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Between Credibility and Misinformation: How Young Adults Navigate Sexual and Mental Health Content on Social Media

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Abstract

Introduction
As part of a second study within a broader research project grounded in the Elaboration Likelihood Model, this qualitative study explored how young adults navigate, assess, and use sexual- and mental-health information encountered on social media, examining the perceived impacts on behaviors, emotional well-being and peer support.

Objective
To explore how young adults evaluate, interpret, and use sexual- and mental-health information encountered on social media, examining credibility assessment, perceived behavioral and emotional effects, self-regulation strategies, and peer-support dynamics.

Methods
Semi-structured interviews were conducted with seven young adults aged 18–30. Data were analyzed using Bardin's content analysis framework, following pre-analysis, systematic coding and interpretative categorization.

Results
Participants reported daily social media use and frequent exposure to content on anxiety, sleep hygiene, consent, sexually transmitted infection prevention and contraceptive practices. Credibility was judged through professional credentials, the presence of references, linguistic tone and triangulation across sources. While high-quality content encouraged protective behaviors, such as consistent condom use, scheduling sexually transmitted infection testing and adopting coping strategies, misinformation triggered verification behaviors, unfollowing, or reporting posts. Social media exerted ambivalent effects on mental health: short-term relief coexisted with increased anxiety, comparison pressure, and sleep disruption.

Conclusion
The findings indicate that the impact of social media depends less on exposure and more on the perceived credibility of content and the digital competencies of users. Interventions aiming to improve youth sexual and mental health should integrate evidence-based content creation, inclusive communication, and targeted digital literacy training.

Keywords
Social Media; Sexual Health; Mental Health; Digital Literacy; Young Adults; Qualitative Research.

Introduction

The growing centrality of social media in the lives of young adults has profoundly transformed how they access, interpret, and use information related to sexual and mental health. In this study, we use the DeCS/MeSH "young adult" category (19–24 years) as a conceptual anchor, but operationally include participants aged 18-30 years to capture a broader phase of transition into adulthood.[1] Digital environments play a key role in shaping norms surrounding gender, sexuality, and self-concept during adolescence and young adulthood,[2] influencing expectations and behaviors. At the same time, social media platforms have evolved into hybrid spaces where credible educational content coexists with distorted information, decontextualized opinions, and highly persuasive messages,[3] creating an ambivalent ecosystem for users seeking health information.

This ambivalence is particularly relevant when considering exposure to sexuality-related content. Young people's digital literacy does not evolve at the same pace as the rapidly increasing complexity of online platforms, leaving many users vulnerable to simplified or normative messages.[4] This vulnerability is further intensified by the proliferation of health misinformation, a phenomenon widely documented in public health research,[5] which shows how easily false content circulates through algorithms designed to maximize engagement.

The perceived quality of health information on social media is heavily shaped by peripheral cues such as professional credentials, the presence of references, and a balanced communicative tone. These cues significantly influence judgments of credibility[6] and can determine how young adults select content for decision-making. This credibility appraisal process is consistent with classic persuasion theories, particularly the Elaboration Likelihood Model (ELM), which distinguishes between heuristic and systematic routes of information processing.[7]

Parasocial relationships also play a central role in the way health messages are internalized. These perceived one-sided emotional connections, originally conceptualized as part of mass media dynamics[8] and later expanded within social media contexts,[9] can heighten trust, reduce critical evaluation, and enhance the persuasive impact of digital influencers, thereby shaping health-related attitudes and behaviors.

The role of social media in sexual health promotion amongst young people has been widely examined. Well-designed digital interventions can improve knowledge and promote safer sexual practices,[10] and online educational strategies have been shown to complement gaps in formal sex education.[11] Conversely, social media also hosts content that romanticizes risky practices or perpetuates myths about sexuality,[12] underscoring the need for critical evaluation and contextual sensitivity.

Mental health is another domain strongly intertwined with young people's daily engagement with social media. Increases in depressive symptoms, particularly among heavy users, have been associated with heightened social comparison and screen time,[13] while prolonged exposure to emotionally charged content may amplify anxiety and psychological distress.[14] Systematic reviews consistently show that problematic social media use is linked to poorer mental health among adolescents and young adults,[15] through mechanisms such as compulsive engagement, doom scrolling, and sleep disruption.

