

COULD I SATIATE THE ABSENCE IN ME?: A GLANCE TO THE DREAMS  
OF THE PEOPLE WITH DISORDERED EATING HABITS

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**COULD I SATIATE THE ABSENCE IN ME?: A GLANCE TO THE DREAMS  
OF THE PEOPLE WITH DISORDERED EATING HABITS**

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## ABSTRACT

The present study aimed to examine whether individuals with disordered eating habits differ in their dream content compared to those without such tendencies. A total of 216 participants completed a Demographic Information Form, the Eating Disorder Examination Questionnaire – 13 (EDE – Q – 13), and the Dream Themes Scale. Preliminary analyses indicated that age, gender, and psychiatric diagnosis significantly affected dream themes; these variables were then controlled in the main analyses. A new grouping variable was created to observe both the combined and individual effects of disordered eating and psychiatric diagnosis. Results from MANOVA analyses revealed that individuals with psychiatric diagnosis and high disordered eating habits had significantly more negative-, anxiety-, fear-, and inhibition-themed dreams compared to individuals with no psychiatric diagnosis and low disordered eating habits. Additionally, participants with no psychiatric diagnosis high disordered eating habits reported significantly more anxiety-themed dreams compared to individuals with no psychiatric diagnosis low disordered eating habits. Disordered eating combined with psychiatric diagnosis was also found to be related to anxiety-, and fear- related dream themes. These differences were interpreted using psychoanalytical theories, as well as contemporary dream theories. Overall, the findings suggest that disordered eating behaviors may be associated with specific dream patterns, reflecting underlying emotional conflicts, possible trauma residues, and defensive processes. These results highlight the symbolic value of dreams in understanding psychic dynamics and suggest new directions for further research on dream content in clinical and non-clinical populations.

Keywords: Eating Disorder; Disordered Eating Habits; Psychiatric Diagnosis; Dreams; Dream Themes

## ÖZ

Bu çalışma, bozulmuş yeme alışkanlıklarına sahip bireylerin rüya içeriklerinin, bu tür eğilimlere sahip olmayan bireylerden farklılaşıp farklılaşmadığını incelemeyi amaçlamıştır. Toplamda 214 katılımcı Demografik Bilgi Formunu, Yeme Bozukluğu Değerlendirme Ölçeği- 13 (EDE – Q – 13) ve Rüya Temaları Ölçeği'ni doldurmuştur. Ön analizler, yaş, cinsiyet ve psikiyatrik tanının rüya temalarını anlamlı şekilde etkilediğini göstermiştir; bu değişkenler ana analizlerde kontrol edilmiştir. Bozulmuş yeme davranışları ve psikiyatrik tanının hem birleşik hem de bireysel etkilerini gözlemek amacıyla yeni bir gruplama değişkeni oluşturulmuştur. MANOVA analizlerinden elde edilen sonuçlar, psikiyatrik tanısı olan ve yüksek düzeyde bozulmuş yeme davranışı gösteren bireylerin, psikiyatrik tanısı olmayan ve düşük düzeyde bozulmuş yeme davranışı gösteren bireylere kıyasla anlamlı derecede daha fazla negatif, anksiyete, korku ve engellenme temalı rüyalar gördüğünü ortaya koymuştur. Ayrıca, psikiyatrik tanısı olmayan ancak yüksek düzeyde bozulmuş yeme davranışı gösteren katılımcılar, psikiyatrik tanısı olmayan ve düşük düzeyde yeme bozukluğu davranışı gösteren bireylere kıyasla anlamlı derecede daha fazla anksiyete temalı rüyalar bildirmiştir. Bozulmuş yeme davranışının psikiyatrik tanı ile birlikte görülmesi, anksiyete ve korku temalı rüyalarla ilişkili bulunmuştur. Elde edilen bulgular, psikanalitik kuramlar ve çağdaş rüya kuramları çerçevesinde yorumlanmıştır. Genel olarak bulgular, bozulmuş yeme davranışlarının, alta yatan duygusal çatışmaları, olası travma kalıntılarını ve savunma süreçlerini yansıtan belirli rüya örüntüleriyle ilişkili olabileceğini göstermektedir. Bu sonuçlar, rüyaların psişik dinamikleri anlamadaki sembolik değerine işaret etmekte ve hem klinik hem de klinik dışı örneklerde rüya içeriği üzerine yapılacak ileri araştırmalar için yeni yönler önermektedir.

Anahtar Kelimeler: Yeme Bozuklukları; Bozulmuş Yeme Davranışı; Psikiyatrik Tanı; Rüyalar; Rüya Temaları

To my father, whose quiet strength smiled through every shadow...

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## LIST OF ABBREVIATIONS

AN:	Anorexia Nervosa
ARFID:	Avoidant/Restrictive Food Intake Disorder
BED:	Binge Eating Disorder
BN:	Bulimia Nervosa
DE:	Disordered Eating
DTS:	Dream Themes Scale
ED:	Eating Disorders
EDE – Q - 13:	Eating Disorder Examination Questionnaire - 13
NES:	Night Eating Syndrome
OSFED:	Other Specified Feeding or Eating Disorder
PC:	Pica
PD:	Psychiatric Diagnosis
RD:	Rumination Disorder
USFED:	Unspecified Feeding or Eating Disorder

## INTRODUCTION

The current study was initially inspired by Wooldridge's (2022) exploration of the psychological underpinnings of binge eating, particularly the roles of dissociation, emotional expression, and object hunger. Wooldridge posits that binge eating may represent a behavioral expression of dissociated emotions— affective experiences that, having been insufficiently integrated, manifest through disordered eating. This proposition prompted further examination of existing literature, which reinforced the link between eating issues, early aversive experiences (Allison et al., 2007), and dissociative tendencies (Palmisano et al., 2018a; 2018b). Building on this foundation, the investigation expanded to other eating disorders such as anorexia nervosa and bulimia nervosa. These conditions, too, appeared consistently associated with histories of trauma, abuse, emotional suppression, and dissociation (Brewerton, 2007; Racine & Wildes, 2014; Mitchell et al., 2012). Taken together, these findings suggest that various forms of disordered eating may serve as indirect expressions of unmetabolized or dissociated affective states, often rooted in early relational and emotional trauma.

Within a psychoanalytic framework—particularly Sigmund Freud's (1955) conceptualization of the unconscious as a repository for repressed, dissociated, and conflict-laden material—dreams offer a symbolic and meaningful pathway for accessing such unprocessed content. If disordered eating is indeed intertwined with dissociative and traumatic experiences, then it may implicate that the dreams of individuals with eating disorders may reflect different thematic patterns than those of individuals without such conditions.

Another line of thought, emerging from contemporary psychodynamic and embodied approaches, also emphasizes the role of unmetabolized emotional states in the development and maintenance of eating disorders (Bromberg, 2001; Granieri & Schimmenti, 2014; Lunn & Poulsen, 2012). These perspectives propose that when individuals lack the capacity or support to process overwhelming emotional experiences, these affective states may instead be enacted somatically—through the body—rather than

symbolized or verbalized. In this view, disordered eating behaviors can function as attempts at affect regulation or communication, especially when words fail. The body becomes the site where unresolved experiences are expressed or contained, often without conscious awareness (Kohut, 1968). This aligns with theories suggesting that eating disorders may be deeply rooted in difficulties with emotional embodiment, interoceptive awareness, and the capacity to symbolize inner states (Bruch, 1973). Such frameworks further support the idea that dream content might reveal traces of these embodied, dissociated experiences (Skancke et al., 2014).

On the basis of the premises that are summarized above and will be presented in detail in the Literature Review section, the focus of the present study became the differences, if any, of the dream themes of individuals with and without disordered eating, reflecting their deeper dissociative and emotional processes. To investigate this, a quantitative, survey-based research design was adopted. As will be detailed in the Method section, this approach was selected in order to explore potential patterns across a broader sample and to test the relationship between disordered eating and thematic variations both in terms of type and intensity in dreams.

Although the literature on eating disorders is vast, the ones that specifically study the dream content were scarce. Thus, the focus of the study was kept on a main hypothesis that expects dream themes to be different, and an exploratory approach was adopted toward examining the variations in terms of type, intensity, and direction of associations. Since, to the author's knowledge, this is the first study conducted in Türkiye with this specific question in mind, particular attention was given to identifying relevant demographic and psychological control variables—such as age, gender, and general psychological distress—to ensure that any observed differences in dream content could be more confidently attributed to eating pathology rather than confounding factors.

This methodological stance was intended not only to strengthen the validity of the present findings, but also to lay a foundation for more fine-grained future research. As presented in the Results section, by controlling for broad individual differences, the current study aims to offer a robust initial answer to whether and how dream content varies with eating disorder symptomatology. In doing so, as discussed in the final section of the current

study, it opens space for future investigations to explore more nuanced patterns—such as differences across specific diagnostic categories, links with particular types of trauma or dissociation, or how dream content evolves with treatment and recovery. On the clinical side, this study still holds potential implications for deepening our understanding of the symbolic and unconscious dimensions of eating issues, prompting clinicians for a more refined ear for dreams.

## LITERATURE REVIEW

### 2.1. Eating Disorders

Food is a basic need of a human starting as early as a newborn being fed with the mother's breast. Since it is a basic need for survival, the relationship with food remains central throughout one's life, but sometimes the relationship could be changed and disrupt one's life through a disorder. Eating and feeding disorders are summed in a category under the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM -V; American Psychiatric Association, 2013) and explained briefly as continuous disruption in eating habits or eating behaviors that lead to change in food intake or food absorption that negatively affect physical or psychosocial well-being. The book classifies these disorders as Pica (PC), Rumination Disorder (RD), Avoidant/Restrictive Food Intake Disorder (ARFID), Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge – Eating Disorder (BED), Other Specified Feeding or Eating Disorder (OSFED) and Unspecified Feeding or Eating Disorder (USFED) depending on their characteristics (p. 329 – 354).

