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PERSONALITY DIMENSIONS AND SELF-REGULATION STYLES IN THE MANIFESTATION OF ORTHOREXIC TENDENCIES IN YOUNG PEOPLE

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Orthorexia is an emerging psychological construct characterized by a rigid preoccupation with consuming foods perceived as "pure" or "healthy." Although not formally recognized in the DSM-5-TR or the ICD-11, growing research suggests a distinct behavioral pattern associated with maladaptive perfectionism, cognitive rigidity, and excessive self-control. This article examines orthorexic tendencies in young people from the perspective of personality dimensions and self-regulation styles. It highlights how the interaction between relatively stable traits, such as conscientiousness and neuroticism, and dysfunctional self-regulatory mechanisms may increase vulnerability to the development and maintenance of orthorexic behaviors. The study advances an integrative conceptual model intended to guide future empirical research and inform prevention and psychological intervention programs focused on adaptive self-regulation and psychological well-being among young individuals.

Keywords: *orthorexic tendencies, personality dimensions, self-regulation styles, perfectionism, cognitive rigidity, psychological vulnerability.*

DIMENSIUNILE PERSONALITĂȚII ȘI STILURILE DE AUTOREGLARE ÎN MANIFESTAREA TENDINȚELOR ORTOREXICE LA TINERI

Ortorexia este un construct psihologic emergent, caracterizat prin preocuparea rigidă pentru consumul alimentelor percepute ca „pure" și „sănătoase". Deși nu este recunoscută oficial în DSM-5-TR sau ICD-11, cercetările recente indică un pattern comportamental distinct, asociat cu perfecționism dezadaptativ, rigiditate cognitivă și autocontrol excesiv. Articolul analizează tendințele ortorexice la tineri din perspectiva dimensiunilor personalității și a stilurilor de autoreglare. Se evidențiază faptul că interacțiunea dintre trăsături relativ stabile, precum conștiinciozitatea și nevrotismul, și mecanismele autoreglatorii disfuncționale poate crește vulnerabilitatea la dezvoltarea și menținerea comportamentelor ortorexice. Studiul propune un model conceptual integrativ, util pentru fundamentarea cercetărilor viitoare și pentru dezvoltarea programelor de prevenție și intervenție orientate spre autoreglare adaptativă și promovarea stării de bine în rândul tinerilor.

Cuvinte-cheie: *tendințe ortorexice, dimensiuni ale personalității, stiluri de autoreglare, perfecționism, rigiditate cognitivă, vulnerabilitate psihologică.*

Introduction

Contemporary socio-cultural transformations, marked by the globalization of lifestyles, media hyperexposure, and the definition of health as an identity value, have generated not only a diversification of eating behaviors, but also a redefinition of the individual's relationship with their own body and with food. In this context, nutrition no longer represents merely a biological necessity, but becomes an instrument of self-representation, control, and social validation. Against this axiological and cultural background, orthorexia emerges as an emerging psychological construct that reflects the highlighting of the boundary between adaptive concern for health and the pathological rigidification of eating behavior.

Although orthorexia is not recognized as a distinct diagnosis in international classification systems (DSM-5-TR; ICD-11), scientific literature highlights the existence of a relatively stable behavioral pattern characterized by obsessive concern with food purity, restrictive avoidance of products considered „impure", and progressive impairment of social and emotional functioning. The controversies regarding its nosological status – whether it represents a variant of eating disorders, an expression of obsessive-compulsive disorders, or a manifestation of accentuated personality traits – indicate the necessity of initiating integrative research and/or approaches [1].

In the Republic of Moldova, the growing interest in healthy lifestyles, amplified by social networks, migration, and the culture of academic and professional performance, may favor the internalization of rigid dietary standards, especially among young people. Although local research explicitly dedicated to orthorexia is limited, data regarding dietary restriction, perfectionism, and excessive control suggest the existence of relevant vulnerability factors.

Within this framework, investigating orthorexia from the perspective of personality dimensions and self-regulation styles becomes essential. The interaction between stable traits (such as heightened conscientiousness, neuroticism, or perfectionism) and rigid or hypercontrolled self-regulatory mechanisms may constitute an explanatory core for the development and maintenance of orthorexic tendencies. Such an approach allows going beyond an exclusively symptomatological perspective and opens directions for scientifically grounded conceptualization, prevention, and psychological intervention.

