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SCROLLING THROUGH MISINFORMATION: HEALTH ANXIETY AND MEDIA TRUST AMONG DUTCH GENERATION Z

Student name: Pem (B.) Groothuis

Student ID: 3291588

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Faculty of Behavioural, Management and Social Sciences (BMS)

Frist Supervisor: Dr. R. S. Jacobs

Second Supervisor: Dr. E. van Laar

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Abstract

Background: Health misinformation spreads rapidly through social media and may contribute to increased health anxiety and declining media trust, especially among Generation Z. This study investigates the relationship between health misinformation, health anxiety and media trust among Dutch Generation Z, focusing on the role of misinformation recognition and previous misinformation experiences. In addition, the moderating effects of emotional involvement, trait anxiety and media literacy are analysed.

Method: A cross-sectional online survey study was conducted among 198 Dutch adolescents (16 - 29 years). Participants were recruited via social media and educational institutions. Validated scales were used to measure recognising and experiencing health misinformation, health anxiety, media trust, emotional involvement, trait anxiety, and media literacy. Data analysis was conducted with linear regression and moderation subgroup analysis.

Results: The results show a significant negative relationship between recognising health misinformation and health anxiety. In addition, a negative relationship was found between experiences with health misinformation and media trust. No relationships were found for the other direct correlations. The moderation analysis shows that trait anxiety eliminates the negative relationship between misinformation recognition and health anxiety, while media literacy weakens the negative relationship between experiences with health misinformation and media trust. Other moderations were not significant.

Conclusion: The results show that recognizing misinformation reduces health anxiety, but its effectiveness depends on individual differences, such as psychological predispositions. Misinformation experiences go hand in hand with lower media confidence, with media literacy acting as a protective factor. This underlines the importance of both cognitive and emotional factors in the processing of misinformation. Future interventions should focus not only on media literacy, but also on psychological resilience to misinformation**.**

Keywords: *health misinformation, health anxiety, media trust, generation Z, emotional involvement, trait anxiety, media literacy*

Table of Contents

1. Introduction

Emma, a 21-year-old student from the Netherlands, is mindlessly scrolling through TikTok while on the train. Suddenly, a video comes along of an influencer posing as an expert claiming that drinking celery juice is the solution to feeling bloated and having skin problems. “Doctors won't share this with you, but is a natural miracle cure,” the influencer confidently claims. In response, other users confirm that their intestines were “cleansed” and that their skin had never shined like this before. Emma is unsure what to do with this information. For some time, she has been suffering from bloating and she is often insecure about her skin. Would this really work? The video sounds convincing, but she also doesn't want to be naive and try something again that doesn't work. Frustrated, she clicks the app away, then decides not to look anything up for now—it feels too complicated to distinguish fact from fiction.

With the increasing popularity of short-form video platforms such as TikTok, Instagram Reels, and YouTube Shorts, health-related misinformation has become a pervasive issue. According to a Dutch consumer research platform, 40% of medical TikTok videos contain false claims, as determined by an analysis of 139 videos reviewed by medical experts (AVROTROS, 2023). This misinformation can lead to negative consequences, including heightened fear, confusion, and distrust in official sources, which may deter individuals from seeking accurate health information (Chou et al., 2020). This issue is particularly concerning for specific demographics, such as Generation Z, who are uniquely affected by the dynamics of social media consumption.

Generation Z (born between 1997 and 2012) is a particularly vulnerable group in this context. As digital natives who have grown up with social media as an integral part of their daily lives, they frequently engage with platforms like TikTok, where short and engaging content caters to their decreasing attention spans (Van der Hoeven, 2021; Suárez-Lledó & Álvarez-Gálvez, 2021). This constant exposure to health-related misinformation can have serious implications for their mental well-being and trust in media sources. The Dutch government has recognized this issue, raising concerns about the public health risks associated with the spread of health misinformation (Ministerie van Volksgezondheid, Welzijn en Sport, 2022). These risks highlight important questions about the specific

challenges Generation Z faces in distinguishing accurate information from misinformation and how their unique characteristics shape their responses.

Research has shown that health misinformation not only fuels health anxiety, but it can also lead to reduced trust in the media. Exposure to misinformation could lead to scepticism about reliable sources and may increase distrust of both traditional and digital media platforms (Chou et al., 2020). Nonetheless, little is known about how these effects manifest specifically in Generation Z. Research by Jia and Li (2024) shows that Generation Z, as digital natives, are often inundated with information and struggle with the credibility of health information. This cognitive overload is often exacerbated by conflicting values and risk perceptions, so much of Generation Z deliberately chooses to avoid health information when it causes negative emotions, such as anxiety or frustration. Among Generation Z, social norms and peer expectations also play a role in behaviour, given that young people often avoid discussions to preserve their social identity.

Similarly, Nascimento et al (2022) point out that infodemics - characterised by an abundance of information - can reduce trust in media and it can lead to psychological problems. This media environment not only increases scepticism, but also exposes Generation Z to frightening stories, which can impair the ability to distinguish correct information from incorrect information. This emphasises the need to investigate how health misinformation is related to health anxiety and media trust among Generation Z, in order to better understand how cognitive and emotional factors determine responses.

This study aims to investigate how both recognition and experiences of health misinformation are related to health anxiety and trust in the media among Dutch Generation Z, also investigating how emotional engagement, trait anxiety and media literacy play a role in this. The study aims to gain insight into the psychological and perceptual relationships of health misinformation, with the ultimate goal of contributing to strategies to increase resilience to health misinformation.

The central research question guiding this study is: ***To what extent does health misinformation on social media relate to feelings of health anxiety and trust in media among Generation Z in the Netherlands?***

2. Theoretical Framework

This study investigates how health misinformation on social media platforms such as TikTok, Instagram and YouTube may contribute to health anxiety and media trust among Dutch Generation Z. To gain a deeper understanding of these relationships, it is essential to explore the key variables and the expected relationships between them, as described in this study.

2.1 Health Misinformation

For this study, it is important to first understand the concept of health misinformation. Health misinformation is defined as any health-related claim that is incorrect according to current scientific consensus (Chou et al., 2020). This form of misinformation can potentially arise from incomplete or erroneous interpretation of scientific research conducted. It can also arise from the dissemination of misinformation to achieve political, personal or financial gains with deliberate intent. When intent applies, it is called disinformation (Villarruel & James, 2022). Defining health misinformation and its different forms is essential for exploring the relationships between misinformation, health anxiety and media trust within Generation Z.

The increasing rise of the internet with social media platforms such as TikTok, Instagram (Reels) and YouTube (Shorts) has democratised health information greatly. This has made information easily accessible to a large audience. These platforms are mostly unregulated and misleading and also erroneous information is often shared on them, making it difficult for users to distinguish between fact and fiction (Swire-Thompsen & Lazer, 2020). During the COVID-19 pandemic, the problem of health misinformation emerged clearly. A lot of misinformation was shared about the virus and its vaccines and this spread rapidly, leading to confusion and fear among the public (Freiling et al., 2023).

According to Pillai and Fazio (2021), people experience most of the information they hear daily as true, regardless of the source. They stress that exposure to false and misleading information from different sources, such as politicians, advertisers, or misguided friends, can have negative effects on belief systems, especially when this information is heard or read repeatedly. Repetition reinforces belief in the information even when it is false (Fazio et al., 2022). This mechanism is particularly relevant in

the context of health misinformation, as it not only shapes distorted beliefs but can also contribute to increased health anxiety. Repeated exposure to false health claims can lead individuals to misinterpret normal bodily sensations as symptoms of serious illness, resulting in excessive worry and anxiety, a phenomenon known as health anxiety (Feemster & Chandrasekar, 2024). Consequently, consumers of health information should be particularly cautious of the emotional and politically charged nature of such content, critically evaluating both the sender and the message itself.

2.2 Health Anxiety

Health anxiety is an excessive and irrational fear of being seriously ill, usually without medical indications. It is characterized by persistent worry about one's health, even in the absence of medical evidence supporting an illness. Individuals with health anxiety often misinterpret normal bodily sensations as signs of severe disease, which can lead to heightened stress, frequent reassurance-seeking, and compulsive behaviours such as repeatedly checking symptoms or seeking medical consultations (Tyrer & Tyrer, 2018). These behaviours not only reinforce anxiety but can also create a cycle in which fear leads to further monitoring and heightened sensitivity to bodily sensations, further exacerbating distress.

The Cognitive-Behavioural Model of Health Anxiety (Asmundson et al., 2010) describes how cognitive biases and behaviours contribute to this excessive health-related worry. Specifically, individuals with high levels of health anxiety tend to interpret benign bodily sensations or information as indicators of severe illness. This can lead to avoidance behaviours or compulsive information-seeking, a behaviour often referred to as cyberchondria (Tyrer & Tyrer, 2018). Given the increasing availability of health-related content online, these tendencies are further amplified in digital environments, where misinformation can shape individuals' perceptions of their health.

Health anxiety is also known as Illness Anxiety Disorder according to diagnostic contexts and is classified as a form of obsessive-compulsive disorder (American Psychiatric Association, 2013; WHO, 2019). The term cyberchondria is increasingly relevant in today's digital society, as it describes that compulsive searching for online medical information more often exacerbates anxiety than alleviates it (Starcevic & Berle, 2013). As individuals seek reassurance, they may unintentionally encounter

misleading or alarmist health information, which can reinforce their existing fears. Rask et al. (2020) emphasize that health anxiety can significantly disrupt everyday life, creating a cycle of persistent worry and medical check-ups in the absence of any medical cause. This suggests that health misinformation probably contributes to reinforcing health anxiety, by spreading misinformation and maintaining unfounded concerns. In the context of this study, it is crucial to examine how experiences with health misinformation and individuals' ability to recognise false health claims are related to health anxiety.

