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The Dark and Comforting Side of Night Eating: Women's Experiences of Trauma

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Abstract: Objectives: Night eating syndrome (NES) is classified as a delay of food intake, reflected by consuming large amounts after the evening meal or ingesting food after sleep onset (DSM-5). This article aims to describe NES experience, awareness, narratives, and behavior from the perspectives of patients with NES in light of their history of traumatic life events. **Method:** Semi-structured interviews based on the phenomenological approach were conducted with 18 women (aged 19–60) diagnosed with NES. **Results:** The analysis raised two themes: 1. References to NES as an experience that represents the darker sides of patients' behaviors and involves helplessness, contempt, self-loathing, and a loss of control. Patients also related to difficult memories concerning sexual, physical, and emotional abuse. 2. References to the comforting side of NES patients' behaviors that involves soothing, regulating, emotional disconnecting, and a sense of calm, control, and the ability to function. **Conclusion:** Findings present the relationship between traumatic life events, dissociation, and EDs. Clinically, they highlight the importance of an early assessment and a traumatic life history and suggest giving special treatment attention to the role of dissociation and night eating as regulatory mechanisms in the therapeutic process and alliance.

Keywords: night eating syndrome; trauma; eating disorders; qualitative study; women

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1. Introduction

A growing body of research over the last five decades has indicated a consistent rise in the prevalence of eating disorders (EDs), especially among young women in industrialized modern Western societies. EDs are complex psychiatric illnesses characterized by objective disturbances in eating patterns and probably originating in the interplay of psychosocial, biological, and genetic factors [1]. The most common EDs are anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorders (BED), and other specified feeding and eating disorders (OSFED). Night eating syndrome (NES) is currently classified as an OSFED according to the Diagnostic Statistical Manual-5 [2] and based on a definition composed by an international NES working group comprising sleep and EDs experts that convened in Minneapolis in 2008 [3].

NES is conceptualized as a delay in the circadian pattern of food intake, reflected by two core criteria: (1) evening hyperphagia, namely, a large caloric intake after the evening meal, and (2) nocturnal ingestion, namely, the ingestion of food after sleep onset [2,3]. Psychological and psychiatric comorbidity factors play a significant role in the etiology of EDs, including NES [4–8].

One of the risk factors related to levels of psychopathology, psychiatric comorbidity, symptom severity, and poorer prognosis in EDs is a history of traumatic life events and maltreatment [9,10]. The relationship between traumatic life events and EDs has been

widely reported, focusing mainly on sexual abuse. Childhood maltreatment, including sexual, physical, and emotional abuse and physical and emotional neglect, has also been found to be a significant risk factor for EDs [9].

However, only a few quantitative studies have examined the history of traumatic life events and childhood maltreatment of patients with NES [7,11]. In one recent quantitative study, Latzer et al. (2020) [12] examined childhood maltreatment and levels of psychopathology in women with BN or BED with and without NES compared to healthy controls. They recruited 426 women (aged 18–60), of whom 158 had EDs, with and without NES, and 268 were controls. The results indicated no significant differences for most variables within the ED subgroups except for physical neglect, which was more prevalent in NES with BED than the healthy control. Child maltreatment rates significantly differed between EDs and the healthy controls in sexual abuse (27.6% vs. 12.3%, respectively, $p < 0.001$), physical abuse (20.1% vs. 6.7%, $p < 0.001$), physical neglect (46.8% vs. 19.4%, $p < 0.001$), emotional neglect (33.1% vs. 12.3%, $p < 0.001$), and emotional abuse (48.7% vs. 14.2%, $p < 0.001$).

To the best of our knowledge, no qualitative study has examined the experience, awareness, and narratives of NES from the patients' perspectives in light of their history of traumatic life events and childhood maltreatment. The current article, therefore, aims to fill this knowledge gap.

2. Method

This article uses a qualitative design as a suggested approach to studying the newly complex phenomenon, as it allows for an investigation of participants' experiences, perceptions, and meanings in their own words [13].

