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Disordered Eating and Psychological Distress: Internalized Thinness and Sociocultural Pressures as Mediators for Black Women

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Abstract

Disordered eating and psychological distress among Black women are understudied, despite similar prevalence rates to those of White women and persistent health disparities. Sociocultural attitudes toward appearance, including internalized thinness ideals and pressures from family, peers, and the media, may influence these outcomes. This study examined whether sociocultural appearance attitudes mediate the relationship between disordered eating and psychological distress in Black women in the U.S. A sample of 187 Black/African American women completed self-report measures assessing disordered eating, psychological distress, and sociocultural appearance attitudes. Regression analyses tested the association between disordered eating and psychological distress, and mediation analyses examined whether appearance attitudes explained this relationship. Disordered eating significantly predicted higher psychological distress. Mediation analyses indicated that internalized thinness ideals and sociocultural pressures partially mediated this association. Sociocultural appearance pressures play a significant role in Black women's mental health, challenging assumptions of protection from thin-ideal influences. Findings underscore the importance of culturally responsive assessments and interventions addressing relational, media, and systemic factors affecting body image and eating behaviors.

Introduction

Disordered eating and its psychological correlates occur among Black women at rates comparable to those observed among White women, yet Black women remain significantly less likely to be accurately diagnosed or to receive appropriate treatment (Goode et al., 2022; Michel, 2020; Spates, 2012). This disparity has been attributed to clinician bias, the persistent misconception that eating disorders are a "White woman's problem," and limited attention to how sociocultural appearance pressures, transmitted through family, peers, and media, shape body image and eating behavior among Black women specifically (Goode et al., 2022; Gray, 2020; Harris, 2015). These sociocultural pressures often appear in mainstream media discourse; Kate Moss stated, “Thin is in. Nothing tastes as good as skinny feels” (Costello, 2009).

The *Wicked: For Good* press tour, featuring Ariana Grande and Cynthia Erivo, reignited longstanding debates about the thinness ideal after both actors appeared significantly slimmer than when they were cast (Iwegbue, 2025). This transformation has prompted renewed discourse on fat phobia, *thinness*, and the risky measures women and girls may adopt to conform to sociocultural beauty standards. Media scrutiny of these actors’ weight loss underscores broader concerns about how sociocultural messaging perpetuates thinness as an aspirational norm and influences body image, eating behaviors, and weight-control practices (Boutté et al., 2025; Gentles-Peart, 2018). Extensive research links media consumption to negative body evaluation, body image dissatisfaction, and disordered eating behaviors (Allen, 2022; Sanzari et al., 2023; West, 2018). Eating disorders affect women across racial, socioeconomic, and educational backgrounds in the U.S. Eating disorders are not exclusive to white women. Black women experience comparable prevalence rates, yet they remain significantly less likely to receive accurate diagnoses or appropriate treatment (Goode et al., 2022; Michel, 2020; Spates, 2012). This disparity reflects clinical bias, persistent myths that eating disorders do not affect Black women, and limited awareness of how thinness discourse contributes to psychological distress in this population (Goode et al., 2022; Gray, 2020; Harris, 2015). Sociocultural pressures, shaped by family, peers, and media, also influence Black women’s experiences, requiring culturally informed approaches to care (Acle et al., 2021; Boutté et al., 2022; Labarta et al., 2024; Jones & Shorter-Gooden, 2025).

Black women navigate competing appearance ideals: the dominant *thinness* ideal and the culturally salient *thickness* or curvaceous ideal (Capodilupo, 2015; Gentles-Peart, 2016; Hughes, 2021; Williams et al., 2025). The thinness ideal upholds slenderness and a small waist as markers of beauty, encouraging disordered eating behaviors aimed at conforming to these unrealistic beauty standards (Aparicio-Martinez et al., 2019; Jones & Shorter-Gooden, 2025). While some reject thinness, others embrace curvaceousness as a marker of attractiveness (Awad et al., 2014; Gentles-Peart, 2016; Hughes, 2021). These ideals intersect with controlling images, racialized stereotypes such as the Jezebel trope, which portrays Black women as hypersexual and curvy, reinforced through mass and social media (West, 2018). Such stereotypes perpetuate unrealistic beauty standards, fostering body dissatisfaction and shaping identity development (Collins, 2000; Gentles-Peart, 2016; Jerald et al., 2017; Williams et al., 2025). Friends and family may internalize these messages, exerting pressure to conform and amplifying risks for disordered eating and negative self-perceptions (Allen, 2022; Harris, 1995). Internalization of these controlling images can lead to harmful behaviors, including restrictive dieting, weight cycling, emotional eating, and compulsive body monitoring (Chilson et al., 2025; Diggins et al., 2015; Hoggard et al., 2023; Williams et al., 2024).

Despite the prominence of the curvaceous ideal, American cultural norms often stigmatize larger body sizes as unhealthy or undesirable, sustaining the thinness ideal as a dominant beauty standard (Gentles-Peart, 2016; Hughes, 2021; Williams et al., 2024). Conformity to these standards frequently results in dieting, weight loss efforts, and disordered eating, all of which negatively impact mental health outcomes among Black women (Chilson et al., 2025; Michel, 2020; Ross, 2019). Sociocultural pressures from media, peers, and family contribute to elevated risks for depression, anxiety, and trauma in this population (Boutté et al., 2022, 2025; Jones & Shorter-Gooden, 2025). Yet,

scholarship on disordered eating and body image among Black women remains limited, and misconceptions persist that these concerns are rare or nonexistent (Gray, 2020; Williams et al., 2025). The present study addresses these gaps by examining the effects of disordered eating on psychological distress, specifically depression, anxiety, stress, and trauma, among Black women, and by testing the mediating role of sociocultural influences. Findings will inform culturally responsive interventions to reduce disparities in eating disorder treatment and improve mental health outcomes for Black women (Goode et al., 2022; Gray, 2020; Labarta & Bendit, 2024; Wilfred & Lundgren, 2021).

Preoccupations with weight and the thin ideal have long permeated Western culture, both through mass media and culturally engendered beauty standards (Owen & Laurel-Seller, 2006). The thinness ideal functions as a risk factor for eating-disorder onset and relapses (Schaefer et al., 2019), elevates body dissatisfaction (Fitzsimmons-Craft et al., 2012), and contributes to depressed mood (Munsch et al., 2021). In turn, body dissatisfaction is associated with a range of adverse outcomes, including eating disorders, depression, and compromised psychosocial functioning (Rodgers et al., 2023). Despite these well-established links, research on thin-ideal internalization has largely centered on white women, historically marginalizing Black women's experiences (Capodilupo, 2015; Boutté et al., 2022). Early work suggested Black women may experience less pressure to be thin than their white counterparts (Demarest & Allen, 2000), yet recent evidence indicates that greater enculturation within the white American mainstream is associated with increased body dissatisfaction among Black women (Awad et al., 2020; Gentles-Peart, 2016). A scoping review further finds that, despite the prevalence of a "curvy" ideal, the thin ideal remains salient in Black communities; importantly, Black women who feel compelled to conform to both white and Black appearance norms face heightened risk for eating pathology (Chilson et al., 2025). These patterns underscore sociocultural attitudes as a potential mediator of Black women's perceptions of appearance, shaped by influences from family, peers, and media (Boutté et al., 2025; Mingoia et al., 2017; Capodilupo, 2015; Javier et al., 2016).

