

Adolescents' Trust in Various Medical Pathways

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Abstract

The rapid expansion of social media has introduced a largely unregulated channel through which adolescents increasingly have access to health information, raising concerns about how it shapes their trust in professional healthcare. In order to understand how to address potential issues caused by the use of social media in healthcare, this study examined whether adolescent trust in social media and trust in doctors independently exist or compete with one another, and whether stated trust tendencies are reflected in responses to hypothetical medical scenarios of varying severity. A survey was administered to 154 high school students containing six sections covering demographics, social media trust, doctor trust, vignette-based scenarios, information navigation behaviors, and a free response section. One-way ANOVAs were used to compare trust scores across participant groups. Results revealed that social media trust impacted the probability that an adolescent would trust a doctor in our scenarios ($f = 7.4$ and $p = 0.00728$). However, most adolescents who had significant trust in social media still demonstrated a strong tendency to choose doctor associated responses in vignette scenarios. These findings suggest that attempts at reducing the spread of adolescent health misinformation may be more effective if the emphasis was directed at improving content accuracy rather than limiting social media use.

Keywords: Healthcare, Social Media, Trust, Student Study, Survey

1. Introduction

A recent rise in the usage of social media has introduced a new source from which anyone, regardless of age, can access health information. Once a conversation exclusively for doctors offices, influencers, health trends, and the amount of attention a social media post gets are now shaping how individuals understand and act on health information. This shift has raised the question of how adolescents interpret and evaluate what medical advice they see. Witnessing the volume of health content being posted on social media and being exposed to the clinical side of doctor-patient relationship helped to formulate this question and motivated this study.

Trust in medical contexts is a multidimensional construct built on competence and honesty, and has been linked to long-term engagement with healthcare (Mayer et al., 1995; Richmond et al., 2022). However, in digital environments, trust functions differently, operating as a cognitive shortcut driven by factors such as popularity, aesthetics, and emotional connection rather than clinical credibility (Metzger & Flanagin, 2013; Sundar, 2008).

Individuals who report feeling dismissed or disrespected by providers show diminished trust in professional care and are more likely to seek health information elsewhere (Hardin et al., 2021). Adolescence compounds this dynamic, as it is a formative period during which independent health behaviors begin to develop and social media plays a central role in shaping identity and information consumption (Freeman, 2023; Engel et al., 2024). Together, these factors contribute to a fragmented trust landscape in which accessibility and perceived authenticity frequently compete with medical accuracy, further complicated by the volume of misinformation circulating in digital spaces (Denniss & Lindberg, 2025; Freeman, 2023).

Adolescents are particularly susceptible to this construct due to the way social media encourages emotional rather than analytical processing. This vulnerability is further heightened by limited access to professional healthcare, as many adolescents avoid medical visits due to cost, discomfort, or perceived judgment, making free and easily understandable online content a natural alternative (Hardin et al., 2021; Denniss & Lindberg, 2025). Richmond et al. (2022) further showed that experiences of perceived discrimination or feeling misunderstood by providers can diminish trust and push adolescents toward alternative sources for medical advice. The result is a situation in which adolescents turn to online communities seeking autonomy and encouragement, yet that same independence exposes them to an unregulated space where it is difficult to distinguish qualified experts from convincing but untrained creators (Gabarron et al., 2021; Denniss & Lindberg, 2025).

This study hypothesized that adolescents who primarily rely on social media for health information would exhibit overtrust in non-professional sources and distrust in professionals. Overtrust is defined as trust that exceeds a system's capabilities, leading to misuse, while distrust is trust that falls short of a system's capabilities, leading to disuse (Lee & See, 2004). Those who regularly engage with healthcare professionals were expected to demonstrate greater trust in doctors. To investigate this, a survey was administered to 154 adolescent high school students. This survey consisted of four main sections: demographics, social media trust, doctor trust, and a vignette section that presented hypothetical health scenarios. One-way ANOVAs were used to compare assigned trust scores across groups divided by responses to prior questions.