2.1. Participants

Qualitative research is based on a small sample size of individuals who intensively experienced the phenomenon under study [14]. Therefore, we used 82 in-depth interviews conducted for ED treatment assessment with patients diagnosed with NES. All assessment interviews were designed as semi-structured interviews with standardized questions for all patients. These interviews formed an integral part of a semi-structured diagnostic interview process conducted in the clinical practice of the eating disorders (EDs) institution. The research team meticulously reviewed all 82 interviews; some offered more extensive, informative, and expressive responses. From this pool, 18 interviews were selected for this study due to their inclusion of the most detailed and expressive information (that included a wealth of information describing the patient's experience of the illness and its consequences). There is much debate in the literature about the necessary sample size to reach saturation in qualitative data analysis. It has been argued that the sample size should reflect the thematic analysis, which cannot be determined before the data analysis takes place [15]. We, therefore, believe that 18 participants is a sufficiently representative sample for the topic under examination here, and we selected only the detailed interviews for use as material for our content analysis.

Regarding demographic details, the participants were Hebrew-speaking women aged between 20 and 70 with a BMI of 22.2–46.7 (17% average weight, 83% including being overweight, obese, or morbidly obese). Of the 18, 61% were born in Israel (11 women), while the rest had immigrated to Israel. Among the 18 women, 55% were married, 45% lived by themselves, either separated (28%), single (11%), or widowed (5.5%), and they had 0–4 children. Levels of education ranged from elementary school (17%) to high school (50%) and higher education (33%).

Regarding the participants' clinical details, 56% reported childhood sexual abuse, mainly by a family member; 67% reported physical abuse, mainly by parents; 78% reported emotional abuse, mainly related to weight or eating issues; and 78% reported emotional and physical neglect, mainly the absence of parents. All the participants reported one or more other traumatic events, such as death, illness, immigration, being second-generation

Holocaust survivors, and others. All were diagnosed with psychiatric comorbidity, primarily depression, anxiety, PTDS, and OCD, and all reported having physical comorbidity, primarily morbid obesity, hypothyroidism, fibromyalgia, sleep apnea, and insomnia. Demographic and clinical information was gathered from the patient's records, and the traumatic life events were collected from the patient's charts as described by the patients during the in-depth interviews.

All the participants had been referred for diagnostic and treatment assessment at the ED treatment center in the north of the country. Exclusion criteria included men, a diagnosis of AN, severe psychiatric comorbidity (psychosis), and a diagnosis of sleep-related eating disorders. Inclusion criteria included a diagnosis of NES according to the DSM-5 [2,3]. Only patients with NES-night ingestion (NES-NI) (waking up at least twice a week for at least six consecutive months, having uncontrolled binge eating episodes in the middle of the night after sleep onset, and then going back to sleep) were selected.

2.2. Data Collection

This article is a retrospective qualitative study based on in-depth interviews conducted with patients diagnosed with NES-NI as part of an assessment process for diagnosing and treating EDs. The semi-structured interviews included open-ended questions that enabled the interviewee to answer by describing their personal experiences and the interviewer to add unplanned questions asking for clarification and further exploration of their answers [16]. The interviews included questions about the course of their illness, background history including traumatic life events, family information, and current clinical and functional status. This made it possible to collect information directly and to gain in-depth insight into the patient's narrative, perception, and experience of their illness. The interviews lasted one and a half to two hours, and the transcriptions were written during the interview by the interviewers, who were psychotherapists experienced in treating EDs in general and NES in particular [16]. The study was approved by the Ministry of Health and the hospital's Helsinki Ethics Committee (RAB-0389-09).

2.3. Analysis

The researchers used thematic analysis to identify themes from the data (Braun and Clarke, 2013) [15] and implemented six steps: (1) familiarizing themselves with the data; (2) repeatedly reading the interviews; (3) producing initial units of meaning; (4) grouping the units of meaning into themes; (5) evaluating the themes and writing the analysis; and (6) formulating the themes and sub-themes emphasizing the participants' experiences [17].

The first and second authors transcribed the 18 interviews conducted during the assessment period and were selected for this research. They meticulously reviewed each transcript at least three times to gain a thorough understanding of the data. Subsequently, the data underwent a rigorous coding process, with all codes subject to review and discussion with the co-authors. Collaborative decisions were made to ensure consensus and support for each identified theme.