2.3 Recognition of Health Misinformation

Recognition of health misinformation refers to a person's ability to identify misleading or inaccurate information, which can be presented convincingly (Amazeen, 2023). This means more than being able to tell something is factually wrong, it also encompasses being able to identify where information may be misleading. In this research study, the recognition of health misinformation is understood as the person's subjective level of certainty in identifying what information is truthful and what is not, as opposed to an objective assessment. This fits into the broader understanding of self-efficacy, associated to self-belief in one's ability to carry out a particular task effectively (Bandura, 1997). When it comes to health misinformation self-efficacy, it exemplifies the individual's ability to differentiate between accuracy and inaccuracy in the immensely complex world of health information in social media.

As a result, identifying health misinformation helps an individual mitigate psychological distress, such as health-related anxiety. The outbreak of crises like the COVID-19 pandemic saw a surge in anxiety due to the rapid spread of health misinformation through social media channels such as Facebook, WhatsApp, and YouTube which further spread confusion and uncertainty during an already distressing time (Rocha et al., 2021). Individuals with strong insight problem-solving abilities experience reduced cognitive overload and are better equipped to identify misinformation, which stems from a belief in their ability to handle complex information effectively. This reduces their susceptibility to excessive worry and stress (Salvi et al., 2023). This self-assurance reinforces a sense of control over health information and fosters resilience to misinformation's psychological impacts, breaking the cycle of anxiety and uncertainty (American Psychological Association, 2023). Understanding these cognitive

mechanisms is essential for examining how the ability to recognize health misinformation relates to levels of health anxiety, particularly among Generation Z, who are frequently exposed to digital health content.

Although people often tend to take information as true regardless of its source, research suggests that recognising misinformation can act as a cognitive buffer. This enables individuals to evaluate information more critically and process it more effectively (Ahmed, 2021; Pennycook & Rand, 2019). The extent to which a person is affected by misinformation depends on how information is processed. According to the Elaboration Likelihood Model (ELM), individuals engaging in central route processing—critical and logical analysis of information—are less influenced by the manipulative elements of misinformation (Petty & Cacioppo, 1986). Such resilience helps maintain emotional stability and mitigates health anxiety driven by conflicting and inaccurate information. Based on this theoretical perspective, the study proposes the following hypothesis:

H1: Higher levels of recognition of health misinformation are related to lower levels of health anxiety.

2.4 Experiences with Health Misinformation

In this study, 'experiences with health misinformation' refer to situations where individuals, based on prior knowledge or personal health experiences, later recognize that the information they encountered on social media was inaccurate. These experiences are shaped by subjective evaluation and reflection on discrepancies between previously held knowledge and misleading information. Such experiences are especially prevalent in digital contexts, where the rapid dissemination of misinformation creates challenges for accurate judgment.

The Cognitive-Behavioural Model of Health Anxiety offers a framework for understanding the psychological impacts of these experiences. Individuals with high anxiety sensitivity are particularly vulnerable, as they are more likely to interpret health-related misinformation as indicative of serious health threats (Asmundson et al., 2010). This interpretation triggers a cycle of heightened worry and compulsive behaviours, such as excessive searching for (mis)information. These dynamics underscore how prior experiences with misinformation and individual predispositions can amplify health anxiety.

Research further highlights the profound psychological toll of repeated exposure to health misinformation. This exposure can lead to increased anxiety, confusion, and feelings of vulnerability, particularly during crises such as the COVID-19 pandemic (Schmidt et al., 2020; Fernández-Torres et al., 2021). The effects range from mild symptoms, such as stress, to severe consequences like depression and insomnia (Secosan et al., 2020). The emotionally charged nature of misinformation compounds its impact, leaving residual effects even after the information is recognized as false. For example, discrepancies between an individual's personal knowledge and misleading claims can foster a profound sense of doubt and loss of control, which are hallmarks of health anxiety (Kelly-Turner & Radomsky, 2020).

Social media platforms further exacerbate this cycle. Their algorithms amplify exposure to repetitive or conflicting health claims, increasing cognitive load and perpetuating emotional distress. This dynamic often results in individuals becoming more sensitive to perceived health risks, even when these risks lack validity. The interplay between prior experiences and emotionally charged misinformation is likely to contribute to a vicious cycle of anxiety and uncertainty.

While recognizing misinformation has been shown to reduce health anxiety by fostering self-confidence and control (as described in H1), experiences with health misinformation tend to have the opposite relationship. These experiences undermine individuals' sense of control and stability, fostering feelings of insecurity and doubt. Research has shown that exposure to misinformation during health crises, such as the COVID-19 pandemic, contributes to increased anxiety, confusion and emotional stress (Rocha et al., 2021). According to this research, the rapid dissemination through social media of misinformation, has been associated with an increase in psychological symptoms, including anxiety, panic and depressive symptoms. This suggests that exposure to health misinformation may lead to increased health anxiety. This duality illustrates the contrasting roles of recognition and experience in shaping responses to health misinformation. This study posits the following hypothesis: ***H2: More experiences of health misinformation are related to higher levels of health anxiety.***

2.5 Media Trust

'Media trust' refers to the trust people have in the media as a source of information, focusing on fairness, accuracy and objectivity. This trust is influenced by several factors, including political preferences and social trends, such as the general decline in trust in institutions. Schudson (2022) emphasises that this concept has become more complex with the rise of social media, where users must place trust not only in professional journalism, but also in content generated by other users. Social media thus introduce both opportunities and risks, such as the faster spread of disinformation. In this study, the focus will be on media trust on social media.

Trust in social media is becoming increasingly complex, mainly due to the growing presence of fake news. Fake news negatively affects users' trust in social media as a reliable source of information (Dabbous et al., 2022). Research shows that trust is often built through successful sharing of useful information (Grabner-Kräuter & Bitter, 2015), but the spread of misinformation has led to growing concerns about the trustworthiness of these platforms. Hocevar et al. (2014) argue that people assess the reliability of information on social media differently, depending on how well they think they can recognise misinformation. The more users feel confident about recognising misinformation, the less they regard social media as a reliable source of information (Talwar et al., 2019).

When individuals perceive they can identify misinformation, they become more aware of inaccuracies or misleading content. This awareness often results in a perception that media outlets are not reliable or accurate enough in their reporting. Wang et al. (2019) supports this relationship by highlighting that when people recognise misinformation, they become more aware not only of its dissemination but also of shortcomings in the way media control and present information. The research of Wang et al. (2019) suggests, based on their systematic review, that critically assessing misinformation can lead to a growing awareness that media sources may be incomplete or even misleading.

In the context of health information, the relationship between recognizing misinformation and declining media trust becomes even more significant. Health-related inaccuracies can undermine trust in the media as they may directly impact public health and safety (Hameleers et al., 2022). For example, encountering false or misleading claims about treatments or vaccines leads individuals to doubt the

reliability of the media as a source of information. Over time, this doubt creates a feedback loop: the more misinformation people recognize, the lower their trust in the media becomes (Tsfati & Cappella, 2003; Bennett & Livingston, 2018). Based on these insights, the following hypothesis is formulated:

H3: Higher levels of recognition of health misinformation are related with lower levels of trust in the media.

When individuals realize that health-related information they received from the media is incorrect, they may generalize this distrust to the broader media system. This sense of structural unreliability contributes to a weakening of trust (Tsfati & Peri, 2006). Repeated experiences with misinformation reinforce the decline in trust in media and health institutions. Studies suggest that individuals who frequently encounter misinformation begin to perceive the media as consistently failing to provide accurate information, leading to a general erosion of trust. This distrust extends beyond the media itself to health institutions and medical experts frequently cited in news coverage (Bennett & Livingston, 2018). The prevalence of misinformation on social media further amplifies this dynamic, as these platforms enable the rapid and widespread dissemination of conflicting or inaccurate health claims. As individuals repeatedly experience misinformation, they become more convinced that both the media and associated institutions are unreliable sources of information, reinforcing a cycle of skepticism and distrust (Schudson, 2022). Based on these insights, the following hypothesis is formulated:

H4: More experiences with health misinformation are related with lower levels of trust in the media.

2.6 Emotional Involvement

Emotional involvement is a motivational concept that refers to the extent to which a person is emotionally affected or connected to a media stimulus, such as a film, social media content or health information (Wirth et al., 2012). It covers a wide range of emotions, including fascination, excitement, empathy, surprise, anger or fear, and is not limited to specific feelings or valences (positive or negative). Instead, it revolves around the subjective intensity of the emotions experienced, associated with the duration, peak intensity and frequency of these feelings (Step, 1998; Sonnemans & Frijda, 1994, 1995). This emotional involvement is at the heart of the emotional experience and influences how people experience and process media consumption (Wirth, 2006). In the context of health information, such as

this study on Generation Z, emotional involvement offers a possible explanation for how and why some individuals react more strongly to health misinformation. Emotional involvement can strongly influence the way information is processed by giving emotional responses more weight than rational evaluation, which can result in stronger psychological effects such as increased health anxiety or increased perception of risk. Referring to the Elaboration Likelihood Model (Petty & Cacioppo, 1986), emotional involvement can distract people from the central route and make them process information via the peripheral route. Instead of evaluating rationally, they give more weight to emotional responses to information.

An individual's ability to think misinformation can be recognized on social media works as a cognitive buffer against the negative effects of misinformation. Emotional involvement can reduce the protective effects of recognizing health misinformation. This is because intense emotions such as fear, empathy or fascination can cause rational evaluation to fade into the background. According to the Elaboration Likelihood Model (ELM), information can be processed in two ways: by the central route, where careful and rational evaluation takes place, or by the peripheral route, where superficial cues such as emotions or the credibility of the source play a greater role (Petty & Cacioppo, 1986). When strong emotions such as fear, empathy or fascination are triggered, a person is more likely to use peripheral processing, where heuristic judgements prevail over analytical thinking. This makes critical assessment of misinformation less likely, making individuals more susceptible to misleading health claims even if they are able to recognise misinformation. This suggests that recognising misinformation alone is not enough to be unaffected by it; when strong emotions come into play, the likelihood of peripheral processing increases, allowing misleading information to still be persuasive.

