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Feminine Gender Norms and Eating Disorders in Women: Evidence from an Exploratory Pilot Study

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Abstract

Background: Eating disorders (EDs) are multifactorial mental health conditions that predominantly affect adolescent girls and young women and constitute a major public health concern due to their severe and often chronic impact on physical, psychological, and psychosocial functioning. Although existing research suggests that gender-related constructs and traditional gender roles may influence the etiology and clinical expression of EDs, empirical evidence remains limited. Accordingly, this study examines clinical and health-related variables from a gender perspective in women diagnosed with an eating disorder. **Methods:** Forty women aged 14 to 50 years completed an assessment protocol including measures of gender norms, eating disorder symptomatology, and physical and psychological health. **Results:** Participants exhibited significantly poorer mental and physical health compared to normative samples and showed greater adherence to traditional feminine gender norms, particularly those related to thinness and investment in appearance. Several gender norms were significantly associated with health outcomes, and gender norms explained additional variance in ED symptomatology beyond established clinical predictors. **Conclusions:** These findings highlight traditional gender norms as a significant social determinant negatively impacting the health of women with EDs. Greater conformity to norms related to thinness, appearance, domestic roles, and sexual fidelity was associated with poorer health outcomes and increased engagement in disordered eating behaviours.

Keywords: eating disorders; social norms; gender roles; feminine gender norms; women's health; mental health

1. Introduction

Eating disorders (EDs) constitute a group of mental health conditions with complex and multifactorial etiology that predominantly affect adolescent girls and young women, representing a significant public health problem in developed countries [1]. According to the American Psychiatric Association [2], these disorders are characterized by persistent patterns of disturbed eating and dysfunctional behaviors related to food intake, such as extreme restriction, binge eating episodes, or compensatory behaviors, typically accompanied by intense concerns about body weight, body shape, or both. The high prevalence of EDs, together with the severity of their clinical manifestations and their frequently chronic course, leads to a significant deterioration in physical and mental health, along with psychosocial functioning in affected individuals [3,4].

Scientific evidence has consistently shown a higher prevalence of EDs in women compared to men, particularly during adolescence and early adulthood [5,6]. Traditionally, this disparity has been explained through biological and epidemiological factors; however, these approaches are insufficient

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to fully understand the observed differences in incidence, symptom expression, and clinical course of eating disorders. In this regard, several studies have highlighted the need to incorporate analyses of gender constructs and traditional roles as key elements in the etiology and manifestation of EDs [7,8]. Sociocultural pressures that associate thinness with femininity, self-control, and personal success create a normative context that promotes body dissatisfaction and the adoption of dysfunctional eating behaviors, particularly among women and girls [9,10].

From a gender-based health perspective, gender is conceived as a fundamental analytical category for understanding how roles, norms, and social expectations influence patterns of well-being, morbidity, and access to health resources [11]. Gender roles and identities, along with associated power relations, act as social determinants that can either increase vulnerability or exert a protective effect on physical and mental health. In the context of EDs, the assignment of traditional gender roles may directly influence body image perception, the internalization of normative aesthetic ideals, and the adoption of eating-related risk behaviors [8].

Empirical evidence has supported this relationship from the early stages of research. Classical studies, such as those by Murnen and Smolak [12] and Cantrell and Ellis [13], demonstrated that gender-role-related identities are associated with differential risk patterns for the development of EDs. More recently, the meta-analysis conducted by Thapliyal, Hay, and Conti [14] concluded that the therapeutic experiences of women and men with eating disorders differ significantly according to their alignment with gender expectations, underscoring the importance of incorporating a gender-informed perspective in both research and clinical practice. Similarly, Griffiths and Yager [15] introduced the concept of gender embodiment, which describes how bodily experience and identity are shaped in relation to cultural norms of femininity and self-control.

In addition, current research agrees that gender socialization processes play a central role in the onset and maintenance of EDs. Cultural pressures regarding the female body, thinness ideals, and norms of bodily self-control have been identified as structural determinants that increase eating-related vulnerability among young women [16]. In this context, psychosocial factors such as body dissatisfaction, depression, and low self-esteem are more prevalent among adolescent girls and act as relevant precursors to eating disorders [4,17]. This vulnerability is intensified by the influence of mass media and social networks, which promote restrictive beauty ideals and reinforce the association between thinness, success, and social value [18,19]. The high prevalence of body dissatisfaction in this group has led to the description of this phenomenon as *normative discontent*, reflecting its normalization in adolescent female experience [20].