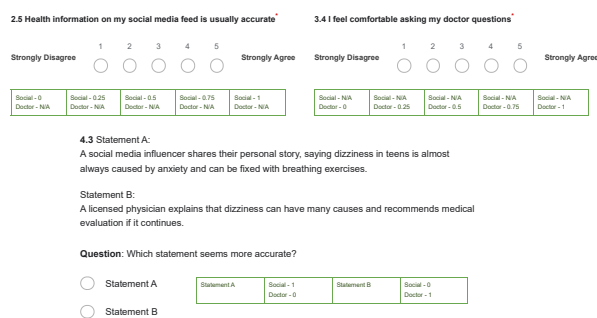
2. Materials and Methods

This study employed a survey with both quantitative and qualitative components to investigate how adolescents assess and trust various sources of medical information, primarily social media platforms and licensed healthcare professionals.

2.1 Study Overview

The survey was organized into four core sections where responses were required: (Su.1) demographic and pre-screening information, (Su.2) trust in social media sources, (Su.3) trust in professional healthcare providers, and (Su.4) vignette-based decision-making scenarios. Additionally, two optional sections were included for exploration of further work and to give willing participants a chance to share their personal insights: (Su.5) information navigation behaviors, and (Su.6) open-ended questions. These sections were not required to complete the survey, and were labeled clearly as such.

Su.1 was used to collect baselines, such as age, gender, social media usage, and trust in doctors. No questions were asked about race, ethnicity, household income, physician names, or geographic identifiers. This limitation was intentional to reduce participant identification risk and protect student privacy, and all information was anonymized. Su.2-4 were assigned trust scores reflecting how well a response aligns with either doctor or social media trust, see Section 2.2 and Figure 1. Su.2-3 contained multiple choice questions about either doctors or social media values. Su.4 consisted of medical vignettes and had ratings for both trust metrics on each question. Vignettes were used in Su.4 to measure how trust operates in hypothetical situations rather than through direct quesapture participants' reasoning and explanations for their preferences in earlier sections. An example of questions from Su.2, Su.3, and Su.4 and their trust values can be seen in Figure 1. Table 1 onally, aesble summarizing each survey section



2.5 Health information on my social media feed is usually accurate*

Strongly Disagree 1 2 3 4 5 Strongly Agree

Social - 0	Social - 0.25	Social - 0.5	Social - 0.75	Social - 1
Doctor - N/A	Doctor - N/A	Doctor - N/A	Doctor - N/A	Doctor - N/A

3.4 I feel comfortable asking my doctor questions*

Strongly Disagree 1 2 3 4 5 Strongly Agree

Social - N/A	Social - N/A	Social - N/A	Social - N/A	Social - N/A
Doctor - 0	Doctor - 0.25	Doctor - 0.5	Doctor - 0.75	Doctor - 1

4.3 Statement A:
A social media influencer shares their personal story, saying dizziness in teens is almost always caused by anxiety and can be fixed with breathing exercises.

Statement B:
A licensed physician explains that dizziness can have many causes and recommends medical evaluation if it continues.

Question: Which statement seems more accurate?

☐ Statement A ☐ Statement B

Statement A	Social - 1	Statement B	Social - 0
	Doctor - 0		Doctor - 1

Figure 1: (Upper Left) An example of a question in Su.2. (Upper Right) An example of a question in Su.3. (Bottom) An example of a vignette question in Su.4. The tables indicate calculated social media and doctor trust values for each question that were utilized in data analysis.

and the scoring system used is in Table 1.

Table 1: Summarizes each survey section's purpose, amount of questions, responding scaling, and how it was scored in the doctor/social trust construct.