Emotional involvement can also lead to a higher subjective perception of risk. Fear or fascination with the content of the message may cause people to perceive the potential threat described in the misinformation as greater and more likely, regardless of their ability to judge it as misinformation (Loewenstein et al., 2001). This is because people often rely on their immediate emotional response when assessing risk, rather than making a rational analysis. Research shows that emotionally charged

information can cause risks to be perceived as greater than objectively justified (Slovic et al., 2007). This reasoning leads to the following hypothesis:

H5: Emotional involvement weakens the negative relationship between recognition of health misinformation and health anxiety.

Looking at experiences with health misinformation, the relationship with health anxiety is seen as positive because the discrepancies can cause confusion. Emotional involvement reinforces this positive relationship by evoking intense emotions such as fear, frustration or uncertainty, which dominate an individual's attention and cognitive resources. These emotions make the discrepancy between previous knowledge and misinformation not only confusing, but also emotionally taxing, which increases the perceived severity and risk of the situation. This shifts the focus more towards the emotional impact of the misinformation from rational processing, and this can lead to enhanced health anxiety. This reasoning leads to the following hypothesis:

H6: Emotional involvement strengthens the positive relationship between experiences of health misinformation and health anxiety.

2.7 Trait Anxiety

Spielberger (1983) defined trait anxiety as “an individual's predisposition to respond, and state anxiety as a transitory emotion characterized by physiological arousal and consciously perceived feelings of apprehension, dread, and tension”. Trait anxiety is "a more stable personality feature, defined as a constant individual difference related to a tendency to respond with concerns, troubles, and worries to various situations" (Saviola et al., 2020).

Individuals with increased trait anxiety have impaired cognitive processing capacity, which impairs their ability to process and assess information effectively. According to Eysenck et al. (2007), anxiety causes individuals to focus their attention on threat-related stimuli rather than content-related information, disrupting the balance between task-driven and stimulus-driven attention. These cognitive impairments reduce working memory capacity, leading to impaired processing of complex or conflicting information (Owens et al., 2008).

In addition, individuals with high trait anxiety appear to be less able to analyse substantive cues in depth and rely more often on peripheral cues, such as source attractiveness or emotional charge, to make decisions (DeBono & McDermott, 1994). This indicates increased vulnerability to emotionally charged information and misinformation, even when this information is not fully accurate. These cognitive limitations and sensitivity to peripheral cues are an important explanation for how individuals with high trait anxiety process information and respond to health-related misinformation.

Trait anxiety could weaken the negative relationship between health misinformation recognition and health anxiety. Individuals with high trait anxiety are likely to interpret health misinformation, even when they recognise it as misinformation, as potentially threatening. As a result, the protective effect of recognition may decrease and it may not lead to a reduction in health anxiety. Because they have increased levels of trait anxiety, they may continue to be directed towards the potential risks of health misinformation, despite realising that the information is false. This reasoning leads to the following hypothesis:

H7: Trait anxiety weakens the negative relationship between recognition of health misinformation and health anxiety.

The relationship between experiences with health misinformation and health anxiety is expected to be positive. More experiences with health misinformation should lead to increased health anxiety. In this relationship, trait anxiety could serve as a moderator. Research has shown that individuals with increased trait anxiety tend to overgeneralise fear responses, especially under ambiguous conditions, leading them to perceive a wide range of stimuli as threatening (Wong & Lovibond, 2018). This could mean that when individuals with high trait anxiety are exposed to health misinformation, they are likely to interpret the content with a bias towards danger, increasing their perception of health risks. Moreover, they may have difficulty managing the emotional impact of such health information, which may mean that by experiencing health misinformation, they may experience even higher health anxiety. This reasoning leads to the following hypothesis:

H8: Trait anxiety strengthens the positive relationship between experiences of health misinformation and health anxiety.

2.8 Media Literacy

Health-related misinformation is increasingly prevalent on social media, and anyone can access this information and content. It is therefore increasingly important for people to be able to approach media critically. In this, media literacy is a crucial factor (Ivanović, 2014). Given the widespread exposure to misinformation, understanding the role of media literacy is essential in this study, as it may influence individuals' ability to critically assess and navigate health-related information on social media.

Hobbs (2001) defines media literacy as "literacy is the ability to access, analyse and communicate messages in a variety of forms". Chan (2022) examined how news literacy helps people recognise and respond appropriately to fake news about COVID-19 on social media. In this study, news literacy is considered a specific form of media literacy. Both terms refer to skills that help individuals critically analyse, understand and verify media content. News literacy is defined as the 'knowledge of the personal and social processes by which news is produced, disseminated and consumed, and the skills that give users some control over these processes' (Vraga et al., 2021). Chan's (2022) research mainly looks at fake news. Fake news and misinformation are closely related as both involve inaccurate or misleading information (Islam et al., 2020). Fake news is often spread with the intention to mislead, while misinformation can be accidentally shared without malicious intent. The results of Chan's (2022) study are relevant to the current research as they highlight that good news literacy among the public can have a protective effect against the negative effects of online disinformation. Chan (2022) shows that individuals with higher levels of news literacy are better able to distinguish genuine from fake news and are more likely to engage in verification behaviour, such as checking source information and looking up additional data to confirm the accuracy of news stories.

2.8.1 The Moderating Role of Media Literacy Between Recognition and Experiences and Health Anxiety

Media literacy can play a role in how people deal with health misinformation and health anxiety. Media-literate individuals are more confident in their ability to recognize misinformation, which increases their sense of control and self-efficacy. This confidence reduces uncertainty and emotional

stress—key drivers of health anxiety. Bandura's (1997) concept of self-efficacy explains that confidence in one's competence helps to regulate emotional stress and reduce feelings of helplessness. As a result, media-literate individuals benefit more strongly from the protective effects of recognizing misinformation because they can critically evaluate the information and better regulate their emotional reactions. This theoretical underpinning leads to the following hypothesis:

H9: Media literacy strengthens the negative relationship between recognition of health misinformation and health anxiety.

Experiences with misinformation often trigger emotional responses, such as disappointment and a loss of control, which are expected to contribute to heightened health anxiety. However, media-literate individuals are better equipped to contextualize and critically assess these experiences. For example, Pennycook and Rand (2019) argue that media literacy minimizes the emotional impact of misinformation by encouraging a critical approach, which helps buffer against its psychological effects. Individuals are expected to cope better with the emotional consequences of misinformation, reducing its influence on health anxiety. This reasoning leads to the following hypothesis:

H10: Media literacy weakens the positive relationship between experiences of health misinformation and health anxiety.

2.8.2 The Moderating Role of Media Literacy Between Recognition and Experiences and Media Trust

In this study, recognition of health misinformation is expected to lead to reduced trust in the media. Recognition of health misinformation involves a critical assessment of media content. Media-literate individuals are more adept at identifying errors or inaccuracies, which makes them more likely to interpret these as indicative of systemic or structural unreliability within the media. Media literacy enhances critical thinking, making individuals more sceptical and, in turn, amplifying the negative impact of recognizing misinformation on media trust. This reasoning leads to the following hypothesis:

H11: Media literacy strengthens the negative relationship between recognition of health misinformation and trust in the media.

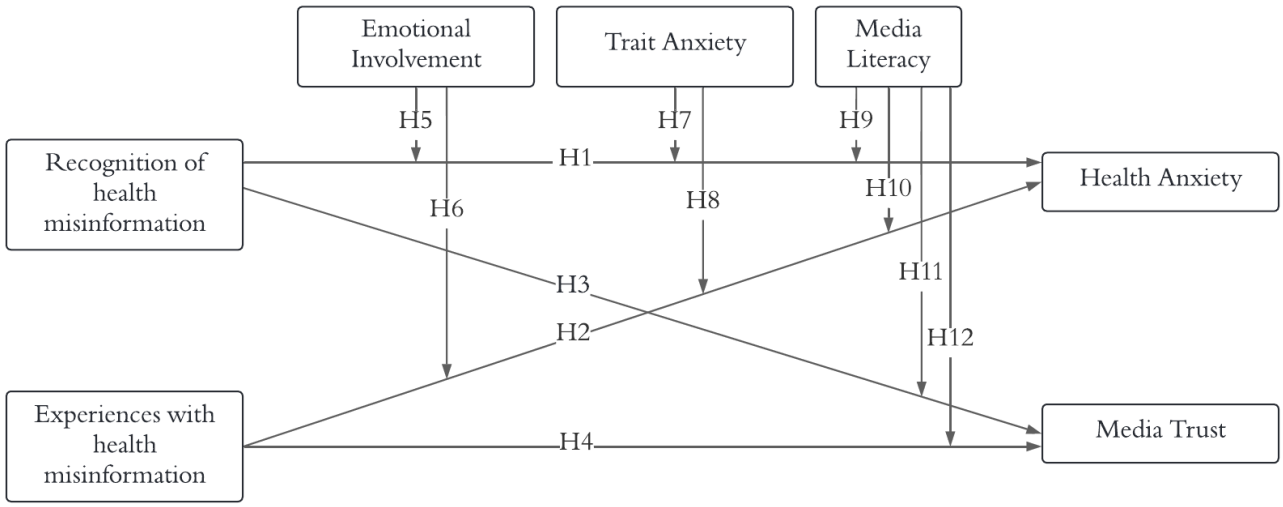
In this study, experiences of health misinformation are expected to lead to reduced trust in the media. Experiences with health misinformation are often retrospective and emotionally charged, which can lead to generalizations about the unreliability of media. However, media-literate individuals can likely contextualize these experiences by attributing errors to external factors such as social media algorithms, commercial pressures, or incomplete information. This reduces the tendency to generalize these experiences as evidence of structural unreliability, thereby tempering emotional reactions and mitigating the decline in media trust. This reasoning leads to the following hypothesis: ***H12: Media literacy weakens the negative relationship between experiences of health misinformation and trust in the media.***

2.9 Conceptual Model and Hypothesis

Figure 1 below shows the visual conceptual mode of this study. The independent variables are recognition of health misinformation and experiences with health misinformation. The dependent variables are health anxiety and media trust. In this study, three moderating variables are emotional involvement, trait anxiety and media literacy.