Before moving on to the section below, it would be necessary to briefly explain the behaviors conducted in eating disorders (ED). First one is binge eating; that is consuming excessive amount of food that most people would not consume in the same period and also feeling lack of control related to one's eating is present during this period and also, binge eating episodes are marked by consuming large amount of food in a fast manner until being overly full and this behavior conducted alone - due to the shame - and feeling guilty after the episode (American Psychiatric Association, 2013). The other term is compensatory behaviors that are engaged by the one to prevent weight gain, these are fasting, making oneself vomit, usage of laxatives, diuretics, and doing intense exercise (American Psychiatric Association, 2013). If we were to continue with the classified disorders, AN is associated with limiting one's calorie intake severely and having excessive fear about weight – gain, and distorted perception about one's body shape and weight although having critically low weight, it has two subtypes one is restrictive one, that the individual does not engage in binge eating nor purging and solely restricts one's

calorie intake and the other one is binge-eating/purging or bulimic type, that is marked by engaging in bingeing and/or purging (American Psychiatric Association, 2013). BN is marked by both binge eating and compensatory behaviors, and one's self-evaluation is largely affected by one's body shape and weight, whereas BED is characterized solely by binge eating episodes (American Psychiatric Association, 2013).

When the etiology of these disorders is investigated, biological, social, and psychological causes have been found (Jacobson et al., 2012) that would be summarized below.

### **2.1.1. Biological Aspect of Eating Disorders**

Genetic components in ED have been investigated and, in particular, brain regions and neurotransmitters have been focused on since they regulate appetite, feeding-related stimuli, thoughts, and behaviors. Serotonin, one of the neurotransmitters, has a key role in mood, appetite, maintaining satiety and weight, suppression of nutrition and its reward; distortions in its function could lead to hyperphagia, weight gaining, hyper-reward and result in affective disorders or bulimia (Hoebel et al., 1992). Kaye (1992) reported that distortions in the serotonin pathways is found to be linked with distortions in nutrition, affect regulation, and obsessional thinking. The proof might be that observation of altered serotonin activity in the acute state of the disorder and its persistence after recovery from ED (Kaye & Weltzin, 1991; Kaye et al., 2001) and also the benefit these patients receive from Selective Serotonin Reuptake Inhibitors (SSRI) (Frank et al., 2001). However, Polivy & Herman (2002) proposes that this difference on serotonin level could not easily explain the fluctuation between bingeing and restriction in BN and AN. Depending on anorexic symptom of obsessive thinking about food, it is thought that they experience elevated levels of serotonin activity whereas bulimic symptom of distortions in impulsivity and mood regulation is thought to be related with lower levels of serotonin activity (Polivy & Herman, 2002).

Another neurotransmitter that is thought to be related with ED is dopamine. Dopamine is a reward-related neurotransmitter that is also found to be related with addictions including food (Wise, 2006) and increased dopamine in nucleus accumbens is found to be associated with nutrition, reward, and sexual interest (Hoebel et al., 1992), and in cortical

area, might be related to food-seeking behavior (Hernandez & Hoebel, 1988; Hernandez et al., 1990). Similar to dopamine's role on addictions, Hoebel et al. (1992) suggest that binge eating and purging might be associated with dopamine as well, as engaging in binge eating dopamine would be released, and by purging the individual would avoid the negative outcome of the food consumed. The authors underline the role of dopamine in BN and propose that food might become as a psychostimulant and ease food addiction, since for some people binge eating might stimulate dopamine release at least in the nucleus accumbens. Whereas in AN, decreased synaptic dopamine levels in nucleus accumbens, the area that is related to nutrition, reward and sexual interest, might be responsible (Hoebel et al., 1992). Dopamine could also affect feeding behavior through its terminals in hypothalamus (Hoebel et al., 1992). Hypothalamus, which plays a role in appetite control, is also thought to be related with ED (Wakeling, 1985). However it is observed in animals, which have lesions in their hypothalamus that could lead to overweight or underweight, would save their body weight (Hoebel & Teitelbaum, 1966). Regarding the inheritance aspect of ED, the high rate of genetic transmission of ED in families is highlighted but how they contribute is still unclear (Klump et al., 2001; Polivy & Herman, 2002). Sex and age differences in ED have also been shown. Women outnumber men in ED diagnosis although the amount of men with the diagnosis have been increased (Valente et al., 2017). The authors also showed that men tend to have BED whereas women are mostly diagnosed with AN or BN. The reason might be that women tend to perceive themselves more overweight compared to men, although they were significantly less overweight than them (Tiggemann et al., 1994).

### **2.1.2. Social Aspect of Eating Disorders**

An individual is embedded within the context of peers, family, and culture: both influencing and being influenced by them, therefore, the social dimensions of ED should also be considered. Striegel – Moore & Bulik (2007) conclude in their review that slenderness is idealized and valued in the culture, and feeling compelled to maintain this ideal would lead to concerns related to body image. It is found that exposure to media that value thinness negatively affects body satisfaction, worry about weight, and eating

habits (Spettigue & Henderson, 2004). As the exposure time to these visuals increases, particularly through magazine reading, internalization of the thin ideal increases as well (Tiggemann, 2003). Exposure to television is positively correlated with disordered eating habits and body dissatisfaction (Slevec & Tiggemann, 2011). However, there are findings contrary to that and extend the findings: it is not the amount of time exposed to media that matters, but the type of media, whether it is a soap opera, a sports programme, or music videos (Tiggemann & Pickering, 1996).

If we move from the macro level of culture to the micro level of peers and family: it is found that individuals who report being teased about their body tend to be dissatisfied with their body and that leads them to exhibit more disordered eating behaviors (Cattarin & Thompson, 1994; Lunner et al., 2000). Individuals who reported peer bullying about their appearance and verbal bullying by their family in childhood reported significantly higher on body dissatisfaction scales in adulthood (Sweetingham & Waller, 2008). The researchers also found that shame and social anxiety were related to dissatisfaction with the body, and they proposed a model in which shame was a mediator in the relationship between peer bullying and body dissatisfaction. Briefly, being bullied by peers is frequently linked to ED and disordered eating habits (Lie et al., 2019; Striegel-Moore et al., 2002).

Regarding the families of individuals with ED, these patients had families who avoided open and direct expression of feelings, and they were less supportive and close-knit (Hodges et al., 1998). Minuchin et al. (1978) suggest that psychosomatic individuals usually have families that are rigid, enmeshed, over-involved, over-protective, and they have insufficient capacity for conflict resolution skills and tend to reject one's affective needs. Similar to this observation, Mintz (1983) described the parents of individuals with ED as rigid, demanding, controlling, and attached to their children. These individuals often describe coming from families where parents are vastly critical, emphasize the topic of weight, and exercise parental coercive control (Haworth-Hoepfner, 2000). Similarly, individuals with BN describe their parents as intrusive, overconcerned about their eating-related issues, particularly their mothers as envious, competitive, and violating privacy, and fathers as tempting (Rorty et al., 2000). Individuals who have BED reported that they

had more rule-oriented families, they were more isolated and structured, and they had more conflict, and lastly, their families do not value independence when compared to families of the AN or BN groups (Hodges et al., 1998).

Parental overweight is not a distinguishing feature between eating disordered groups and psychiatric control groups, nor between separate ED diagnoses (Hilbert et al., 2014). However familial relationship with food seem to have a role on predicting ED (Hasan et al., 2018) such that, adults with ED reported retrospectively had consuming large amount of snacks and sweet that had prepared for them and also they and their families had placed emphasis on food, and also studies showed having breakfast regularly was associated decreased chance for developing ED (Fernandez-Aranda, 2007; Krug et al., 2008).

### **2.1.3. Psychological Aspect of Eating Disorders**

In this section, ED would be focused on from the personality aspect, trauma history, and psychoanalytic theories. The psychoanalytic perspective will be further elaborated through multiple theoretical frameworks. Finally, relevant empirical studies that support these conceptualizations will be presented to provide a more comprehensive understanding of the study.

#### **2.1.3.1. Personality Aspect of Eating Disorders**

Individuals with ED have divergent personality patterns depending on their diagnosis, including the subgroups (Farstad et al., 2016; Ghaderi & Scott, 2000). Individuals with ED had significantly decreased scores on emotional stability, agreeableness, and conscientiousness aspects and increased scores on the openness aspect of the Big Five (Ghaderi & Scott, 2000). The authors reported that the ED group scored higher on openness, even when controlled for emotional stability, compared to the non-ED group, and they suggest that the finding might suggest the sensitivity to society's valuation of slim appearance that leads to diets and restrictive intake that are risk factors for ED. They add that the finding underlines emotional stability might not contribute to the

development of an ED when considered alone, but openness plays a role. Continuing with the Big Five, Heaven et al. (2001) reported that conscientiousness, neuroticism, and emotionality play a significant role in eating behaviors such that less conscientious people tend to engage in emotional and external eating. The authors also found that people who engage in restrained eating have decreased self-efficacy, and further, they tend to experience negative affect, such as anxiety and depression. Thus, they suggest that ED are more likely to increase as depression increases. Another study by Gual et al. (2002) showed that the likelihood of developing an ED is reported to be significantly linked with low self-esteem and high neuroticism. Bollen & Wojciechowski (2004) investigated the personality structures in the subtypes of AN, which are binge eating - purging and restrictive subtypes, and found that both group had higher scores on neuroticism compared to control group and, restrictive subtype had greater scores on agreeableness and conscientiousness to a significant degree compared to binge eating and purging subtype. The authors underlined that both subtypes had increased psychological stress and emotional instability compared to the control group.