Digital literacy emerges as a crucial factor in mitigating these risks. eHealth literacy encompasses the technical, cognitive, and social skills needed to evaluate and use digital health information effectively.[16] More recent evidence suggests that higher levels of digital literacy can reduce vulnerability to misinformation,[17] although this protective effect varies depending on content type, platform structure, and user motivations.

Taken together, existing research demonstrates that the impact of social media on young adults' sexual and mental health is multifaceted. It depends not only on exposure to content but also on individual emotional context, digital literacy skills, credibility assessment strategies, and relational dynamics with content creators. Nevertheless, key gaps remain, including limited qualitative understanding of how young adults navigate credible and misleading content in their daily routines, negotiate social pressures, and integrate online messages into their behaviors and interpersonal relationships.[2-6,8-10,12-16]

This study adopts the ELM[7] as the main theoretical framework for analyzing how young adults process sexual and mental health information on social media. The ELM posits two routes of persuasion: a central route, involving in-depth scrutiny of arguments when individuals are highly motivated and have sufficient cognitive capacity, and a peripheral route, based on heuristics such as the sender's credentials, presence of references, or a balanced linguistic tone. The peripheral route relies heavily on heuristic processing, depending on surface-level contextual cues and cognitive shortcuts that bypass rigorous information scrutiny.[7,18] In highly visual and fast-paced digital environments, this pathway is triggered by superficial elements such as the aesthetic appeal of infographics, engagement metrics including likes and shares, peer consensus, and the perceived authority of verified profiles.[6,19] The use of these peripheral cues acts as an initial credibility filter for users with lower immediate involvement or lower digital health literacy; however, this reliance also renders users highly

vulnerable to sophisticated health misinformation that mimics these exact formal attributes.[20] Applied to digital contexts, the model helps explain why content with strong peripheral cues (e.g., verified professional profiles) encourages protective behaviors (condom use, STI testing), whereas alarmist or unsourced misinformation tends to trigger verification or rejection. Additionally, digital literacy modulates elaboration: users with more advanced skills are more likely to engage in central-route processing, mitigating risks such as social comparison anxiety or doom scrolling.

Methods

Study type and location

This qualitative study constitutes the second phase of a broader mixed-methods research project. It was designed to complement and deepen the findings of the quantitative component through an in-depth exploration of participants' experiences and perceptions. The qualitative approach was based on semi-structured individual interviews, conducted virtually, within the context of a university, ensuring coherence between the research objectives and the empirical field under investigation.

Population and sample

The study population comprised university students aged between 18 and 30 years. Inclusion criteria were: (i) being enrolled in a higher education institution; (ii) being between 18 and 30 years old; (iii) reporting regular use of at least one social media platform; and (iv) having previous exposure to, interaction with, and personal reflection on sexual- and/or mental-health-related content on social media. Participants who did not meet these criteria or who were unable to provide informed consent were excluded. A purposive sampling strategy was adopted to ensure the inclusion of participants with relevant experience related to the phenomenon under study. The final sample consisted of seven participants, all female, which reflects the pattern of self-selection observed in the recruitment process. Although both male and female students were invited, only female students volunteered to participate, which is consistent with previous evidence that women are more likely to engage in research on sexual and mental health. This gender composition is therefore interpreted as a contextual characteristic of the sample rather than an a priori inclusion criterion. After the sixth and seventh interviews, no new themes emerged, and previously identified categories were consistently reinforced, which was interpreted as an indication of thematic saturation within the scope and aims of this exploratory study.

Study variables

In line with the qualitative design, study variables were conceptualized as analytical categories and subcategories emerging inductively from the data. These categories reflected participants' meanings and experiences and were subsequently interpreted in dialogue with the theoretical framework and the quantitative findings of the mixed-methods project.

Data collection instruments

Data were collected using a semi-structured interview guide developed to address the study objectives while allowing flexibility to explore emergent topics. The interview guide was aligned with the broader mixed-methods protocol and ensured consistency across interviews, while preserving openness to participants' narratives. The questions asked to participants are shown in Table 1.