Section	Purpose	# of Questions	Response Scale	Scoring System
Su.1 – Demographics & Pre-Screening	Collects age, gender, academic interest, and baseline habits to screen and characterize participants	10	Mixed: multiple choice, checkbox (select all), 5-point scale, open response	Not scored on a trust scale
Su.2 – Trust in Social Media	Trust in health information encountered on social media platforms	9 (2.1–2.9)	5-point Likert (2.1–2.5, 2.7); Yes/No (2.8)	Each response mapped to a social trust score, 0.0–1.0 scale.
Su.3 – Trust in Professional Healthcare	Trust in and satisfaction with licensed healthcare providers	9 (3.1–3.9)	5-point Likert (3.1–3.4); Yes/No (3.6, 3.7, 3.9); 1 open response (3.8, unscored)	Each response mapped to a doctor trust score.
Su.4 – Vignette-Based Decision-Making	Hypothetical medical scenarios to assess real-world decision patterns between online sources vs. professional care	7 (4.1–4.7)	Forced-choice (2–5 options per item); 1 item on 5-point Likert (4.7)	Each answer choice mapped to a (social, doctor) score pair reflecting how strongly it favors social sources vs. professional care.
Su.5 – Information Navigation Behaviors (Optional)	Frequency of use of different sources (AI, search engines, social media, family, friends, healthcare professionals, official health sites) for health info	7 (5.1–5.7)	5-point scale (Never–Always)	Not used in analysis
Su.6 – Open-Ended Questions (Optional)	Qualitative reasoning behind trust patterns and source preferences	5 (6.1–6.5)	Open-ended response	Evaluated qualitatively

2.2 Measures and Trust Constructs

In this study, trust is defined as a cognitive and emotional state in which an adolescent accepts health information as reliable and unbiased based on observed credibility rather than scientific verification (Metzger & Flanagan, 2013).

Trust was measured using Likert-scale-based questions and strategies drawn from existing literature on digital credibility and patient-provider trust (Mayer et al., 1995; Richmond et al., 2022; Metzger & Flanagan, 2013; Sundar, 2008). These questions captured participants' perceptions of accuracy, understanding, and credibility across a wide variety of sources, including social media, artificial intelligence, family, and healthcare professionals.

In order to track participants' trust in various responses across sections of the survey, a linearly scaled trust scoring system was created. For Likert-scale style questions, the response options (1-5) were converted into proportional trust values ranging from 0.00 to 1.00 either toward doctors or social media, see Figure 1. In cases where question responses reflected a partial trust in both pathways, values were proportionally split between the two scores. This approach created numerical trust variables that can then be used for comparison and analysis.

2.3 Recruitment Strategy

Study participants were recruited from a single private high school. All participants were students currently enrolled in grades 9 through 12.

Recruitment materials included flyers that provided a brief description of the study's purpose without emphasizing specific outcomes. Survey completion time was offered during advisory time (a time in which students

are able to work at their discretion). The advisory teacher explained that this survey was entirely anonymous and voluntary, and no incentives were provided. Students were also informed that their responses would have no academic, social, or disciplinary consequences and would solely benefit the research being conducted.

2.4 Ethical Oversight and Approval

This study was conducted without access to a formal Institutional Review Board (IRB) due to the regulation of the private school it took place at. In place of IRB review, all study materials, which included survey questions, vignettes, consent language, and recruitment plans, were reviewed by the head of school and the head of upper school before recruitment and data collection began. In place of the IRB, this review of the documents by the head of school and head of upper school provided clearance for the study to begin. Efforts were made to follow ethical practices in recruitment, data collection, and analysis.

Ethical risk mitigation measures included clearly voluntary participation, informed consent, and anonymous data collection consistent with federal guidelines for IRB-exempt research. The study design aligns with exemption categories described in DHHS regulations (45 CFR Part 46) and FDA regulations (21 CFR Part 50 and 56), as it involves non-invasive, anonymous survey procedures with no collection of identifiable or sensitive information.

2.5 Informed Consent and Participant Safety

The survey begins with an informed consent page. Participants all had access to full information about the nature of the study, data retention policies, data anonymity, and an anonymous contact email to request further information. This page also explained the purpose of the study, what participating meant, approximate time required, and again stated that it was completely voluntary and could be ended at any time.