Perfectionism, which is related to conscientiousness, is also thought to be related to ED. Stackpole et al. (2023) conclude in their meta-analysis of ninety-five studies that both striving and concern for perfectionism are related to ED symptomatology. Women who score higher on body dissatisfaction and perfectionism also have elevated scores on ED symptomatology (Boone & Soenens, 2015). Perfectionistic thinking raises the chances of an individual negatively assessing their own body, which in turn, contributes to ED symptoms (Hu et. al, 2023). Fairburn et al. (1999) reported that perfectionism and evaluating oneself in a negative way before the onset are common in both BN and AN. Perfectionism, but in particular strong fear of mistakes and worrying about self-efficacy, were found to be significantly linked with AN and BN (Bulik et al., 2003). Individuals with AN are often characterized by a strong desire for approval, a tendency to doubt themselves, avoidance of conflict, increased dependency on others, and significant anxiety in social situations (Nye & Johnson, 1999, as cited in Jacobson et al., 2012). Similar to that, Katzman and Wolchik (1984) underlined that women with BN, as well, exhibit greater need for approval, concern for dieting, and have higher expectations from themselves compared to those who do not have the disorder. Further, the researchers

demonstrated that these individuals had decreased scores on self-esteem, body image and had increased scores on depression compared to controls. When the BED group is compared with the BN group, the authors saw that individuals with BN had more dieting preoccupation, had lower self-esteem scores, they engaged in binge eating more than the BED group.

Moving on to other personality features, Silva (2007) found in a correlational study that in adolescents, traits such as being reserved, emotionally unstable, easily excitable, opportunistic, timid, and highly individualistic, tendency to experience guilt, a strong sense of self-sufficiency, and increased levels of tension were related to ED. Furthermore, impulsivity can also be related to ED since binge eating seems like an impulsive act. Patients with BN were found to be more impulsive during their adolescence compared to individuals with AN (Mintz, 1983) and in adulthood, individuals with BED had increased scores on impulsivity compared to individuals with AN and individuals with BN, the latter groups did not differ in the means of impulsivity (Hilbert et al., 2014).

Regarding the present and past link in the disordered eating habits, Bemporad et al. (1992) underlined that individuals with ED reported a history of problems in early relationships that led them to have difficulty in depending on others and being truly themselves in social situations in later years. These individuals share certain characteristics experienced by individuals with personality disorders, such as feeling empty inside, identity problems, worry about abandonment, and peer relationships (Clarkin et al., 1993).

#### **2.1.3.2. Eating Disorders and Trauma**

Several types of abuse, trauma, and ED links are mentioned frequently in the literature. As the severity of abuse during childhood increases, dissatisfaction with the body, binge eating, and overevaluation of weight increase (Rosenberg et al., 2023). Jacobson et al. (2012) point out that ED generally occur after traumatic events. In line with this statement, individuals with ED frequently report rape and/or sexual abuse (Everill & Walter, 1995; Root & Fallon, 1988). Longo et al. (2019) reported that AN patients with binge eating and/or purging subtype had more traumatic events, sexual trauma in particular, than

patients with the restrictive subtype. The researchers revealed that they also scored significantly higher on post-traumatic stress symptoms. Also, the finding of physical and sexual abuse during childhood is a risk factor for developing BED (Striegel–Moore et al., 2002) might highlight the particular result of binge eating symptoms in response to trauma. In general, women with physical abuse history at childhood are more likely to report disordered eating, and women who were exposed to sexual and physical abuse during childhood tend to report ED symptoms and meet criteria for ED diagnosis (Rayworth et al., 2004). When emotional, physical, and sexual abuse were assessed in patients with AN, it was revealed that emotional abuse was strongly related to hardship in emotional regulation and severity of AN (Racine & Wildes, 2014).

Being exposed to bullying and teasing is found to be associated with disordered eating (de Oliveira Galvão et al., 2023), BN, and BED (Lie & Bang, 2019; Striegel–Moore et al., 2002). Another study found the same risk for BN and also added AN as well (Copeland et al., 2015). Childhood emotional neglect and emotional abuse predict ED in adulthood (Allison et al., 2007; Kennedy et al., 2007; Kent et al., 1999), likely due to its impact on self-esteem and anxiety (Kent & Waller, 2000).

Lev-Ari et al. (2021b) underlined that ED could not be a direct result of traumatic events and pointing out possible mediators and moderators in this relationship. They found that the effect of traumatic events' frequency on ED symptomatology and body dissatisfaction is mediated by affective dysregulation and dissociation, whereas body mass index acted as a moderator in this relationship. They explained that the finding of traumatic events' frequency was not directly related to ED symptoms, as the path may not always be that clear, but rather has a complex underlying path. Similar to these results, emotion dysregulation is found to be the mediator between childhood trauma, specifically emotional abuse, and ED (Moulton et al., 2015). Maltreatment during childhood is found to be related to higher self-criticism that leads to unfavorable outcomes such as depression, self-injury, and dissatisfaction with the body (Dunkley et al., 2010; Glassman et al., 2007). An internal voice, that is the source of the self-criticism, comments on eating, shape, and weight issues, is common in ED (Pugh & Waller, 2016a) and the power of this voice is correlated positively with emotional abuse in childhood, and dissociation is acted

as mediator in the relationship (Pugh & Waller, 2018). It is found that emotional dysregulation and negative affect are related to increased emotional eating (Czeczor–Bernat et al., 2019). In another study, anxiety and self-esteem are found to act as mediators between the relation of childhood neglect and disordered eating (Kennedy et al., 2007). Walter et al. (2007) suggest that emotional abuse, which is a form of traumatic experience, can alter one’s cognition about emotions and beliefs about the self, leading to difficulties in affective functioning. The researchers add that these difficulties might give rise to maladaptive use of defenses that predispose one to disordered eating habits. In their review, Everill & Waller (1995) state that there are possible mediators in this relation that are dissociation mechanisms, feelings of worthlessness, and borderline personality features. Although, Gerke et al. (2006)’s finding is partially contradictory, it is suggested that depression, not the dissociation, was the mediator between emotional abuse and symptoms of BN, still dissociation is the mediator that highlighted frequently in this relation (Kent et al., 1999; Moulton et al., 2015).

In order to see whether dissociation is found in several psychiatric diagnoses or it is characteristic of ED, several studies have been conducted, and the results are contradictory. A study conducted on individuals with AN, individuals with other psychiatric diagnoses, and a non-clinical sample showed that dissociation is related to symptomatology levels in all groups (Farrington et al., 2002). In the study, it is revealed that adolescents with AN did not significantly differ in the means of dissociation, but they use the mechanism to avoid processing anger in relationships. On another study, La Mela et. al (2010) conducted a research on patients diagnosed with ED, patients diagnosed with anxiety and mood disorders and healthy individuals who had not any psychiatric diagnosis and found that patients with ED had scored higher on dissociation compared to patients diagnosed with anxiety or mood disorder and healthy individuals, likewise they highlighted that number of binge episodes was related to the level of dissociation. Palmisano et. al. (2018a) highlighted the increased scores of dissociation in people with ED and also indicated that traumatic experiences in childhood were linked to higher instances of binge eating behaviors.

Binge eating episodes and obesity could be seen likewise since overconsumption beyond the body's need is a common feature in both of them, and the former could give rise to the latter. Jia et al. (2004) found that physical abuse history and obesity were related. However, a study conducted by Palmisano et. al. (2018b) found that people with BED had reported significantly higher traumatic experiences, neglect, and emotional abuse in childhood and dissociation compared to obese individuals and healthy individuals. Last but not least, Allison et. al. (2007) found that people with BED had significantly higher scores on childhood maltreatment compared to obese individuals. In the same study, people with BED and people with night eating syndrome (NES) reported emotional abuse compared to obese controls. Furthermore, people with BED scored higher on emotional neglect, whereas people with NES scored higher on physical neglect, and lastly, both the BED and NES groups had higher depression levels compared to obese individuals (Allison et.al, 2007).

The functions of the symptoms that arise after traumatic history could be questioned, Jacobson et al. (2012) think symptoms serve as a blocker for emotions and protect the person, such as thinking about food, nutrition, and weight might be a way to control unpleasant thoughts and detach individuals, similar to dissociation which is a natural response to traumatic event (Van der Kolk et al., 1996), from experiencing negative emotions. It is also found that individuals with ED have difficulty in experiencing and showing emotions (Fox & Power, 2009). A study conducted with trauma survivors found that disordered eating was engaged for self-soothing, to avoid negative emotions, as a reaction to apathy after the traumatic event (Breland et al., 2017). If sexual trauma is focused in particular, it is thought that amenorrhea, which is caused by starvation in AN, could be a desire to prevent traumatic memories of rape, whereas bingeing and purging in BN and subtype of AN might be an effort to cleanse the body from traumatic memories and related emotions (Ross, 2009). Similarly, purging behavior is defined as using laxatives or forcing oneself to vomit, namely oral or anal areas are involved in the process, which are body parts related to sexual abuse, could be a response to trauma (Ross, 2009).