Despite this well-established theoretical framework, most studies on EDs have approached gender from descriptive or comparative perspectives, focusing on sex differences while neglecting the empirical measurement of gender constructs [8]. The incorporation of instruments to operationalize gender remains limited, although there are relevant precedents, such as the study by Zwetzig [21], which used the *Conformity to Feminine Norms Inventory* (CFNI) and the *Bem Sex Role Inventory* (BSRI) to analyze the relationship between conformity to traditional feminine norms and symptom severity. The findings showed that higher internalization of traditional femininity ideals was associated with greater symptom severity, demonstrating the usefulness of these tools for advancing understanding of the role of gender in EDs.

The novelty of the present study lies in moving beyond the conventional, largely descriptive treatment of "gender" as a proxy for sex differences by empirically operationalizing a specific gender construct—conformity to traditional feminine norms—and examining its associations with eating-disorder-related risk behaviors and health outcomes among women with EDs. While previous literature has extensively documented the higher prevalence of EDs among females and has theorized relevant sociocultural mechanisms, comparatively few studies have incorporated validated instruments to quantify gender-role conformity and link it to both physical and mental health indicators in clinical populations. By conceptualizing conformity to feminine norms as a measurable social determinant of health and analyzing its relationship with psychosocial functioning and disordered eating behaviors, this research offers a more mechanism-oriented, gender-informed

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account of vulnerability in EDs, generating evidence with direct implications for assessment, prevention, and the tailoring of clinical interventions.

In this context, the present research aims to deepen the understanding of the mechanisms through which conformity to traditional feminine gender norms acts as a determinant of health in women with EDs. Specifically, it seeks to examine the relationship between conformity to feminine norms, physical and mental health, and the presence of eating-related risk behaviors, thereby contributing to a more comprehensive understanding of these disorders from a gender perspective and providing empirical evidence to inform both future research and clinical practice.

2. Method

2.1. Participants

The sample was recruited through collaboration with two associations specialized in eating disorders (EDs] from several outpatient and day-care centers in Madrid and Bilbao. Inclusion criteria were participants aged 14 years or older and currently receiving treatment after being diagnosed with an ED. Exclusion criteria included insufficient Spanish language proficiency and a lack of basic education necessary to complete the questionnaires.

The study included 40 women diagnosed with an ED according to Diagnostic and statistical manual of mental disorders criteria [2], who were receiving psychological treatment at one of the participating facilities. All participants were fully informed about the study by the project leaders and provided written informed consent for participation and inclusion of their data in the research. Participation was voluntary, and participants' decision to participate or not participate had no impact on their treatment.

Participants' ages ranged from 14 to 50 years, with a mean age of 26.30 years (SD = 9.52). The sample was heterogeneous in terms of ED diagnosis, illness duration, course, severity, educational attainment, and occupation. Diagnoses covered the full spectrum of EDs according to DSM-5-TR criteria [2] (See Table 1).

Table 1. Sociodemographic and clinical variables (N = 40).

Age (Mean/SD)	**23.30/9.52**
Civil status	
Single	82.5%
Married	15%
Separated	2.5%
Educational attainment	
Primary Education	25%
Secondary Education	20%
Post-secondary or tertiary education	55%
Occupation	
Working	42.5%
Studying	50%
Unemployed	7.5%
Diagnosis	Current/initial

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Anorexia	20%/40%
Bulimia	12.5%/30%
Obesity	15%/10%
EDNOS	52.5%/20%
Current course of illness	
In partial remission	65%
In full remission	10%
Active symptomatology	20%
Other	5%
BMI (Mean/SD)	23.98/8.21
Duration of illness (Mean/SD)	9.21/8.53

Note: EDNOS = Eating disorder not otherwise specified.

2.2. Procedure

This study is part of a broader investigation into reproductive health and employed a cross-sectional design, conducted in accordance with the STROBE Statement for reporting observational studies, enhancing transparency and methodological quality [22] (see supplementary material).

The research protocol was preregistered in both English and Spanish on the Open Science Framework (OSF) (https://osf.io/572ek/overview?view_only=e1ed3450afb74ccbb668c8171785affe) and approved by the Ethics Committee of the University of Murcia (1424/2016). All participants provided written informed consent and agreed to the publication of the data included in the manuscript. The study adhered to current legislation and followed the principles of the Declaration of Helsinki.