Conceptual delimitations regarding the concept of orthorexia

The term „*orthorexia*” was introduced in 1997 by physician Steven Bratman to describe the transformation of concern for healthy eating into a rigid, excessive, and potentially dysfunctional behavior. Etymologically, the term derives from the Greek *orthos* („*right*,” *„correct*”) and *orexis* („*appetite*”), suggesting the idea of a „*correct appetite*”.

Unlike anorexia nervosa, where the emphasis is predominantly placed on body weight control and quantitative restriction of food intake, orthorexia focuses on the perceived quality of food and its purity. The obsession does not concern the quantity consumed, but rather the conformity of food with a strict set of self-imposed rules regarding health, naturalness, or minimal processing [5, p. 12].

A distinctive element of orthorexic behaviors is that they are perceived as congruent with the individual’s personal values. This congruence reduces the likelihood of awareness of the problematic nature of the conduct and contributes to the maintenance and consolidation of restrictive patterns. From this perspective, orthorexia can be conceptualized as a multidimensional pattern involving the interaction between cognitive, emotional, behavioral, and social components:

- *At the cognitive level*, persistent and intrusive concerns related to the selection, preparation, and combination of foods are highlighted.
- From *an emotional perspective*, violation of dietary rules is often associated with intense anxiety, guilt, or heightened self-criticism.
- At *the behavioral level*, it manifests through severe dietary restrictions, rigid rituals, and avoidance of foods considered “impure.”
- At *the social level*, these behaviors may lead to isolation, relational difficulties, and limitation of participation in activities involving food in social contexts.

Orthorexia is thus defined as an obsessive concern with food perceived as „*correct*”, „*pure*”, or „*healthy*”, which, in its severe forms, may affect physical health, psychological balance, and the individual’s social functioning [5, p. 11-17].

In analyzing the relationship between orthorexia and personality structure, several psychological constructs are relevant. Personality represents the set of relatively stable traits that provide coherence and predictability to human behavior, including cognitive, affective, and volitional dimensions. Self-regulation refers to the individual’s capacity to monitor and adjust cognitive, emotional, and behavioral processes in order to achieve goals or adapt to environmental demands. Deficits or distortions in self-regulatory processes may contribute to the rigidification of eating behaviors. Perfectionism, characterized by excessively high standards and severe self-criticism, is frequently associated with restrictive tendencies and the need for strict dietary control. In the context of orthorexia, it may manifest through the pursuit of an „ideal” diet, without compromises or deviations. Cognitive rigidity, in turn, refers to the difficulty of modifying thinking schemes or behavioral strategies when context requires it. It is expressed through inflexible rules, low tolerance for ambiguity, and resistance to change, supporting the maintenance of obsessive-restrictive behaviors characteristic of orthorexia [1, 3].

Psychological dimensions of orthorexia

Orthorexia can be analyzed from a multidimensional perspective that integrates cognitive, emotional, behavioral, and social components. This approach allows understanding the phenomenon not merely as a concern for healthy eating, but as a complex structure of interrelated psychological mechanisms.

A. Cognitive dimension. The cognitive dimension occupies a central place in the conceptualization of orthorexia. Although the term was introduced by Steven Bratman, understanding the cognitive mechanisms involved can be achieved by reference to theoretical models developed in cognitive and cognitive-behavioral psychology. From the perspective of rational-emotive-behavioral therapy and cognitive-behavioral approaches promoted by D. David, dysfunctional behaviors are supported by irrational cognitions and rigid beliefs. In the case of orthorexia, the cognitive dimension includes:

- *Absolutist beliefs* („must" type needs), such as *„We must consume exclusively pure foods, otherwise the consequences are severe*".

- *Low frustration tolerance* – the difficulty of accepting deviations from the diet perceived as ideal.

- *Global negative self-evaluation* – the tendency to condition personal worth on strict adherence to dietary rules, whose violation leads to severe self-criticism and self-devaluation.

From the perspective of cognitive mechanisms, orthorexia involves distortions at the level of information processing and mental representations:

- *Perceptual selectivity* – predominant focus on food quality, origin, and processing, to the detriment of other life domains.

- *Polarized mental representations* – rigid classification of foods into dichotomous categories („pure" vs. „impure", „clean" vs. „toxic").

- *Excessive planning* – disproportionate allocation of cognitive resources to meal organization, reducing flexibility and availability for other activities.

Recent research highlights that the cognitive dimension of orthorexia is characterized by:

- dichotomous thinking („all-or-nothing" pattern);

- illusion of absolute control, whereby the individual attributes to diet the capacity to guarantee health or existential safety;

- confirmation bias, manifested through preferential selection of information validating beliefs about the dangerousness of certain foods.