In one study, the timing of traumatic experience was investigated, and it was found that people who report trauma in childhood and adulthood engaged in purging behavior

significantly higher than the no trauma group, the childhood trauma group, and the adulthood trauma group (Vidaña & Forbush, 2020). They did not find any significant difference in the means of other symptomatology of ED, such as binge eating, restriction, and body dissatisfaction. Pearlman (2005) observed the patients with ED and suggested that adverse events during critical periods in infancy influence attachment and leave children with psychic wounds. The author pointed out other commonalities of these patients as follows: mothers of these patients reported having been anxious with maternal issues while raising their kids and receiving inadequate support from their spouses, some of the mothers reported extreme social and affective withdrawal during early years of their kids.

### **2.1.3.3. Psychoanalytical Perspective of Eating Disorders**

The psychoanalytical perspective will be discussed under several subheadings, starting with classical psychoanalytic theory and continuing through attachment theory. In the last subheading, the symbolic meanings attributed to the symptoms of ED will be explored within the psychoanalytic perspective. Each theoretical approach will be examined in relation to its understanding of the development and dynamics of eating disorders.

#### **2.1.3.3.1. From Drive to Individuation: Classical and Neoanalytic Approaches**

Starting with classical psychoanalytic theory, Freud (2011) proposed psychosexual stages in human development and named them as oral stage, anal stage, phallic stage, latency stage and, genital stage. Each stage centers on a different erogenous zone and includes specific tasks and conflicts (Freud, 2011). In the literature oral stage and phallic stage are mostly mentioned for ED. In the oral stage, the child's attention is focused on the mouth, the child interacts with the environment through their mouth, and derives pleasure from breastfeeding. The task of weaning must take place in this period, that is, the first experience of loss (Freud, 2011). If the child is overly satisfied or deprived during this process, oral fixation may occur, which in adulthood can manifest itself as smoking, over-eating, or dependency. The other stage is the phallic stage, which is marked by the

emergence of the Oedipus complex (Freud, 2011). During this stage, the child develops unconscious sexual desire for the opposite-sex parent and rivalry towards the same-sex parent. To resolve this conflict, the child must repress these desires and begin to identify with the same-sex parent (Freud, 2011).

It is posited by Bruch (1973) that hunger is not a function coming from birth but needs to be learned, and lack of attunement in the nurturing could cause problems in the separation–individuation process. Not surprisingly, ED are perceived from a separation–individuation perspective (Kernberg, 1995). Similar to Freud, Mahler, a pioneer of ego psychology, proposed the Separation–Individuation Theory of child development (Mahler et al., 2000). According to the theory, there are 3 main stages that are: the normal autistic stage, the normal symbiotic stage, and the separation-individuation stage. In the first stage, the baby is focused on self and not aware of the external world nor the mother. In the second stage, the baby begins to notice the mother as the one who fulfills their needs, but does not recognize her as a separate entity. In the final stage, as the child begins crawling and talking, the infant gradually develops a sense of individuality and separateness from the mother.

There are contradictory thoughts about the quality of ED, whether it has pre-oedipal or oedipal features. For AN, it is theorized that anorexic women turned from their mother to father after experiencing disappointment with her in their early experiences (Buchholz, 1991 as cited in Vonwyl, 2000; Willenberg, 1986 as cited in Vonwyl, 2000). Vonwyl (2000) suggests that this early disappointment might give rise to the common Oedipal theme observed in these patients. The author suggests that these patients have their childish and male-like bodies as a tool against heterosexual seduction. Mintz (1983) approaches from a more comprehensive perspective and suggests that the causes of AN, which are acted out through the illness, are separation anxiety, difficulty with aggression, problems with female roles, pregnancy, and motherhood fears.

For BN, the same contradiction continues. On one hand, it is found in the stories they told that patients with bulimia are not object-oriented but wish to share other people's abilities and capacity, such that the other person is expected to calm down and take care of the patient (Vonwyl, 2000). Similar to the theory of object relations on bulimia, it seems that

patients with ED have oral conflict that might be aroused from the separation and individuation process (Vonwyl, 2000). The dominance of the pre-oedipal theme might be due to regression, as the author states, since all of the participants were acutely ill and had therapy during the research period. On the other hand, Yarock (1993) points out more oedipal issues in women with BN who mostly have a hysterical personality type and they engage in “oralization of sex” and “sexualization of food” (p.5). The author adds that these individuals share some defenses, such as repression, dissociation, somatization, and denial, with hysterical personalities. On the other hand, the role of denied femininity in ED has also been a focus of attention. For instance, Freud perceives “hysterical vomiting” (Freud & Masson, 1985, p.345) as being pregnant in the fantasy, but also the same act of vomiting, which causes her to become unattractable to men, is a way to escape from pregnancy and sexuality.

In line with these, a Jungian psychoanalyst, Woodman (1980), underlines that women with anorexia and bulimia have mothers who are dominated by negative animus, and they rarely experience appropriate masculinity in their fathers, so they grow up detached from feminine instinct and lack of basis for authentic masculinity. Brink & Allan (1992) suggest that ‘repression, projection, projective identification, and introjection of rage against self’ and also a deficient emotional bond with the paternal figure, which causes underdeveloped animus, might contribute to these (p.278).

#### **2.1.3.3.2. Relational Models: Object Relations and Attachment Theories**

ED have also been a focus of relational and attachment theory. Before moving to its specificity on ED, relevant parts are discussed in this and the following paragraphs. A pioneer in Object Relations Theory, Melanie Klein (1946) suggests that when a baby’s ego is at its weakest period, the baby relates to the world through the mechanism of splitting and experiences part-objects, rather than whole objects, in its early phantasies. For instance, the mother’s breast is split into a good breast, which is experienced as satisfying, regulating, and soothing, and a bad breast, which is perceived as withholding, frustrating, or even torturing when it fails to respond to the baby’s hunger (Klein, 1957).

Over time, the baby comes to realize that good and bad breasts belong to the same object, and the baby is expected to integrate these part objects into a whole internal representation (Klein, 1957).

Close to Kleinian Theory, Bion (1962) proposes that the baby is initially filled with raw, unprocessed experiences, which are called beta elements, such as hunger, coldness, anxiety, or pain. Without the capacity to contain and make sense of these sensations, the baby projects them into the mother (Bion, 1962). The mother, through her alpha function, receives and transforms these beta elements into alpha elements, giving them symbolic meaning and making them tolerable (Bion, 1962). In time, the infant internalizes this containing function and gradually develops the capacity to process and manage emotional experience with the help of the internalized mother (Bion, 1962).

Similar to these perspectives, Bowlby (1988) suggests that a responsive caregiver provides the infant a secure base and allows the infant to experience the world as a safe and predictable place. Through a responsive, consistent, and attuned caregiver, who shapes expectations about the self and others (Bowlby, 1988). This internal representation, which is called the internal working model, is carried into later relationships and influences the individual's capacity for trust, regulation, and intimacy (Bowlby, 1982 ).

Savelle – Rocklin (2017) posits that since a baby's first love experience is being satisfied with food, it represents mother and love and is encoded in our psychic structure as the first relationship with the other. Besides, this first relationship is needed for the infant in order to make meaning from sensations and emotions (Wooldridge, 2018). During infancy, through the caregiver's emotional availability, attunement, and interaction, the infant could develop a sense of self, and also words and experiences could be integrated (Chefetz & Bromberg, 2004). However, if this process is failed and also child's relational needs are dissatisfied repetitively, the child could not contain and tell self-states of its own thus they are dissociated, becoming storage for unidentified experiences and emotions and could not internalize the other and in time, lacks the ability to supply its own needs, thus leading to severe "object hunger" (Kohut, 1968, p.89) which is a great

amount of relational need with the other that can provide the alternative absent aspects of one's psyche (Chefet & Bromberg, 2004; Wooldridge, 2018).

The internalization is seen in the body of the patient with AN, which contains negative and defeating aspects of the mother; moreover, it does not just contain rather becomes the bad object itself, and this might explain the rage turned against oneself (Selvini Palazzoli, 1974). The author also underlines body perception of these individuals as omnipotent, undestroyable, self-sufficient, expanding and threatful just like primary object and exemplifies it with the following dream: a patient's dream that she cannot do anything to her mother, to confront her, that stands in front of her because her legs are "two bleeding stumps" (p.87). The author points out the exhausting helplessness, repressed and passive aggression that turned against the self in the dream.

Furthermore, a mother who cannot perceive her child as an individual, might project her affects and needs to the child which cause the child to deny the borders of the ego and distort the ability of body image construction and lack of differentiation between sensations such as hunger, temperature or emotions (Bruch, 1973). Denial of these borders might lead people with ED to prioritize conforming to others' wishes and needs, which could be either the mother's or culture's, and the experience of being in contact with one's self is replaced with this (Brisman, 2018). Moreover, individuals with ED suffer from a lack of containment, and they also perceive themselves as recipient of projected unmetabolised parental fantasies, and to protect themselves, they develop a defense that denies entry to the body, which is commonly seen in AN (Williams, 1997).