Table 1. Questions posed to participants.

#	Questions
1	Describe how you use social media on a daily basis.
2	Describe the health content you most often find on social media.
3	How do you decide what to trust when you see health tips (sexual/mental) online?
4	Give an example of a time when content helped you (regarding sexuality or mental health).
5	And a case that left you with doubts or seemed wrong. How did you handle it?
6	Has content ever influenced your decisions about sexual protection or testing?
7	Have you ever felt pressured by social media norms/challenges regarding body image, sex, or relationships? How did you deal with it?
8	When you feel down/anxious, do you use social media to feel better? Does it work? Why?
9	Have you ever helped someone deal with mental health issues? If so, how did you do it?
10	If a friend or colleague approached you with sexual and/or mental health issues, would you feel able to support them? Why?

Data collection

Individual interviews were conducted with participants at a time and format convenient to them. Prior to data collection, informed consent was obtained, including explicit authorization for audio recording. Interviews were audio-recorded and transcribed verbatim, ensuring accuracy and completeness of the data. Participants were informed of their right to decline answering any question, pause, or withdraw from the study at any point without any consequences.

Data treatment and analysis

The interviews were transcribed verbatim and subjected to qualitative content analysis following Bardin's methodological framework, structured into three sequential phases: pre-analysis, exploration of the material, and treatment and interpretation of the results.[21] During the pre-analysis phase, a floating reading of the full transcripts was conducted to organize the corpus and identify initial thematic impressions. In the exploration phase, a line-by-line manual coding process was undertaken, identifying recording and context units, which were progressively grouped into meaning units, subcategories, and overarching thematic categories. This process followed Bardin's criteria of mutual exclusivity, internal homogeneity, pertinence, objectivity, and productivity.[21] Coding grids were iteratively refined to ensure categorical stability and theoretical relevance. Qualitative quantification of category occurrences was used not for statistical generalization, but to reinforce the internal consistency and robustness of the emerging analytical structure. In the final phase, the initial coding was conducted inductively, allowing categories and subcategories to emerge from the data with minimal imposition of a priori theoretical constructs. In a subsequent analytic phase, the emergent categories were interpreted in dialogue with the ELM, which served as a sensitizing framework to examine how central- and peripheral-route processing, as well as digital literacy features, were reflected in participants' accounts. This iterative movement between data and theory reflects an inductive–deductive reasoning process rather than a purely inductive approach. To minimize interpretative bias, the analytical process involved repeated readings of the transcripts, systematic documentation of analytical decisions, and continuous reassessment of the internal coherence of categories. Reflexivity was an integral component of the analysis, acknowledging that qualitative interpretation is influenced by the researchers' professional backgrounds, experiences, and underlying assumptions.[25]

Ethical aspects

This qualitative study was conducted in accordance with the ethical approval granted by the Research Ethics Committee (REC) from a public university in the State of São Paulo (Approval nº 7.776.474, August 19th, 2025), which approved the project as a mixed-methods protocol encompassing both quantitative and qualitative components. The qualitative phase was explicitly included in the approved protocol. Informed consent was obtained from all participants prior to data collection. Participants were informed about the study objectives, procedures, voluntary nature of participation, and their right to withdraw at any stage without any negative consequences. Written informed consent to participate in the study and recording of the interviews was obtained. Given the potentially sensitive nature of the topics discussed, measures were taken to minimize psychological discomfort. Participants were free to skip questions or interrupt the interview at any time, and information about psychological support services was made available when necessary. Confidentiality and data protection were strictly ensured. Audio recordings and transcripts were pseudonymized, and all identifying information was removed during transcription. Data were stored securely on encrypted devices with restricted access limited to the research team. To ensure transparency and methodological rigor in reporting, the study adhered to the COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines. The completed COREQ checklist is provided as supplementary material.

Results

The sample consisted of seven students, all female, aged between 18 and 30 (M=24.4 years), mostly from the Nursing degree (four from Nursing, two from Psychology, and one from Biochemistry), with a geographical distribution spread across Brazil (states of Goiás, São Paulo, Pernambuco, and Paraná). The analysis yielded seven main categories and seventeen subcategories, organized into a categorical system that reflects the central dimensions of the participants' experiences regarding the consumption of sexual and mental health content on social media.