Media exposure, across traditional channels and social networking platforms, tends to promote unattainable beauty standards (Mingoia et al., 2017). Among Black women, greater internalization of "idealized" media imagery is associated with more negative evaluations of physical appearance (Capodilupo, 2015). Romantic partners, peers, and family members are also salient agents of influence (Boutté et al., 2025), and peer attitudes specifically correlate with body dissatisfaction (Javier et al., 2016). Collectively, Black women's appearance perceptions emerge from an intersection of intra- and intercultural pressures, rendering it essential to examine how they negotiate thinness discourse and related sociocultural messaging to address disordered eating and its psychosocial sequelae in this underserved population.

The appearance pressures shaping body image among Black women operate in distinct ways and should neither be simplified nor treated as interchangeable with other groups. Disordered eating in this context is best understood within racialized beauty standards and gendered racism that define attractiveness and impose social costs when women deviate from these norms (Boutté et al., 2025; Williams et al., 2024). Body dissatisfaction extends beyond thinness to encompass hair texture, skin tone, and body shape, with many women reporting persistent pressure to conform to these norms in educational and workplace settings (Awad et al., 2015; Boutté et al., 2025). Coping responses vary; some engage in "shifting" to mitigate stigma in predominantly white environments, whereas others resist normative whiteness (Boutté et al., 2025; Jones & Shorter-Gooden, 2025). Both strategies entail tradeoffs that can accumulate and undermine health. Relatedly, controlling images and racialized stereotypes, such as the Jezebel trope, sustain Eurocentric beauty standards, shaping body image and contributing to poorer mental health outcomes, including disordered eating (Chilson et al., 2025; Goode et al., 2022; West, 2018; Williams et al., 2025).

Eating disorders and mental health are tightly coupled for Black women: distress may be both a consequence of appearance-based oppression and a risk context for disordered eating (Goode et al., 2022; Harris, 2015; Williams et al., 2025). The continual anticipation of judgment and pressure to manage others' perceptions can produce chronic stress and vigilance that erode well-being (Boutté et al., 2025; Williams et al., 2024). Depression can function as an outcome of such pressures and as a risk factor for disordered eating, helping to explain their co-occurrence (Ross, 2019; Watson et al., 2015; Williams et al., 2025), while anxiety can be intensified by gendered racial microaggressions and beauty-based evaluation (Goode et al., 2022; Hoggard et al., 2023; Williams et al., 2025). Exposure to trauma and posttraumatic stress disorder (PTSD) are associated with increased disordered eating behaviors and food insecurity and can complicate treatment outcomes (Becker et al., 2018; Convertino et al., 2022; Hübel et al., 2025). Consistent with this framework, stronger endorsement of Eurocentric beauty standards is associated with higher depressive and anxiety symptoms among Black women; however, racial identity centrality can buffer these links, indicating a protective identity process even under persistent exposure (Jones & Shorter-Gooden, 2025; Williams et al., 2025).

Body image is thus a key mechanism connecting distress to disordered eating and a treatment-relevant target (Boutté et al., 2022; Williams et al., 2025). Higher BMI is associated with greater disordered-eating symptoms, and lower body appreciation partially explains this association (Awad et al., 2020; Boutté et al., 2022). These findings challenge assumptions that Black women are "protected" from eating pathology and support direct assessment of disordered eating (rather than weight alone), coupled with interventions to strengthen body appreciation (Acle et al., 2021; Boutté et al., 2022). More broadly, culturally responsive care must foreground relational and systemic

contexts rather than focusing solely on symptom reduction (Acle et al., 2021; Boutté et al., 2022; Williams et al., 2024). Clinically, this includes establishing safe, affirming spaces in which Black women can discuss racialized and gendered experiences tied to beauty standards, body image, and coping (Goode et al., 2022; Williams et al., 2024).

Current Study

Taken together, the literature clarifies how thinness discourse, competing appearance ideals, and sociocultural pressures converge to shape body image and mental health among Black women, pointing to sociocultural attitudes, as transmitted via family, peers, and media, as a plausible mediator of the disordered eating–distress association and motivating an empirical test of this pathway in the present work. Black women contend with intersecting beauty standards and controlling images that can intensify body dissatisfaction and elevate risk for disordered eating and psychological distress, even as protective identity processes may attenuate some effects. Building on this evidence, the current study investigates whether disordered eating behaviors predict psychological distress (depression, anxiety, stress, and trauma) and whether sociocultural attitudes toward appearance mediate these relationships.

Hypotheses

1. Disordered eating behaviors will positively predict psychological distress, symptoms of depression, anxiety, stress, and trauma, among Black women.
2. Internalized thin ideals will mediate the association between disordered eating behaviors and psychological distress, symptoms of depression, anxiety, stress, and trauma, among Black women.
3. Sociocultural attitudes toward appearance will mediate the associations between disordered eating behaviors and psychological distress.

Materials and Methods

Participants

The sample comprised 187 participants in the United States who identified as Black and/or African American women. Participants were between 18 and 83 (*M* = 47.18, *SD* = 17.09), and approximately 88% of the sample (*n* = 166) identified as straight, 3.2% (*n* = 6) identified as lesbian, 6.4% (*n* = 12) identified as bisexual, and 1.07% (*n* = 2) as pansexual. Approximately 45% (*n* = 85) of the sample reported being single, 33% (*n* = 61) reported being married, and 11% (*n* = 20) reported being divorced. Approximately two-thirds of the sample (*n* = 119) reported having *at least* some college, including bachelor's, master's, and doctoral degrees. Slightly more than half of the sample (51.3%, *n* = 96) reported living in the southern region of the United States, and less than half of the sample (42.2%, *n* = 79) reported being employed. Finally, almost two-thirds of the sample (64.7%, *n* = 121) reported an annual income of less than $50,000.

