerable people or groups, as he considered them useful tools for everyday work:

P8: *“[...] I use my life experience, and my life path as a tool to solve my problems”.*

At the same time, P7 highlighted creativity and “out of the box” thinking as something indispensable in the path of learning and in solving unpredictable situations in contact with vulnerable people or groups:

P7: *“[...] we often need to be creative [...] in the sense of creating other options for what would be obvious to resolve [...] It is often necessary to think outside the box, completely “out of the box”, to be able to resolve immediate situations [...]”.*

4. Discussion

This qualitative study, using a semi-structured interview strategy, aimed to give voice to professionals who attend to people with different experiences of vulnerability in the hope of finding ways to strengthen a socially inclusive society. In the post-COVID-19 world, professionals are asked to contribute with an unprecedented effort to deal with the greatest sudden increase in vulnerability in society since the 20th century, as well as to mitigate effects that stem from social inequalities (Mezzina et al. 2022).

Our study suggests that deprivation of human rights sustains and generates vulnerability. In this sense, vulnerability in today's human rights discourse is often depicted in collective terms: groups who are seen to be more in danger of having their rights infringed should receive extra protection. These groups often have extra and specific human rights protections consolidated in group-differentiated catalogs of rights that are special to that group of people because of shared characteristics or experiences (Mustaniemi-Laakso et al. 2016). In general, such a communal approach to protecting those who are vulnerable is seen as appropriate and important (Mezzina et al. 2022; Solomon 2013).

However, we emphasize Rendtorff's warning against trying to make humans perfect by eradicating their vulnerability (Rendtorff 2002). The participants viewed vulnerability as an expression of human ecology, similar to the "universal and constant" component of human vulnerability proposed by Fineman (2021). Therefore, to lessen vulnerability, we need to pay more attention to building and maintaining social structures and methods, as well as address their inherent inequalities (Clark and Preto 2018).

Moreover, categorizing every member of a certain group as marginalized or vulnerable may be (further) disempowering (Gilodi et al. 2022; Pratt 2019). A person's ability to resist and change the path of their life may be hidden and their agency minimized or denied by labeling them as "vulnerable" (Peroni and Timmer 2013). Disempowerment is connected to material circumstances of existence, as well as psychological (an individual's capacity to regulate their life) and political elements, i.e., making their voices heard, whether at the individual or collective level (Marmot 2015). Individuals possess a variety of skills; therefore, labeling them as vulnerable might be inaccurate in terms of determining priorities and policies. This imposes an ethical duty to develop fair and equitable healthcare systems that encourage autonomy; stimulate involvement; increase cultural safety; and support the well-being of everyone, rather than relieving us of our responsibility to address vulnerability (Adobor 2022). To meet the needs of vulnerable people, governments should invest in the community health and social sectors, focusing on health literacy approaches to address the needs of the more vulnerable and provide the resources they require (Richard et al. 2016).

All people are susceptible but have varying degrees of resilience to deal with or lessen vulnerability. Such resilience, which represents an individual's agency, is socially formed and, therefore, is supported, facilitated, and hindered by institutional and other structures and connections in society. The degree of access to these resources and assets serves as the foundation for individual disparities in vulnerability (Fineman 2019).

The fact that society may externally cause vulnerability is becoming more widely acknowledged. This may be especially important in situations like the refugee crisis, climate hazards, or socioeconomic marginalization, where a person's fate is essentially dependent on the cooperation and support of others (either directly or indirectly through institutional and societal arrangements) and where they may be exposed to a variety of factors that contribute to or accentuate vulnerability. The end effect might be a vicious spiral that traps those impacted in a cycle of vulnerability, loneliness, and other unfortunate occurrences. Assigning causation to one particular aspect may be difficult when several drawbacks combine to form a self-reinforcing loop. Awareness of these potential vicious loops is crucial to fully understand the complex challenges at hand while trying to reduce biopsychosocial effects on impacted vulnerable groups.

While various structural factors (e.g., poor access to facilities, a lack of amenities, issues with service providers, and difficulties with COVID-19) affect the access of marginalized and disadvantaged communities, professionals must adopt an empowering approach to

vulnerability based on removing structures that sustain or create vulnerability (Klassen 2022). Structures provided by the social and healthcare systems are not as diverse as needed to cover all situations, and the compensation system is often insufficient. Concomitantly, our findings underline that services are often not customized to serve the needs of people with vulnerable conditions. One way to overcome this barrier includes a relational approach, given that good interactions between institutions and professionals impact their responsiveness. Attaining the ultimate objective of people-centered care (Delgado 2021; Symonds et al. 2019) requires a set of professional skills and competencies, such as socioemotional competencies (such as empathy, patience, self-esteem, and collective orientation) and self-awareness (Carden et al. 2022).