Characterization of participants

The seven interviews were conducted with young adults (A to G) who actively use social media to access health information. The sample was diverse in terms of usage patterns, ranging from heavy users to those with

deliberate strategies to limit screen time. This heterogeneity allowed us to capture different perspectives on the relationship between social media and health.

Category 1: Social media usage patterns

Digital platforms used

Instagram, WhatsApp, and YouTube emerged as the dominant platforms, being used by six of the seven participants. TikTok was mentioned by five participants, although some referred to deliberately limited use or even uninstalling it. Professional networks such as LinkedIn were only mentioned by participants who seek to use networks in a more intentional and targeted way.

"I use social media platforms such as TikTok, Twitter, and X daily to consume reels" (Participant A)

"Instagram and WhatsApp to keep in touch and organize my schedule; LinkedIn for work-related topics" (Participant F)

Intensity and time management

All participants reported daily use of social media, although the intensity varied considerably. Three participants estimated one to two hours of use per day, while two reported approximately 30 minutes. Four participants demonstrated an intentional approach to use, implementing time limits and management strategies.

"About half an hour a day, because it's addictive" (Participant G)

"Today, I use it intentionally. (...) I've turned off almost all notifications and have offline periods to protect my focus and sleep" (Participant F)

Category 2: Health content consumed

Mental health

Content related to mental health was mentioned across the board, with particular emphasis on *anxiety* (5/7), *breathing and coping techniques* (4/7), *stress and burnout management* (3/7), and *sleep hygiene* (3/7). The most consumed formats include Reels, short 30-60 second TikToks with practical tips, and carousels with checklists and infographics.

"A lot of mental health: anxiety, burnout, '5 a.m. routines'. I also see psychologists' accounts explaining signs of depression, checklists, and breathing techniques" (Participant E)

"I follow identified professionals - psychologists, doctors - who use clear infographics and short videos with references" (Participant F)

Sexual health

Sexual health content was a central dimension, with six participants reporting exposure to information on *protection methods and condom use* (5/7), *sexually transmitted infections and screening* (5/7), and *consent* (4/7). Two participants specifically highlighted content on *LGBTQIA+ sexuality*, including protection barriers for women who have sex with women.

"I see a lot of content about (...) responsible sexuality (protection methods, STIs, consent)"(Participant B)

"I see a lot of content about sexual health for women who have sex with women (barrier protection, sex toy hygiene, vaccines such as HPV)" (Participant C)

Other topics

A minority of participants reported consuming content related to *nutrition and weight loss* (2/7) and *dermatology/aesthetics* (1/7), suggesting that the algorithm personalizes exposure based on previous interests.

Assessment of the credibility of information

Confidence indicators

Participants demonstrated sophisticated strategies for assessing the credibility of online health information. The most valued indicators included: *professional credentials and qualifications* (6/7), *presence of sources and references* (5/7), *balanced language without miraculous promises* (5/7), and *triangulation with multiple sources* (4/7).

"First, I look at who is speaking: if the person is a healthcare professional and identifies their field (and ideally their registration number). Then, I see if they cite sources such as the Directorate-General for Health/World Health Organization or studies" (Participant D)

"I check whether the person is a healthcare professional (bio with credentials, institution). I look for references/links (studies, guidelines) and whether there is consensus with other sources" (Participant B)

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Red flags identified
Participants consistently identified warning signs that lead them to distrust or reject content: *miraculous or healing promises* (6/7), *aggressive sales of products or supplements* (4/7), *alarmist language* (3/7), and a *complete lack of sources* (4/7).
"I am suspicious of anyone who sells "the course that solves everything" or uses fear to sell" (Participant E)
"I avoid content that promises 'cures' or uses alarmist language" (Participant D)

Verification strategies
Most participants developed active verification strategies: *comparison with multiple sources* (5/7), *additional research in official sources* (4/7), *consultation with known health professionals* (3/7), and *reading comments for validation by experts* (3/7).
"I cross-check the information with other professionals; if everyone points in the same direction and they are not selling 'the solution' at the end, I feel more confident. I even read the comments to see if other experts validate it" (Participant D)
"I ask family members who are doctors to assess whether what I see is correct" (Participant A)