Procedure

The [institution redacted] IRB approved the study materials and methods. Data were collected between January and April 2023. We collected data via Qualtrics, a third-party vendor. Previous literature has suggested that Qualtrics panels yield higher-quality data than Amazon Mechanical Turk (MTurk) or campus SONA samples (Douglass et al., 2023). Prior to viewing any survey materials, participants provided informed consent and agreed to participate in the research. Participants were immediately compensated $10, and the survey took an average of 20 minutes to complete. The informed consent and final pages of the survey provided participants with psychological resources if they experienced any discomfort during or after the survey. These resources included contact information for the Substance Abuse and Mental Health Services Administration (SAMHSA) Hotline, the National Suicide Lifeline/988 Suicide & Crisis Lifeline, and the National Crisis Text Line.

Measures

Disordered Eating

To assess disordered eating behaviors in the study's participants, the 28-item Eating Disorder Examination – Questionnaire (EDE-Q; Fairburn & Beglin, 2008) was employed. The instrument has four subscales, including Restraint (5 items; e.g., "Have you been deliberately trying to limit the amount of food you eat to influence your shape or weight?"), Eating Concern (5 items, e.g., "Has thinking about food, eating, or calories made it very difficult to concentrate on things you are interested in?"), Shape Concern (8 items, e.g., "Have you had a definite desire to have a totally flat stomach?"), Weight Concern (5 items, e.g., "Has your weight influenced how you think about (judge)

yourself as a person?"). The subscales are averaged, with scores ranging from 1 to 7. A total score (i.e., disordered eating behaviors) is generated by averaging the subscale scores. In this sample, the instrument's internal reliability (α = .88) was acceptable.

Depression, Anxiety, and Stress

Utilizing the 21-item short form of the Depression, Anxiety, and Stress Scale (DASS-21; Lovibond & Lovibond, 1995), the variables of depression, anxiety, and stress were measured from the corresponding subscales. Each subscale contains seven items rated on a four-point Likert scale ranging from 0 (*Did not apply to me at all*) to 3 (*Applied to me very much, or most of the time*). Examples of items include "I couldn't seem to experience any positive feeling at all" for depression, "I felt I was close to panic" for anxiety, and "I felt that I was using a lot of nervous energy" for stress. Raw scores 0–21 are multiplied by two and range from 0–42, with higher scores indicating more endorsement of depression, anxiety, or stress symptomology. In this sample, the internal reliability estimates for depression (α = .91), anxiety (α = .86), and stress (α = .88) subscales were acceptable.

Traumatic Stress

To assess symptoms of post-traumatic stress, the 20-item Posttraumatic Stress Disorder Checklist (PCL-5; Blevins et al., 2015) was employed. The instrument utilizes a 5-point strength-of-agreement Likert scale, ranging from 0 (*Not at All*) to 4 (*Extremely*). Higher scores are indicative of more severe PTSD symptoms, with scores ranging from 0 to 80. Items in the scale align with the four symptom clusters of a PTSD diagnosis which include re-experiencing the traumatic event (Criterion B; 5 items; e.g., "Having strong physical reactions when something reminded you of the stressful experience"), avoidance behaviors (Criterion C; 2 items; e.g., "Avoiding external reminders of the stressful experience"), negative mood and cognition (Criterion D; 7 items; e.g., "Having strong negative beliefs about yourself, other people, or the world"), trauma-related arousal and reactivity (Criterion E; 6 items; e.g., "Having difficulty concentrating"). In this sample, the PCL-5 demonstrated acceptable internal reliability (α = .96).

Sociocultural Attitudes Toward Appearance

To assess sociocultural influences on the appearance of ideals in the study's participants, the 22-item Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ-4; Schaefer et al., 2013) was employed. The instrument utilizes a five-point strength-of-agreement Likert response scale ranging from 1 (*Definitely Disagree*) to 5 (*Definitely Agree*), and measures five factors including Internalization: Thin/Low Body Fat (5 items; e.g., "I think a lot about looking thin"), Internalization: Muscular/Athletic (5 items; e.g., "It is important for me to look athletic"), Pressures: Family (4 items; e.g., "I feel pressure from my family to look thinner"), Pressures: Media (4 items; e.g., "I feel pressure from the media to improve my appearance"), and Pressures: Peers (4 items; e.g., "I get pressure from my peers to decrease my level of body fat"). In this sample, the subscales of Internalization: Thin/Low Body Fat (α = .85), Pressures: Family (α = .88), Pressures: Media (α = .95), Pressures: Peers (α = .93) demonstrated internal reliability. The internalization of muscular/athletic ideals was not utilized in this research study.

Analytic Strategy

All analyses were conducted in SPSS version 31. Before hypothesis testing, we screened data for missing values, outliers, and normality violations; Table 1 reports skewness and kurtosis for all study variables, and no variable exceeded conventional thresholds for substantial non-normality (Kline, 2016). We inspected variance inflation factors to rule out problematic multicollinearity among predictors and covariates. Hypothesis 1 was tested using a series of linear regression models predicting each psychological distress outcome (i.e., depression, anxiety, stress, PTSD) from disordered eating behaviors, controlling for geographic region, sexual orientation, relationship status, and socioeconomic status. We retained these covariates because prior research links each to disparities in body image, eating pathology, or access to mental health care among Black women (e.g., Schooler et al., 2004; Stanton et al., 2022); we dropped no covariates based on non-significance, consistent with a confirmatory covariate-adjustment approach. Hypotheses 2 and 3 were tested using simple mediation models (Hayes, 2022, PROCESS Model 4) with disordered eating as the predictor (X), each of the four SATAQ-4 subscales (i.e., internalized thin ideals, family pressure, peer pressure, media pressure) entered as a separate mediator (M), and each of the four distress outcomes entered as the criterion (Y), controlling for the same covariates as above. This yielded 16 mediation models in total. Each mediator was tested separately, rather than as parallel mediators in a single model, because the SATAQ-4 subscales were moderately-to-strongly intercorrelated (*r*s = .39–.72; see Table 1), raising concerns about multicollinearity and shared variance masking unique indirect effects in a combined model; findings should therefore be interpreted as evidence for each pathway independently rather than as evidence that these pathways operate uniquely of one another. Indirect effects were estimated using 5,000 bootstrap resamples with 95% bias-corrected and accelerated (BCa) confidence intervals, and an indirect effect was interpreted as statistically significant when its BCa *CI* did

not contain zero. Given the cross-sectional design, mediation results are interpreted as evidence of statistical, not causal, mediation (Shrout, 2011).