2.3. Measures

Assessment protocols were self-administered by participants, while clinical variables related to ED diagnosis were completed by the treating clinicians. The instruments used were:

- Sociodemographic Questionnaire: Collected data on age, marital status, origin, residence, educational attainment, and occupation.

- Clinical Questionnaire: Included variables related to illness development and course (i.e., diagnosis, current course of illness and duration).

- Health Self-Perception (HS): Adapted from the Spanish National Health Survey [23]. Items were rated on a 5-point Likert scale (1 = very poor, 5 = very good).

- SCOFF Questionnaire [24], Spanish adaptation by García-Campayo et al. [25]: A 5-item screening tool for EDs, dichotomous responses. Cut-off ≥2 indicates risk behaviors. Sensitivity: 98%, specificity: 98% for bulimia, 93% for anorexia, 100% for EDNOS. Internal consistency in the present sample: $\alpha = 0.59$.

- General Health Questionnaire (GHQ-12) [26]; Spanish adaptation by Sánchez-López & Dresch [27]: Brief self-administered instrument screening for psychological morbidity (range 0–12). Higher scores indicate worse mental health. Internal consistency in this sample: $\alpha = 0.92$.

- Conformity to Feminine Norms Inventory (CFNI) [28]; Spanish adaptation by Sánchez-López et al. [29]: 84 items rated on a 4-point Likert scale (strongly disagree to strongly agree), assessing conformity to eight femininity subscales (See Table 2). Internal consistency for total conformity in this sample: $\alpha = 0.82$; subscale reliability ranged from 0.72 to 0.91.

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Table 2. Description of the Conformity to Femininity Norms Inventory (CFNI) scales.

Subscale	Definition of feminine Norm
Nice in relationships	Develop friendly and supportive relationships with others.
Care for children	Take care and be with children.
Thinness	Pursue a thin body ideal.
Sexual fidelity	Keep sexual intimacy contained within one committed relationship.
Modesty	Refrain from calling attention to one's talents or abilities.
Romantic relationship	Invest self in romantic relationship.
Domestic	Maintain the home.
Invest in appearance	Commit resources to maintaining and improving physical appearance.

Source: Adapted from Mahalik et al., 2005.

2.4. Data Analysis

To determine the optimal sample size based on anticipated effect sizes, the software G*Power 3.1.7 was used [30]. An a priori power analysis using GPower 3.1.7 for a two-tailed Pearson correlation ($\alpha = 0.05$, $1-\beta = 0.80$) indicated a required total sample size of N = 40 for an anticipated effect size of = 0.43. An effect size of r = 0.43 corresponds to a medium-to-large effect according to conventional benchmarks [31,32]. Statistical analyses were conducted using SPSS version 23.0 (IBM Corp., Armonk, NY, USA). Data from the general Spanish population [23] were used as reference values for comparison.

Analyses included descriptive and frequency analyses for Health Self-Perception (HS). Independent-samples t-tests were conducted to compare mean scores in mental health (GHQ-12) and gender variables (CFNI). Correlational analyses examined relationships among HS, BMI, SCOFF scores, GHQ-12, and CFNI subscales. A hierarchical regression analysis was performed to evaluate the contribution of clinical, health, and gender variables to the presence of eating disorder (ED) risk behaviors. In the first step, clinical and health variables were entered, and variables exhibiting multicollinearity (tolerance < 0.10; VIF > 10) were removed. In the second step, gender variables were added to assess their additional contribution.

3. Results

The Results section is organized into four subsections: Participant Sociodemographic and Clinical Characteristics, Physical and Mental Health, Feminine Gender Norms, and Traditional Femininity and Health.

3.1. Participant Sociodemographic and Clinical Characteristics

Table 1 displays the sociodemographic and clinical variables of the sample. The sample had a mean age of 23.30 years (SD = 9.52). Most participants were single (82.5%), followed by married (15%) and separated (2.5%). Regarding educational attainment, 25% reported primary education, 20% secondary education, and 55% post-secondary or tertiary education. In terms of occupation, 50% were studying, 42.5% were working, and 7.5% were unemployed.

For diagnosis, current/initial data comprised: anorexia (20%/40%), bulimia (12.5%/30%), obesity (15%/10%), and EDNOS (52.5%/20%). Concerning the current course of illness, 65% were in partial remission, 10% in full remission, 20% showed active symptomatology, and 5% were classified as others. Mean BMI was 23.98 (SD = 8.21), and mean duration of illness was 9.21 years (SD = 8.53).