Category 4: Impact on health behaviors
Perceived positive impact
Six of the seven participants reported that health content on social media positively influenced their *sexual protection behaviors*, namely by motivating them to get screened, use condoms consistently, and communicate about protection with their partners. Five participants reported applying *emotional management techniques* learned online, such as breathing techniques and sleep hygiene.
"A well-explained carousel reminded us that condoms are important even with hormonal contraception and talked about the frequency of STI testing. I went to buy condoms and scheduled a routine test" (Participant D)
"I saw a video by a psychologist about anticipatory anxiety (...) She explained the 4-7-8 breathing technique (...) I tried it for a week: I slept better" (Participant D)
"A short video about 'micro-goals' to overcome apathy (...) That day, I managed to go to the practical class and, in the end, I felt a little relief - it didn't 'cure' me, but it stopped the downward spiral" (Participant E)

Misinformation management
Participants demonstrated an active stance toward misinformation: *unfollowing accounts with dubious content* (6/7), *reporting incorrect content* (4/7), and *not sharing content of dubious credibility* (3/7).
"I saw a TikTok suggesting that there is "no risk of STI" between women. I was suspicious. I looked for sources and learned that there is a risk. I reported the video for misinformation and unfollowed the account"(Participant C)
"I saw a video claiming that a vitamin 'cured' PMS and depression (...) I realized that the evidence did not support that claim. I left a comment asking for studies and did not follow the recommendation. I ended up unfollowing the account" (Participant D)

Category 5: Social pressure and coping
Pressure sources
Six of the seven participants acknowledged feeling pressure related to *aesthetic standards and body image*, which was the most prevalent source of pressure. Other sources of pressure included *social comparison* (4/7), *expectations about sexual performance* (2/7), and *unrealistic productivity routines* (2/7).
" Yes, especially with the idea of the 'perfect body' and impossible routines like waking up at 5 a.m. to be productive, as well as unrealistic expectations about sex life" (Participant D)
" The pressure from TikTok was enormous, so I stopped using it" (Participant G)

Coping strategies
Participants developed multiple strategies to cope with social media pressure: *muting or unfollowing accounts* (6/7), *limiting screen time* (5/7), f*ollowing body-positive or body diversity accounts* (3/7), and *communicating openly with partners about expectations* (3/7).
" I silenced accounts that drew me into comparisons, followed body-positive profiles, and focused on more realistic goals" (Participant D)
" Mute/unfollow accounts that make me feel insecure, limit screen time, and focus on creators who talk about pleasure, consent, and body diversity in a realistic way" (Participant C)

Category 6: Mental health and problematic use
Ambivalent effect of networks
A perception of ambivalence regarding the effect of social media on mental health emerged consistently. Five participants simultaneously acknowledged *temporary benefits* (relaxation videos, coping techniques) and *negative effects* (doom scrolling, sleep disturbance). This duality reflects the complexity of the relationship between social

media use and well-being, aligning with quantitative results that showed an association between problematic use and symptoms of depression, anxiety, and stress.
" Sometimes it helps to watch coping content (breathing, grounding) or lighthearted videos. But if I get caught up in doom scrolling, it makes my anxiety worse and steals time from studying/sleeping" (Participant B)
" I use it sometimes, but it's a double-edged sword. Breathing or autonomous sensory meridian response (ASMR) videos calm me down for a few minutes; doomscrolling makes me feel worse and robs me of sleep" (Participant E)

Self-regulation strategies
Most participants implemented self-regulation strategies: *timers and time limits* (6/7), *substitution with offline activities* (5/7), *do not disturb mode* (3/7), and *uninstalling applications* (2/7).
" I use a timer to limit its use. I uninstalled YouTube from my phone to avoid excessive use" (Participant G)
" If I notice that I am putting off problems, I switch off and call a friend or go for a walk" (Participant D)

Category 7: Peer support
Peer support
All seven participants reported experiences of peer support in mental health issues, highlighting active and non-judgmental listening (7/7), sharing resources and support contacts (5/7), accompanying others to appointments (4/7), and using grounding techniques (2/7).