3. Findings

Two central themes about the patients' experience of night eating emerged from the thematic analysis of the interviews. The first theme refers to night eating as an experience that represents the darker sides of patients' behaviors, involving helplessness, contempt, self-loathing, and loss of control. Patients also related to difficult memories concerning sexual, physical, and emotional abuse and neglect. Some patients linked their experience of NES-NI with their difficult memories, but most described the difficult memories without necessarily linking them to their night eating. The second theme refers to night eating as a soothing experience that offers comfort while also regulating and disconnecting, which facilitates, to a certain extent, a sense of calmness and control and the ability to function (see Table 1).

3.1. Theme 1: The Dark Side of Night Eating

Many patients described their experience of night eating as accompanied by a sense of loss of control in overeating, feelings of self-disgust and self-hatred, fullness and heaviness throughout the night following the binge eating episode and the following morning, and difficulty eating until lunchtime (morning anorexia). They reported despising themselves and being angry at their inability to control their eating, describing the food and eating as the source of all the problems in their lives, especially being overweight. They also described enduring traumatic life experiences, such as severe physical, emotional, or sexual abuse, and physical and emotional neglect by, primarily, family members who should have protected them but who, instead, left them in a state of loneliness and helplessness with uncontrolled feelings.

3.1.1. Loss of Control Overeating: "I Eat My Heart Out in the Refrigerator"

Patients portrayed their experiences of night eating as involving a total loss of control: they wake up in the middle of the night, rush to the refrigerator, and eat indiscriminately. In the words of patient no. 17, "Food attacks me; it has taken control over my life." They reported that this eating behavior is not necessarily a result of physical hunger; rather, it is linked to the sensation of a "black hole" that cannot be filled or satisfied and disrupts their lives. For example, patient no. 14 stated:

> I eat very quickly, barely chewing, mix everything and eat as if I were a vacuum cleaner: spicy, sour, sweet, salty, everything mixed, indiscriminately, an entire pack of ice cream, two bars of chocolate, crisps, puddings, and then I wake up with heartburn. . . I go shopping every three days, I can't control it.

Likewise, patient no. 6 reported:

> The TV is on all night. . . I can't stop gorging on nuts and sunflower seeds. . . I have no control over quantities. . . when I start eating, I want more and more. . .. It has nothing to do with hunger; there is a huge hole that will never be filled. I eat until I explode and then fall asleep. . .. I feel like an injured, bleeding animal.

3.1.2. Feelings of Disgust and Shame Related to Eating: "I Am Fat and Disgusting"

Patients described their night eating as an experience that involves feelings of suffocation, disgust, shame, rejection, and self-contempt. They also disclosed feelings of shame in front of their children and spouses. They described their unpredictable episodes of uncontrolled eating metaphorically in animalistic terms. For example:

> In the evenings, I become a predator; in the morning, I am disgusted by the horror in the bed—the food I have taken with me. (patient no. 18)

> I am ashamed to eat next to other people because I feel disgusted; I feel like an animal, something embarrassing. (patient no. 13)

> I eat without stopping, day and night, regardless of the time and the day, there is no [sense of] hunger or satisfaction. . .everything comes in a cycle of crazy binge eating. I cram food into me. . . I feel suffocated. I can open the refrigerator at night, usually at 3 a.m., it's really disgusting. (patient no. 6)

> I finish the kids' food and spend 2000 shekels [USD 600] on groceries. My husband sees the packages, and I am so ashamed. . . My body repulses me; I have rashes because of the sweating. . . I am fat and disgusting. (patient no. 14)

3.1.3. Memories of Sexual, Physical, and Emotional Abuse: "I Was Brought Up with Beatings"

Patients also talked about their sense of loss of control concerning painful memories from their past, which included sexual, physical, and emotional abuse, as well as physical and emotional neglect. While they did not link these complicated feelings from their past to their night eating, they did mention them as painful memories associated with loss of

control, helplessness, pain, and self-disgust. The same emotions emerged in descriptions of their night-eating behavior. Their descriptions of past traumatic events included physical and sexual abuse they experienced as an invasion of their body accompanied by pain, confusion, and a feeling that their body does not belong to them but is an object for fulfilling the other's needs. They did not explicitly link these difficult feelings to their night-eating behaviors.