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3.2. Physical and Mental Health

The mean score on the 12-item General Health Questionnaire (GHQ-12) in the present sample was 3.83 (SD = 3.64), which was significantly higher—indicating poorer mental health—than that observed in the general Spanish population ($t = 3.69$, $p < 0.01$). Similarly, participants' self-perceived health (HS) was markedly poorer than that of the general population: only 37.5% reported good or very good physical health (compared with 70.2% of Spanish women aged 15 and over), whereas 22.5% reported poor or very poor health (versus approximately 6.9% in the general Spanish female population). Consistent with the aims of this study, these differences highlight the psychological vulnerability of the participants and provide a basis for exploring how gender-related variables interact with health status.

Disordered eating behaviors were significantly associated with health outcomes. Specifically, SCOFF scores were positively and significantly correlated with poorer self-perceived physical health ($r = 0.46$, $p < 0.01$) and poorer mental health ($r = 0.49$, $p < 0.01$).

3.3. Feminine Gender Norms

Women with eating disorders showed significantly higher scores on total conformity to feminine norms (CFNI total score) ($M = 156.00$, $SD = 21.71$, $p < 0.01$) compared to reference values. Significant differences were particularly evident in the norms related to thinness ($M = 24.08$, $SD = 6.89$, $p < 0.001$) and investment in appearance ($M = 13.28$, $SD = 3.15$, $p < 0.001$).

Contrary to expectations, no statistically significant differences emerged in conformity to the norms of modesty, care for children, or romantic relationships, differing from the findings reported by Mahalik et al. [28]. These discrepancies reinforce the need to consider sociocultural context when interpreting gender norms across samples.

3.4. Traditional Femininity and Health

Total CFNI scores were significantly associated with disordered eating behaviours measured by the SCOFF ($r = 0.46$, $p < 0.01$). SCOFF scores were also associated with the Thinness, Sexual fidelity, Domestic and Appearance subscales (see Table 3).

Table 3. Pearson's correlations between Body Mass Index (BMI), Course Duration (CD), Health Self-perception (HS), symptomatology (SCOFF), Mental health (GHQ-12) and Conformity to Feminine Norms Inventory.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14.
1. BMI	1													
2. CD	0.497**	1												
3. HS	-0.063	-0.121	1											
4. SCOFF	0.084	0.324*	0.462**	1										
5. GHQ	-0.027	-0.138	0.382*	0.486**	1									
6. CFNI 1	0.049	-0.028	0.019	0.051	-0.123	1								

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7. CFNI 2	.111	.081	-.184	-.060	-0.188	0.638**	1							
8. CFNI 3	0.293	0.181	0.135	0.611**	0.341*	0.205	0.201	1						
1. CFNI 4	0.014	-0.004	0.092	.363*	0.289	0.068	0.011	0.097	1					
2. CFNI 5	-0.068	-.039	-.150	.183	.323*	.052	0.047	0.284	0.239	1				
3. CFNI 6	-0.104	-0.177	0.178	0.200	0.168	-0.183	-0.177	0.163	0.390*	-0.113	1			
4. CFNI 7	0.048	0.073	0.134	0.377*	0.028	0.327*	0.232	0.233	0.157	0.071	-.008	1		
5. CFNI 8	0.253	0.159	-0.041	0.376*	0.105	0.049	0.160	0.497**	0.093	-0.075	0.323*	0.321*	1	
6. CFNI TOT	0.164	0.077	0.015	0.462**	0.190	0.617**	0.654**	0.668**	0.452**	0.366*	0.229	0.509**	0.494**	1

Notes: *$p < 0.05$; **$p < 0.01$. 1. **Abbreviations:** BMI=Body Mass Index; 2. CD= Course duration; 3. HS= Health self-perception; 4. SCOFF=Eating Disorder Screening; 5. GHQ= General Health Questionnaire; 6. CFNI 1= Nice in relationships; 7. CFNI 2= Care for children; 8. CFNI 3= Thinness; 9. CFNI 4= Sexual fidelity; 10. CFNI 5= Modesty; 11. CFNI 6= Romantic relationship; 12. CFNI 7= Domestic; 13. CFNI 8= Invest in appearance; 14. CFNI TOT= Total.

Poorer mental health, as measured by the GHQ-12, was also associated with higher conformity to thinness ($r = 0.34$, $p < 0.05$) and modesty ($r = 0.32$, $p < 0.05$). Although these association were modest in magnitude, it suggests subtle effects linked to internalised femenine gender expectations.