Figure 1

Conceptual model



3. Methods and Data Collection

The aim of this study is to investigate whether there are relationships between the main variables: Health Misinformation, Health Anxiety, and Media Trust among Generation Z in the Netherlands. It examines Gen Z's ability to recognize health misinformation, their experiences with it, and how these factors relate to health anxiety and media trust. Additionally, the study explores the role of moderating variables in influencing these relationships. This chapter provides a detailed explanation of the research design, participants, procedure, measurements and data analysis.

3.1 Research Design

This study uses a quantitative, survey-based research design to investigate the relationships between health misinformation, health anxiety and media trust among Generation Z in the Netherlands. A cross-sectional design was chosen because it allows data to be collected at a single point in time, this is suitable for analysing patterns and relationships between variables (Wang & Cheng, 2020). This type of design provides an effective way to analyses a broad sample and is particularly appropriate for an exploratory study aimed at identifying relationships rather than establishing causal relationships.

The purpose of this study is to understand the relationships between health misinformation, health anxiety and media trust. The insights can contribute to strategies to make young people more resilient to health misinformation. The focus of this research is on Generation Z in the Netherlands, a demographic group that is very active on social media platforms such as TikTok, Instagram and YouTube. A lot of health misinformation is spread on these platforms, and this group is especially vulnerable to the psychological effects of this information.

3.2 Participants

The target group of this study consists of Generation Z (born between 1997 and 2012) living in the Netherlands, as they are very active on social media platforms such as TikTok, Instagram and YouTube and may be particularly susceptible to health misinformation. As this study focuses on Dutch Gen Z, the questionnaire was administered in Dutch. A minimum of 150 participants was required, and

recruitment took place through the researcher's social media channels (WhatsApp, Instagram, LinkedIn and Facebook) using snowball sampling, as well as through a secondary school where students were invited to complete the questionnaire. The level at this school was HAVO and VWO. Participants had to be between 16 and 28 years old, actively use social media and be proficient in the Dutch language. Due to ethical considerations, only participants aged 16 and above were included, as obtaining parental consent for minors was beyond the scope of this study. This recruitment method aimed to ensure a diverse and representative sample.

A total of 305 respondents participated in the study. In the final analysis, not only fully completed responses were included, but also partially completed responses that met a predefined threshold. A cutoff of 80% completion was applied, as responses above this threshold retained the majority of the data, with only two scales and the optional open-ended question missing. This decision was made to maximize the use of valuable data while maintaining analytical reliability. As a result of this decision, the final analysis was conducted with 198 respondents. Respondents ages ranged from 16 to 54 years (M = 24, SD = 4.38). Two respondents were older than the Generation Z age range; both were 54 years old. In the analysis, these respondents were retained. The sample consisted of 62 males, 134 females and 2 non-binaries. The respondents in this study had diverse educational backgrounds. The largest group was enrolled in an HBO Bachelor program (91 respondents, 46%), followed by WO Master (37 respondents, 18.7%) and MBO (33 respondents, 16.7%). A smaller portion, 19 respondents (9.6%), were in secondary education. Additionally, 10 respondents (5.1%) were pursuing an HBO Master, and 8 respondents (2%) were enrolled in a WO Bachelor program. No respondents reported being in a PhD program. Respondents were asked how much time they spend on social media on average per day. This showed that the average time was 4 hours and 24 minutes per day. Respondents also indicated which social media platforms they use. The results showed that Instagram is the most widely used social media platform among respondents (187 times mentioned), followed by TikTok (140 times) and YouTube (138 times) Facebook is used less frequently (93 times) and Twitter/X is mentioned the least (19 times). Besides the standard options, some respondents also mentioned other social media platforms. The most

frequently mentioned additional platforms were Snapchat (8 times), LinkedIn (4 times) and WhatsApp (2 times). Pinterest and Reddit were both mentioned once.

3.3 Procedure

To conduct the study, a survey was developed. The survey was conducted online and developed with Qualtrics. Qualtrics is an online survey tool offered by the University of Twente. Before respondents could participate in the survey, they were asked to give informed consent confirming that they were 16 years or older and voluntarily participating in the study. After giving consent, an infographic was first shown on the topic of health misinformation. This gave the respondents a better idea of the concept with the support of some examples. Respondents could go through this information but were not required to continue with the questionnaire. After this, respondents were required to fill in some demographic data on age, gender, education level, choice of social media platforms and number of hours spent on social media.

Upon completion of the demographic questions, the administration of the scale-based items was initiated. In total, there were seven scales in the order of media literacy, media trust, recognition, experiences, emotional involvement, health anxiety and trait anxiety. This order was chosen because it made the questions increasingly personal. By not placing heavy questions at the beginning, it tries to avoid scaring off respondents.

After completing the scale questions, there was another optional open-ended question about personal experiences with health misinformation. This question was not mandatory to answer. The reason for this question is to gain insight into topics that respondents consider to be health misinformation. After this open question, respondents were given another opportunity to leave a comment or a question and after this, they were thanked for participating in the survey. The questionnaire developed in Qualtrics can be found in the appendix.

3.3 Measurement

To measure the variables, seven scales were used, some of which were newly developed, while others were based on existing scales. Questions on the variables were asked according to the Likert scale, from completely disagree to completely agree. A Likert scale is a measurement method used to evaluate attitudes, opinions, and perceptions (Qualtrics, 2023).

After conducting survey and collecting the data, honour factor analysis was conducted to assess the validity of the scales. Prior to factor analysis, the adequacy of the dataset was analysed using the Kaiser-Meyer-Olkin (KMO) test and Bartlett's test for sphericity. The KMO value was .81, indicating good factorizability of the data (Kaiser, 1974). The KMO values per item were mostly above 0.60, meaning that most variables have sufficient correlations with other variables in the data. In addition, the Bartlett's test was significant ($X^2(1176) = 4487.32$, $p < .001$), this shows that the correlation matrix is not an identity matrix and that the factor analysis is appropriate for the dataset in question (Bartlett, 1950). Next, the factor analysis was performed. To ensure that only the meaningful relationships were retained, all items higher than .40 or lower than -.40 were retained. Items falling in between were critically examined. In addition, factors with low communality ($h^2 < .0.30$) were also critically assessed. The factor analysis can be found in the appendix. Based on the results, certain items were removed to improve the reliability and internal consistency of the scale.

3.3.1 Recognizing of Health Misinformation

The construction of this scale was based on the concept of Self-Efficacy (Bandura, 1997), which refers to an individual's perceived ability to recognize health misinformation. As a reference, the Self-Efficacy Scale by Schwarzer & Jerusalem (1995) served as a model. Based on this, a set of custom scale items was developed to measure this construct. An example of an item used in the survey is: *'I am sure I can recognize health misinformation.'* In total, six scale items were formulated. The scale demonstrated strong internal consistency, with a Cronbach's Alpha of .85.

3.3.2 Experiences with Health Misinformation

The concept of Experiences with Health Misinformation is specific to this study and refers to individuals' past encounters with incorrect health information, including discrepancies between their personal knowledge and information found on social media. To measure this construct, a set of five scale items was developed based on this study-specific framework. One example of such an item is: *'I have seen health misinformation on social media that later turned out to be untrue.'* The scale demonstrated acceptable internal consistency, with a Cronbach's Alpha of .78.

3.3.3 Health Anxiety

The Health Anxiety scale was adapted from the Short Health Anxiety Inventory developed by Salkovskis (2002), which originally consists of 18 items. For this study, items related to health and illness were carefully examined, resulting in the selection of six items for the survey. An example of an included item is: *'I am often afraid that I have a serious disease.'* After conducting the factor analysis, one item was removed to improve the scale's internal consistency. The final scale demonstrated strong internal consistency, with a Cronbach's Alpha of .84.

3.3.4 Media Trust

To create this scale, scale items appropriate to the content of this study were developed. The focus was mainly on trust in social media, specifically the credibility of the displayed information and its sources. One of the items used to assess this construct is: *'I think information on social media is often accurate.'* A total of eight scale items were developed, which together demonstrated an internal consistency of .75 (Cronbach's Alpha). This scale assesses trust in the reliability and honesty of information on social media.

3.3.5 Emotional Involvement

To create the scale for Emotional Involvement, the content of the study was taken into account. The scale primarily measures how a person reacts emotionally to situations and events. An example of an item used in this scale is: *'I often feel strong emotions about what I experience or see.'* The scale

originally consists of eight items for the survey, after factor analysis, one item was removed to improve internal consistency. The final scale demonstrated good internal consistency, with a Cronbach's Alpha of .86.

3.3.6 Trait Anxiety

The Trait Anxiety scale was developed based on the State-Trait Anxiety Inventory developed by Spielberger (1989). The focus of this scale is on general sensitivity to anxiety. One of the items used in this scale is: *'I often feel tense, even when there is no obvious reason.'* The scale consist of ten items and demonstrated excellent internal consistency, with a Cronbach's Alpha of .91.

3.3.7 Media Literacy

The Media Literacy scale was based on the Media Literacy Skills Scale (Erdem & Erişti, 2017). It assessed the evaluation of information sources, analytical skills, and understanding of media influence. One of the items included in this scale is: *'I can distinguish facts from opinions in media reports.'* Two scale items were included per category, resulting in a slightly lower internal consistency, with a Cronbach's Alpha of .67. After factor analysis, no items were removed, as this would not have improved internal consistency.