Regarding their sexual abuse, the patients reported a loss of control and helplessness in the face of the abuser, alongside feelings of guilt and isolation. Patients described the experience of eating as a means of distancing themselves from the abuser by getting fat and making themselves repulsive:

> When I was 10, I was hungry for attention. I was afraid not to please. Mum would only come home at 6 pm. . . I was alone. . . [While alone at home], the sexual abuse began, initially with touching by my relative. Until my engagement day, I was scared not to please him. Being overweight helped me later to stop him from touching me. (patient no. 6)

> When I was eight or nine, I was sexually abused by my uncle and my grandfather. The story came out only two months ago during my latest hospitalization when we talked about my night-eating episodes. Only now am I able to say that I am not to blame. (patient no. 7)

> My dad sexually abused us, especially the older girls. . . I didn't understand what was happening. He tried to touch us all the time. . . I wrapped myself in my sheets to make it difficult for him to get to me. (patient no. 4)

Patients portrayed a similar lack of control, helplessness, and defenselessness in their painful memories of physical and emotional abuse. In descriptions of the former, they emphasized their sense of confusion and unexpectedness both before and after the abuse:

> Dad threw and broke chairs over me, my sister, and my mum; we were hit on the head, on the back. . . As a child, I didn't understand how a person could flip by 180 degrees, loving you [one moment] and then suddenly throwing a chair at you. (patient no. 1)

> From the age of 11 to 16, my mum used to beat me up. If I did something wrong, I knew it would come. . . Dad would say to her: "Deal with her." I would lie in bed, and Mum would have her fists on me. I wouldn't show that it hurt, and she just kept on hitting me. (patient no. 3)

> I was brought up with beatings. Mum would get into a rage and hit me with a slipper. . . she had attacks of anger about things we did, if we woke [her] from a nap, or did something terrible. . . Dad was distant. (patient no. 5)

In their descriptions of emotional abuse, patients focused on experiencing extreme criticism, rejection, and humiliation, mainly around issues of weight, eating, and appearance:

> Dad would look at me and my sister and say to our faces with no filter: "Wow, how fat you got. . . He was constantly mocking me about my weight, commenting about me being fat and that I shouldn't be eating too much. . .I was prevented from eating fattening foods. . . Until I got married, I used to hide a pita under my pillow. . . and eat in secret." (patient no. 9)

> Mom used to say that what determines how you do in life is whether you are thin. If you look good, life will be good. You'll find a boyfriend, find a job. (patient no. 11)

> Dad always laughed at me, telling me that I was fat and stupid. . . "What are you worth?. . . In the army [Israel has compulsory military service for 18-year-old girls and boys], they will need to make your clothes from tents, you will never succeed in life." (patient no. 10)

3.1.4. Memories of Physical and Emotional Neglect: "There Was no Food at Home; We Were Alone"

This fourth sub-theme includes a further dominant experience among the patients of memories related to physical and emotional neglect. This was described in most of the interviews as involving a lack of control, security in the family, and parental presence alongside feelings of isolation:

> There was no food at home, we were alone... No one took care of us. I raised my four siblings on my own, sometimes not eating so that they could eat. (patient no. 4)

> I was nine, I had no cooked food, and no one was waiting for me after school to serve me a hot meal. I was thrown from one [sisters'] house to the next. (patient no. 6)

> Mum was very ill and never came back to herself afterward. The financial situation at home was very difficult, and my dad was unemployed for a long time... his business collapsed... We [my siblings and I] were alone a lot. (patient no. 13)

> When I was about seven, my parents got divorced. My mum had a boyfriend who used to beat me terribly from the age of eight because I couldn't fall asleep at night and was afraid to sleep. I slept on the floor, and my mum didn't help me... she let him beat me... she didn't intervene. (patient no. 14)

To conclude, the first theme, the dark side of night eating, portrays the experience of night eating as representing the patients' painful and damaging feelings and behaviors, involving lack of control, helplessness, contempt, and self-disgust for their animalistic and uncontrolled eating. Patients described experiences and sensations involving loss of control pertaining to difficult memories of sexual, physical, and emotional abuse and neglect. Some linked their night-eating experiences with these difficult memories, but most described their experiences without making this explicit connection.

3.2. Theme 2: The Comforting Side of Night Eating

The second theme emerging from the interviews describes night eating as an experience that comforts and calms and, thus, provides the patients with a certain level of control over their lives. The patients portrayed night eating as a type of regulator aimed at reducing the pain and attempting to fill the "black hole" within them—a hole which, in their experience, can never be filled. They also experience night eating as a solution for falling asleep and sleeping well, relieving loneliness, disassociating from difficult emotions, and, to some extent, enabling daily functioning: as explained by Patient No. 9, "Feeling nice in the tummy while feeling sad in the head."