A hierarchical regression analysis (Table 4) showed that clinical and health variables (BMI, illness duration, HS, GHQ-12) explained 45% of the variance in disordered eating behaviours. Adding gender-related variables produced a significant increase in explained variance ($\Delta R^2 = 0.257$). The final model explained 70% of total variance and indicated that clinical variables and four of the eight femininity norms were associated with ED risk behaviours. This incremental contribution highlights the explanatory value of gender norms beyond traditional clinical variables.

Table 4. Hierarchical regression analysis. Contribution of clinical and health variables to the presence of ED symptomatology (SCOFF).

Modelo	Coeficientes de Regresión				Coeficientes de Determinación			
	B	ES	β	t	R^2	R^2cor.	ΔR^2	ΔF
1					0.508	0.449	0.508	8.535***
IMC	-0.018	0.024	-0.110	-0.782				
CD	0.076	0.023	0.468	3.304**				

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HS	0.553	0.213	0.338	2.602*				
GHQ-12	0.085	0.025	0.437	3.376**				
2					0.765	0.700	0.257	7.924***
IMC	-0.039	0.018	-0.234	-2.175*				
Duration	0.066	0.017	0.405	3.850***				
HS	0.508	0.160	0.310	3.175**				
GHQ-12	0.038	0.021	0.196	1.835				
CFNI-3	0.076	0.022	0.386	3.403**				
CFNI-4	0.060	0.025	0.230	2.394*				
CFNI-7	0.053	0.036	0.142	1.460				
CFNI-8	0.042	0.047	0.098	0.901				

Notes: *p ≤ 0.05 **p ≤ 0.01 ***p ≤ 0.001. B: Unstandaridzed coefficient; β: Standardized coefficient; SE: Standard Error; R2: Coefficient of determination R square; R2adj.: Adjusted coefficient of determination R square; ΔR2: R square change. Abbreviations: BMI=Body Mass Index; CD=Course Duration HS= Health self-perception; CFNI 3= Thinness; CFNI 4= Sexual fidelity; CFNI 7= Domestic; CFNI 8= Invest in appearance.

4. Discussion

The aim of the present study was to examine the relationship between conformity to traditional feminine gender norms, physical and mental health, and the presence of clinical indicators of eating disorders (EDs) in a sample of women diagnosed with EDs. The findings provide further evidence regarding the associations between gender norms and ED symptomatology and contribute new empirical insights into the role of gender as a determinant of women's health. By explicitly measuring gender-related constructs, the study responds to current calls for a more nuanced operationalisation of gender in mental health research.

Consistent with previous research, the women in this sample reported significantly poorer self-perceived physical and mental health compared to women in the Spanish general population. Prior studies have documented similar associations, showing links between EDs, anxiety, depression, and impaired well-being [4,33,34]. Likewise, Zeiler et al. [35] using the SCOFF questionnaire and measures of self-perceived health, found strong associations between disordered eating behaviours, general psychopathology, and reduced quality of life among adolescents. Together with the present findings, this evidence highlights the multifaceted nature of EDs and underscores the need for holistic approaches to their prevention and treatment that address both physical and psychological dimensions of health [1,36].

Recent research also documents substantial impairments in quality of life among individuals with EDs [5,16]. These findings provide the necessary clinical context for examining the specific role of gender norms in shaping health outcomes.

With regard to conformity to traditional feminine gender norms, women in the present study showed higher overall conformity compared to women from the Spanish general population, particularly in norms related to thinness and investment in appearance. These findings partially align with those reported by Mahalik et al. [28], who observed higher conformity across a broader range of feminine norms, including romantic relationships, modesty, and childcare, among women with EDs. The discrepancies between studies may be explained by differences in sample characteristics. Specifically, the present study relied on a smaller convenience sample with a higher mean age, whereas Mahalik et al. [28] examined a younger and more culturally heterogeneous sample. These

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differences may influence the salience of certain gender norms across life stages and sociocultural contexts.

Previous research has consistently shown that the internalisation of sociocultural norms and engagement in social comparison processes are positively associated with eating disorder psychopathology [37]. Similarly, conformity to traditional gender roles, together with dominant beauty ideals and the cultural valorisation of thinness, has been linked to the development of eating disorders such as anorexia nervosa and bulimia nervosa [38,39]. Recent reviews also emphasise the intensifying role of digital media and appearance-based evaluation in shaping body dissatisfaction and eating disorder risk [19,20]. In line with these findings, our results suggest that greater conformity to traditional gender norms may increase women's vulnerability to eating disorder risk behaviours.