3.4 Data Analysis

To analyse the data obtained, R Studio was used, under version 4.3.3. A linear regression was chosen because the resulting regression coefficients directly indicate how strongly and in what direction an independent variable affects the dependent variable. A linear regression also shows whether the relationship between variables is statistically significant via the p-values.

The remaining hypotheses concerned three types of moderators, namely emotional involvement, trait anxiety and media literacy. For the moderators, a subgroup analysis was chosen. This method allows the relationships between the independent and dependent variables to be examined and compared separately within different groups. Here, the moderators were split into two groups where the classification was made using the median, with respondents placed in low and high groups. In this way,

it is possible to examine whether the strength or direction of the relationships differ depending on the degree of the moderator. The subgroup analysis thus provides a clear and intuitive method for understanding these possible differences.

4. Results

This section presents the research's findings. To determine whether there are correlations between the main variables Recognition and Experiences of Health Misinformation and Health Anxiety and Media Trust, correlation tests were conducted. Next, the moderating variables Emotional Involvement, Trait Anxiety and Media Literacy were examined, and a Moderation Analysis was performed with them in the form of a subgroup analysis. This section discusses the results of the tests.

4.1 Linear Regression Analysis

The main variables in this study are recognition and experiences of health misinformation, health anxiety and media trust. To investigate whether there are direct relationships between these variables, linear regression analyses were conducted on the first four hypotheses. Linear regression is an appropriate method because it offers insight into the strength and direction of the relationship between variables (IBM, n.d.).

It was hypothesized (H1) that Generation Z individuals who were better at recognizing health misinformation would experience lower levels of health anxiety. The mean score for recognition of health misinformation was 3.17 (SD = .65), while the mean score for health anxiety was 2.43 (SD = .75). The analysis revealed a significant, weak, and negative relationship, $F(1, 191) = 4.44$, $p = .036$, $\beta = -.15$. This suggests that individuals with greater recognition of health misinformation generally reported lower levels of health anxiety, supporting H1. However, while the relationship is statistically significant, the weak effect size ($\beta = -.15$) indicated that the ability to recognize health misinformation only explains a small portion of the variance in health anxiety levels.

H2 proposed that individuals with more experiences with health misinformation would report higher levels of health anxiety. The mean score for experiences with health misinformation was 3.74 (SD = .60). Contrary to expectations, the analysis showed a non-significant relationship, $F(1, 191) = 0.81$, $p = .370$, $\beta = -.06$. Furthermore, the direction of the relationship was negative rather than positive, indicating that more experiences with health misinformation were not associated with greater health

anxiety. Given the lack of significance and the weak relationship, these findings do not support H2, suggesting that the number of experiences with health misinformation does not influence health anxiety.

H3 expected that individuals with higher recognition of health misinformation would have lower trust in the media. The mean score for media trust was 2.56 (SD = .51). The analysis showed that this relationship was not significant, $F(1, 196) = 0.0009$, $p = .976$, $\beta = .002$. The nearly zero effect size indicates that recognition of health misinformation does not influence trust in the media. Given the lack of significance, these findings do not support H3.

Finally, H4 proposed that individuals with more experiences of health misinformation would have lower media trust. The analysis demonstrated a significant, moderate, and negative relationship, $F(1, 196) = 14.74$, $p < .001$, $\beta = -.26$. This suggests that individuals who have encountered more health misinformation tend to exhibit lower trust in the media. The moderate effect size indicates that while this relationship is present, additional factors likely play a role in shaping media trust. These findings provide support for H4.

4.2 Moderating Analysis

In this study, subgroup analysis was chosen to explore whether the moderators (emotional involvement, trait anxiety, and media literacy) influence the main relationships. This method is suitable because it allows for a clear comparison between groups (e.g., high vs. low anxiety) and is appropriate given the cross-sectional design and sample size. It offers practical insights into how individual differences shape susceptibility to misinformation.

Emotional involvement

According to H5, emotional involvement (M = 3.1, SD = .69) was expected to weaken the negative relationship between health misinformation recognition and health anxiety. For the group with low emotional involvement, the model was not significant $F(1, 93) = 2.35$, $p = .129$, $\beta = -.16$. For the group with high emotional involvement, the model was also not significant, $F(1, 96) = 1.90$, $p = .171$, $\beta = -.14$. Given that no significant relationship was found in either subgroup, the results suggest that

emotional involvement does not play a moderating role in the relationship between recognition of health misinformation and health anxiety. This does not support the hypothesis that emotional involvement weakens the negative relationship between recognition of health misinformation and health anxiety.

According to H6, emotional involvement was expected to enhance the positive relationship between experiences with health misinformation and health anxiety. For the group with low emotional involvement, the model was not significant, $F(1, 93) = 0.50$, $p = .480$, $\beta = -.07$. For the group with high emotional involvement, the model was also not significant, $F(1, 96) = 0.002$, $p = .968$, $\beta = .00$. As no significant relationship was found in either subgroup, the results suggest that emotional involvement does not play a moderating role in the relationship between experiences of health misinformation and health anxiety. moreover, the initial relationship between experiences of health misinformation and health anxiety was not found, making the likelihood of emotional involvement acting as a moderator in this relationship small. These findings do not provide support for H6.

Trait anxiety

According to H7, trait anxiety was expected to weaken the negative relationship between health misinformation recognition and health anxiety. The results indicate that this moderation effect was present. For individuals with low trait anxiety, the model was significant, $F(1, 100) = 5.69$, $p = .019$, $\beta = -.23$, indicating that those who were better able to recognize health misinformation experienced lower levels of health anxiety. However, for individuals with high trait anxiety**,** this relationship disappeared completely, as the model was not significant, $F(1, 89) = 0.10$, $p = .755$, $\beta = .03$. These results support H7 and suggest that trait anxiety weakens the negative relationship between health misinformation recognition and health anxiety, as expected.

According to H8, trait anxiety was expected to enhance the positive relationship between experiences with health misinformation and health anxiety. However, for the group with low trait anxiety, the model was not significant, $F(1, 100) = 0.09$, $p = .769$, $\beta = .03$. Similarly, for the group with high trait anxiety, the model was also not significant, $F(1, 89) = 0.76$, $p = .385$, $\beta = -.09$. No significant relationships were found in either subgroup, suggesting that trait anxiety does not play a moderating

role in the relationship between experiences with health misinformation and health anxiety. Moreover, the initial relationship between experiences with health misinformation and health anxiety was not found, further reducing the likelihood of a moderation effect. These findings do not provide support for H8.

Media literacy

According to H9, media literacy was expected to enhance the negative relationship between recognition of health misinformation and health anxiety. For the group with low media literacy, the model was not significant, $F(1, 84) = 0.78$, $p = .380$, $\beta = -.10$. For the group with high media literacy, the model was also not significant, $F(1, 105) = 2.77$, $p = .099$, $\beta = -.16$. In the group with high media literacy, a slight trend is visible in the expected direction, however, it is not significant. This means that there is no evidence that media literacy plays a moderating role in the relationship between recognition of health misinformation and health anxiety. As no significance relationship was found in both subgroups, these findings do not provide support for H9.

According to H10, media literacy was expected to weaken the positive relationship between experiences with health misinformation and health anxiety. For the group with low media literacy, the model was not significant, $F(1, 84) = 0.21$, $p = .649$, $\beta = -.05$. For the group with high media literacy, the model was also not significant, $F(1, 105) = 0.45$, $p = .505$, $\beta = -.07$. The results show that experiences with health misinformation are not related to health anxiety, regardless of the level of media literacy. This means at people who encounter health misinformation more frequently do not necessarily experience more or less health anxiety, regardless of media literacy level. Moreover, the initial relationship between experiences with health misinformation and health anxiety was not found, further reducing the likelihood of a moderation effect. These findings do not provide support for H10.

According to H11, media literacy was expected to enhance the negative relationship between recognition of health misinformation and health anxiety. For the group with low media literacy, the model was not significant, $F(1, 87) = 0.25$, $p = .620$, $\beta = .05$. For the group with high media literacy, the model was also not significant, $F(1, 107) = 0.01$, $p = .917$, $\beta = .01$. The results indicate that recognition of health misinformation is not associated with trust in the media, regardless of the level of media

literacy. This means that people who are better able to recognise health misinformation do not necessarily have less trust in the media, regardless of their level of media literacy. As no significant relationship was found in either group, these findings do not provide support for H11.

According to H12, media literacy was expected to weaken the negative relationship between experiences of health misinformation and trust in the media. The results show that this negative relationship was stronger among individuals with low media literacy and weaker among individuals with high media literacy**.** For the low media literacy group, the model was significant, $F(1, 87) = 12.07$, $p < .001$, $\beta = -.35$, suggesting that people who are more likely to encounter health misinformation report lower trust in the media. In contrast, for the high media literacy group, the relationship was also negative but weaker and not significant, $F(1, 107) = 3.32$, $p = .071$, $\beta = -.17$. These findings align with the expectation that media literacy weakens the negative relationship between experiences of health misinformation and trust in the media. However, at high levels of media literacy, the relationship was not significant. This means that while there is no conclusive evidence for moderation, the results do indicate that media literacy may help reduce the negative effect of misinformation experiences on media trust. Therefore, these findings provide partial support for H12.

4.3 Additional Analysis

In addition to the primary analyses, additional regression analyses were conducted to examine whether the relationships between recognition and experiences of health misinformation, health anxiety and media trust differ between age groups (16-23 years vs 24-29 years) and whether it differs between gender. These analyses aimed to determine whether age and gender plays a moderating role in the relationship examined in H1 to H4

Age

The results for H1 (recognition and health anxiety), showed that the relationship was weak but significant across the total sample, but there were no meaningful differences between age groups. This

suggests that although there is a general relationship between recognition of health misinformation and health anxiety, this relationship does not necessarily differ by age within Generation Z.