3.2.1. Food as Relaxing and Calming: "Food Is Comforting and Quiets My Thoughts"

The patients described the food during night eating as a type of mechanism aimed at reducing painful obsessive thoughts and memories. In their experience, their night eating comforts and suppresses these thoughts and enables them to fall asleep and to function and serves as a distraction.

> When I eat crisps, it calms me, and then I think about what to do with my life. I am worried and scared [about] everything in my life [so I] turn to food; it's the solution for everything, especially in the small hours of a difficult night. (patient no. 2)

> The hardest part is the craziness in my head; there are so many thoughts [so] I need food to relax... The first thing I think about and go to is good food, OK... I go and eat, it doesn't matter what... in difficult situations, I might eat a schnitzel even though I'm vegetarian. (patient no. 13)

> When I was 26, I would sleep during the day, stay awake at night, and eat. There were several times when I went to sleep and got up to eat in the middle of the night, even when I was staying at my sister's... The hardest part is the craziness in my head; there are so many thoughts [so] I need food to relax. (patient no. 17)

> I always have snacks with me so that I have something to help me relax. . .
>
> Food is an enabler of sleep. (patient no. 8)
>
> In order to sleep well, I fed myself any available carbohydrates to get a sense of heaviness, as something that could help me fall asleep. . . Falling asleep for an hour, waking up, eating, falling asleep. (patient no. 15)

3.2.2. Food as a Tool for Filling the Emptiness: "I Feel like a Black Hole"

The patients described the food consumed during night eating as a type of tool for filling the "black hole", namely, the emptiness within them. They claim that nothing can fill this emptiness and regard the refrigerator as a powerful source of fullness. Food serves as a mechanism of comfort and compensation.

> I opened the refrigerator and cupboard 20 times in search of something to eat, I could eat anything that moves. . . I feel I must do something so as not to feel anything; it doesn't matter if I ate before; I want to gobble down food when I don't want to feel something. . . It has nothing to do with hunger, it's beyond that. (patient no. 13)
>
> There is a deep hole that will never be filled. . . I feel like a black hole, and there is an internal void. I give so much of myself, I need to be OK with the entire world; there is no source that fills me, nothing, absolutely nothing, so the refrigerator is my permanent address. I'm fed up with moving mountains, managing the world, and being emptied from the inside. (patient no. 1)

3.2.3. Food as a Way of Having Some Control over Life: "I Have Created the Kingdom of the Night"

The patients described the food consumed during night eating as giving them a sense of control over life. They claim that the only way to restore their self-control is to control what they eat and how much they eat. For example:

> I have no room in life. I don't do what I want, I'm no mother of the year, no wife of the year, I don't give my husband what he deserves, I don't have any strength, and so I have created the kingdom of the night. There is silence; I eat what I want. (patient no. 11)

3.2.4. Food as a Way of Dissociating from Reality: "I Go Back to Being the Beautiful Girl"

Many patients described their night eating as an experience of disconnection and dissociation, which takes them away from their difficult emotions. For some, this is experienced as depersonalization, as if it is not, they themselves who are eating; for others, it is derealization—they find themselves in the kitchen eating without knowing how they got there and experience a complete loss of control as well as a sense of disconnecting and splitting from their body. Nonetheless, this may also allow them to be somewhat connected to life. They reported managing their night eating as a different and separate person from the one who functions during the day:

> When I get up at night, I am an ageless human being, escaping childhood because there, I don't feel the loneliness at night; I go back to being the beautiful and well-treated girl. (patient no. 8)
>
> Those who regard their night eating as depersonalization explained it as follows:
>
> It is as if I have two entities within me—one that wants to eat and one that wants to stop eating and—they observe me from the side. I am ageless, and for me, nothing is simple or normal. . . I feel like a balloon is about to burst. (patient no. 16)
>
> It's not me eating, it's someone else. (patient no. 17)
>
> I have in me "Georgette", [a woman] who looks on and tries to make me not eat, and I have "Odette", [a woman] who eats. I keep feeling that the guarding

> person within me [the Georgette in me] splits off from me and cannot stop me from eating. (patient no. 18)

Likewise, patient no. 12, for whom night eating is derealization, reported:

> It happens like this: I'm sleeping, and it's as if someone wakes me up and tells me to wake up. . . then I find myself eating from small quantities to crazy amounts.