Thus, orthorexia does not represent a simple orientation toward health, but a rigid, self-validating, and self-referential cognitive system [4, p. 103-105; 11, p. 78].

B. Emotional dimension. The emotional dimension of orthorexia can be analyzed through the process model of emotion regulation proposed by James J. Gross. Although Gross did not directly theorize orthorexia, his model provides a relevant explanatory framework for understanding how eating becomes a strategy for managing affects. Recent studies indicate that individuals with orthorexic tendencies use rigid dietary control as a compensatory mechanism for managing anxiety, uncertainty, or other negative emotions. The main mechanisms involved are:

- *Deficits in emotional regulation* – difficulty in identifying, accepting, and modulating emotions.

- *Inefficient use of cognitive reappraisal* – reduced capacity to flexibly reinterpret stressful situations, leading to externalization of control in the dietary domain.

- *Expressive suppression* – inhibition of emotional expression and substitution with a sense of self-control or moral superiority derived from adherence to diet.

From a functional perspective, orthorexic symptomatology may play the role of an „emotional regulator." Strict dietary control provides temporary anxiety reduction and a sense of stability, but reinforces dependence on food-related rituals. Research also suggests an association between severity of orthorexic symptoms and higher levels of alexithymia (difficulty identifying and describing emotions). In such cases, affective discomfort is „translated" into dietary rules, and emotional regulation becomes conditioned by adherence to self-imposed norms. Consequently, the emotional dimension of orthorexia is defined by the use of food as a primary strategy for affect management, increasing vulnerability to stress and rigidifying behavior [5, p. 15; 6, p. 275–278].

C. Behavioral dimension. From a behavioral perspective, orthorexia can be explained through learning mechanisms.

In classical conditioning (John B. Watson), initially neutral foods may become aversive stimuli through repeated association with alarmist messages about health risks. Thus:

- fear of foods perceived as „processed” or „toxic” is learned;
- stimulus generalization occurs, extending avoidance reactions to broad food categories.

Within operant conditioning (B.F. Skinner), orthorexic behaviors are maintained through reinforcement mechanisms:

- *Positive reinforcement:* social praise, online validation, sense of control or moral superiority.
- *Negative reinforcement:* reduction of anxiety associated with fear of illness.
- *Intermittent reinforcement,* making the behavior resistant to extinction.

At an observable level, the behavioral cycle includes excessive monitoring of labels and ingredients, systematic avoidance of certain foods, and temporary anxiety reduction, reinforcing the pattern. Over time, progressive restriction may lead to nutritional imbalances, weight loss, and impairment of daily functioning [7, p. 92–94].

D. Social dimension. The social dimension of orthorexia reflects the impact of eating conduct on interpersonal relationships and social integration. Main manifestations include:

- *Social isolation* – avoidance of events involving food due to inability to control ingredients.
- *Sense of moral superiority* – the diet is invested with ethical meaning, becoming an indicator of personal worth.
- *Self-punishment and social withdrawal* when self-imposed rules are violated.

Unlike anorexia or bulimia, where emphasis falls on quantity and body weight, orthorexia focuses exclusively on food quality:

- *obsession with quality* – the diet becomes so restrictive that it eliminates entire food groups considered “dangerous” (fats, sugar, preservatives, GMOs);
- *time devoted* – planning, purchasing, and preparing meals occupy much of the day, interfering with professional or educational activities;
- *physical consequences* – although the goal is health, severe restrictions may lead to malnutrition, significant weight loss, and hormonal imbalances [3; 7, p. 92–94].

Currently, orthorexia remains an intensely debated subject, often associated with social pressure exerted through social media and the intense promotion of „clean” lifestyles, which may contribute to consolidating orthorexic beliefs by amplifying external validation of restrictive behaviors. Socially, withdrawal from food-related contexts (social events, dining out), deterioration of interpersonal relationships, and progressive isolation are observed.

Overall, the analysis of the cognitive, emotional, behavioral, and social dimensions suggests that orthorexia does not represent an isolated phenomenon, but rather the expression of a complex interaction between personality structure and self-regulatory mechanisms (*see* Figure 1).