From an attachment perspective, it is suggested that people with ED "internalize a primary sadistic object with which they identify in an adhesive way" (Granieri & Schimmenti, 2014, p.53). Similar to that, it is suggested that these patients also form an attachment with their disorder (Forsén Mantilla et al., 2018). Although the anorexic voice is thought, patients report affiliation towards it, and this might emphasize their resistance to change (Tierney & Fox, 2010). Depending on these, Forsén Mantilla et al. (2018) found that the more the attachment insecurity, the more patients form enmeshed relationships with the ED in which the patients are more obedient and the disorder is more controlling. They suggest that this attachment might explain the maintenance of the disorder, such

that the disorder provides a certain amount of secure base that is in line with the internalized attachment figure; treatment might mean separation from the attachment figure and lead to separation anxiety. Having a negative perspective on eating, increased severity in compensatory actions, extended period of the illness, and being diagnosed with the binge eating-purging subtype of anorexia are the commonalities between the individuals with a stronger anorexic voice (Pugh & Waller, 2016b). These patients often score high in insecure attachment (Tasca & Balfour, 2014; Zachrisson & Skarderud, 2010). Tasca & Balfour (2014) underlined in their review that attachment anxiety was related to symptom severity of ED and perfectionism, and self-regulation methods could be mediators in these relationships.

From a relational perspective, since these patients have a history of neglect or mistreatment, they have left trusting in human for regulation and approach to solutions other than humans such as food and the best part of it is being at hand anytime needed thus being more controllable, dependable and less disappointing than humans that the patients have grown up with (Sands, 2022). Their relationship with food could also be observed in their interpersonal relationships, their longing for symbiosis and fear of abandonment, combined with fear of losing oneself and control, the closeness (Yarock, 1993). Sands (2022) proposes that there are two mechanisms related to desire and need. In the first one, food is the focus of massive desire, and it is a substitute relationship for the prolonged need of the responsive and soothing other. Food represents an object that is calming, trustworthy, and omnipotently controllable (Kohut, 2009). Hunger is experienced differently in eating disorders, for instance, in BN it is encountered with greed and then discharged, whereas in AN hardly have a conscious experience, as if it is reversed (Sands, 2022). In the second mechanism body becomes the container of the desire that is dissociated and embodied, where it encounters strict control and is attacked through restricting, binge eating, purging, and excessive exercise (Selvini Palazzoli, 1974). Using the body, the target of unbearable desires can ease one's control over tough experiences since the body provides more containment than emotional experience can give (Sands, 2022). The solution they find benefits them by saving relations with the caregivers by not depending on them for regulation, thus not requesting more than they could give (Sands, 2022).

Emphasis made on maternal function due to symbiotic breast feeding period and possible oral character of ED but fathers have a crucial role in this process as well, they separate the mother-infant dyad and promote separation and independence by encouraging the child to discover the external world but when this task is failed to accomplish, the child is left alone to achieve the process and might develop ED as a coping mechanism (Savelle-Rocklin, 2017). Maine (2004) underlines that the father–daughter relationship is more crucial than a father-son relationship in the means of ED since women have more relational needs and are affected by them more. When the father fails to understand his daughter’s increasing relational needs with him in adolescence years, the daughter starts to question herself and her appetite, in the means of food, sex, or relationships (Maine, 2004). She might deny her relational needs toward her father or might punish herself with the symptoms of bingeing, purging, or restricting (Maine, 2004). The author suggests that this hunger persists unless it is satisfied. Salman Akthar contributes to paternal function by telling that children learn how to express aggression in a healthy and non-destructive way from their father, and when he is absent, it turns inward and is usually directed toward the body, as seen in ED (Savelle-Rocklin, 2017).

Overall, early relational patterns with the parents might affect the development of ED later in life. It is suggested that parental abuse and neglect might cause children to have pessimistic expectations, and leave them lacking appropriate coping skills in the face of helplessness and anxiety aroused from adverse events, and feel inefficacious, anxious, and lonely (Granieri & Schimmenti, 2014). When parents fail to attune to their child’s affective needs, children might be left unable to regulate their emotions, which might give rise to the ED through a distorted relationship with food (Granieri & Schimmenti, 2014). Bromberg (2001) puts it differently; the symptoms in individuals with ED and also in so-called difficult patients stem from an early and prolonged need to regulate emotional distress caused by trauma during infancy. Patients with ED had no chance to receive responses from affective and available caregivers during their childhood, and suffer from unbearable physiological and emotional states in their adulthood (Bromberg, 2001).

### **2.1.3.3.3. The Symbolic Meaning of the Symptoms**

The symptoms could also be interpreted from a functional perspective within the individual's life, focusing on how the symptom serves a purpose or what the symptom represents. For instance, Lunn & Poulsen (2012) suggest that symptoms in ED could be seen as an effort to regulate emotions, particularly negative affects, since the individual could not contain and metabolize emotions. Sands (2022) adds that obsessive thoughts about food and eating, commonly seen in ED, can serve as an alternative to a bond with a wanted and self-soothing other.

In particular, in BN, the aggressiveness is mostly split off and not acted out since perceived as threatening and destroyable (Yarock, 1993), and the symptom of binge eating serves as a self-soothing method, and purging is engaged to regain the self-control (Willner, 2004), although exhausting affects could only be regulated through binge eating or vomiting (Granieri & Schimmenti, 2014). If AN is focused on, Hogan (1983) states that these individuals exhibit poor toleration to frustration and expect immediate gratification, which implies impulsivity. When it does not occur, they become furious and want to act aggressively, such individuals use denial and repression toward the wishes that create frustration and conflict (Hogan, 1983).

Regarding the sexuality link of ED, findings show that individuals with AN tend to express their sexuality in more childlike and normative ways, whereas individuals with increased purging history tend to express it in a more seductive and harmful way (Eddy et al., 2004). Wooldridge (2018) suggests that the pattern in their sexuality is a genital manifestation of their object hunger, whereas people with AN strictly defend against it, people with BN overconsume and then undo by vomiting. Since the patients with ED are bingeing or, on the contrary, severely restricting themselves, it is suggested that body of these patients are deprived in the sense of joy and desire (Graineri & Schimmenti, 2014).

When symptoms are approached from relational perspectives, Granieri & Schimmenti (2014) state that they might be manifestations of caring for oneself, hope for individuality, and relational capacity, and the person achieves autonomy to a certain extent through the symptoms.

The symptom of binge eating might be an episode of rejection of dependency and manifestation of anger due to the abandonment, and purging could be a representation of taking off the hazardous food that is extracted forcefully from the mother (Kernberg, 1995). On the other hand, the same symptoms can also be a symbolic form of uniting with the absent mother, taking and keeping her inside (Savelle- Rocklin, 2017), in other words an expression of object hunger but then it is followed by sense of shame, guilt and disgust arose from being ate mother as a whole, good and bad all integrated, that leads to vomiting which is a symbolization of undoing of object hunger (Yarock, 1993). Furthermore, restriction is mostly perceived as the rejection of the need for nurturing and dependency (Savelle- Rocklin, 2017; Yarock, 1993), which might imply a restricted relationship with external world and affects (Williams, 1997) and bulimia is confusion about needs and wishes (Savelle-Rocklin, 2017) or a relationship with the world to a larger extent through taking in and out (Williams, 1997).

It is suggested that the psyche and the soma are split in these individuals, and it is a way to sustain a relationship with objects without being occupied by them (Granieri & Schimmenti, 2014). Bruch & Garfinkel (1985) suggest that extreme controlling behavior on food and body, and also apparent weight loss, symbolize the personal belief in being effective and in control in relationships. Inability to regulate emotions could lead distorted relationship with food and not surprisingly, eating disordered patients perceive themselves as incompetent in relational aspects (Granieri & Schimmenti, 2014). Sands (2022) suggests that the desires and needs of eating disordered patients are dissociated through their bodies, where they are strictly controlled and attacked through symptoms, and in that way, they could sustain their independence from others.

Yarock (1993) suggests that the behaviors in BN, such as binge eating and purging, might be an unconscious representation of the sexual abuse (e.g., forced penetration and effort to get rid of the memory of it), which is mostly reported in their histories. Sometimes it is not reported, and when severe trauma is not encountered in the history of a patient with ED, the dissociated parts cannot be mentioned, not because they are not reachable, but because they are not permitted (Brisman, 2018). Maybe as an act out of dissociated parts,

Bromberg (2001) suggests, depending on his clinical observations, that ED symptoms are a natural result of dissociation.

#### **2.1.4. Empirical Studies on Eating Disorders**

Empirical research on ED spans a wide range of paradigms, including cognitive-behavioral (Williamson et al., 2004), neurobiological (Von Hausswolff–Juhlin et al., 2014), sociocultural (Ata et al., 2015), and psychodynamic approaches (Zerbe, 2015). However, depending on the scope of the study, relevant studies on the abovementioned headings would be mentioned in this section, such as trauma and ED relation, emotional issues in ED, and the effect of the act of eating is discussed.

Trauma and ED link has been shown in several studies, but the type of trauma and the type of ED have been controversial. For instance, it is found that trauma history was more frequent among both men and women diagnosed with BED and BN (Mitchell et al., 2012), but Brewerton (2007) suggested that it is more prevalent among individuals with BN. It is stated that, particularly, those who are diagnosed with BN reported interpersonal trauma frequently (Mitchell et al., 2012). As one might expect, it is observed that PTSD and disordered eating are comorbid in individuals (Mitchell et al., 2016; Trottier & MacDonald, 2017) and for the comorbidity, it is suggested that symptomatology of ED might ease escape from adverse memories and emotions of PTSD (Brewerton, 2004; Brewerton & Brady, 2014). The causality might be the other way around, such that the symptoms might prevent the individual from prospected danger, for instance, Mitchell et al. (2012) suggested that people with a sexual trauma history might want to change their body's appearance to seem less attractive to prevent another possible trauma.