"I listened without judging, did the 5-4-3-2-1 grounding exercise with her, and shared the university's psychological support contacts. I agreed to accompany her to her first appointment to make it easier for her to take that step"(Participant D)
" I wrote to her saying that I missed her and suggested we meet for coffee somewhere quiet. I listened without trying to 'fix' things. I shared resources that had been useful to me and offered to accompany her to her first appointment" (Participant E)

Perception of competence and limitations
All participants expressed feeling capable of *providing initial support to peers with sexual or mental health problems*, while maintaining awareness of their limitations (6/7) and *valuing professional referral* as a priority (7/7).
"I feel that I can provide initial support: listening, validating, sharing reliable resources, and reinforcing the importance of sexual protection and seeking professional help. But I know my limits - I am not a substitute for a professional" (Participant D)
" Maturity, for me, is knowing when to support and when to pass the ball to someone who knows what they're doing" (Participant F)

Integrative synthesis
Qualitative analysis revealed that young adults develop sophisticated strategies for navigating the digital health information ecosystem (Table 2). Triangulation with quantitative data allows us to identify important convergences: while the quantitative study found no significant association between searching for sexual information online and safer sexual behaviors, the qualitative data suggest that positive impact critically depends on the quality of the content consumed and users' digital literacy skills. The quantitative correlation between problematic social media use and symptoms of depression, anxiety, and stress is reflected in the narratives about the ambivalent effects of social media use and the deliberate self-regulation strategies implemented by participants.
The results show that perceived credibility, rather than simple exposure to content, is the central mechanism in the relationship between health information consumption on social media and protective behaviors. This conclusion aligns with the quantitative result that greater perceived credibility and trust predict stronger intentions to use sexual health content ($\beta = 0.34$, $p = 0.012$), reinforcing the need for interventions that simultaneously promote digital health literacy and the production of evidence-based content by accredited professionals.

Table 2. Overview of the thematic categories and subcategories identified in the content analysis

Main Categories	Subcategories	Participants who mentioned
Social media usage patterns	Digital platforms used	6/7
	Intensity and time management	7/7
Health content consumed	Mental health	7/7
	Sexual health	6/7
	Other topics (nutrition, dermatology, aesthetics)	2/7
Assessment of the credibility of information	Confidence indicators	6/7
	Red flags identified	6/7
	Verification strategies	5/7
Impact on health behaviors	Perceived positive impact	6/7
	Misinformation management	6/7
Social pressure and coping	Sources of pressure (body image, sexual performance, productivity)	6/7
	Coping strategies	6/7
Mental health and problematic use	Ambivalent effect of networks	5/7
	Self-regulation strategies	6/7
Peer support	Peer support	7/7
	Perception of competence and limitations	7/7

Discussion

The present qualitative study examined how young adults navigate, evaluate, and use sexual- and mental-health information on social media, revealing a complex interplay between credibility appraisal, emotional regulation, behavioral influence, and peer dynamics. From a theoretical standpoint, these dynamics are highly consistent with the ELM,[7] which distinguishes between central and peripheral routes of information processing. Participants' emphasis on professional credentials, evidence-based claims, and clinical cross-referencing reflects high-elaboration processing via the central route, driven by strong intrinsic health motivations. Conversely, the widespread reliance on relatable aesthetic presentation, peer validation, and content-creator charisma points to peripheral route processing, where heuristic cues dominate.

These findings are in line with recent studies showing that social media use among young adults is not limited to entertainment or communication, but is also intertwined with identity construction, self-presentation, and everyday coping.[23,24] Our study extends this literature by showing that the same platforms are simultaneously used to access sexual and mental health information, suggesting that informational and relational uses of social media are deeply interconnected.

This pattern is consistent with recent work showing that credibility judgments on social media depend not only on content quality, but also on visible cues such as clarity, balance, apparent expertise, and the presence of supportive references.[6] In the present study, however, these cues were interpreted in a specifically health-related context, revealing that young adults apply credibility heuristics differently when the topic concerns sexual or mental health, where perceived sensitivity and personal relevance are especially high.