No significant age differences were also found for H2 (experiences and health anxiety and H3 (recognition and media trust). In both age categories, the relationships were not significant, and the direction and strength of the relationships were similar. This suggests that age does not play a crucial role in these relationships.

In contrast, for H4 (experiences and media trust), differences did emerge between the two age groups. The results of the analyses can be seen below in Table 1.

Table 1

Regression results by Age Group H4

Age Group	***N*=**	***B***	***R^2***	***p***
16 - 23	82	-.21	.056	.035
24 - 29	116	-.24	.083	.001

The results show that there is a negative relationship between experiences of health misinformation and media trust in both age groups. This relationship is significant in both groups, but the relationship is weaker among the younger respondents (16-23 years) and explains a relatively small proportion of the variance in media trust. The relationship in the older group is statistically stronger, suggesting that individuals who are more frequently exposed to health misinformation tend to have even lower trust in the media. The explained variance in this group in media trust is also slightly larger, suggesting that experiences with health misinformation play a slightly larger role in determining trust in media among the older respondents (24 - 29 years). The results indicate that the negative relationship between experiences of health misinformation and media trust is stronger among older respondents (24-29 years) than younger respondents (16-23 years).

Gender

To investigate whether the relationships between recognition and experiences of health misinformation, health anxiety and media trust differ between gender, additional regression analyses were conducted for hypotheses 1 to 4. For this analysis, two genders were measured, male ($N = 62$) and female ($N = 134$). Gender non-binary ($N = 2$) was excluded, as this group was too small to analyse with. Although it was possible to make the groups statistically equal by applying random down sampling or weights, we chose to keep the full dataset. Random down sampling would have resulted in the loss of 72 respondents and lower statistical power. Running the regressions separately by gender provides a direct comparison.

For H1 (recognition and health anxiety), a weak but significant negative relationship was found in the total sample ($N = 198$). During gender disaggregation, it was observed that this relationship was somewhat stronger in men but not significant, while in women the relationship was weaker and also not significant. This means that gender does not have a determinant role in the relationship between recognition of health misinformation and health anxiety.

For H2 (experiences and health anxiety) and H3 (recognition and media trust), no significant relationships were found in both men and women. This means that regardless of gender, in this sample there is no relationship between experiences of health misinformation and health anxiety and also no relationship between recognition of health misinformation and media trust.

For H4 (experiences and media trust), however, a difference was found between men and women. The results of the regression analyses by gender are shown below in Table 2.

Table 2

Regression results by Gender H4

Gender	***N*=**	***B***	***R²***	***p***
Male	62	-.03	.001	.785
Female	134	-.28	.122	< .001

The results of the regression analysis showed differences between men and women. Among men, no significant relationship was found between experiences with health misinformation and media trust. This indicates that experiences with health misinformation hardly play a role in explaining media trust within this group.

Among women, unlike men, a strong and significant relationship was found. This indicates that women who encounter health misinformation more often have less trust in the media. The variance in this group is also higher, this shows that experiences with health misinformation is a relevant predictor of media trust.

These findings suggest that women are likely to be more sensitive to the impact of health misinformation on their media trust than men. However, differences in sample size should be taken into consideration here. The sample size of women was more than twice that of men, which may have contributed to finding a significant relationship. Despite the differences in sample size, it is noteworthy that the relationship was strong and statistically significant among women, while no relationship was observed at all among men. This could mean that gender plays a role in how experiences of health misinformation affect trust in the media.

4.4 Personal Experiences

Although this is a quantitative study, an open-ended question was included in which respondents could voluntarily share a personal experience of health misinformation. This question was asked at the end, and 35 respondents left a response. The answers showed the forms of health misinformation people encountered and which ones they stayed with.

What recurs mostly is the role social media plays in spreading and amplifying misinformation. Respondents indicated that mainly TikTok, Instagram and YouTube play an important role in spreading misinformation and misleading health information. Some respondents mention being exposed to misinformation about ADHD and autism through social media, where broad symptoms are presented as indicative of a diagnosis. Others especially name the influence of algorithms, which place people in an information bubble, making them see mainly content that reinforces certain (often not scientifically

based) beliefs. According to respondents, this can lead to the risk of people being less open to contrary informed views.

Another recurring topic is nutrition and weight-loss methods. Respondents indicate that diets, supplements, and weight-loss products are often presented without scientifically substantiated arguments. Respondents also noticed that so-called 'experts' without a medical background often share nutrition and health advice that could potentially be harmful to the recipient.

Misinformation about vaccinations also emerged among respondents. Conspiracy theories and misleading information about corona vaccines what was spread through social media mainly stuck with the respondents. This included the influence of Facebook groups and YouTube videos where information was shared by individuals posing as experts.

Finally, several respondents indicated that the internet, especially search engines such as Google, contribute to misinformation. People looking up health complaints are regularly presented with worrying or misleading information: this can lead to unnecessary fear or self-diagnosis without medical justification.

These personal experiences give an indication of how respondents encounter health misinformation. The experiences confirm that health misinformation is a broad and multifaceted problem, with social media playing a major role in how people consume and interpret information.

4.5 Overview of the tested hypothesis

In the theoretical framework, 12 hypotheses were drawn up for this study. Below in Table 3, all the hypotheses are clearly laid out and it is hereby indicated whether the hypothesis is supported based on the analyses.

Table 3

Overview of the tested hypothesis

	Content	Results
H1	Higher levels of recognition of health misinformation are related to lower levels of health anxiety.	Supported
H2	More experiences of health misinformation are related to higher levels of health anxiety.	Not-supported
H3	Higher levels of recognition of health misinformation are related to lower levels of trust in the media.	Not-supported
H4	More experiences with health misinformation are related to lower trust in the media.	Supported
H5	Emotional involvement weakens the negative relationship between recognition of health misinformation and health anxiety.	Not-supported
H6	Emotional involvement strengthens the positive relationship between experiences of health misinformation and health anxiety.	Not-supported
H7	Trait anxiety weakens the negative relationship between recognition of health misinformation and health anxiety.	Partially supported
H8	Trait anxiety strengthens the positive relationship between experiences with health misinformation and health anxiety.	Not-supported
H9	Media literacy strengthens the negative relationship between recognition of health misinformation and health anxiety.	Not-supported
H10	Media literacy weakens the positive relationship between experiences of health misinformation and health anxiety.	Not-supported
H11	Media literacy strengthens the negative relationship between recognition of health misinformation and trust in the media.	Not-supported
H12	Media literacy weakens the negative relationship between experiences with health misinformation and trust in the media.	Partially supported

5. Discussion and conclusion

The main aim of this study was to investigate whether there are relationships between health misinformation, health anxiety and media trust. For health misinformation, this focused on two types, namely recognition of misinformation and experiences with it. A quantitative online survey was designed to conduct this research. To determine whether there are relationships, scales were developed to test this. Moderation variables were also examined, namely emotional engagement, trait anxiety and media literacy. These moderation variables were tested on the main relationships to see if they influence the relationship. This study looks not only at what people believe, but what psychological traits determine whether humans are susceptible to health misinformation. This chapter will cover the general discussion of the results, theoretical and practical implications, the limitations of the study, recommendations for further research, and the conclusion.

5.1 General Discussion of the Results

This study examines the relationships between health misinformation, health anxiety and media trust among Dutch Generation Z, focusing on the role of misinformation recognition and previous experiences with misinformation. Specifically, it addresses the research question: "*To what extent does health misinformation on social media relate to feelings of health anxiety and trust in media among Generation Z in the Netherlands?* The results show that both cognitive and emotional processes play a role in how young people process health misinformation. Recognition of health misinformation appears to be associated with less health anxiety, while experiences of health misinformation are associated with lower trust in the media. However, individual factors such as trait anxiety and media literacy influence this relationship, suggesting that the impact of misinformation varies by individual.

The findings of this study are largely consistent with previous research on the effects of misinformation. Previous studies highlighted the importance of media literacy in reducing the negative effects of misinformation (Pennycook & Rand, 2019). The current study confirmed that cognitive skills, such as recognizing health misinformation, may indeed play a protective role in health anxiety. However, the finding that trait anxiety negates this protection is an important addition to the literature. This

suggests that not everyone benefits equally from recognizing health misinformation and that psychological factors such as trait anxiety play a crucial role in how misinformation is processed.

Another interesting finding is that recognition of misinformation is not directly related to lower trust in the media. This is remarkable because previous research has suggested that critical thinking skills can lead to greater distrust in the media (Tsfati & Cappella, 2003). One possible explanation is that people who recognize misinformation do not necessarily trust the media less but rather make more conscious choices in their media use. Instead of losing blind trust, they may switch to sources they consider more reliable (Vraga & Tully, 2019). This could mean that media trust is not only diminished by misinformation, but also actively shaped by selective media use. In addition, this study found a negative relationship between experiences with health misinformation and media trust, indicating that frequent exposure to misinformation is associated with lower trust in the media. This suggests that when individuals repeatedly encounter false or misleading health information, they may become more sceptical of media sources in general. However, media literacy was found to mitigate this negative relationship, meaning that young people with higher media literacy are less likely to lose trust in the media after exposure to misinformation. This is an important insight because it suggests that media literacy not only protects against misinformation itself but also helps individuals differentiate between unreliable and trustworthy sources. As a result, those with higher media literacy may maintain a more critical yet balanced perspective on media rather than developing outright distrust.