Regarding the type of trauma, it is found that sexual abuse could significantly predict symptoms of ED in BN but not in AN (Tagay et al., 2014). The researchers also found that a sense of coherence could predict ED symptoms in both AN and BN. Different forms of abuse and neglect were also found to be associated with ED (Brewerton, 2007). For instance, Oliveria et al. (2023) reported that individuals who are exposed to bullying are at increased risk for developing ED. The study indicates that male individuals who were exposed to any kind of bullying -verbal, physical, and psychological- tend to exhibit oral

self-control behaviors, whereas no association between physical bullying and ED symptoms could be found for female individuals. It is added that individuals tend to show compensatory behaviors after engaging in binge eating episodes to prevent weight gain. From an interpersonal point of view, AN was significantly linked with decreased reflective functioning (Tasca & Balfour, 2014), which implies problems in relationships. Jenkins and O'Connor (2012) observed that patients with ED have a disparity between their emotional and cognitive level of understanding; they understand intellectually but not emotionally.

Regarding the emotional part of ED, the most relevant affects are disappointment, loneliness, sorrow, anger, and add that individuals with ED engage in suppression and rumination of these emotions (Dingemans et al., 2017). Brink & Allan (1992) underline that the intensity of negative emotions is one of the main distinguishing points between women with ED and without ED, thus hindering the convenient ego development. Authors suggest that these emotions in AN, buried in the deep layers of the psyche and defended against with denial, splitting, repression, and projection mechanisms. The key features of anorexic experience are as follows: anger, neediness, and guilt laid in the unconscious of women with ED are experienced as overwhelming ineffectiveness (Brink & Allan, 1992), and Bruch (1982) specified these are the cardinal features. In line with this statement, Strauss & Ryan (1987) underlined that the feeling of ineffectiveness is a unique feature of individuals with restrictive AN. They also reported that individuals with restrictive AN and individuals with bulimic AN had decreased self-other differentiation, applied self-regulation in a more controlling way, had worse familial communication, and felt compelled to meet internal standards of perfectionism. Similar to their findings, McLaughlin et al. (1985) underlined strict controlling ego in AN, and also these individuals and individuals with BN tend to be more field dependent, which might arise from limited self-other differentiation, and also reflecting their mistrust in their own internal experience. When BED is investigated, Dingemans et al. (2017) suggest that negative affect and dysfunctional affect regulation mechanisms contribute to the onset and persistence of bingeing in BED. In another study, bingeing and irritability were found to be associated, and depending on this finding, they hypothesize that escalation in irritability could cause binge eating or the other way around (Vanzhula et al., 2018).

Dieting is thought to be related to disordered eating behaviors, if one restricts a group of food intake, it ends with craving and bingeing of that group of food (Polivy & Herman, 1985). A proof might be that, majority of women with AN revealed that their distorted eating pattern had begun with dieting, whereas the majority of women with BN and BED patterns had started with binge eating (Hilbert et al., 2014). However, it is also beneficial to keep in mind that, food is basic need and learnt first way to regulate emotions, clinical experiences of Savelle-Rocklin (2017) show that lot of patient meet their needs, whether it is psychological or physiological, with food, for instance they turn to food to soothe themselves when they are tired.

## **2.2. Dreams**

Dreams have been a subject of interest across various disciplines; however, psychoanalysis has offered some of the most influential and enduring frameworks for understanding the meaning and function of dreams. In the current study, a foundational understanding of how dreams are theorized and studied is essential – particularly before turning to the intersection of dream content and disordered eating. To establish that groundwork, in the following subsections, first, psychoanalytic perspectives on dreams will be reviewed in detail. Then, neuroscientific and cognitive perspectives on dreams will be explained, and lastly, emprical studies on dreams will be presented.

### **2.2.1. Psychoanalytic Perspectives on Dreams**

Beginning with Freud, psychoanalysis has long attempted to theorize dreams. Some of the most comprehensive theories relevant to this study have been offered by Sigmund Freud, Carl Gustav Jung, and Wilfred F. Bion, whose perspectives will be discussed in the subsections below. Additionally, the ideas of other psychoanalysts, such as Sándor Ferenczi, W. R. D. Fairbairn, and Heinz Kohut, will also be briefly presented.

### **2.2.1.1. Sigmund Freud's Dream Theory**

Freud's interest in dreams was initiated as he noticed his patients telling them during free association, and he started to analyze his dreams and also the dreams of the people around him (Auchincloss, 2015). He suggests that the ego is unable to sustain its inhibitory function during the sleep period so that the desires are satisfied via dreams in this time period (Auchincloss, 2015). The dream theory of Freud emphasizes two main purposes of dreams: to shelter the sleep and fulfill the repressed infantile wishes (Freud, 1955). In his own words, Freud (1955) states that "a dream is a (disguised) fulfillment of a (suppressed or repressed) wish" (p.183) and "guardians of sleep" (p.253). According to him, dreams consist of two parts: the manifest content and the latent thought. Manifest content refers to the narrative part that is recalled and narrated by the dreamer, whereas the latent thought is the hidden aspect and could be analyzed through associations of the dreamer (Coolidge, 2006). The latent thought of a dream needs to be changed and transformed into manifest content to bypass the censor mechanism, which is responsible for keeping unacceptable materials out of awareness (Auchincloss, 2015). The latent thought is attached to day's residue, or current conscious experience, through dream dream-making process, and this way, it could go through censorship and be experienced as a dream (Auchincloss, 2015). Otherwise, the "unconscious wishes" that are not disguised enough would cause anxiety, and the sleep would be interrupted (Auchincloss, 2015, p.95). The unconscious wishes that are libidinal or aggressive in nature, disguised through mechanisms called displacement, condensation, conditions of representability, and secondary revision, and this whole process is called "dream work" (Perelberg, 2000, p.4).

Freud insists that dreams serve for the wish-fulfillment function although they might seem saddening on the surface and exemplifies with the following instances, someone might have a loved one passed away in a dream and it still serves for the function, the loved one might be desperately ill and the death would end the one's pain or from the dreamer's perspective, the sorrow would come to an end (Coolidge, 2006). When a healthy loved one passes away in a dream, Freud explains it from the Oedipus complex that mostly

males have their fathers pass away in their dreams, whereas females have their mothers (Coolidge, 2006).

He also acknowledges that there are frightening dreams and anxiety dreams which seem contradictory to the wish-fulfillment function and he explains that the conscious ego is still on duty to some extent during sleep and when a repressed desire or wish is staged in the dream, the conscious part of the ego acts fiercely and the dreamer wakes up in an anxious state or the ego penalize the dreamer for having improper desire in the manifest content (Coolidge, 2006). Another possibility offered by Freud is that the unconscious produces the penalty in order to penalize the wish which is common in masochistic personalities (Coolidge, 2006). Freud (1955) also points out that there are people who have masochistic material in their sexuality rooted from “reversal of aggressive and sadistic component” to its counterpart and it seems plausible for these people to have unpleasurable or “counter-wish dreams” and it still serves for the wish fulfillment function (p.182).

Later on, Freud (1962b) refreshed his theory on dreams and emphasized that there are dreams that are contradictory to the wish-fulfillment function, such as anxiety dreams, trauma survivors’ dreams, or nightmares. He explained that recurring dreams in trauma are a form of repetition compulsion in which the traumatic situation is re-enacted unconsciously to make the event part of the psyche.

#### **2.2.1.2. Carl Gustav Jung’s Dream Theory**

Before moving to Jung’s dream theory, it is crucial to understand his model of the psyche. Jung suggests that the psyche has three main parts: ego, personal unconscious, and collective unconscious (Coolidge, 2006). According to Jung, self is the center of the whole psyche and responsible of it’s order and the term is used when referring to the psyche as a whole and also is “archetypal basis of the ego”, whereas the ego, which is ‘I’, is the center of the personal consciousness (Hall, 1983, p.10).

Personal unconscious is a storage for complexes, which are clusters of similar images kept together with a shared affective nuance and had been conscious before but now

suppressed or repressed, and is also the storage for various emotions, experiences, and thoughts that are suppressed or forgotten (Coolidge, 2006). Whereas the collective unconscious keeps the “archetypal images” or archetypes, which can be explained as a tendency to think in a particular way, for instance, people tend to form a mother image, but the image would be peculiar for everyone (Coolidge, 2006; Hall, 1983, p.10). Complexes are built on “archetypal core,” and their structure could be changed by the ego and the self (Hall, 1983, p.34). The self could play both direct and indirect roles in this process, such as through dream-making and forcing the ego to face challenges that had been previously avoided (Hall, 1983).

According to Jung, the self is composed of personality structures and interpersonal structures: ego and the shadow could be mainly defined as personality structures, whereas persona and anima/animus were to be interpersonal structures (Hall, 1983). The shadow carries qualities such as sexuality or aggressiveness that are dissociated from the ego in childhood, but later on in adulthood, they should be integrated into the ego for healthy functioning (Hall, 1983). Animus and anima, which are also fantasy or dream items, could be understood as gender roles, such as features that are accepted as inappropriate for women are combined around animus, whereas features that are accepted as inappropriate for men are clustered around anima (Hall, 1983).

Jung shared the idea with Freud that dreams provide information from the unconscious of an individual, although everyone shares the collective unconscious in his theory, the information in the dream is custom-made for each individual (Coolidge, 2006). He posits that dreams could show the psyche’s deeper parts (Hall, 1983). However his ideas depart from Freud’s in the sense that he does not believe in the latent thought of a dream, rather they are symbols, but not in a disguised form, of the psyche such as animus, anima, ego, self, archetypes, complexes and ego’s missions (Hall, 1983). Dream symbols are the representation of archetypes or primordial images that are produced by consciousness, and the roots of the symbols are embedded deeply in our history of evolution and might not even have a human origin (Coolidge, 2006).

