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Embodied Experience and Health Communication among Vulnerable Populations: Insights from MHM 2026

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Abstract

This conference report provides an analytical synthesis of five studies presented in Panel 3, "Bodily Experiences and Health Communication among Vulnerable Populations: From Qualitative to Quantitative Approaches (Part I)," at the 9th "Medicine, Humanity and Media" (MHM 2026) Health Communication International Conference and PhD Symposium. The five studies examined health communication across diverse populations and contexts, including AI-mediated intergenerational communication, online social support among people with eating disorders, social media health practices among migrant workers with pneumoconiosis, cancer-prevention self-efficacy in resource-scarce settings, and caregiver-mediated communication of autistic embodied experience. Although differing in theoretical perspectives and methodological approaches, the studies collectively drew attention to several interconnected issues: the articulation and mediation of bodily experience, the role of digital technologies and social relationships in shaping health communication, the structural conditions that enable or constrain health-related action, and the representation and agency of vulnerable populations. The panel discussion further highlighted shared theoretical, methodological, and ethical challenges, particularly those concerning conceptual clarity, theory–method alignment, research design, sampling, use of empirical materials, and the representation of vulnerable groups. Taken together, the studies demonstrate the value of examining health communication not solely as the transmission of information, but as a socially and structurally embedded process involving embodiment, mediation, support, representation, and agency.

Keywords: vulnerable populations; bodily experience; health communication; digital media; social support

Introduction

Health communication among vulnerable populations involves more than the dissemination and reception of health information. Experiences of illness, disability, aging, and health risk are embodied and socially situated, while the capacity to understand, articulate, and respond to these experiences is shaped by interpersonal relationships, digital technologies, access to resources, and broader structural conditions. The growing involvement of social media, online communities, and artificial intelligence in health-related communication has further complicated these processes, creating new possibilities for self-expression, social support, and public participation while also raising questions concerning inequality, representation, privacy, and communicative agency.

Corresponding author: Yutong Meng, Social Policy & Practice, University of Pennsylvania, United States. **Email:** rosie.mengyutong@gmail.com. © The Author(s), 2026. Published under the Creative Commons Attribution 4.0 International License (CC BY 4.0; https://creativecommons.org/licenses/by/4.0/), which permits use, distribution, adaptation, and reproduction in any medium, provided the original work is properly cited.

These concerns formed the central focus of Panel 3, "Bodily Experiences and Health Communication among Vulnerable Populations: From Qualitative to Quantitative Approaches (Part I)," at the 9th "Medicine, Humanity and Media" (MHM 2026) Health Communication International Conference and PhD Symposium. Held at the School of Journalism and Communication at Peking University, the panel brought together five studies that approached bodily experience and health communication from distinct theoretical and methodological perspectives. Yidan Yang, an associate professor at Tianjin University of Traditional Chinese Medicine, and Qijun He,an associate professor at Shanghai University, served as discussants for this panel. Their comments provided further reflections on the conceptual, methodological, and ethical issues raised by the studies.

The five studies addressed different populations and health contexts. Xuanlin Hu of Shenzhen University examined AI-generated aging images and intergenerational prosocial behavior; Fangxin Huang of Nanjing University investigated how people with eating disorders sought and obtained online social support across social media platforms, private online communities, and large language models; Yihang Ding and Jiayi Li explored the social media health practices of migrant workers with pneumoconiosis; Yina Ding of Zhejiang Cancer Hospital examined the construction of cancer-prevention self-efficacy in resource-scarce settings; and Junchen Chen, Mingxi Hang, and Yidi Zhang investigated how caregivers interpret and communicate the embodied experiences of autistic individuals. Methodologically, the studies ranged from between-subjects experiments and questionnaire surveys to digital ethnography, in-depth interviews, grounded theory, structural equation modeling, and computational text analysis.

Digital Mediation of Embodied Experience and Social Support

Digital technologies emerged across the panel not simply as channels for delivering health information, but as environments in which individuals perceive themselves and others, seek emotional support, negotiate stigma, and establish or maintain social relationships. This dimension was particularly evident in the studies by Xuanlin Hu and Fangxin Huang, which approached digital mediation from different but complementary perspectives.

Xuanlin Hu's study, Seeing the Future Self: How AI-Generated Aging Images Promote Prosocial Behavior Across the Intergenerational Communication Divide, examined whether AI-generated aging images could enhance young people's understanding of older adults and encourage prosocial behavior across generations. Drawing on perspective-taking theory, the empathy–altruism hypothesis, and cognitive appraisal theory, the study employed two between-subjects experiments to examine how the temporal framing of the aging images, the person depicted, and the valence of the depicted content shaped participants' emotional responses, attitudes toward helping older adults, and related behavioral intentions.