Results

Preliminary Analyses

Descriptive statistics, zero-order correlations, and internal reliability estimates for all study variables are presented in Table 1. Among sociocultural appearance variables, media pressure was the most strongly endorsed (M = 9.20, SD = 5.60), followed by internalized thinness ideals (M = 12.70, SD = 5.30), family pressure (M = 7.00, SD = 4.10), and peer pressure (M = 6.20, SD = 3.80). Internal reliability estimates were acceptable to excellent for all scales: disordered eating (α = .88), depression (α = .91), anxiety (α = .86), stress (α = .88), PTSD (α = .96), internalized thinness ideals (α = .85), family pressure (α = .88), peer pressure (α = .93), and media pressure (α = .95). Zero-order correlations revealed that disordered eating was significantly and positively associated with all psychological distress outcomes: depression (r = .43), anxiety (r = .33), stress (r = .40), and PTSD (r = .41), all ps < .001. Disordered eating was also significantly correlated with all four sociocultural appearance variables, most strongly with internalized thinness ideals (r = .55) and media pressure (r = .48), and more modestly with family pressure (r = .37) and peer pressure (r = .30). The four SATAQ-4 subscales were moderately-to-strongly intercorrelated (rs = .39–.72), consistent with their shared sociocultural conceptual domain; this pattern was considered in the interpretation of individual mediator findings.

Table 1
Study Variable Correlations, Means, Standard Deviations, Skewness, Kurtosis, and Reliability Estimates

1. DE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	***M***	***SD***	***s***	***k***
	(.88)									**2.3**	**1.3**	**1.2**	**0.9**
2. Dep	.43***	(.91)								8.2	11.2	1.4	1.0
3. Anx	.33***	.78***	(.86)							6.2	8.5	1.8	3.1
4. Str	.40***	.83***	.83***	(.88)						8.5	9.5	1.2	0.6
5. PTSD	.41***	.77***	.69***	.73***	(.96)					24.2	18.8	0.6	-0.6
6. IntT	.55***	.34***	.23***	.25***	.37***	(.85)				12.7	5.3	0.4	-0.4
7. PreF	.37***	.41***	.52***	.41***	.52***	.41***	(.88)			7.0	4.1	1.5	1.5
8. PreP	.30***	.25***	.38***	.26***	.36***	.39***	.72***	(.93)		6.2	3.8	1.8	2.1
9. PreM	.48***	.39***	.31***	.37***	.38***	.45***	.44***	.49***	(.95)	9.2	5.6	0.6	-1.1

Note. DE = disordered eating; Dep = depression; Anx = anxiety; Str = stress; IntT = internalization thin ideals; PreF = pressures from family; PreP = pressures from peers; PreM = pressures from media; *** = p < .001

Direct Effects of Disordered Eating on Psychological Distress

Linear regression analysis suggested that disordered eating behaviors in Black women were a statistically significant predictor of depression (B = 3.39, p = < .001), anxiety (B = 1.94, p = < .001), stress (B = 2.64, p = < .001), and trauma symptoms (B = 5.34, p = < .001; see Table 2). With effect sizes ranging from .30 to .40, these results are practically significant by conventional benchmarks for medium effects (Cohen, 1992). The findings support Hypothesis 1, suggesting that increased disordered eating behaviors were associated with increased psychological distress across all four outcome domains.

Table 2

Linear Regression of Disordered Eating on Psychological Distress

	Depression			Anxiety			Stress			PTSD		
	B (SE)	**t**	**β**	**B (SE)**	**t**	**β**	**B (SE)**	**t**	**β**	**B (SE)**	**t**	**β**
DE	3.39 (0.55)***	6.17	.40	1.94(0.44)***	4.37	.30	2.64(0.48)***	5.52	.37	5.34(0.95)***	5.63	.37
Reg	0.91(0.61)	1.50	.10	0.55(0.49)	1.12	.08	0.10(0.53)	0.19	.01	-0.56(1.05)	-0.53	− .04
Ori	2.44(0.68)***	3.59	.23	1.60(0.55)**	2.92	.20	1.69(0.59)**	2.84	.20	4.08(1.18)***	3.47	.23
RS	0.82(0.65)	1.26	.08	0.89(0.52)	1.70	.12	0.36(0.57)	0.63	.04	0.34(1.12)	0.30	.02
SES	-0.88(0.38)*	-2.32	− .15	-0.45(0.30)	-1.49	-0.10	-0.81(0.33)**	-2.46	− .16	-0.60(0.65)	-0.92	− .06
Cons	-2.24(3.21)	-0.70	-	-1.19(0.30)	-0.46	-	3.00(2.80)	1.07	-	9.62(5.54)	1.74	-

Note. DE = disordered eating; Reg = geographic region; Ori = sexual orientation; RS = relationship status; SES = socioeconomic status

Mediator of Disordered Eating and Psychological Distress

Four sets of simple mediation models were estimated to test whether internalized thinness ideals, family pressure, peer pressure, and media pressure each mediated the relationship between disordered eating behaviors (X) and psychological distress outcomes (Y: depression, anxiety, stress, and PTSD), yielding 16 models in total. Each model controlled for geographic region, sexual orientation, relationship status, and socioeconomic status. Indirect effects were estimated using bootstrapping with 5,000 resamples, with 95% bias-corrected and accelerated (BCa) confidence intervals; an indirect effect was considered statistically significant if its 95% BCa CI excluded zero. Total, direct, and indirect effects are reported for each mediator–outcome combination in Tables 3–6. Proportions of mediation (PM) are reported as descriptive effect-size indices. Hypotheses 2 and 3 received partial support, as detailed below.