5.2 Theoretical and Practical Implications

Theoretical Implications

This study aligns with and deepens existing theories on the cognitive and psychological processing of health misinformation. First, the results confirm the Elaboration Likelihood Model (Petty & Cacioppo, 1986): adolescents who are better able to recognise health misinformation experience less health anxiety, indicating central processing of information. However, an important addition is that not only cognitive ability but also self-confidence in that ability (self-efficacy) is a determinant. This shows

that the subjective estimation of ability is just as important as actual knowledge - a deepening of the ELM, which traditionally mainly emphasizes rational ability.

In addition, the study contributes to literature on media trust (Tsfati & Cappella, 2003; Schudson, 2022). Whereas previous studies mainly point to a decline in trust due to exposure to misinformation, this study shows that this decline is more strongly related to personal experiences of misinformation than to pure recognition of it. Moreover, it turns out that media literacy can partly offset this decline in trust, as people are better able to put misinformation in context. This means that critical media consumption does not necessarily lead to distrust but can actually contribute to more selective and aware media choices.

Finally, this study nuances the supposed effectiveness of cognitive protection against misinformation. Although recognition helps against health anxiety, it appears that in young people with high trait anxiety, this protective effect disappears. This supports theories of impaired information processing in anxiety (Eysenck et al., 2007) and shows that psychological vulnerabilities can undermine the functioning of cognitive buffers. It implies that effective interventions should focus not only on knowledge and skills, but also on mental resilience.

Practical Implications

On a practical level, this study contributes to media literacy programmes, public health communication and social media policy. Given the ability in confidence to recognise health misinformation is related to lower levels of health anxiety, educational institutions and policymakers should invest in media literacy initiatives that empower young people to critically evaluate health misinformation. This will increase confidence in one's own ability and make a lower level of health anxiety more likely to apply. For public health organisations, the findings show that experiences of health misinformation significantly undermine media trust among Generation Z. This shows the importance of the media providing transparent and engaging fast-checking strategies that not only debunk false claims but also restore trust in credible health sources. Health authorities can use social media influencers or interactive campaigns in which to disseminate accurate health information in an appealing way. This would reduce scepticism due to misinformation. The negative impact of

misinformation experiences on trust suggests that platforms should take a more proactive approach in identifying, labelling, and restricting the spread of false health information. Current algorithmic interventions, such as fact-check warnings and source transparency labels, may need to be further optimized to prevent users from encountering misleading content repeatedly.

5.3 Limitations and Future Research

An important limitation of this study is the cross-sectional research design, where all data were collected at a single point in time. As a result, it is not possible to establish causal relationships - only correlations between variables. Thus, it cannot be concluded from this study whether recognizing health misinformation leads to less health anxiety, or whether people with less health anxiety are simply better able to recognize misinformation. Thus, there is a possible reverse causality or the influence of a third variable explaining both. To establish a more conclusive causal mechanism, longitudinal research is needed, where respondents are followed over a longer period. For instance, it could be investigated whether changes in exposure to misinformation or in recognition ability over time precede changes in fear and media trust. In addition, experimental designs could also help provide causal evidence. For example, by deliberately training a group of young people to recognize and become more confident in recognizing misinformation and comparing this group with a control group. This would allow a more specific determination of the psychological effects directly resulting from increased recognition.

Second, the survey was administered online and so the study also makes full use of self-reporting, with respondents themselves indicating the extent to which they think they can recognise health misinformation and the experiences they have with it. In doing so, it is possible that respondents might give socially desirable answers or misjudge their own abilities. This raises concerns about validity, as the extent to which respondents think they can recognize misinformation does not necessarily reflect their actual ability. To strengthen validity, future research could adopt an experimental approach to objectively measure how well individuals recognize misinformation about health. For example, respondents could be presented with real and false information about health and asked to classify them. This would provide a more accurate assessment of recognition skills. A complement to this could be

triangulation of data, supplementing self-reported data with objective measurements (e.g. online history).

The sample of this study was also not fully representative. There was a skewed gender distribution, with women predominating. In the final sample, the group consisted of 134 women and 62 men. This may affect the generalizability of the results, as previous research suggests that men and women may interact differently with misinformation (Almenar, 2021). For subsequent research, it is desired to have a more equal distribution. Besides the skewed gender distribution, it is notable that the majority of respondents are from the eastern part of the Netherlands. This is probably due to the sampling method used, where recruitment took place mainly online through the researcher's social network, which is largely located in this region. This regional concentration limits the generalizability of the results to the entire Dutch Generation Z. Factors such as regional differences in socioeconomic status, education level and the way health information is consumed may affect the variables studied. Future research should therefore aim for a more geographically dispersed sample to gain more representative insights into the Dutch situation.

5.4 Conclusion

The results of this study make it clear that dealing with health misinformation differs from one individual to another, as both cognitive and emotional processes have an input on it. This means that future interventions should focus not only on increasing media literacy and analytical skills, but also on psychological resilience and self-confidence in recognising misinformation. This study contributes to the understanding that rational recognition of misinformation alone is not always sufficient to reduce its negative effects; emotional reactions and individual vulnerabilities, such as fear sensitivity, play a decisive role in this. This underlines the need for an integrated approach combining both cognitive strategies and psychological support to make young people more resilient to misinformation. Through this broader approach, interventions can not only reduce the impact of misinformation on health perceptions but also contribute to stronger and more resilient trust in reliable sources of information. This research thus contributes to a deeper understanding of how Generation Z in the Netherlands

processes health misinformation and what factors determine whether they are susceptible to it, focusing on the interplay between cognitive and emotional resistance to misinformation.

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7. Appendix

7.1 AI declaration

In the writing of this thesis, artificial intelligence (AI) was utilized to support the writing process. ChatGPT was employed to enhance language use, structure the text, and occasionally serve as a source of inspiration. Additionally, DeepL was used to translate certain parts of the text.

7.2 Survey

Start of Block: Introductie

Welkomstwoord
Beste respondent,

Dit onderzoek richt zich op gezondheidsmisinformatie, gezondheidsangst en mediavertrouwen, en wordt uitgevoerd in het kader van mijn Master Communicatie Wetenschappen aan de Universiteit van Twente. Je antwoorden worden volledig anoniem verwerkt en strikt vertrouwelijk behandeld. De verzamelde gegevens zullen uitsluitend voor wetenschappelijke doeleinden worden gebruikt. Het invullen van de enquête neemt ongeveer 10 minuten in beslag.

Dit onderzoek is uitgevoerd onder leiding van de Universiteit van Twente en is beoordeeld en goedgekeurd door de ethische commissie van de faculteit BMS.

Mocht je vragen of opmerkingen hebben, neem dan gerust contact op via: p.b.groothuis@student.utwente.nl

Alvast hartelijk dank voor je deelname!

Met vriendelijke groet,
Pem Groothuis

Page Break

Informed Consent

Om door te gaan met deze enquête, bevestig je dat je 16 jaar of ouder bent en akkoord gaat met deelname aan dit onderzoek.

- ○ Ja, ik bevestig dat ik 16 jaar of ouder ben en vrijwillig deelneem aan dit onderzoek. (1)
- ○ Nee, ik voldoe niet aan de voorwaarden of kies ervoor niet deel te nemen. (2)

Skip To: End of Survey If Om door te gaan met deze enquête, bevestig je dat je 16 jaar of ouder bent en akkoord gaat met de... = Nee, ik voldoe niet aan de voorwaarden of kies ervoor niet deel te nemen.

End of Block: Introductie

Start of Block: Infographic

Infographic Informatie

In deze enquête bespreken we meerdere malen het onderwerp **gezondheidsmisinformatie**. Om je een beter beeld te geven van wat hiermee bedoeld wordt, tonen we hieronder een infographic. Deze infographic legt uit wat gezondheidsmisinformatie is en geeft enkele voorbeelden. Je kunt deze informatie doornemen als je dat wilt, maar het is niet verplicht om verder te gaan met de vragenlijst.

Infographic

Timer Timing

First Click (1)
Last Click (2)
Page Submit (3)
Click Count (4)

End of Block: Infographic

Start of Block: Algemene gegevens

Demografische Informatie

De eerste paar vragen gaan over wie jij bent en hoe je social media gebruikt.

*

Age Wat is je leeftijd? (in jaren)

_____

Gender
Wat ben je?

- ○ Ik ben man (1)
- ○ Ik ben vrouw (2)
- ○ Ik ben non-binair (3)
- ○ Zeg ik liever niet (4)
- ○ Anders, namelijk (5) _____

Education

Wat is je opleidingsniveau? (afgerond of waar je momenteel mee bezig bent)

- ○ Voortgezet onderwijs (1)
- ○ MBO (2)
- ○ HBO Bachelor (3)
- ○ HBO Master (4)
- ○ WO Bachelor (5) a
- ○ WO Master (6)
- ○ PhD (7)
- ○ Anders, namelijk: (8) _____

End of Block: Algemene gegevens

Start of Block: Sociale Media gegevens

SocialMedia

Welke sociale mediaplatforms gebruik je regelmatig? Er zijn meerdere antwoorden mogelijk

- ☐ TikTok (1)
- ☐ Instagram (2)
- ☐ Youtube (3)
- ☐ Facebook (4)
- ☐ Twitter/X (5)
- ☐ Anders, namelijk: (6) _____

Time Social Media

Denk na over de afgelopen dagen: hoeveel tijd heb je gemiddeld per dag op sociale media doorgebracht? Vul hieronder het aantal uren in.

○ Aantal uur: (1) _____

End of Block: Sociale Media gegevens

Start of Block: Media geletterdheid

Media Literacy

In dit deel stellen we vragen over hoe jij informatie uit media begrijpt en beoordeelt. Geef aan in hoeverre jij het eens bent met de volgende stellingen.