Furthermore, he suggests the dreamer’s context should also be taken into account for dream interpretation, for instance, a dream of a key opening a lock might not be a distorted

version of an intercourse for a locksmith (Coolidge, 2006). Apart from Freudian dream interpretation, Jungian dream interpretation points out the risk of evaluating a dream as wish fulfilling that could cause discouragement in the individual, for instance, the smokers usually dream about smoking after they quit, this shows the continuing shadow activity in the “ego-identity”, but the ego is not attached with it anymore (Hall, 1983, p.13).

For the function of dreams, Jung suggests that dreams provide a compensatory function in which they compensate for the partial perspective of the conscious ego by providing a contradictory perspective of it to the ruling ego (Hall, 1983). The compensatory function could be exemplified as follows: someone who might be outraged at his friend might hold himself back from being furious at him, and later on, could have this scene in a dream (Hall, 1983). Moreover, dreams could forward messages to the ego, especially when it needs close monitoring in the “individuation process”, which is a process of personal effort to apprehend and promote inborn potentials (Hall, 1983, p.24). The interpretation of them tells us the effort of the unconscious in changing and direction of the “ego-image” through individuation and well-being (Hall, 1983, p.28). He suggests that, conscious and unconscious are linked to each other for psychological and physical health, otherwise psychological problems may arise and also the symbols in dreams should be perceived as messengers from instinctive part of oneself to the rational part and the interpretation of them provides a chance to learn to listen to the instincts and enriches the conscious (Jung, 1968).

Further in the therapeutic dyad, Jung suggested that dreams could be a useful tool for analysts for diagnosing, deciding about the medication, session frequency, and even for hospital stay (Hall, 1983). For instance, a dream of a patient with the “psychogenic depression”, which is related to insufficiently expressed anger in the consciousness and the anger is turned toward oneself, could include another person acting aggressively toward the “dream-ego” (Hall, 1983, p.68). Also the reflection of an improvement of an analysand could be seen in her dreams, for instance a lady with depression had been dreaming of herself being surrounded by poisonous animals during night time and as she became more assertive, her depression level decreased which led her to dreams of less

threatening animals in distant and the scenery changed into day time from the night (Hall, 1983).

### **2.2.1.3. Wilfred R. Bion's Perspective on Dreams**

Before moving to Bion's perspective on dreams, the terms he contributed to the psychoanalytical theory should be explained briefly. Bion claims that there are alpha and beta elements in the mental processing (Bion, 1962). If these were to be exemplified from early experiences, Bion asserts that when an infant is disturbed and anxious, she projects these unbearable sensations, which are called beta elements, into her mother and a capable and attuned mother could contain and transform them in her unconscious and respond to the infant accordingly by decreasing the disturbance of sensations and giving meaning to them, which are now called alpha elements (Segal, 1993). Then the infant could introject the "maternal object" as a container which could contain disturbing feelings and process them in a meaningful way, and give back to the infant, and this whole process is called alpha function (Segal, 1993, p.81). Briefly, beta elements are unprocessed perceptions and feelings that can be used solely for projective identification and acting out (Bion, 1962; Segal, 1993). These beta elements are needed to be discarded (Segal, 1993). The alpha function plays a role in this process by changing beta elements into alpha elements, which could be repressed, processed, kept in memory, and used for dream thoughts (Bion, 1962; Segal, 1993). If there only existed beta elements, there would not be "repression, suppression, or learning," and this would leave one unable to discriminate and unable to become unaware of any "sensory stimuli," and this hyperarousal is not compatible with reality (Bion, 1962, p.8).

According to Bion, affective experiences that take place during daily life and sleep are not different from each other, both experiences have to be transformed into alpha elements via alpha function before they can be included in the dream thoughts (Bion, 1962). The alpha function operates on affects and sensations and makes them conscious and ready for dream thought: if the function cannot operate, then the affects and sensations remain the same, and one could not dream (Bion, 1962). Alpha elements,

which are transformed from affective experiences, appear in dreams as visual imagery (Bion, 1962). Bion asserts that if someone has an affective experience during sleep or during waking life and is capable of transforming them into alpha elements, then the experience could either stay unconscious or become conscious for the one (Bion, 1962). As the affective experience during sleep becomes alpha elements, dream thoughts become available to the one, so the one is able to become conscious and narrate the experience that “usually known as dream” (Bion, 1962, p.15).

#### **2.2.1.4. Other Psychoanalytical Perspectives on Dreams**

Sandor Ferenczi shares similar ideas with Freud that dreams serve for wish-fulfillment function, but he makes a distinction that some of adults' dreams and most of children's are in line with this function (Ferenczi, 1910). He exemplifies the idea with children having the most-liked toys in their dreams and adults having back their beloved deceased in their dreams. Similar to Freud, he states that repressed unacceptable things appear in dreams (Ferenczi, 1910). Another example of Ferenczi, regarding the function is that, the nerve stimuli both from inner sources -such as thirstiness- or outer sources -such as pressure on a body part-, occurring during one's sleep, are distorted and appear in the dream with the wish-fulfillment quality like a thirsty man drinks liters of water in his sleep (Ferenczi, 1910). Regarding the meaning of dreams, Ferenczi states that although there are common dreams for everyone, the meaning ascribed to them might be different for each individual and even for the same person at different times (Ferenczi, 1910). Later on, he became the first one to refer to the recurring traumatic event in the dream (Flanders, 1993). Ferenczi points out the “traumatolytic function of dreams” to refer to recurring dreams that occur after a traumatic event, with the need to be resolved and mastered (Ferenczi, 2002).

Moving to the British Object Relations School, Fairbairn (1994) suggests that dreams prove the fact that everyone is schizoid at deeper levels. He underlines Freud's observation on dreams that people usually have two or more people in their dreams, and he adds that these people reflect an aspect of the dreamer or symbolize an object the

dreamer relates to through an aspect of her personality, usually with identification, from her inner reality (Fairbairn, 1994). Furthermore, he disagrees with Freud about the wish-fulfillment function of dreams; rather, he posits that dreams are short versions of the events taking place in the inner reality (Fairbairn, 1994). Dreams, as well as fantasies during waking life, reflect the relationships between endopsychic structures (Fairbairn, 1994).

Heinz Kohut, who is a representative of Self Psychology, agrees with the idea that most of the dreams are disguised illustrations of wishes, drives, or conflicts (Livingston, 1998). Further, he noticed that the free association of some dreams did not reveal essential latent thought (Kohut, 2009; Livingston, 1998). He suggests that these dreams and their associations could be perceived as an expression of and an effort to link the anxiety or dread of self-fragmentation through the utilization of visual imagery (Kohut, 2009; Livingston, 1998). The process of covering the non-verbalizable dread with the narratable imagery is an attempt of healthy parts of the person's psyche to cope with the anxiety of psychological threat (Kohut, 2009). Kohut called such dreams "self-state dreams" (Kohut, 2009, p.109). Regarding the traumatic experiences, he suggests that the trauma material is linked with less disguised dream material and could be seen through the manifest content (Kohut, 2009).

### **2.2.2. Theoretical Approaches to Dreaming Beyond Psychoanalysis**

Several functions have been proposed for dreams. For instance, Revonsuo (2000) investigates dreams from an evolutionary perspective and proposes the threat simulation hypothesis in which dreams provide a rehearsal opportunity for people on how to behave when faced with a threat. The chance for reproduction increases as one rehearses threat avoidance and threat perception during the sleep period through dreams (Revonsuo, 2000). Similar to this functionality, there are theories evaluating dreams from an information processing, memory, and learning perspective, suggesting that during sleep, the data is processed and combined more flexibly, providing new ways to solve the life problems of the dreamer (Breger, 1967; Greenberg, 1970).

Levin & Nielsen (2009) think that dreaming is a natural way of self-regulation and causes extinction of fear by decreasing or even eliminating fear-loaded memories, so nightmares show the disruption in the emotion regulatory system. They propose a model called “The AMPHAC/AND” which highlights that disturbing dreams occur from disruption in emotional processes (p.86).

Far from these, Hobson & McCarley (1977) adopt a non-functional point of view by suggesting random quality of dreams and propose the activation- synthesis hypothesis in which neural activity persists during sleep and the brain tries to combine and make sense of this internal activity, similar to combining sensory data during waking life, which in turn causes dreams.

Briefly, Scredl (2003) summarizes dream hypotheses in three groups as follows: the compensation hypothesis, in which discarded issues in daily life appear in dreams, the random dreams hypothesis, which states that dreams have incidental content, and the continuity hypothesis, which dreams are a reflection of daily life. Domhoff (1996) states that continuity hypothesis is usually perceived as continuity of waking behaviors and waking thought in dreams but sometimes, it could only be continuity of waking thoughts in dreams further he exemplifies this with people who do not have aggressive manners in daily life but have aggressiveness in dreams report having thoughts and fantasies in that theme.

### **2.2.3. Empirical Studies on Dreams**

Domhoff (2010) reports that when people are young, their dreams differ mostly depending on gender and individual features. The author also states that psychological well-being could play a significant role in dream formation, but the research could not go beyond the point that patients with a psychiatric diagnosis have fewer social interactions in their dreams. It is also suggested that, similar to Freud’s “day’s residues” (Freud, 1955, p.564), an individual’s life experiences, thoughts, and likenings contribute to dream content and make them unique for each individual (Domhoff, 2010). Moreover, about the uniqueness, Zadra & Domhoff (2016) assert that dream content mostly clusters around personal issues such as relationships with colleagues, family members, and friends. They

suggest that, contrary to early theories pointing out the dreams as symbolic and disguised, dreams were to be clearer.