This consent page also clarified that the survey did not collect medical diagnoses, medical records, names, email addresses, phone numbers, IP addresses, or any other identifying information. No questions required participants to share medications or sensitive personal health details. All scenarios were realistic yet hypothetical, and participants were given instructions not to identify themselves in any way in their responses.

2.6 Data Handling, Anonymization, and Deletion

All responses were collected through Google Forms with settings to disable email collection and IP tracking. No identifying information was collected. The data was stored in a Google account accessible only to the author. Data will be kept for 5 years before deletion in case the data is requested by any organization for verification, with demographics removed.

All data will only be seen by the author, myself, who is the sole analyst. Tools for analysis and data in aggregate will be on my personal computer.

2.7 Demographic Information

A total of 154 survey responses were collected. After data screening/cleaning, 4 were removed due to patterns suggesting low-quality or low-effort responses.

Figure 2 shows the distribution of age and gender. As this survey was given to highschoolers, the age range is quite narrow, mostly in the 15-18 range. Gender was a relatively even split between male and female, with two nonbinary participants.

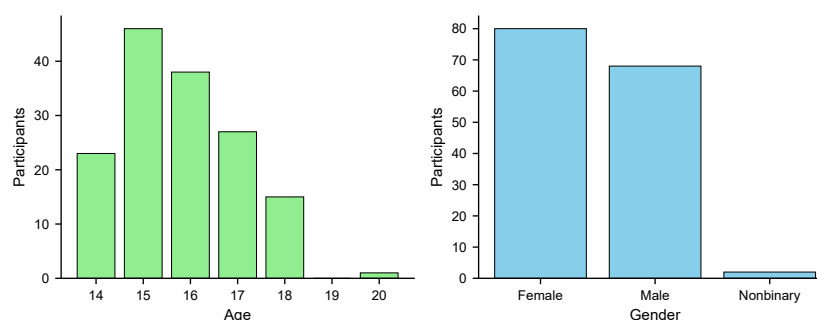


Figure 2: (Left) Self-reported age information. All participants were high schoolers, so the narrow range makes sense. (Right) Self-reported gender information. We have a fairly even split of male/female and two nonbinary participants.

2.8 Data Analysis Plan

Quantitative data will be examined by identifying patterns in trust, frequency of use, and preferred information sources, with comparisons between key variables explored through one-way ANOVAs to determine whether mean trust scores differ significantly across participant groups.

Qualitative responses will be analyzed by identifying common patterns among responses in optional sections Su.5-6.

3. Results

This section contains the results of data analysis. Findings are organized as follows: participant characteristics, self reported trust, vignette-based responses, and free-response answers.

3.1 Variables and Trust Outcomes (Su.1)

This section evaluates participant characteristics and behaviors from Su.1 with trust in Su.2 and Su.3.

Three findings were statistically significant when comparing participants' first choice of health information source (grouped as: Social Media, Search Engine, AI, Personal Relatives or Healthcare Professional) against trust scores in Su.2, Su.3 and Su.4, as seen in Table 2. Participants who turned to healthcare professionals as their first choice of health information tended toward higher doctor trust scores, while those who first turned to social media tended toward higher social media trust scores. These results suggest a participants preference for their first source reflects in their responses in Su.2-4.

Self-reported confidence in recognizing accurate health information was significantly associated with social media trust scores, $F(4, 145) = 2.58$, $p = .0399$, $\eta^2 = .066$. Participants who expressed higher confidence in being able to identify credible sources tended to also show higher social media trust scores, suggesting that confidence could increase adolescent's trust in social media as a health resource.

No significant distributions were found when comparing gender or age groups to results.

Table 2: Statistical Analysis for comparison between participants' first choice in health information and their trust scores.