To conclude, the second theme describes night eating as a "guardian angel" that provides a sense of security and comfort—a sort of friend that helps calm them and dissipates loneliness, especially in the middle of the night. Night eating was also portrayed as a dissociating experience, reminiscent of coping mechanisms for dealing with bad memories of traumatic life events and enabling daily functioning.

Table 1. A summary table of the main themes and sub-themes.

Themes / Sub-Themes	The Dark Side of Night Eating	The Comforting Side of Night Eating
1.	Loss of control overeating	Food as relaxing and calming
2.	Feelings of disgust and shame related to eating	Food as a tool for filling the emptiness
3.	Memories of sexual, physical, and emotional abuse.	Food as a way of having some control over life
4.	Memories of physical and emotional neglect	Food as a way of dissociating from reality

4. Discussion

The relationship between childhood trauma and eating disorders has been widely reported, with a particular focus on sexual abuse [10]. Childhood maltreatment has also been found to be a nonspecific risk factor for EDs [9]. Only a few quantitative studies have examined the history of traumatic life events and childhood maltreatment among patients with NES [7,11,12]. To the best of our knowledge, no qualitative research has examined NES patients' own experience of their night eating behavior. This article, therefore, aimed to fill this gap by describing and better understanding patients' perspectives and experiences of night eating in light of their history of traumatic life events.

The thematic analysis of the semi-structured interviews raised two central themes. The first refers to night eating as representing the darker side of patients' behaviors and feelings around food and eating, which involves loss of control, helplessness, contempt, and self-loathing. Similarly, patients described feeling a loss of control in relation to difficult memories involving sexual, physical, and emotional abuse and neglect. While some patients made explicit connections between their night eating behaviors and feelings and these difficult memories, most described similar experiences without necessarily linking them to each other. The second theme refers to night eating as representing the comforting side of patients' behaviors around food and eating, which involves soothing, regulating, and emotional disconnecting and, thus, facilitates, to a certain extent, a sense of calm and control and the ability to function.

The dark and comforting sides of the experience of night eating may reflect a vicious cycle within which patients with NES are trapped while using the symptom as a vehicle. Therefore, as with any other ED, NES serves as a tool for managing negative emotions when lacking the ability to escape or resolve the pain.

The patients portrayed night eating as a "monster" and the source of all the harm in their lives—an igniter of past traumatic experiences and memories. At the same time, they also regarded night eating as a "guardian angel" that provides a sense of security and comfort and helps them with their loneliness late at night. Eating during the night was also experienced as an escape door through which the patients can disconnect from painful

memories and distress: a refuge from difficult life events, reminiscent of mechanisms for coping with past trauma, which enable reasonably daily functioning.

Despite the many traumatic events experienced and their physical and emotional distress, most patients expressed pride in their ability to function in their daily lives, support their families, take care of their children, and cope with life's challenges. This pride may be related to the feeling they expressed that the only thing they cannot control is their night eating. Paradoxically, it may be their night eating that helps them regulate their memories and daily hardships and enables them to function reasonably well in their everyday lives.

The vicious cycle experience of "monster" and "guardian angel" binge eating episodes at night is circular and allows momentary relief, comfort, regulation, relaxation, and even a certain level of functioning; however, the relief is temporary, and the pain recurs and requires reregulation. This is how the trauma is reproduced through the symptoms, which hurts and comforts at the same time. This circle is also reflected in the experience of the symptom itself, namely, binge eating episodes at night accompanied by a loss of control, which contrasts with the relatively good day-time functioning described by most of the patients: as one of the patients described, "During the day I'm an angel [but] at night I'm a monster." As mentioned above, dissociation and disconnecting can sometimes play a positive role in dealing with difficult life events by becoming the main mechanism for coping with daily difficulties) [18]. Night eating can, thereby, serve as a multiple disconnection from the wounded girl, the painful memories, and daily hardships: a mixture of detachment from the self, the past, and everyday life.