Internalized Thin Ideals

Regarding depression, the total effect of disordered eating behaviors was statistically significant (*B* = 3.390, *SE* = 0.541, *z* = 6.272, *p* < .001, LLCI = 2.2670, ULCI = 4.4403). This is the estimate of the total effect of disordered eating behaviors on depression if the proposed mediator of internalized thin ideals were not in the model. The direct effect of disordered eating on depression was also statistically significant (*B* = 2.645, *SE* = 0.640, *z* = 4.130, *p* < .001, LLCI = 1.2990, ULCI = 3.8772). The indirect effect of disordered eating behaviors that passes through internalized thin ideals was statistically significant (*B* = 0.745, *SE* = 0.363, *z* = 2.054, *p* = .040, BootLLCI = 0.0926, BootULCI = 1.5798). These findings indicate that the proportion of the total effect of disordered eating on depression that is mediated by internalized thin ideals is approximately 21.98 percent (see Table 3). These findings indicate partial mediation of the relationship between disordered eating behaviors and depression by internalized thin ideals. Regarding anxiety, the total effect of disordered eating behaviors was statistically significant (*B* = 1.936, *SE* = 0.435, *z* = 4.446, *p* < .001, LLCI = 1.0408, ULCI = 2.7867). This is the estimate of the total effect of disordered eating behaviors on anxiety if the proposed mediator of internalized thin ideals were not in the model. The direct effect of disordered eating on anxiety was also statistically significant (*B* = 1.669, *SE* = 0.521, *z* = 3.204, *p* = .001, LLCI = 0.5877, ULCI = 2.6793). The indirect effect of disordered eating behaviors that passes through internalized thin ideals was not statistically significant (*B* = 0.267, *SE* = 0.289, *z* = 0.924, *p* = .355, BootLLCI = -0.2698, BootULCI = 0.9118). These findings do not indicate mediation of the relationship between disordered eating behaviors and anxiety by internalized thin ideals (see Table 3). Regarding stress, the total effect of disordered eating behaviors was statistically significant (*B* = 2.644, *SE* = 0.471, *z* = 5.612, *p* < .001, LLCI = 1.6982, ULCI = 3.5807). This is the estimated total effect of disordered eating behaviors on stress when the proposed mediator of internalized thin ideals is not included in the model. The direct effect of disordered eating on stress was also statistically significant (*B* = 2.405, *SE* = 0.564, *z* = 4.266, *p* < .001, LLCI = 1.2709, ULCI = 3.5282). The indirect effect of disordered eating behaviors mediated by internalized thin ideals was not statistically significant (*B* = 0.238, *SE* = 0.312, *z* = 0.764, *p* = .445, BootLLCI = -0.3543, BootULCI = 0.8568). These findings do not indicate mediation of the relationship between disordered eating behaviors and stress by internalized thin ideals (see Table 3). Regarding trauma symptoms, the total effect of disordered eating behaviors was statistically significant (*B* = 5.340, *SE* = 0.934, *z* = 5.719, *p* < .001, LLCI = 3.4952, ULCI = 7.2290). This is the estimate of the total effect of disordered eating behaviors on trauma symptoms if the proposed mediator of internalized thin ideals were not in the model. The direct effect of disordered eating on trauma symptoms was also statistically significant (*B* = 3.781, *SE* = 1.100, *z* = 3.437, *p* < .001, LLCI = 1.6214, ULCI = 6.0306). The indirect effect of disordered eating behaviors mediated by internalized thin ideals was statistically significant (*B* = 1.559, *SE* = 0.631, *z* = 2.472, *p* = .013, BootLLCI = 0.4423, BootULCI = 2.9174). These findings indicate that the proportion of the total effect of disordered eating on trauma symptoms that is mediated by internalized thin ideals is approximately 29.19 percent (see Table 3).

These findings indicate partial mediation of the relationship between disordered eating behaviors and trauma symptoms by internalized thin ideals.

Table 3
Internalized Thin Ideals as a Mediator

	Depression		Anxiety		Stress		PTSD	
	B	**SE**	**B**	**SE**	**B**	**SE**	**B**	**SE**
Indirect Effect	0.75*	0.36	0.27	0.27	0.24	0.31	1.56*	0.63
Direct Effect	2.65***	0.64	1.67	0.52	2.41***	0.56	3.78***	1.10
Total Effect	3.39***	0.54	1.94	0.44	2.64***	0.47	5.34***	0.93
Mediation	22%		-		-		29%	

Pressures from Family

Regarding depression, the total effect of disordered eating behaviors was statistically significant (B = 3.390, SE = 0.541, z = 6.272, p < .001, LLCI = 2.2670, ULCI = 4.4403). This is the estimate of the total effect of disordered eating behaviors on depression if the proposed mediator of familial pressures was not in the model. The direct effect of disordered eating on depression was also statistically significant (B = 2.551, SE = 0.553, z = 4.609, p < .001, LLCI = 1.3974, ULCI = 3.6302). The indirect effect of disordered eating behaviors mediated by family pressure was statistically significant (B = 0.839, SE = 0.255, z = 3.293, p < .0001, BootLLCI = 0.3609, BootULCI = 1.6029). These findings indicate that the proportion of the total effect of disordered eating on depression that is mediated by pressures from family is approximately 24.75 percent (see Table 4). These findings indicate partial mediation of the relationship between disordered eating behaviors and depression by familial pressures. Regarding anxiety, the total effect of disordered eating behaviors was statistically significant (B = 1.936, SE = 0.435, z = 4.446, p < .001, LLCI = 1.0408, ULCI = 2.7867). This is the estimate of the total effect of disordered eating behaviors on anxiety if the proposed mediator of pressures from family were not in the model. The direct effect of disordered eating on anxiety was also statistically significant (B = 0.898, SE = 0.416, z = 2.159, p = .031, LLCI = 0.0390, ULCI = 1.7135). The indirect effect of disordered eating behaviors mediated by family pressure was statistically significant (B = 1.037, SE = 0.247, z = 4.194, p < .001, BootLLCI = 0.5028, BootULCI = 1.8529). These findings indicate that the proportion of the total effect of disordered eating on anxiety that is mediated by familial pressures is approximately 53.56 percent (see Table 4). These findings indicate partial mediation of the relationship between disordered eating behaviors and anxiety by pressure from family. Regarding stress, the total effect of disordered eating behaviors was statistically significant (B = 2.644, SE = 0.471, z = 5.612, p < .001, LLCI = 1.6982, ULCI = 3.5807). This is the estimate of the total effect of disordered eating behaviors on stress if the proposed mediator of familial pressures was not in the model. The direct effect of disordered eating on stress was also statistically significant (B = 1.870, SE = 0.480, z = 3.899, p < .001, LLCI = 0.9046, ULCI = 2.8266). The indirect effect of disordered eating behaviors mediated by family pressure was statistically significant (B = 0.774, SE = 0.226, z = 3.417, p < .001. BootLLCI = 0.3343, BootULCI = 1.4646). These findings indicate that the total effect of disordered eating on anxiety that is mediated by familial pressures is approximately 29.27 percent (see Table 4). These findings indicate partial mediation of the relationship between disordered eating behaviors and stress by pressures from family. Regarding trauma symptoms, the total effect of disordered eating behaviors was statistically significant (B = 5.340, SE = 0.934, z = 5.719, p < .001, LLCI = 3.4952, ULCI = 7.2290). This is the estimate of the total effect of disordered eating behaviors on trauma symptoms if the proposed mediator of familial pressures were not in the model. The direct effect of disordered eating on trauma symptoms was also statistically significant (B = 3.211, SE = 0.902, z = 3.561, p < .001, LLCI = 1.4261, ULCI = 5.0442). The indirect effect of disordered eating behaviors mediated by familial pressures was statistically significant (B = 2.128, SE = 0.518, z = 4.108, p < .001, BootLLCI = 1.1374, BootULCI = 3.5304). These findings indicate that the proportion of the total effect of disordered eating on trauma symptoms that is mediated by familial pressures is approximately 39.85 percent (see Table 4). These findings indicate partial mediation of the relationship between disordered eating behaviors and trauma symptoms by familial pressures.