The coexistence of sexual, mental, and other health-related content reflects the broader ambivalence of digital environments, where informative, normative, and emotionally charged messages circulate side by side.[6,25] This reinforces recent evidence that young people encounter health information in fragmented and highly heterogeneous forms, which may shape how they interpret relevance, risk, and credibility.

Consistent with previous literature, participants described an ecosystem marked by both opportunity and risk. Many relied on social media for accessible information on anxiety management, sleep hygiene, consent, and STI prevention - domains in which digital resources can complement traditional education.[10,11] However, participants were acutely aware of misinformation, frequently encountering posts containing exaggerated claims, alarmist tone, or commercial pressure. These findings align with research showing that misleading health content proliferates rapidly on social media due to algorithms optimized for engagement.[3,5] In response, participants adopted verification strategies, such as source triangulation, examination of professional credentials, or consultation of trusted health professionals, which mirror peripheral and central credibility cues described in persuasion models.[6,7]

The mixed-methods triangulation further reinforces the explanatory value of the ELM in this context. Quantitatively, within the broader mixed-methods project, higher perceived credibility and trust in sexual health content predicted stronger intentions to use that information, whereas mere exposure or time spent on platforms did not show the same effect. Qualitatively, the narratives show that peripheral cues of credibility serve as a gateway to attention, but that the effective integration of messages into protective behaviors occurs mainly when participants engage in more central processing, analyzing arguments, comparing sources, and articulating the content with their own experience.

A key contribution of this study lies in highlighting the role of perceived credibility as a central mechanism shaping behavioral outcomes. High-trust content encouraged protective sexual behaviors, such as consistent condom use, routine STI screening, and improved communication with partners, and supported mental-health self-management through grounding or breathing techniques. These qualitative patterns converge with the quantitative findings from the larger mixed-methods project, which showed that credibility and trust predicted intentions to rely on sexual-health content beyond mere exposure or platform usage intensity. Together, the results underscore that digital health interventions must prioritize evidence-based communication, transparency, and professional identification to meaningfully influence behavior.

Prior research on online health misinformation has shown that exposure to digital content can shape behavior both directly and indirectly, through altered beliefs, concern, and decision-making.[5] Our findings add that, in the case of sexual and mental health information, participants often translate perceived credibility into concrete self-protective actions, such as seeking further verification, reflecting before acting, or adopting more cautious behaviors.[23,24]

At the same time, participants described an ambivalent relationship with social media regarding mental health. Many experienced temporary emotional reliefs through coping-oriented content, yet also reported increased anxiety, comparison pressure, and sleep disruption - particularly when doom scrolling or engaging with idealized representations of body image and productivity. These accounts echo concerns documented in previous research, which links problematic use and compulsive consumption to heightened psychological distress.[13,15] Notably, participants attempted to mitigate these effects through deliberate self-regulation strategies, such as disabling notifications, limiting screen time, or curating feeds to reduce exposure to triggering content. Such practices illustrate emerging forms of digital self-care and highlight the importance of supporting young adults in developing healthier relationships with technology.

These accounts resonate with recent literature linking social media use to body image pressure, self-comparison, and psychological strain among young adults.[23,24] What our study adds is that these pressures are not experienced only as individual discomfort, but as socially shared expectations that participants actively manage through coping strategies aimed at preserving emotional balance and social functioning.

The study also sheds light on the social dimension of digital health practices. Participants frequently assisted peers facing emotional distress, using active listening, nonjudgmental support, and sharing of reliable resources. Although they felt comfortable offering initial guidance, they maintained clear boundaries and emphasized the importance of professional referral. This balance between peer support and recognition of limitations reflects increasing expectations placed on young people within digitally mediated social networks, where mental health advice circulates rapidly and informally.

Taken together, these findings point to several implications for education, clinical practice, and public health. First, promoting critical digital health literacy, including skills for evaluating credibility, recognizing persuasive cues, and identifying misinformation, may enhance young adults' capacity to navigate digital environments safely. Second, interventions addressing sexual health should incorporate inclusive language and representation, as participants sought content relevant to diverse identities and relational contexts, including LGBTQIA+ experiences. Third, mental-health promotion initiatives must account for the ambivalent emotional effects of social media and equip young adults with strategies to manage problematic use, sleep disruption, and comparison dynamics. Finally, professionals in healthcare and education should recognize the pivotal role of peers as first-line support, offering tools and training that strengthen safe, informed, and ethical peer-support practices.