One of the possible explanations for this vicious cycle is that the comforting side of night eating is compensation for the inner emptiness and loneliness that characterize victims of sexual assault and children who experience emotional and physical neglect [19] Eating, thus, offers feelings of fullness, satiety, relaxation, and comfort, albeit only temporarily. On the other hand, the dark side of eating represents the deep feelings of guilt and self-punishment that also characterize victims of sexual and physical assault and neglect. The abused girl believes that she is partially responsible for the injury, neglect, and rejection and, therefore, self-punishment and self-harm to the internalized objects through episodes of night eating offer a certain sense of relief [20] This vicious cycle can also refer to the dissociative detachment that characterizes people who have experienced traumatic life events [21]. Indeed, patient no. 17 stated: "I just found myself in the kitchen, I don't know how I got there. . . it wasn't me, someone else took me there."

These findings support and strengthen results from previous quantitative studies demonstrating the relationship between a history of traumatic life events in early childhood and the development and maintenance of EDs, as well as their high severity and bad prognosis [22,23]. The current study findings are also in line with previous findings indicating that ED symptoms serve as a mechanism linking a patient's history of childhood trauma and difficulty regulating psychobiology systems that relate to various emotional problems, including EDs [24]. They are also supported by a recent review of qualitative meta-synthesis on the emotional development of EDs, which indicates that Eds function as a major regulator of negative emotions [25].

It is, therefore, suggested that EDs in general and NES in particular can, paradoxically, serve as one of the coping strategies for reducing distress and disconnecting from traumatic memories [26]. Survivors of sexual assault try to fill an inner emptiness and overcome the feelings that arise as a result of their trauma by isolating themselves from the outside world, protecting themselves from harmful environments and emotional contact, and suppressing sexual arousal. In addition, they binge eat and gain weight as a way of making their bodies unattractive to realistic or introverted sexual abusers [20] as described by patient no. 18: "I stuffed myself with food, ate and ate so that it would be difficult to reach me." In line with this explanation is the description of the experience of loneliness and helplessness as a "black hole" that cannot be filled even with food, as described by patient no. 9: "It has nothing to do with hunger. Beyond that. . . there is a deep hole which will never be filled".

The current findings add a qualitative layer to the existing quantitative research, indicating a relationship between EDs and dissociative symptoms, uncontrolled eating, derealization, depersonalization, revictimization, and the lack of a sense of time, all of which are especially common during episodes of binge eating [27–29]. The current qualitative study is innovative in its examination of the perspectives of patients with NES on the experience of night eating in light of traumatic life events.

5. Limitations, Strengths, and Future Research

The current study used a phenomenology approach to present a subjective and multifaceted reality as identified from in-depth experiences. Despite its contribution and novelty, several limitations should be considered. First, it uses a small sample, which restricts any generalization of the findings to patients with NES receiving treatment for EDs. The sample size is, nonetheless, larger than usual in qualitative studies whose aim is not to generalize findings but to better understand the participants' subjective experiences [13]. Qualitative studies prioritize reflection overgeneralization as a means to ensure trustworthiness [30]. According to the initial criterion outlined by Guba (1981) [31] the credibility of the current findings is considered very high since they authentically represent the perspectives of patients with NES. However, it is important to note that these findings may not be readily generalizable to the entire NES population. Instead, they offer valuable insights into the individual experiences of NES patients and their relationship with trauma.

Second, even though qualitative research is based on researchers collecting and analyzing the data, in the current article, only two authors were involved in the data collection; all of the authors did, however, participate in the data analysis. Third, the interviews did not specifically explore the relationship between NES and a history of traumatic life events, which might have added more insight into this topic. Further research on this issue would be an interesting direction. Fourth, in the absence of in-depth interviews conducted specifically for this article, data were collected from the patient's charts, which may impact the in-depth perspective.

This article supported and strengthened existing studies on the relationship between a history of traumatic life events and EDs, particularly NES. It also added to knowledge about the relationship between dissociative symptoms and EDs as a regulator of traumatic memories and difficult experiences, whether food and eating are referred to as a "monster" or as a "guardian angel," namely, as harmful or as comforting. The novelty of this study is its use of the patients' own perspectives to emphasize these relationships.

We suggest that future qualitative studies focus on the relationship between night eating and a history of various traumas. We also recommend using quantitative tools to examine the same variables for the purpose of validating and generalizing the findings.

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Data Availability Statement: The data presented in this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical restrictions.

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