The findings showed that viewing a future aging image, compared with viewing a current-state image, significantly increased personal distress, empathic concern, supportive attitudes toward older adults, and willingness to engage in related helping behaviors. Personal distress and empathic concern mediated these effects. Emotional arousal was particularly pronounced when

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the aging image depicted the participant rather than another person, while negative aging scenarios generated stronger effects than positive scenarios, although positive representations also produced favorable responses. Hu's findings therefore suggest that highly self-relevant AI-based aging visualizations may reduce psychological distance between younger and older people through emotional arousal and self-referential processing.

The study also illustrates the theoretical and ethical questions that accompany the use of generative AI in health and intergenerational communication research. Professor Yang and professor He recognized the originality of using AI-generated aging images to address an established problem in intergenerational communication, while emphasizing that technological novelty should remain clearly connected to the underlying theoretical question. They also drew attention to privacy, data security, and related ethical concerns associated with the use of AI-generated facial images. From a methodological perspective, the discussants suggested that a more integrated factorial design, such as a 2 × 2 × 2 experiment, could enable simultaneous examination of main and interaction effects and clarify the relationship between the two experiments.

A related but distinct form of digital mediation appeared in Fangxin Huang's study, Digital and AI-Mediated Healing: A Triple-Flow Mechanism of Online Social Support among People with Eating Disorders. Huang examined how people with eating disorders seek and receive social support across public social media platforms, private online communities, and large language models (LLMs). The study adopted a mixed-methods design combining content analysis, digital ethnography, and structural equation modeling to investigate platform content, peer-support communities, and patterns of LLM use.

The study identified different affordances and limitations across these three communicative environments. On public platforms, individuals sought support by documenting symptoms, recounting treatment experiences, and using metaphorical forms of expression, but also encountered problems such as disillusionment with the promise of platform anonymity. Private online communities enabled deeper empathy, experiential sharing, and companionship, while potentially producing closed emotional loops, delayed responses, and limitations in the transferability of peer experience. LLMs offered immediate responses, information integration, and nonjudgmental interaction, but remained limited in their ability to connect users with offline resources.

On this basis, Huang proposed a "platform–community–LLM" triple-flow mechanism. Rather than treating the three domains as separate communication spaces, the study described them as permeable environments among which users strategically move according to perceived stigma, the timeliness of support, and specific resource needs. The model thus shifts attention from the characteristics of individual platforms toward the ways users assemble different sources of support across digital environments.

The discussants recognized the study's engagement with an important real-world problem while also identifying several issues requiring further clarification. Professor He noted that the relationships among the research questions, methods, and conclusions needed to be more closely aligned and that the organizing logic of the mixed-methods design remained insufficiently clear. The survey sample also appeared limited for a structural equation model incorporating a relatively large number of variables. Professor Yang further advised caution in using the concept of "digital and AI-mediated healing" and encouraged clarification of whether the proposed

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platform–community–LLM mechanism should be understood primarily as a descriptive account of observed support-seeking practices or as a model capable of informing intervention design.

Taken together, Hu's and Huang's studies demonstrate two different ways in which digital technologies are becoming embedded in experiences of vulnerability. In the former, AI-generated representations of the future self shape emotional and intergenerational responses through self-referential processes. In the latter, digital platforms, online communities, and LLMs constitute a changing support environment that users navigate strategically. Both studies therefore suggest that digital technologies should be examined not only as information channels but also as mediating environments that shape perception, emotion, social connection, and access to support.

Structural Vulnerability and Health Agency

A second recurring concern across the panel involved the relationship between health communication and structural conditions. The studies by Yihang Ding and Jiayi Li and by Yina Ding both challenge explanations that locate health communication outcomes primarily in individual knowledge, attitudes, or motivation. Instead, they draw attention to the medical, economic, geographic, familial, and communicative conditions within which health-related agency becomes possible or constrained.

Yihang Ding and Jiayi Li's study, Social Media Health Practices among Migrant Workers with Pneumoconiosis: A Culture-Centered Approach, examined health-related content production and social interaction among migrant workers with pneumoconiosis on short-video platforms such as Douyin and Kuaishou. Combining netnography, in-depth interviews, and grounded theory, the study employed the culture-centered approach to examine the interaction among structure, agency, and culture in the formation of health rationalities within this population.

The findings indicated that participants' health practices were shaped by structural conditions including access to medical resources, economic constraints, and family responsibilities. At the same time, patients were not represented simply as passive recipients of these constraints. They sought possibilities for self-help through traditional Chinese medicine, reflections on life and illness, and online appeals for assistance, while gradually forming networks of mutual support through digital interaction. Some patients and family members also transformed personal illness narratives into forms of public health communication by warning others about occupational risks, sharing treatment experience, and disseminating legal knowledge. The study therefore described a movement from self-narration and self-help toward collective mutual aid and proposed an altruistically oriented form of health rationality.