For that purpose, professionals need to embrace a growth mindset approach toward building competencies (Han and Stieha 2020; Han et al. 2022). This approach contrasts with a fixed mindset, which assumes that learning and performance capacities are unchanging. People with a growth mindset have a stronger capacity for risk taking because they think their talents and abilities can be developed through time. This aids professionals in improving working circumstances, which in turn improves the outcomes of their interactions with people in vulnerable situations.

Personalized care planning aims to provide professional support tailored to the needs of the people, and includes ensuring that leadership, good coordination, and engagement are aligned and directed toward an effective response. However, some constraints do arise, particularly an imbalance between individual and outcome expectancies. As shown in this research, professionals in constant contact with situations of vulnerability experience significant frustration. These tensions might be understood as reflecting poor management of professional expectations, which should be addressed by training and supervision (Ruiz-Fernández et al. 2021).

The findings of the current study are consistent with those of previous studies regarding some strategies to overcome vulnerability. Some good practices, such as empowering and creating intersectional approaches, can enhance, unpack, and deepen the dynamics of vulnerability and resilience, enabling policies and programs to be more inclusive and ensuring no one is left behind (European Commission 2021). Raising awareness about social protection referral networks and exchanging experiences through regular meetings and interfacility communication may better equip these professionals to respond to vulnerable people's needs responsibly and effectively (Kruk et al. 2018).

4.1. Study Limitations

This study does have some limitations. First, it is qualitative research that focuses exclusively on professionals who work in a single institution (in Leiria, Portugal). Therefore, multi-center study designs should be used in future studies. Further research is also needed to evaluate whether the conceptual map of content resonates with professionals from other geographic areas as well. A more comprehensive strategy that incorporates all stakeholders, combines qualitative and quantitative data, and allows for greater comprehension of the study's numerous facets is required. Furthermore, the question of which social, economic, and environmental factors increase susceptibility to the impacts of hazards should be further explored. Lastly, future studies should integrate data triangulation with the perspectives of vulnerable people in order to provide a holistic analysis of the research problem.

4.2. Implications for Policy and Practice

Overall, the research emphasizes that comprehending how sensitive vulnerable groups are to health and socioeconomic disadvantages is critical. This study's findings suggest that policymakers must be mindful of the exclusions and inequities that exist across groups. Our findings are consistent with the premise that health and social intervention tactics might be enhanced by incorporating general population-focused strategies, since the operation of contextually appropriate mechanisms depends on individual, community, and social

perceptions, attitudes, and will. Strengthening vulnerable and marginalized people's voices and promoting social inclusion is possible.

The need for social workers and healthcare professionals to participate in skill-building opportunities that help them work with vulnerable populations is another pertinent implication (Amann and Sleigh 2021). Personal storytelling in ways that improve connection, relevance, and drive is encouraged by the pedagogy of vulnerability. The pedagogy of vulnerability in community settings is based on several assumptions, including the following: "vulnerability invites vulnerability; vulnerability opens up emotions; self-disclosure must be deliberate and purposeful; sometimes the risks outweigh the benefits; depth and pace matter; and privilege and power operate in vulnerability" (Brantmeier 2021, pp. 2–3). The representation of human vulnerability can be an engine toward adopting a new care paradigm, which is why developing a pedagogy of vulnerability in the near future, one capable of transforming future caregivers into vehicles of humanization, is important. While a vulnerability-based educational approach is required to increase professional sensitivity, it must be properly researched and contextualized.

Lastly, self-knowledge and self-care are also relevant implications from this study for professionals who deal with human vulnerability in their daily lives. Some participants emphasized the importance of self-care to avoid becoming vulnerable themselves, particularly in terms of mental health (Lewis et al. 2022b).

5. Conclusions

Based on semi-structured interviews with 15 professionals who attend to vulnerable individuals, this qualitative research gives a conceptualization of vulnerability within the framework of community care. Three key themes emerged from the study: (1) meanings of human vulnerability; (2) barriers to vulnerability mitigation; and (3) approaches to addressing vulnerability. Our research demonstrates that vulnerability is a multifaceted, humanizing notion that includes a wide range of elements and characteristics. The accelerated pace of globalization and an exponential increase in the complexity of systems and people's needs tend to make vulnerability more visible, but this only highlights the urgency in finding cultural, institutional, and political responses to balance the ideals of integration with respect for cultural differences and the growth of greater resilience.

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