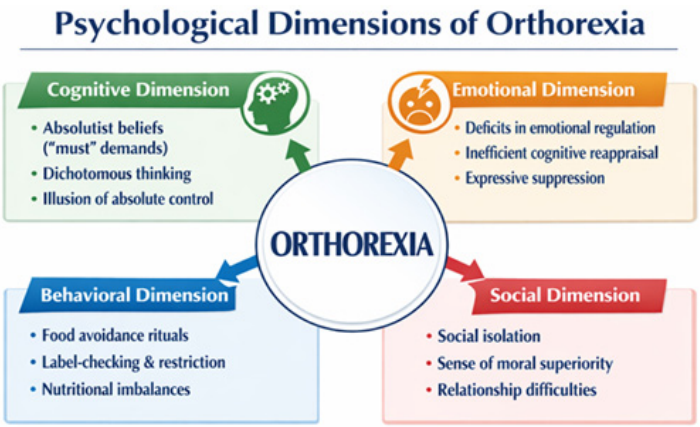

Figure 1. Psychological Dimensions of Orthorexia

In this context, the exploration of the main theories of personality and behavioral control becomes essential for understanding the individual vulnerabilities that may facilitate the development and maintenance of orthorexic behaviors.

For an in-depth understanding of the mechanisms underlying these manifestations, it is necessary to refer to the main theories of personality and self-regulation, which provide an explanatory framework regarding the structural vulnerabilities involved in the development of orthorexic behaviors.

A. The Five-Factor Model of Personality. A consistent theoretical framework is provided by the Five-Factor Model of Personality, developed by Paul Costa and Robert McCrae. This model postulates the existence of five fundamental dimensions of personality.

In the context of orthorexic eating behaviors, the specialized literature indicates a significant association with high levels of conscientiousness (manifested through excessive self-discipline and rigid rule orientation) and neuroticism (correlated with anxiety regarding health and food contamination). Thus, from the perspective of the Five-Factor Theory of Personality (McCrae & Costa, 2008), orthorexic behaviors may be correlated with high levels of rigidified conscientiousness and increased neuroticism. At the same time, self-regulation theory (Carver & Scheier, 1998) explains the tendency toward dietary hypercontrol through the excessive internalization of personal standards.

Complementarily, the multidimensional theory of perfectionism formulated by Paul Hewitt and Gordon Flett highlights the role of self-oriented perfectionism and socially prescribed perfectionism in the development of excessively restrictive dietary standards. The internalization of socially promoted ideals may lead to the establishment of rigid criteria regarding the "purity" of food, transforming eating behavior into an indicator of personal worth.

Moreover, obsessive-compulsive traits, such as cognitive rigidity, intolerance of ambiguity, and an intensified need for control, represent predisposing factors for the development of restrictive eating patterns. Thus, personality may constitute a vulnerability ground upon which orthorexic behaviors are structured. Maladaptive perfectionism represents one of the central variables, being associated with excessively high internal standards and severe self-criticism. At the same time, obsessive-compulsive traits–characterized by orderliness, rigidity, and an intensified need for control–may amplify vulnerability to the development of an orthorexic pattern. Within this framework, orthorexia may be interpreted as the behavioral expression of a personality structure oriented toward control, order, and error avoidance [3, 9].

B. Theories of Self-Regulation and Behavioral Control. Self-regulation represents the process through which the individual monitors and adjusts behaviors in relation to internal standards. From a dynamic perspective, orthorexic behaviors can be analyzed through the lens of the self-regulation theory proposed by Charles Carver and Michael Scheier. According to this cybernetic model, behavior is guided by a system of continuous feedback between internal standards, performance monitoring, and action adjustment. When standards become excessively rigid and behavioral monitoring is hyperactivated, self-regulation may acquire a maladaptive character.

In the case of orthorexia, dietary standards are internalized in the form of inflexible rules, and the constant monitoring of food intake leads to overcontrol and anticipatory anxiety. Thus, the mechanism of self-regulation, normally adaptive, becomes a source of rigidity and behavioral restriction. From the perspective of self-regulation theory, orthorexic behaviors can be interpreted as the result of a distorted feedback system, in which evaluation criteria are exaggerated and moralized. Emotional regulation becomes mediated by adherence to dietary norms, generating a behavioral dependence on diet control [2, p. 402–405].

C. Self-Determination Theory. Self-Determination Theory, formulated by Edward Deci and Richard Ryan, provides an additional analytical framework by distinguishing between autonomous motivation and controlled motivation. In the context of orthorexia, motivation may be predominantly controlled, determined by external pressures or by the rigid internalization of social norms regarding health and the ideal body. The lack of satisfaction of fundamental psychological needs—autonomy, competence, and relatedness—may intensify compensatory behaviors centered on dietary control [11].

D. The Process Model of Emotion Regulation. The process model of emotion regulation developed by James Gross allows the conceptualization of orthorexia as a strategy for managing negative emotions.