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik kan feiten van meningen onderscheiden in mediaberichten (1)	○	○	○	○	○
Ik kan herkennen welke technieken worden gebruikt om mensen te overtuigen in mediaberichten. (2)	○	○	○	○	○
Ik kan bepalen of een mediabron betrouwbaar is. (3)	○	○	○	○	○
Ik kan zien wanneer een mediabericht een bepaalde voorkeur of vooroordeel heeft. (4)	○	○	○	○	○
Ik kan bedenken hoe media invloed heeft op wat ik belangrijk vind en hoe ik over dingen denk. (5)	○	○	○	○	○
Ik kan nadenken over hoe mediaberichten mijn beeld van de wereld veranderen. (6)	○	○	○	○	○

End of Block: Media geletterdheid

Start of Block: (sociale) mediavertrouwen

Media Trust

We willen weten hoe jij denkt over de betrouwbaarheid van sociale media en de informatie daarop. Geef aan in hoeverre jij het eens bent met de volgende stellingen.

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik denk dat de informatie op sociale media vaak klopt. (1)	○	○	○	○	○
Ik geloof dat sociale media goede bronnen van informatie kunnen zijn. (2)	○	○	○	○	○
Ik vind dat informatie op sociale media eerlijk wordt gedeeld. (3)	○	○	○	○	○
Ik denk dat sociale mediaplatforms duidelijk zijn over wat ze laten zien. (4)	○	○	○	○	○
Meestal vertrouw ik mensen die gezondheidsinformatie delen op sociale media. (5)	○	○	○	○	○
Ik geloof dat experts op sociale media te vertrouwen zijn. (6)	○	○	○	○	○
Ik denk dat sociale media vaker goede informatie laten zien dan misleidende informatie. (7)	○	○	○	○	○
Ik vertrouw erop dat sociale media mij relevante en juiste informatie tonen. (8)	○	○	○	○	○

End of Block: (sociale) mediavertrouwen

Start of Block: Herkenning van gezondheidsmisinformatie

Recognition

Dit deel gaat over hoe goed jij denkt onjuiste gezondheidsinformatie te kunnen herkennen. Geef aan in hoeverre jij het eens bent met de volgende stellingen.

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik weet zeker dat ik gezondheidsmisinformatie kan herkennen. (1)	○	○	○	○	○
Ik denk dat ik onjuiste gezondheidsclaims kan herkennen. (2)	○	○	○	○	○
Ik vertrouw erop dat ik feiten en fabels in gezondheidsinformatie uit elkaar kan houden. (3)	○	○	○	○	○
Ik kan zien of gezondheidsinformatie op sociale media betrouwbaar is. (4)	○	○	○	○	○
Ik kan gezondheidsinformatie zelf beoordelen, zonder hulp van anderen. (5)	○	○	○	○	○
Ik weet zeker dat ik misleidende informatie over gezondheid kan herkennen. (6)	○	○	○	○	○

End of Block: Herkenning van gezondheidsmisinformatie

Start of Block: Ervaringen met gezondheidsmisinformatie

Experiences

Hier vragen we naar jouw ervaringen met gezondheidsinformatie op sociale media. Geef aan in hoeverre jij het eens bent met de volgende stellingen.

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik heb gezondheidsinformatie gezien op sociale media die achteraf niet bleek te kloppen. (1)	○	○	○	○	○
Ik ben berichten tegengekomen die niet overeenkwamen met wat betrouwbare bronnen, zoals artsen of wetenschappers, zeggen. (2)	○	○	○	○	○
Ik zie vaak gezondheidsinformatie die achteraf misleidend blijkt te zijn. (3)	○	○	○	○	○
Ik heb berichten gezien die anders waren dan wat ik al wist over gezondheid. (4)	○	○	○	○	○
Ik kan me specifieke voorbeelden herinneren van onjuiste gezondheidsinformatie op sociale media. (5)	○	○	○	○	○

End of Block: Ervaringen met gezondheidsmisinformatie

Start of Block: Emotionele betrokkenheid

Emotional Involvement

We willen weten hoe jij je voelt bij dingen die je ziet of meemaakt. Geef aan in hoeverre jij het eens bent met de volgende stellingen

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik voel vaak sterke emoties bij wat ik meemaak of zie. (1)	○	○	○	○	○
Situaties of gebeurtenissen maken mij snel emotioneel. (2)	○	○	○	○	○
Ik voel vaak heftige emoties, of ze nu positief of negatief zijn. (3)	○	○	○	○	○
Ik word vaak emotioneel betrokken bij wat er om mij heen gebeurt. (4)	○	○	○	○	○
Dagelijkse dingen kunnen mijn emoties snel opwekken. (5)	○	○	○	○	○
Mijn emoties beïnvloeden hoe ik naar situaties kijk. (6)	○	○	○	○	○
Sterke emoties blijven vaak lang bij me hangen. (7)	○	○	○	○	○
Als ik iets zelf heb meegemaakt, raakt het me meer. (8)	○	○	○	○	○

End of Block: Emotionele betrokkenheid

Start of Block: Gezondheidsangst

Health Anxiety

Dit deel gaat over hoe vaak jij je zorgen maakt over je gezondheid. Geef aan in hoeverre jij het eens bent met de volgende stellingen.

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik ben vaak bang dat ik een ernstige ziekte heb. (1)	○	○	○	○	○
Gewone lichamelijke klachten maken me vaak ongerust. (2)	○	○	○	○	○
Als ik iets nieuws voel in mijn lichaam, denk ik snel dat het iets ernstigs is. (3)	○	○	○	○	○
Ik let vaak op signalen in mijn lichaam die op een ziekte kunnen wijzen. (4)	○	○	○	○	○
Ik zoek vaak online naar informatie over klachten die ik heb. (5)	○	○	○	○	○
Gezondheidsinformatie op sociale media maakt me vaak bang. (6)	○	○	○	○	○

End of Block: Gezondheidsangst

Start of Block: Persoonlijke angst gevoeligheid

Trait Anxiety

Tot slot vragen we hoe vaak jij spanning of angst voelt in je dagelijks leven. Geef aan in hoeverre jij het eens bent met de volgende stellingen.

	Volledig mee oneens (1)	Oneens (2)	Neutraal (3)	Eens (4)	Helemaal mee eens (5)
Ik voel me vaak gespannen, ook als er geen duidelijke reden is. (1)	○	○	○	○	○
Ik maak me snel zorgen, zelfs over dingen die niet dringend zijn. (2)	○	○	○	○	○
Ik reageer vaak angstig in verschillende situaties. (3)	○	○	○	○	○
Ik voel me vaak onrustig of opgejaagd. (4)	○	○	○	○	○
Ik raak snel gestrest, ook als anderen dat niet lijken te zijn. (5)	○	○	○	○	○
Ik zie situaties vaak als gevaarlijk, ook als dat misschien niet nodig is. (6)	○	○	○	○	○
Ik twijfel vaak aan mijn vermogen om problemen op te lossen. (7)	○	○	○	○	○
Ik pieker veel over wat er mis kan gaan. (8)	○	○	○	○	○
Mijn angsten beïnvloeden vaak mijn keuzes in het dagelijks leven. (9)	○	○	○	○	○
Mijn gedachten en gevoelens overweldigen me vaak. (10)	○	○	○	○	○

End of Block: Persoonlijke angst gevoeligheid

Start of Block: Persoonlijke ervaring

Personal Experiences

Voordat we afronden: heb je een ervaring met gezondheidsmisinformatie die je wilt delen? We zijn benieuwd of je een specifieke ervaring hebt met gezondheidsmisinformatie. Je kunt dit hieronder invullen. Het delen van een ervaring is volledig optioneel.

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Questions

Bedankt! Heb je nog opmerkingen over deze vragenlijst of vragen over het onderzoek? Je kunt dit hieronder aangeven. Voor vragen kun je ook contact opnemen via p.b.groothuis@student.utwente.nl.

_____

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End

Klik op het pijltje om de enquête af te ronden. Bedankt voor je deelname!

End of Block: Persoonlijke ervaring

7.3 Factor Analysis Table

Item	MR1	MR2	MR5	MR4	MR3	MR6	MR7	H^2
EmotionalInvolvement_1			.70					.61
EmotionalInvolvement_2			.74					.67
EmotionalInvolvement_3			.77					.75
EmotionalInvolvement_4			.64					.45
EmotionalInvolvement_5			.54					.46
EmotionalInvolvement_6			.41					.31
EmotionalInvolvement_7			.50					.41
EmotionalInvolvement_8								
Experiences_1						.65		.48
Experiences_2						.70		.56
Experiences_3						.59		.43
Experiences_4						.74		.44
Experiences_5						.60		.41
HealthAnxiety_1				.73				.59
HealthAnxiety_2				.75				.68
HealthAnxiety_3				.80				.70
HealthAnxiety_4				.59				.38
HealthAnxiety_5								
HealthAnxiety_6				.53				.41
MediaLiteracy_1								
MediaLiteracy_2								
MediaLiteracy_3		.46						.47
MediaLiteracy_4							.40	.32
MediaLiteracy_5							.56	.34
MediaLiteracy_6							.46	
MediaTrust_1					.62			.41
MediaTrust_2					.50			.31
MediaTrust_3					.48			.31
MediaTrust_4								
MediaTrust_5					.51			.35
MediaTrust_6					.51			.30
MediaTrust_7					.63			.45
MediaTrust_8					.54			.38

Recognition_1		.68	.52
Recognition_2		.70	.52
Recognition_3		.76	.61
Recognition_4		.67	.46
Recognition_5		.67	.49
Recognition_6		.67	.51
TraitAnxiety_1	.71		.59
TraitAnxiety_2	.76		.66
TraitAnxiety_3	.71		.60
TraitAnxiety_4	.67		.51
TraitAnxiety_5	.70		.59
TraitAnxiety_6	.42		.31
TraitAnxiety_7	.67		.46
TraitAnxiety_8	.67		.51
TraitAnxiety_9	.69		.52
TraitAnxiety_10	.66		.56