The importance of peer support is consistent with studies showing that young adults use social media not only to access information but also to validate experiences and negotiate uncertainty through trusted interpersonal networks.[10,23] Our findings go further by showing that peer support can function both as a protective resource and as a potential source of reinforcement for norms, pressures, or misinformation, depending on the social context in which it occurs.

Overall, this study contributes new qualitative insight into how young adults integrate sexual and mental health information from social media into everyday life. Rather than treating these domains separately, the findings show that credibility assessment, emotional self-regulation, and peer-based validation operate together within a shared digital environment shaped by both informational and relational dynamics.[6,23,24]

A key limitation of this study is that the sample consisted exclusively of women. While this allowed for in-depth exploration of women's experiences, it limits the extent to which the findings can be transferred to men or gender-diverse young adults, whose social media practices, health information needs, and peer support dynamics may differ. Also, participants were relatively educated and digitally literate, which may not reflect the experiences of more vulnerable populations. Self-reported experiences may also be influenced by recall bias or social desirability. Future research should include more diverse samples, including participants of diverse gender identities to enable comparative analyses and broaden the applicability of findings.

Overall, the study highlights that navigating sexual and mental health online is an active, cognitively demanding process in which credibility assessment, emotional needs, social support, and identity intersect. Recognizing these complexities is essential for designing digital environments that promote informed decision-making, reduce vulnerability to misinformation, and support the well-being of young adults.

Conclusion

This qualitative study explored how young adults navigate sexual- and mental-health information on social media, revealing a dynamic interplay between credibility appraisal, behavioral influence, emotional regulation, and peer-support practices. Far from being passive consumers, participants demonstrated active and often sophisticated strategies to evaluate the reliability of online content, such as checking professional credentials, triangulating sources, and monitoring persuasive cues. These findings underscore that the effects of digital health information depend not only on exposure but also on users' critical digital literacy and contextual judgment.

Although social media can serve as a valuable source of accessible health information - supporting protective sexual behaviors, coping strategies, and avenues for peer connection - it also presents risks. Participants consistently described the ambivalent emotional effects of digital engagement, including increased anxiety, comparison pressure, and sleep disruption, particularly when encountering misinformation or idealized portrayals of well-being. The coexistence of beneficial and harmful experiences highlights the need for interventions that strengthen digital literacy, promote inclusive and evidence-based content creation, and address problematic patterns of use.

Importantly, the study illustrates how credibility, rather than mere exposure, functions as a key mechanism linking digital content to behavioral outcomes. This insight aligns with emerging evidence that trust and perceived expertise shape whether young adults integrate online health information into their decision-making. Supporting young people in developing these evaluative skills is therefore essential for enhancing both sexual and mental health outcomes in digital environments.

The study contributes to a growing body of work emphasizing the importance of integrated, user-centered approaches to digital health promotion.

Study limitations

Future research should expand to more diverse populations, examine platform-specific dynamics, and employ longitudinal and mixed-method designs to clarify causal pathways between digital engagement, health literacy, and well-being. By advancing a nuanced understanding of how young adults engage with social media, this study provides a foundation for building safer, more supportive, and more effective digital ecosystems for sexual and mental health.

Authorship and Contributions

GC: Conceptualization, analysis, and writing of the manuscript, approval of the final version and taking responsibility for it.
IJO: Analysis, and writing of the manuscript, approval of the final version and taking responsibility for it.
MTM: Analysis, and writing of the manuscript, approval of the final version and taking responsibility for it.
MPN: Conceptualization, analysis, and writing of the manuscript, approval of the final version and taking responsibility for it.

Conflicts of interest and Funding

The authors have no conflicts of interest to declare.

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Data availability statement

The datasets generated and analyzed during the current study are not publicly available due to participant confidentiality and ethical restrictions. The interview guide and other study materials are available from the corresponding author upon reasonable request.

Supplementary Material:
- Reviewers' comments A
- Reviewers' comments B

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