Dietary restriction may function as a mechanism for reducing anxiety, offering the illusion of control and psychological stability [6].

E. The Integrative Theoretical Model (Integrative Dimensional Model). The integrative theoretical model describes orthorexia nervosa as an eating behavior disorder situated at the intersection between classical eating pathologies and disorders within the obsessive-compulsive spectrum. This model was recently proposed by Octavian Vasiliu (2023). From an integrative perspective, orthorexic eating behaviors can be understood within the vulnerability–stress model, according to which personality predispositions interact with socio-cultural factors and self-regulatory mechanisms.

The model proposes the following perspectives on orthorexia:

- *Dimensional classification* – orthorexia is included within a framework that accommodates both standard diagnoses (anorexia, bulimia) and emerging entities.
- *Symptomatological core* – the presence of obsessive thoughts related to „healthy” meals and lack of flexibility regarding daily dietary composition.
- *Motivational dynamics* – unlike anorexia, where the primary motivation is weight loss, in orthorexia the central focus is the avoidance of illness and the maintenance of dietary purity, even if the final result may be malnutrition.
- *Integrative consequences* – excessive preoccupation leads to significant clinical impairments, both medical and psychosocial (social isolation, intense fears related to food).

This theoretical model serves as a tool for stimulating clinical and epidemiological research, offering a conceptual structure for conditions that are not yet fully recognized in diagnostic manuals, such as DSM-5.

The integration of personality dimensions and self-regulation styles allows the formulation of a coherent explanatory model: traits such as perfectionism, cognitive rigidity, and neuroticism interact with a hypercontrolled self-regulatory style, generating qualitatively restrictive eating behaviors. Socio-cultural pressure and the idealization of health act as triggering factors, while the maintenance of the behavior is supported by the temporary reduction of anxiety through adherence to self-imposed rules.

Thus, orthorexia may be conceptualized not only as an emerging eating disorder, but as the manifestation of a complex dynamic between personality structure and dysfunctional self-regulatory mechanisms. Therefore, orthorexia cannot be reduced to a simple dietary preference, but represents the result of a complex configuration of structural factors (personality dimensions) and dynamic factors (self-regulatory mechanisms), mediated by the contemporary socio-cultural context [3].

The scientific literature of the last two decades highlights a growing interest in the investigation of orthorexia, both from the perspective of conceptual delimitation and the identification of psychological correlations and predisposing factors. Although this clinical entity is not officially included in diagnostic systems (DSM-5-TR, ICD-11), numerous empirical studies support the existence of a distinct behavioral pattern characterized by dietary rigidity, perfectionism, and obsessive concern with the „purity” of food [7].

Research conducted by Poyraz and colleagues (2015) revealed significant correlations between orthorexic tendencies and obsessive-compulsive traits, suggesting that the cognitive mechanisms involved include rigidity, hypercontrol, and dichotomous thinking.

In the same direction, studies by Barrada and Roncero (Italy, 2018) demonstrated consistent relationships between orthorexia and maladaptive perfectionism, particularly the dimension oriented toward excessively high personal standards [8].

Analyses conducted by Strahler and colleagues (2018) indicate the presence of moderate associations between orthorexia, anxiety, and depressive symptomatology, suggesting that excessive concern with „correct” eating may function as a compensatory mechanism in managing emotional distress. Furthermore, Novara and colleagues (2021) identified overlaps between orthorexia and classical eating disorders, highlighting diagnostic delimitation difficulties.

According to the conceptualization proposed by Bratman (2017), orthorexia can be understood as an evolutionary phenomenon structured in two distinct yet interdependent phases. In the initial phase, the individual voluntarily adopts a healthy dietary style, motivated by the legitimate desire to improve health and quality of life. At this stage, eating behaviors are functional and adaptive. Subsequently, however, in

the context of preexisting psychological vulnerabilities (perfectionism, cognitive rigidity, heightened need for control), concern with food progressively intensifies and acquires an obsessive character. The healthy diet transforms into a rigid system of self-imposed rules, and their violation generates guilt, anxiety, and severe self-criticism. Thus, eating behavior becomes central to the organization of daily life, affecting social, emotional, and occupational functioning. This process-oriented perspective allows for a clear distinction between normative interest in health and pathological manifestations of orthorexia, where behavioral flexibility is replaced by cognitive rigidity and internal constraint [8].