The discussants nevertheless emphasized the need to examine carefully whose experiences become visible through social media research. Yang noted that research based on short-video bloggers should consider both the authenticity of participants' identities and the performative dimensions of mediated self-presentation. Importantly, she also encouraged the researchers to consider patients with pneumoconiosis who are unable or unwilling to speak publicly online and to broaden recruitment through offline settings such as hospitals. He similarly suggested making fuller analytical use of the existing material and defining concepts such as "health rationality"

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more precisely. Rather than treating online community formation in general terms, she encouraged closer attention to how patients present themselves, respond to doubt or criticism, seek social recognition, and expand the public visibility of pneumoconiosis.

Structural constraints were approached from another direction in Yina Ding's study, The "Distance" in Health Communication: Challenges in Building Self-Efficacy for Cancer Prevention and Control among Residents of Resource-Scarce Areas. Drawing primarily on self-efficacy within social cognitive theory and incorporating the Health Belief Model, Ding surveyed 116 residents in Xiaoshan District and Kaihua County, Zhejiang Province, to examine the gap between the dissemination of cancer-prevention information, public awareness, and the adoption of preventive behaviors.

Respondents demonstrated relatively good knowledge of some basic issues, including the association between smoked foods and gastric cancer and the purposes of cancer screening, but showed weaker understanding of cancer preventability and early symptoms. Nearly half reported that they never actively sought information about cancer prevention and control, while overall risk perception remained low. Based on these findings, the study proposed four forms of "distance": cognitive distance, belief distance, efficacy distance, and action distance. It argued that inadequate health communication outcomes cannot be attributed solely to individual deficiencies in knowledge or competence, but should instead be understood in relation to interacting geographic, economic, medical, cultural, and psychological conditions.

The discussion of this study centered on both conceptual distinctiveness and empirical comparison. Yang recommended clarifying how the proposed concept of "distance" differs from established concepts such as the knowledge gap and why an additional conceptual framework is necessary. She also suggested strengthening the measurement of self-efficacy. He observed that the available sample and comparison criteria were insufficient to establish the magnitude of health communication disparities in resource-scarce areas and therefore recommended incorporating either a comparison group from less resource-constrained settings or appropriate baseline data.

Considered together, these two studies highlight a common limitation of information-centered explanations of health behavior. Knowing about a health risk does not necessarily translate into the ability to act on that knowledge. For migrant workers with pneumoconiosis, health practices are embedded within economic pressures, family responsibilities, occupational histories, and unequal access to medical resources. For residents in resource-scarce areas, knowledge of cancer prevention must similarly be considered alongside perceived efficacy, resource availability, and broader geographic and social circumstances. Health communication, from this perspective, involves not only improving information provision but also understanding the structural conditions under which individuals can convert information into meaningful action.

Representation, Caregiving, and the Communication of Embodied Experience

The relationship between embodied experience and representation became especially visible in Junchen Chen, Mingxi Hang, and Yidi Zhang's study, When the Body Cannot Speak for Itself:

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Proxy Embodied Communication and Caregiver Translation of Autistic Experience. The study addressed a fundamental communicative problem: how bodily experience is interpreted and communicated when individuals may have difficulty consistently articulating that experience through verbal or nonverbal means.

Combining in-depth interviews with computational text analysis, the authors examined materials from caregivers of autistic individuals, relevant professionals, and mainstream media coverage. The findings suggested that long-term everyday interaction enables caregivers to interpret difficult-to-verbalize experiences through changes in behavior, emotion, and bodily condition and to translate these private experiences into narratives that can be understood in family, clinical, and public communication contexts.

The study proposed the concept of "proxy embodied communication" and distinguished three forms of practice: defensive proxy communication, interpretive proxy communication, and advocacy-oriented proxy communication. Importantly, caregiver translation was not conceptualized simply as speaking in place of autistic individuals. Rather, the study emphasized an ongoing negotiation among communicating lived experience, preserving individual subjectivity, and facilitating broader social understanding.

Media representation added another dimension to this process. Although mainstream media can enhance the public visibility of autism, particular reporting frames may simplify or obscure the complexity of autistic embodied experience. The question is therefore not merely whether autism becomes visible in public discourse, but which experiences become visible, through whose interpretation, and in what form.