Survey Section	F-Value/Degrees of Freedom	P-Value	Effect Size
Social Media Trust in Su.2	$F(4, 145) = 3.44$	$p = .0102$	$\eta^2 = .087$
Doctor Trust in Su.3	$F(4, 145) = 4.51$	$p = .0018$	$\eta^2 = .111$
Doctor/Social Media Trust in Su.4	$F(4, 145) = 3.24$	$p = .0141$	$\eta^2 = .082$

3.2 Self Assessed Social Media and Professional Trust (Su.2-3)

This section focuses on whether stronger trust in social media, as assessed in Su.2, relates to levels of trust in professional healthcare, and how trust in doctors, as assessed in Su.3, corresponds with participant responses across the rest of the survey. Since Su.3 is the most direct measure of professional healthcare trust, it provides a basis for interpreting the patterns and comparisons made in later sections.

A notably significant result was found when comparing responses to question 2.8, "Have you ever followed health advice from social media?", against calculated social media trust scores in Su.2, $F(1, 148) = 129.79$, $p = 5.50 \times 10^{-22}$, $\eta^2 = .467$.

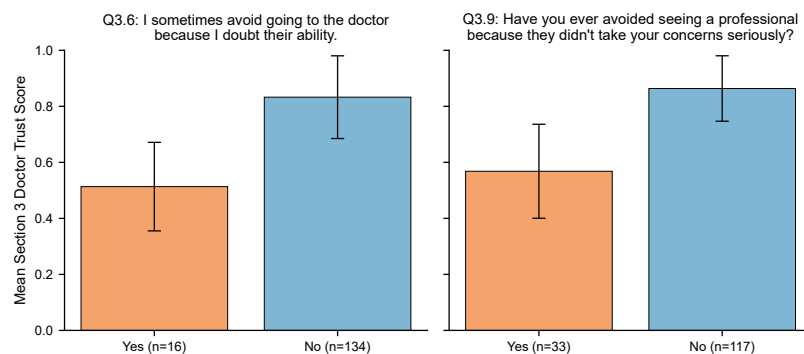


Figure 3: Participants who responded “No” to 3.6 (left) and 3.9 (right) showed substantially higher trust scores than those who responded “Yes”.

Participants who reported previously following social media health advice scored significantly higher on social media trust metrics. By contrast, no significant relationship was found between overall social media trust in Su.2 and overall doctor trust in Su.3, $F(2, 147) = 0.65$, $p = .521$, $\eta^2 = .009$, suggesting that a tendency to trust social media for health information does not necessarily correspond to an altered trust in doctors.

Questions 3.6 and 3.9 produced the largest effect sizes when tested against overall Su.3 doctor trust, as seen in Figure 3. Question 3.6 ("I sometimes avoid going to the doctor because I doubt their ability.") yielded $F(1, 148) = 65.89$, $p = 1.70 \times 10^{-13}$, $\eta^2 = .308$, indicating a strong reason for distrust in doctors being related to ability, despite a strong tendency in the vignettes to go to a doctor for medical issues, see Section 3.3. Question 3.9 ("Have you ever avoided seeing a professional because you felt like they didn't take your concerns/symptoms seriously?") yielded $F(1, 148) = 133.90$, $p = 1.80 \times 10^{-22}$, $\eta^2 = .475$, indicating prior bad experience or fear of a particular experience. In both cases, participants who answered "No" had substantially higher doctor trust scores.

Question 3.7 ("In the past few months, I followed my doctor's advice.") was significantly associated with overall doctor trust, $F(1, 148) = 12.63$, $p = .00051$, $\eta^2 = .079$. However, the same comparison against Su.4 doctor trust was not significant, $F(1, 148) = 0.48$, $p = .491$, $\eta^2 = .003$. This difference suggests that while recent trust in a doctor's advice reflects a participant's broader trust toward professional healthcare advice, it does not consistently predict how they respond when placed in a hypothetical medical scenario.