Higher conformity to feminine norms was also associated with poorer mental health, particularly in relation to thinness- and appearance-related expectations. The association with modesty, although small in magnitude, may reflect internalised norms of self-effacement that are linked to poorer psychological well-being. Moreover, conformity to thinness, sexual fidelity, domestic roles, and investment in appearance was associated with higher engagement in eating disorder (ED] risk behaviours. Taken together, these findings highlight the enduring role of gendered expectations in shaping women's vulnerability to ED symptomatology. This pattern aligns with prior research showing that conformity to traditional gender roles is associated with increased body dissatisfaction and the adoption of dysfunctional eating behaviours, particularly among women and girls [9,10], ultimately undermining psychological well-being [36,40].

Hierarchical regression analyses that gender norms explained additional variance in ED symptoms beyond clinical predictors. The increase in explained variance ($\Delta R^2 = 0.257$) indicates that gender norms provide non-redundant explanatory power. This supports recent arguments calling for integrated gender-sensitive frameworks [7,8].

An additional contribution of this study lies in the explicit operationalisation of gender as a measurable construct. Much of the existing literature on eating disorders has focused on documenting differences between women and men, often attributing these differences to "gender" without directly measuring gender-related variables. As a result, gender is frequently treated as an implicit explanatory factor rather than as an empirically testable dimension. By incorporating a validated measure of conformity to feminine gender norms, the present study moves beyond binary sex comparisons and allows for a more nuanced analysis of how internalised gender norms relate to health outcomes and risk behaviours associated with eating disorders. This approach aligns with calls to distinguish analytically between sex and gender and to conceptualise gender as a social determinant of health rather than merely a demographic variable [7,8].

Several limitations of the present study should be acknowledged. First, the small sample size and convenience sampling limit the generalisability of the findings, although this limitation is partly explained by the difficulty of recruiting clinical populations with eating disorders. Second, the cross-sectional design precludes causal inferences and does not allow for longitudinal analyses of clinical variables such as illness duration or disease course. Finally, the diagnostic heterogeneity of the sample may have constrained the ability to examine disorder-specific patterns, highlighting the need for future research with larger and more homogeneous samples.

Despite these limitations, the present study contributes to the literature by offering a preliminary and exploratory analysis of the role of conformity to traditional feminine gender norms in eating disorders and women's health. The findings suggest that the internalisation of traditional feminine norms may be associated with poorer physical and mental health among women with EDs. Taken together, these results underscore the importance of integrating gender-sensitive and empirically grounded approaches into both research and clinical practice in the field of eating disorders.

5. Conclusions

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The present study provides empirical evidence supporting the role of traditional feminine gender norms as relevant social determinants of health in women diagnosed with eating disorders. Greater conformity to norms related to thinness, appearance, domestic, and sexual fidelity was associated with poorer physical and mental health, as well as with an increased presence of disordered eating behaviours. These findings are consistent with contemporary gender-sensitive models that conceptualise eating disorders as conditions shaped not only by individual vulnerability but also by sociocultural expectations.

These results highlight the importance of moving beyond purely biomedical or symptom-focused approaches to eating disorders and incorporating a gender-sensitive framework that acknowledges the impact of sociocultural norms on women's health. Addressing the internalisation of restrictive femininity norms may represent a valuable complementary target within prevention and intervention strategies aimed at improving health outcomes among women with eating disorders, without replacing established evidence-based treatments.

Future research should seek to replicate these findings using larger and more diverse samples, longitudinal designs, and refined measures of gender norms. Such approaches would allow for a better understanding of the temporal and contextual mechanisms linking gender norms, health outcomes, and eating disorder symptomatology, and would strengthen the empirical basis for gender-informed clinical practice.

Supplementary Materials: The following supporting information can be downloaded at the websitew of this paper posted on Preprint.org. Table S1. STROBE Statement checklist for reporting observational studies.

Author Contributions: R.M.L.-G.: Conceptualization, investigation, methodology, resources, writing—original draft, writing—review and editing, validation, visualization, supervision, project administration, funding acquisition. M.P.-O.: Conceptualization, methodology, data curation, formal analysis, writing—original draft. P.L.-H.: Conceptualization, data curation, writing—original draft, visualization. C.M.G.-S.: Methodology, formal analysis, writing—original draft, writing—review and editing, visualization, supervision. All authors have read and agreed to the published version of the manuscript.

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