The discussants strongly recognized the clarity and social relevance of the research question while noting the analytical difficulty of simultaneously incorporating autistic individuals' embodied experiences, caregivers' interpretations, and media representations as distinct units of analysis. They recommended centering the analysis more clearly on caregiver translation and public media representation and specifying the comparative logic between these two forms of material. In particular, examining which experiences are accurately translated, over-translated, or obscured could make the process of "translation" more analytically visible.

The discussion also raised a broader problem of representational selectivity. Public communication about autism may emphasize narratives of social assistance or a relatively small number of exceptional "genius" cases while providing less visibility to the everyday embodied experiences of many autistic individuals. Comparing caregiver interviews with media texts may therefore offer a way to examine both the possibilities and limitations of mediated representation.

This study extends the panel's discussion of vulnerability beyond access to information and resources toward the broader questions of representation and ethics. When health or bodily experience is communicated through another person, communicative support and representational authority become closely intertwined. The resulting challenge is not simply how to make vulnerable populations more visible, but how to communicate their experiences without reducing their complexity or displacing their subjectivity.

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Cross-Cutting Theoretical, Methodological, and Ethical Reflections

Although the five studies differed substantially in their populations, theoretical frameworks, and methods, the discussion led by Professor Yang and Professor He revealed several recurring concerns of broader relevance to health communication research.

The first concerns conceptual clarity and theoretical contribution. Across studies involving AI-generated aging, digitally mediated support, health rationality, communicative "distance," and proxy embodied communication, the discussants repeatedly emphasized the importance of specifying what a new concept adds to existing theoretical explanations. Emerging technologies or novel empirical settings do not necessarily constitute theoretical innovation in themselves. Their analytical value depends on whether the relationships among concepts, mechanisms, and established theoretical questions are made explicit.

The second concerns the alignment of research questions, methods, and evidence. The panel included experimental research, mixed-methods designs, surveys, digital ethnography, interviews, grounded theory, structural equation modeling, and computational text analysis. This methodological plurality expands the possibilities for studying vulnerable populations, but it also increases the need for coherence between the question being asked and the evidence used to answer it. Concerns raised during the discussion—including factorial experimental design, sample size for structural equation modeling, comparison groups in survey research, the use of multiple units of analysis, and the fuller use of qualitative materials—point to a shared need for methodological choices to remain proportionate to the claims being made.

A third concern involves sampling, visibility, and representation. Research conducted through social media or other digital settings may make certain vulnerable populations more accessible to researchers while simultaneously excluding those who are less digitally visible. The pneumoconiosis study, for example, raised the question of patients who do not or cannot speak publicly online, while the autism study highlighted the possibility that media narratives may selectively represent particular experiences. These issues suggest that visibility in mediated environments should not automatically be treated as representative of the broader population.

Finally, several studies raised ethical questions associated with emerging forms of mediation. AI-generated facial images involve privacy and data-security considerations, while research on eating disorders, occupational disease, and autism requires careful attention to stigma, vulnerability, and the consequences of representation. In studies involving proxy communication, ethical attention is also required to the relationship between making an experience communicable and preserving the subjectivity of the person whose experience is being represented.

Taken together, these concerns suggest that methodological innovation in health communication research needs to be accompanied by equally careful conceptual and ethical reasoning. New technologies and new forms of data expand what researchers can observe and analyze, but they also make questions of interpretation, representation, and research responsibility increasingly important.

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Conclusion

The five studies presented in Panel 3 of MHM 2026 approached bodily experience and health communication among vulnerable populations from markedly different empirical and methodological perspectives. Yet considered together, they reveal a set of closely connected concerns. Bodily and health experiences are mediated through technologies, interpersonal relationships, social institutions, and public representations; access to health-related information does not necessarily translate into the capacity to act; and greater communicative visibility does not automatically ensure accurate or equitable representation.

The studies also demonstrate the value of methodological plurality. Experimental approaches illuminate psychological and emotional mechanisms, surveys identify patterns in knowledge, efficacy, and behavior, while ethnographic, interview-based, and textual approaches reveal how vulnerability is experienced and negotiated within specific social and communicative contexts. At the same time, the panel discussion underscored that methodological diversity must be accompanied by conceptual precision, coherent research design, adequate empirical support, and careful attention to ethical and representational concerns.

Viewed as a whole, Panel 3 suggests that health communication involving vulnerable populations is best understood not simply as the transmission of information, but as a process through which embodied experiences are interpreted, mediated, supported, constrained, and represented. Future research in this area may therefore benefit from bringing individual-level psychological processes into closer dialogue with digital environments, social relationships, structural inequalities, and questions of communicative agency. Such an approach can provide a more comprehensive understanding of how vulnerable populations encounter health information and, more importantly, how they are able to interpret, communicate, and act upon it.

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