Table 4
Pressures from Family as a Mediator

	Depression		Anxiety		Stress		PTSD	
	B	**SE**	**B**	**SE**	**B**	**SE**	**B**	**SE**
Indirect Effect	0.84***	0.26	1.04***	0.25	0.77***	0.23	2.13***	0.52
Direct Effect	2.55***	0.55	0.90*	0.42	1.87***	0.48	3.21***	0.90
Total Effect	3.39***	0.54	1.94***	0.44	2.64***	0.47	5.34***	0.93
Mediation	25%		54%		29%		40%	

Pressures from Peers

Regarding depression, the total effect of disordered eating behaviors was statistically significant (*B* = 3.390, *SE* = 0.541, *z* = 6.272, *p* < .001, LLCI = 2.2670, ULCI = 4.4403). This is the estimate of the total effect of disordered eating behaviors on depression if the proposed mediator of peer pressure were not in the model. The direct effect of disordered eating on depression was also statistically significant (*B* = 2.880, *SE* = 0.559, *z* = 5.155, *p* < .001, LLCI = 1.7281, ULCI = 3.9859). The indirect effect of disordered eating behaviors mediated by peer pressure was statistically significant (*B* = 0.510, *SE* = 0.210, *z* = 2.425, *p* = .015, BootLLCI = 0.1045, BootULCI = 1.1800). These findings indicate that the proportion of the total effect of disordered eating on depression that is mediated by peer pressure is approximately 15.04 percent (see Table 5). These findings indicate partial mediation of the relationship between disordered eating behaviors and depression by peer pressure. Regarding anxiety, the total effect of disordered eating behaviors was statistically significant (*B* = 1.936, *SE* = 0.435, *z* = 4.446, *p* < .001, LLCI = 1.0408, ULCI = 2.7867). This is the estimate of the total effect of disordered eating behaviors on anxiety if the proposed mediator of peer pressure were not in the model. The direct effect of disordered eating on anxiety was also statistically significant (*B* = 1.191, *SE* = 0.427, *z* = 2.789, *p* = .005, LLCI = 0.3139, ULCI = 2.0376). The indirect effect of disordered eating behaviors that passes through peer pressure was statistically significant (*B* = 0.744, *SE* = 0.211, *z* = 3.524, *p* < .001, BootLLCI = 0.2646, BootULCI = 1.5198). These findings indicate that the proportion of the total effect of disordered eating on anxiety that is mediated by peer pressure is approximately 38.43 percent (see Table 5). These findings indicate partial mediation of the relationship between disordered eating behaviors and anxiety by peer pressure. Regarding stress, the total effect of disordered eating behaviors was statistically significant (*B* = 2.644, *SE* = 0.471, *z* = 5.612, *p* < .001, LLCI = 1.6982, ULCI = 3.5807). This is the estimated total effect of disordered eating behaviors on stress when the proposed mediator, peer pressure, is excluded from the model. The direct effect of disordered eating on stress was also statistically significant (*B* = 2.174, *SE* = 0.486, *z* = 4.476, *p* < .001, LLCI = 1.1955, ULCI = 3.1436). The indirect effect of disordered eating behaviors mediated by peer pressure was statistically significant (*B* = 0.470, *SE* = 0.186, *z* = 2.527, *p* = .012, BootLLCI = 0.1171, BootULCI = 1.0917). These findings indicate that the proportion of the total effect of disordered eating on stress mediated by peer pressure is approximately 17.78% (see Table 5). These findings indicate partial mediation of the relationship between disordered eating behaviors and stress by pressures from peers. Regarding trauma symptoms, the total effect of disordered eating behaviors was statistically significant (*B* = 5.340, *SE* = 0.934, *z* = 5.719, *p* < .001, LLCI = 3.4952, ULCI = 7.2290). This is the estimate of the total effect of disordered eating behaviors on trauma symptoms if the proposed mediator of pressure from peers were not in the model. The direct effect of disordered eating on trauma symptoms was also statistically significant (*B* = 3.934, *SE* = 0.932, *z* = 4.220, *p* < .001, LLCI = 2.0715, ULCI = 5.8104). The indirect effect of disordered eating behaviors mediated by peer pressure was statistically significant (*B* = 1.406, *SE* = 0.426, *z* = 3.299, *p* < .001, BootLLCI = 0.5686, BootULCI = 2.7558). These findings indicate that the proportion of the total effect of disordered eating on trauma symptoms that is mediated by pressure from peers is approximately 26.33 percent (see Table 5). These findings indicate partial mediation of the relationship between disordered eating behaviors and trauma symptoms by pressure from peers.

Table 5
Pressures from Peers as a Mediator

	Depression		Anxiety		Stress		PTSD	
	B	**SE**	**B**	**SE**	**B**	**SE**	**B**	**SE**
Indirect Effect	0.51*	0.21	0.74***	0.21	0.47*	0.19	1.41***	0.43
Direct Effect	2.88***	0.56	1.19**	0.43	2.17***	0.49	3.93***	0.93
Total Effect	3.39***	0.54	1.94***	0.44	2.64***	0.47	5.34***	0.93
Mediation	15%		38%		18%		26%	