3.3 Vignettes and Trust Reflection (Su.4)

For the most part, vignette answers leaned toward doctor trust. This section is dedicated to my most interesting result, question 2.8 of the survey, "Have you ever followed health advice from social media?" Interestingly enough, the participants were almost evenly split along these questions with $n=79$ for participants who answered "yes" and $n=71$ for participants who answered "no". Comparing the overall trust score results in the vignettes between these groups resulted in $F(1, 148) = 7.40$, $p = .00728$, $\eta^2 = .048$. Having followed social media health advice strongly predicts how much a participant says they trust social media, but only weakly predicts how they decide in a hypothetical medical scenario. Figure 4 shows the average trust score in doctors of participants in both groups. There is a very high tendency to trust doctor advice in the vignettes, for both mild and more severe medical issues. Participants who did follow social media advice have a wider variance in response and overall doctor trust, and therefore a higher probability of low doctor trust.

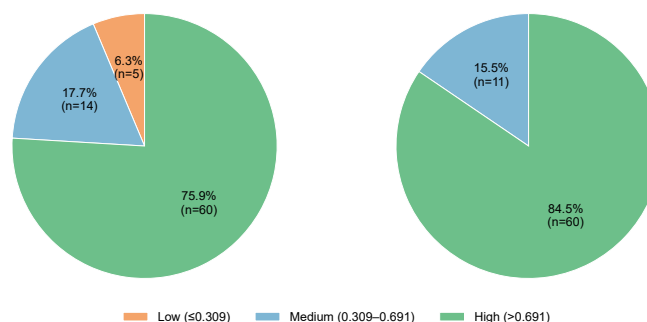


Figure 4: (left) Overall average doctor trust among participants who answered "yes" to taking advice from social media. There is an interesting variance in trust levels among these participants. (right) Overall average doctor trust among participants who answered "no" to taking advice from social media. Participants lean heavily toward doctor trust.

3.4 Open Response Questions (Su.5-6)

Su.5 did not produce any valuable responses. Su.6 of the survey contained free response questions. Two of these questions asked participants to describe a recent health-related experience and share their perspective on why adolescents may prefer online sources over professional healthcare. Some responses are shared.

A recurring pattern in participant responses was that their source of health information changed depending on the severity of the condition the participant had. Many patients described using Google, AI, or other online sources first, then deciding whether the issue required professional advice based on their search results. One participant stated this process explicitly, "I always go to Google, then to my parents and evaluate the severity, then medical professionals if needed." Another stated that after they found advice online that appeared to resolve their symptoms, they didn't feel

the need to see a doctor. This pattern suggests that for a majority of adolescents, online health sources act as an initial stop rather than a replacement for doctors. This aligns with the vignette findings showing a tendency to trust doctors in hypothetical situations.

While participants tend to have a preference for professional advice, there are factors that make social media a more convenient option, especially as a first source. Participants identified accessibility and speed as primary reasons. It delivers much quicker results at a more affordable cost and without the social anxiety a visit to the doctor can cause. One participant noted that "the act of making the doctors appointment and then actually going is widely seen as an act that causes anxiety, causing online information to be convenient and easy," while another cited cost as a barrier, stating that "it's easier to turn to social media than to go see a doctor, which could be expensive." These responses suggest that the obstacles preventing easy access to professional care may pose a bigger issue than distrust in doctors in general.

When asked what creates trust in a doctor/patient relationship, participants listed being listened to and treated as an individual as one of the most important factors, consistent with Hardin et al. (2021), who similarly found that doctor's behavior such as respect and empathy are crucial to adolescent trust in healthcare relationships.

4. Discussion

As the data was analyzed, many patterns were observed that agreed with the hypothesis. However, a differentiation was seen when looking at how adolescents with a high social media trust score demonstrated their trust in medical professionals. While adolescents may report trusting social media health information in Su.2, they still display a tendency to choose doctor associated responses in Su.4. This means that trust in social media isn't necessarily taking away from adolescents' trust in doctors, rather adjusting a different trust scale altogether.

The data showed that individuals who more frequently check the credentials of an online health information source showed a significant association with higher doctor trust scores. This indicates that adolescents who assess online sources may be more aware of the limitations that they carry as a medical resource. This skepticism could cause these individuals to naturally favor professional healthcare advice. By promoting media literacy and encouraging adolescents to check the credibility of their sources, it might be possible to increase trust and engagement with doctors and other professional medical staff.