By analyzing these studies, etiological and risk factors in the manifestation of orthorexia can be identified. The etiology of orthorexia is multifactorial and includes psychological, social, and cultural factors:

1. *Psychological factors:*
- perfectionistic personality traits;
- cognitive rigidity;
- increased need for control;
- obsessive-compulsive tendencies;
- anxiety vulnerability.

2. *Socio-cultural factors:*
- social pressure regarding a "healthy" lifestyle;
- idealization of the body and health in mass media;
- influence of social networks and nutrition influencers;
- proliferation of restrictive diets promoted as universal solutions.

3. *Contextual factors:*
- previous experiences related to illness;
- trauma or stressful events;
- professions centered on body image (athletes, models, fitness instructors).

In contemporary societies, where health is valued not only as a biological state but also as a moral and identity indicator, orthorexia may also be interpreted as the expression of a cultural pathology of control performance. Contrary to the initial intention of optimizing health status, orthorexia may generate significant negative effects: physical consequences, psychological consequences, and social consequences:

1. *Physical consequences:*
- malnutrition;
- vitamin and mineral deficiencies (especially vitamin B12, iron, calcium);
- demineralization of the skeletal system;
- gastrointestinal disorders;
- cardiovascular problems associated with nutritional imbalances;
- excessive weight loss.

2. *Psychological consequences:*
- increased anxiety;
- social isolation;
- risk of comorbidity with depressive or obsessive-compulsive disorders.

3. *Social consequences:*
- deterioration of interpersonal relationships;
- family conflicts;
- difficulties in professional integration [7].

Conclusions

The integrative analysis of the specialized literature and available empirical data supports the conceptualization of orthorexia as a transdisciplinary construct situated at the intersection of eating behaviors, cognitive processes, and personal self-regulatory mechanisms. Although it is not included as a distinct diagnosis in international nosographic systems, orthorexia represents a relevant phenomenon from a psychological perspective due to its implications for individual and social functioning.

Its specificity lies in the rigid focus on the perceived quality of food and in the transformation of eating behavior into an instrument of identity self-regulation. Unlike anorexia nervosa, where the emphasis is predominantly placed on quantitative restriction and body weight control, in orthorexia centrality is given to purity, nutritional value, and the conformity of food with internalized personal standards. This orientation may lead to progressive restrictions, nutritional imbalances, and deterioration of overall health status, despite the declared intention of optimizing lifestyle [10].

From a cognitive perspective, the phenomenon is associated with rigidity in information processing, perfectionism, and an intensified need for control, as well as with the structuring of dichotomous evaluative schemes regarding food. The internalization of dietary norms as absolute personal values gives the behavior an individualized character, which reduces openness to critical reevaluation and contributes to the maintenance of maladaptive patterns. The emotional dimension is marked by anxiety and guilt associated with deviations from self-imposed rules, while the social dimension may include withdrawal, integration difficulties, and relational tensions generated by the rigidity of dietary standards [4].

Overall, orthorexia can be understood as the expression of the interaction between cognitive, motivational, and socio-cultural factors within a contemporary context that values ideals of health, purity, and self-control. The boundary between adaptive eating behavior and rigid-excessive conduct thus becomes gradually blurred, imposing the need for an interdisciplinary approach aimed at clarifying the conceptual status of the phenomenon, identifying the self-regulatory mechanisms involved, and developing preventive strategies intended to promote a balanced relationship with food and lifestyle.

Future Research Directions

Given the multidimensional character of orthorexia, future research should aim to clarify its nosological status and rigorously differentiate it from other eating disorders and disorders within the obsessive-compulsive spectrum. Longitudinal studies are necessary to investigate the role of personality traits - such as maladaptive perfectionism, neuroticism, and cognitive rigidity - in predicting the development of orthorexic behaviors.

Additionally, exploring self-regulation mechanisms and emotional regulation strategies may contribute to understanding the initial adaptive function and its transformation into a maladaptive pattern. Analyzing the influence of socio-cultural pressure and exposure to digital content promoting restrictive dietary ideals represents another relevant direction, especially among young populations.

Last but not least, the development and validation of psychometric instruments sensitive to differentiating between healthy concern for nutrition and its pathological manifestation, as well as the evaluation of the effectiveness of specific psychotherapeutic interventions, constitute essential priorities for consolidating the empirical foundation of the field.

Overall, the integrative investigation of structural factors (personality dimensions) and dynamic factors (self-regulatory mechanisms), in interaction with socio-cultural variables, may contribute to outlining a coherent explanatory model of orthorexia and to substantiating appropriate prevention and intervention strategies.

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