Pressures from the Media

Regarding depression, the total effect of disordered eating behaviors was statistically significant (*B* = 3.390, *SE* = 0.541, *z* = 6.272, *p* < .001, LLCI = 2.2670, ULCI = 4.4403). This is the estimate of the total effect of disordered eating behaviors on depression if the proposed mediator of media pressure were not in the model. The direct effect of disordered eating on depression was also statistically significant (*B* = 2.651, *SE* = 0.603, *z* = 4.394, *p* < .001, LLCI = 1.4125, ULCI = 3.8490). The indirect effect of disordered eating behaviors mediated by media pressures was statistically significant (*B* = 0.740, *SE* = 0.303, *z* = 2.441, *p* = .015, BootLLCI = 0.0755, BootULCI = 1.4878). These findings indicate that the proportion of the total effect of disordered eating on depression that is mediated by media pressure is approximately 21.98 percent (see Table 6). These findings indicate partial mediation of the relationship between disordered eating behaviors and depression by pressures from the media. Regarding anxiety, the total effect of disordered eating behaviors was statistically significant (*B* = 1.936, *SE* = 0.435, *z* = 4.446, *p* < .001, LLCI = 1.0408, ULCI = 2.7867). This is the estimate of the total effect of disordered eating behaviors on anxiety if the proposed mediator of media pressures were not in the model. The direct effect of disordered eating on anxiety was also statistically significant (*B* = 1.306, *SE* = 0.485, *z* = 2.693, *p* = .007, LLCI = 0.3171, ULCI = 2.2698). The indirect effect of disordered eating behaviors mediated by media pressures was statistically significant (*B* = 0.630, *SE* = 0.245, *z* = 2.569, *p* = .010, BootLLCI = 0.1213, BootULCI = 1.2414). These findings indicate that the proportion of the total effect of disordered eating on anxiety that is mediated by media pressure is approximately 32.54 percent (see Table 6). These findings indicate partial mediation of the relationship between disordered eating behaviors and anxiety by media pressure. Regarding stress, the total effect of disordered eating behaviors was statistically significant (*B* = 2.644, *SE* = 0.471, *z* = 5.612, *p* < .001, LLCI = 1.6982, ULCI = 3.5807). This is the estimate of the total effect of disordered eating behaviors on stress when the proposed mediator, media pressures, is excluded from the model. The direct effect of disordered eating on stress was also statistically significant (*B* = 1.837, *SE* = 0.520, *z* = 3.531, *p* < .001, LLCI = 0.7900, ULCI = 2.8771). The indirect effect of disordered eating behaviors mediated by media pressures was statistically significant (*B* = 0.807, *SE* = 0.270, *z* = 2.989, *p* = .003, BootLLCI = 0.2300, BootULCI = 1.5023). These findings indicate that the total effect of disordered eating on stress that is mediated by media pressure is approximately 30.52 percent (see Table 6). These findings indicate partial mediation of the relationship between disordered eating behaviors and stress by media pressure. Regarding trauma symptoms, the total effect of disordered eating behaviors was statistically significant (*B* = 5.340, *SE* = 0.934, *z* = 5.719, *p* < .001, LLCI = 3.4952, ULCI = 7.2290). This is the estimate of the total effect of disordered eating behaviors on trauma symptoms if the proposed mediator of media pressure were not in the model. The direct effect of disordered eating on trauma symptoms was also statistically significant (*B* = 3.721, *SE* = 1.031, *z* = 3.611, *p* < .001, LLCI = 1.6627, ULCI = 5.7974). The indirect effect of disordered eating behaviors mediated by media pressure was statistically significant (*B* = 1.618, *SE* = 0.536, *z* = 3.021, *p* = .003, BootLLCI = 0.5308, BootULCI = 2.9638). These findings indicate that the proportion of the total effect of disordered eating on trauma symptoms that is mediated by media pressure is approximately 30.30 percent (see Table 6). These findings indicate partial mediation of the relationship between disordered eating behaviors and depression by media pressure.

Table 6
Pressures from the Media as a Mediator

	Depression		**Anxiety**		**Stress**		**PTSD**	
	B	**SE**	**B**	**SE**	**B**	**SE**	**B**	**SE**
Indirect Effect	0.74*	0.30	0.63*	0.25	0.81**	0.27	1.62**	0.54
Direct Effect	2.65***	0.60	1.31**	0.49	1.84***	0.52	3.72***	1.03
Total Effect	3.39***	0.54	1.94***	0.44	2.64***	0.47	5.34***	0.93
Mediation	22%		33%		31%		30%	

Discussion

The present study examined whether disordered eating behaviors predict psychological distress (i.e., depression, anxiety, stress, and trauma symptoms) among Black women, and whether sociocultural attitudes toward appearance, specifically internalized thin ideals and pressures from family, peers, and media, help explain that relationship. Across four sets of mediation models, disordered eating was consistently and robustly associated with greater psychological distress, and sociocultural appearance pressures, particularly from family, peers, and media, partially accounted for this association; internalized thin ideals mediated the link for depression and trauma specifically, but not for anxiety or stress. The current findings must be understood within the broader context of sociocultural pressures and intersecting beauty standards that shape body image and mental health among Black women. Prior research highlights how thinness discourse, competing appearance ideals, and sociocultural messaging, transmitted through family, peers, and media, contribute to body

dissatisfaction and disordered eating. The current study examined whether disordered eating behaviors predict psychological distress and whether sociocultural attitudes toward appearance mediate these associations, offering insight into mechanisms that sustain disparities and informing culturally responsive interventions. Support was found for our first hypothesis. Aligning with existing evidence, disordered eating behaviors predicted psychological distress, specifically, increased symptoms of depression, anxiety, stress, and trauma among Black women (Goode et al., 2022; Javier et al., 2016; Mikhail, & Klump, 2021; Ross, 2019). Noticeable effect sizes (ranging from .30 to .40) indicate practical significance and underscore the impact of disordered eating on Black women's well-being. And reinforces the need to increase awareness and reduce disparities in treatment for Black women to dispel myths and bias and misdiagnosis (Goode et al., 2022; Labarta & Bendit, 2024; Spates, 2012).

The results provide partial support for our second hypothesis, suggesting that internalization of the thinness ideal partially mediates the relationship between disordered eating behaviors and symptoms of depression or trauma among some Black women. This finding is consistent with prior research on the influence of thinness ideals on disordered eating and related psychological outcomes, including depression and trauma-related symptoms (Becker et al., 2018; Convertino et al., 2022; Hübel et al., 2025; Ross, 2019; Schaefer et al., 2019; Watson et al., 2015). Contrary to existing literature, however, internalized thinness did not significantly predict the association between eating behaviors and symptoms of anxiety or stress (Diggins et al., 2015; Goode et al., 2022; Hoggard et al., 2023; Owen & Laurel-Seller, 2006; Watson et al., 2015). One possible explanation is that Black women in this sample experience stress and anxiety in ways not adequately captured by the measures employed. Alternatively, symptoms of stress and anxiety may overlap with depression and trauma responses, obscuring distinct associations. Our findings also support the final hypothesis that sociocultural factors, particularly pressures from peers and family, contribute to the link between disordered eating behaviors and psychological distress (depression, anxiety, stress, and trauma). This aligns with research indicating that Black women's conceptualizations of beauty, body ideals, and eating behaviors are shaped by family and peer influences (Boutté et al., 2022; Chilson et al., 2025; Gentles-Peart, 2016; Harris, 1995; Jerald et al., 2017; Javier et al., 2016). Internalized perceptions of thinness or thickness within these social networks can significantly impact eating behaviors and mental health. Consequently, eating disorder treatment should incorporate protective factors such as social support systems (family, friends) and identify individuals who are supportive versus those who may hinder recovery. Clinicians should also explore how these relationships influence eating habits and psychological functioning. Additionally, the findings underscore the substantial role of media pressures in shaping disordered eating behaviors and psychological distress among Black women (Boutté et al., 2025; Capodilupo, 2015; Javier et al., 2016; Mingoia et al., 2017; Munsch et al., 2021; Sanzari et al., 2023). A comprehensive assessment of disordered eating should include an evaluation of media influences, both social and mainstream, on body image, self-perception, and eating patterns. Promoting healthy boundaries and fostering self-awareness regarding media exposure may be critical for improving overall well-being.