An interesting relationship was found between participants' self-reported confidence in their ability to recognize credible online sources and their overall social media trust score. Individuals who reported a high level of confidence showed a higher overall social media trust score. While seemingly counterintuitive to the previous finding, this may reflect that perceived confidence causes adolescents to believe they can filter the online content they see accurately, encouraging them to put more trust into it. This raises the question of if this self-reported confidence accurately translates into an ability to distinguish credible online health content.

A very strong predictor of doctor trust scores was participant responses to Questions 3.6 and 3.9 (See Section 3.2). Participants who answered "Yes" to these questions showed significantly lower doctors' trust scores. The reverse is also true. This suggests the individuals who show avoidance behavior may also have a lack of underlying trust with healthcare professionals. This avoidance of doctors could potentially be a major obstacle to furthered adolescent trust in professionals.

The lack of a significant relationship between a participant's overall social media trust and overall doctor trust suggests that a tendency to trust social media doesn't necessarily mean the participant will have low trust in professional healthcare. The data suggests that participants can exist in both groups simultaneously. Additionally, in Su.4, participants were approximately evenly split on whether they had previously followed social media health advice, yet both groups displayed a high overall tendency to choose doctor associates responses across the vignettes. This suggests that adolescents defer to professional health advice when presented with a hypothetical medical situation, regardless of social media habits. It is worth noting that participants who showed patterns of following social media health advice reflected a wider variance in their vignette responses, see Figure 4, and were the only case of very low doctor trust. This is further supported by free response data analysis from Su.6, in which participants consistently described using online sources as a first stop based on convenience rather than a distrust of doctors. Several participants noted they would trust a doctor more if access to one was more available. This suggests that the barriers

preventing adolescents from seeking professional care may be a more pressing issue than distrust itself. The different distribution of trust across the two groups did lead to significant results, showing that following social media trust can indicate a lower probability of trusting doctors.

Some limitations worth noting are that the survey was administered to students from a single private high school in an urban area in Texas. Participants at this school are likely to have higher income and different healthcare access than students in public or rural areas. Additionally, since the ages of participating adolescents ranged from 14-18, a larger participant group with a wider age range could help to improve on the accuracy and generalizability of the results. Finally, the survey results were all self-reported, and therefore may not accurately reflect healthcare trends.

5. Conclusion

Motivated by concern in the increasing amount of health content circulating on social media, this study provides insights into adolescent trust in doctors and healthcare on social media via a survey of 154 high school students. The survey provides preliminary insights into the balance of trust in professional healthcare and healthcare on social media.

One of the most notable findings was the relationship between self-reported confidence in recognizing credible online sources and overall social media trust. Adolescents who felt more capable of their ability to identify accurate health information tended to score higher in overall social media trust. This perceived confidence appears to encourage greater engagement with online health content among adolescents rather than discourage it. An important question that is drawn from this finding is whether that confidence accurately reflects an ability to consistently distinguish accurate from inaccurate health information.

The most significant finding was that, broadly, adolescents who reported a high trust in social media still often gave a high doctor score in the vignettes. This suggests that social media isn't negatively affecting doctors' standings in the eyes of most youth, but is increasing the probability that a given individual doesn't trust medical professionals. Efforts to reduce adolescents' engagement in online health content may be misplaced. Instead, a more effective approach might be to focus on improving the accuracy and reliability of the health information adolescents are already inclined to trust.

Future research would benefit from examining what specific content characteristics give adolescents a sense of trust, and if interventions targeting content quality would produce meaningful effects. Additionally, future work could be useful in seeing how large distrust in the professional healthcare system, exhibited only by participants with high social media trust, is informed by social media. Both of these directions would build upon the presented work by targeting the two main findings - self reported confidence in social media sources and digging more deeply into where distrust in the professional healthcare system comes from in participants with high social media trust. By better understanding adolescent trust, we can better address concerns that arise from increased social media presence in healthcare.

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