Considering the complex interplay between culturally engendered beauty standards, disordered eating, and mental health, there is a pressing need for mental health providers to center Black women's experiences of body perception in treatment (Acle et al., 2021; Boutté et al., 2025; Michel, 2020; Labarta et al., 2024; Williams et al., 2024). Clinical approaches should be culturally attuned and highlight coping strategies shown to mitigate the impacts of stress, such as racial sexual socialization, social support, collective coping, and religion and spirituality (Labarta & Bendit, 2024; Williams et al., 2024). Black women may present with symptoms that deviate from white, Western norms due to unique cultural factors, systemic racism and oppression, gendered racism, and individual differences (Boutté et al., 2025; Gentles-Peart, 2018; Sanders et al., 2026). Providers should pay close attention and infuse culturally competent assessment into their practice by assessing clients' attitudes towards eating, body image distress, and body surveillance behaviors throughout treatment (Acle et al., 2021; Michel, 2020; Wilfred & Lundgren, 2021).

Therapists must make intentional clinical decisions that emphasize understanding the adaptive, self-protective behaviors that Black women may employ to navigate societal and systemic challenges (Williams et al., 2024). In exploring how stress and trauma impact eating and perceptions of appearance, therapists must ensure that care is approached through the lens of Black women's disproportionate exposure to chronic stressors such as poverty, racism, and microaggressions, with recognition that disordered eating patterns may be worsened by perceived and contextualized stress (Diggins et al., 2015). At the same time, therapists are encouraged to align interventions with cultural identity through strategies rooted in Relational Cultural Therapy (Jordan, 2024) or Psychology of Radical Healing (French et al., 2020), such as self-compassion and strengths-based conceptualizations of eating, which may enhance resilience (Labarta & Bendit, 2024). Such culturally attuned approaches may increase buy-in and enhance outcomes by creating safe, affirming spaces for Black women to engage with their sociocultural contexts.

Limitations and Future Directions

This study relied on participants recruited through Qualtrics, which restricts the sample to individuals with access to that platform. Future research using a nationally representative sample could yield different or more generalizable findings. Replicating the study with a larger and more diverse population may uncover additional nuances. Because the design was cross-sectional, causal relationships cannot be

inferred; longitudinal studies are recommended to examine potential age-related changes in Black women's body image, eating behaviors, sociocultural attitudes toward appearance, and psychological well-being over time. Although there have been arguments against using cross-sectional data for mediation analyses (e.g., Maxwell et al., 2011; O'Laughlin et al., 2018), there has recently been a methodological push to accept their use (Georgeson et al., 2025), especially in cases where there may be ethical or methodological limitations preventing the use of longitudinal approaches or if there is a theoretical foundation that describes the potential causal direction of the processes (e.g., Shrout, 2011). Shrout further argues that cross-sectional mediation approaches can contribute meaningfully to the scientific literature, especially if they use bootstrapping, acknowledge the limitations of cross-sectional designs, and interpret the results as potential mediation rather than as establishing causal mechanisms (2011). The structure and arguments posited in this paper align with Shrout's guidelines for using cross-sectional data for mediation analyses. Furthermore, previous mediation analyses using cross-sectional data align with the findings of this study regarding the relationship between disordered eating behaviors and psychological distress (e.g., Salami et al., 2019). Previous mediation models have also found that body appreciation, identity shifting, body dissatisfaction, and internalization of the Western beauty ideal mediated the relationship between disordered eating behaviors and various psychological outcomes (e.g., Boutté, 2022; Buckingham-Howes et al., 2018; Cotter et al., 2015; Dickens et al., 2024).

Another limitation is that the measures employed were not developed to capture intersectional experiences. Additionally, this study did not assess alternative beauty ideals, such as the curvaceous or "thickness" ideal, which could provide valuable comparisons to the thinness ideal. Finally, Black girls were not included in the sample, despite being highly susceptible to social media influences and beauty standards during formative years. Future research should prioritize this group, as they often evaluate themselves against these pervasive ideals. Historically, Black women have been underrepresented and excluded in the literature related to eating disorders and mental health (Goode et al., 2022; Spates, 2012). This has further reinforced harmful, controlling images associated with beauty and adverse health outcomes (Collins, 2000; Jones & Shorter-Gooden, 2025; Watson & Hunter, 2015). These gaps in the literature are problematic, and differences in published prevalence rates of eating disorders may reflect disparities in access to care over and above true differences, especially for disorders such as bulimia nervosa and binge eating disorder (Goode et al., 2022; Mikhail & Klump, 2021). Researchers must therefore strive to decolonize research related to body image and mental health outcomes by contextualizing patterns of distress beyond Eurocentric ideals about thinness and incorporating culturally relevant stressors within their frameworks. Additionally, by developing and utilizing measures specific to Black women's body image, such as the Double Consciousness Body Image Scale (Wilfred & Lundgren, 2021), researchers will be better positioned to make contextually driven and actionable recommendations. Culturally informed research that recognizes the intersection between race, gender, pressures to uphold the "Strong Black Woman" schema, and increased exposure to chronic stressors will illuminate unique patterns in how Black women conceptualize their body image and which coping strategies may be most apt for countering eating and mental health concerns. By addressing these gaps, researchers can strengthen the knowledge base and develop more effective interventions for Black women. In summary, to investigate the sociocultural mediators that drive Black women's mental health concerns, future research must be inclusive and culturally informed.

Conclusion

Findings from this study highlight the complex interplay between disordered eating behaviors, psychological distress, and sociocultural attitudes toward appearance among Black women. Eating disorders are not exclusive to White women; Black women experience comparable prevalence rates yet remain significantly less likely to receive accurate diagnoses or appropriate treatment. Results indicate that sociocultural pressures, particularly those transmitted through family, peers, and media, partially mediate the relationship between disordered eating and mental health outcomes, including depression, anxiety, stress, and trauma. Internalization of thinness ideals also emerged as a significant mediator for depression and trauma symptoms, underscoring the enduring influence of Eurocentric beauty standards. These patterns emphasize the need for culturally responsive interventions that dismantle harmful stereotypes, address systemic barriers, and incorporate protective identity processes. Future research should employ longitudinal and intersectional approaches to capture the nuanced experiences of Black women and inform evidence-based strategies that advance equity in eating disorder treatment and mental health care.

Declarations

Author Contribution

S.S. and T.W. conceptualized the paper, provided supervision, and were project administrators. All authors contributed to the writing, revising, and editing of the manuscript. S.S. and J.F. were leaders of the formal analysis and investigation, methodology, visualization, validation, and methodology. T.W. was in charge of the data curation while the statistical software was provided by S.S.

Data Availability

The research data that informed the findings in this study, due to their nature, are not publicly available. However, upon a reasonable request submitted via email to Dr. Williams, data requests will be considered and when appropriate (e.g., IRB approval, safeguards for data security in place), the data will be shared with researchers for secondary data analysis.

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