Regarding the sex-related differences in dreams, Cappadona et al. (2021) state that the dream content of men includes more physical aggression, whereas women's includes more family-related scenes. In the same study, the agency of the dreamer also shows sex-related differences; men dream themselves as a third person, whereas women dream as first person. Women have nightmares more frequently, and the difference is found to be related to sleep disorders and psychiatric disorders (Cappadona et al., 2021).

The following findings could answer the question of continuity or discontinuity of waking life to the dream life. Zheng et al. (2024) found that men and women differed in their use of words in dreams, which is similar to the differences found in waking life. Another support is from Kröner-Borowik et al. (2013)'s article, who reported that when participants are instructed to suppress undesirable thoughts just before sleep, they had more of the thoughts and stress in their dreams compared to the non-instructed group. Skancke et al. (2014) argue the same question in their review paper on the findings of psychiatric patients' dreams, and they state that some aspects of their lives continue in their dreams, whereas some do not, and they suggest that this might serve as a compensatory function. Referring to the symbolic quality of dreams, they also suggest that the reported discontinuity in the other aspects might change if the definition of discontinuity changes.

The effect of somatic experiences and psychopathological dreams seems to continue in dream life as well. Mathes and Schuffelen (2023) investigated patients with chronic pain and found that they have nightmares, nightmare stress, and pain dreams more often compared to the healthy control group. The researchers also found that these patients had more negative and anger-related content in their dreams to a significant degree. In another study, it is reported that the level of stress significantly correlates with nightmare recurrence and alexithymia level (Obrebska & Rohoza, 2021). It is found in the study that people with alexithymia have schema-like and expressive dreams. They are less likely to remember them, which might be due to difficulty in verbalization of affects that distorts reconstruction and decoding of them (Obrebska & Rohoza, 2021).

From the compensatory hypothesis or continuity hypothesis, one could raise a question about dissociated parts of the self. Gabel (1989) thinks that dreams might include judgements, evaluations, supportive and confronting comments about the perspective of the conscious ego when faced with external or internal events. Depending on these, the author suggests that dreams might reflect dissociated mental products of the individual. Dreams of people with differing dissociative disorders were investigated and found that the most frequent event was the repressed memories were recovered (Barrett, 1994). Also, the same research highlights that patients with multiple personality disorder had their alters in their dreams. Bob (2004) points out that affective and synaptic work play an important role in memory formation, such as inhibition of a negatively loaded state might lead to dissociation, from milder forms like repression to severe forms such as splitting. Depending on the research findings on multiple personality and dissociative states, the author suggests that dreams of healthy individuals also show the relationship between the dissociated parts of the self and their arrangement within the self.

Keeping in mind that the majority of individuals with ED are insecurely attached (Tasca & Balfour, 2014; Zaccrisson & Skårderud, 2010), studies about the effect of attachment on dreams were investigated. Sándor et al. (2018) found that attachment anxiety was related to emotions in dreams to a significant degree, whereas attachment avoidance was not. They suggested these results might indicate that attachment anxiety, which includes the negative perception of oneself, is a stronger predictor of negative emotional states affecting sleep and dreaming patterns compared to attachment avoidance, which includes negative perception of others. They also found that participants with secure attachment had more positive and less negative affect in their dreams compared to participants with dismissing and preoccupied attachment. In contrast to the previous study, Selterman & Drigotas (2009) proposed that people with different attachment styles would have different contents in their dreams. The results showed that dreams of people with anxious attachment and avoidant attachment included more distress, conflict, anxiety, and jealousy, whereas securely attached people's dreams were not related to any feeling. Similar to these findings, another study found that people with insecure attachment had intense emotions in their dreams and were more likely to report pessimistic and regressive affective content and more nightmares compared to securely attached participants

(McNamara et al., 2001). In the same study, no differences were detected between securely and insecurely attached participants in the means of attachment-related content in dreams, such as loneliness, love, and relatedness.

Related to insecure attachment, studies about the effect of childhood traumatic experiences on the dream life of adults were also investigated. Ma et al. (2022) researched adults and found that early experience of emotional neglect, which is counted as an adverse childhood experience, is associated with changes in dream content. Researchers depicted that the severity of those experiences is negatively correlated to dreams that include characters and social interactions, but positively correlated to dreams including objects. Depending on these findings, Ma et al. (2022) proposed that these adverse experiences could distort one's relationship with people and objects; thus, to cope with emotions such as fear, despair, and loneliness, one could turn to objects rather than turning to social interactions. For instance, one could prioritize meeting physiological needs to psychological needs, like eating more, and these changes could lead to decreased social interactions and escalation of objects in dreams (Ma et al., 2022). Similar to these results, Yu & Au (2023) propose, depending on their findings, that childhood trauma could account for dysfunctional attachment dynamics in adulthood, and as a result, these dynamics could lead to "paranoiac dream experiences" to a certain extent but insecure attachment could not show the link between adverse childhood experiences and current dreams totally (p.230).

Regarding the trauma and dream link, Mathes et al. (2022) found that people with traumatic experiences in their childhood or people who had a major life-changing event recently tend to have distress in their nightmares, also people in the former group are more possibly experience nightmare distress when they become adults. In line with this, Duval et al. (2013) found that women who reported high on the severity of maltreatment in their childhood also had disturbing dreams more often and increased nightmare stress and high levels of psychopathology. Nielsen et al. (2019) report that adults who tend to have nightmares more also scored higher on measures of adverse childhood experiences. Separation adversity that takes place in the first 6 years of life is found to be related to nightmare severity in the same study.

As one might expect, people who had more nightmares tended to report childhood traumatic experiences and scored significantly higher on dissociation measures (Agargun et al., 2003). The researchers suggest that people who had traumatic experiences in childhood were not able to integrate the experience psychologically and coped with it via dissociation, which is related to nightmares later in life. Similar to this, referring to the compensatory hypothesis, Fischmann et al. (2021) propose that the dreamer, with the need for safety, might attempt to free itself from overwhelming affects such as fear, anger, helplessness, and inability aroused from traumatic experience by adopting a more active role in dreams repeatedly.

### **2.3. Eating Disorders and Dreams**

The current study aims to investigate the dreams of people with ED or people with disordered eating habits. So, researches conducted in line with the aim of the current study are searched for. Food is the central theme of ED, and research about food-related content in dreams is as follows. Individuals with ED tend to dream about food compared to depressive people (Dippel et al., 1987) and healthy controls (Skancke et al., 2014). In particular, people with BN tend to have food in their dreams slightly more than twice of people with AN (Dippel et al., 1987). In line with the previous study, Schredl & Montasser (1999) report that people with AN had dreams that include rejection of food and feminine role and lack of relationships, decreased number of people, communication, and male figures, whereas people with BN had a higher number of dreams including food and eating theme.

Since it is supported that individuals with ED are more likely to experience negative affects (Brink & Allan, 1992; Dingemans et al., 2017), its reflection on dreams reveals several results. People with ED had more negative and intense emotions in their dreams compared to the control group (Brink & Allan, 1992; Frayn, 1999; Schredl & Montasser, 1999). Similar to this finding, in their review paper, Skancke et al. (2014) state that people with ED differ in the means of affects and how they show them. They suggest that the difference in dreams of people with AN might serve the function of “discontinuation and compensation” that arises from hardship in emotional expression in this specific diagnosis

group (Skancke et al., 2014, p.48). In particular, patients with BN tend to have dreams that include more negative affects (Dippel et al., 1987; Schredl & Montasser, 1999). However, it failed to find significant differences between the patient group consisting of AN and BN and the control group in the means of intense dream affects, dreams of aggression, and wish for achievement (Schredl & Montasser, 1999).

Regarding the specific themes, it is common that individuals with ED experience helplessness in their dreams (Brink & Allan, 1992). Women with these disorders have dreams that contain violence, suicidal themes, being chased away, choking, suffocation, body parts, and unearthly creatures (Brink & Allan, 1992; Thoma, 1967). There are also dreams of food, specifically aggression is directed toward the dreamer by food, or food that is unsatisfactory, inaccessible, or inedible, or a huge amount (Levitan, 1981; Selvini-Palazzoli, 1974; Thoma, 1967). In particular, women with AN have dreams of repressed aggressive and sexual wishes (Levitan, 1981; Sours, 1980). Mellen et al. (1993) found that participants with ED dream that hostility is directed toward themselves in their dreams. In contrast, in another study, it was found that participants with ED were less hostile in their dreams when compared to control groups, while participants with BN reported more hostility compared to the AN group, and participants with AN had more anxiety in their dreams compared to other groups (Kramer, 2000).

Continuing with the themes in a wider scope, ED and dreams that contain ineffectiveness, hate of oneself, experiencing anger, inability to nourish oneself, being attacked, being controlled, watched and judged by others and experiencing negative affects were found to be related (Brink & Allan, 1992; Brink et al., 1995). These people dream about babies being nurtured in an insufficient or improper way that might be an implication of their child-like condition and their struggle to meet them (Brink et al., 1995). Also, another significant relationship was dreams that were being observed by others with a sense of guilt and the dreams ending negatively (Brink et al., 1995). It is proposed that it stems from 'repression, projection, projective identification and introjection of rage' in early childhood (Brink et. al, 1995, p.340). They suggest that the rage turned against the self is obvious in the dreams, such that the dreamer is behaved in a hostile way or dreams have negative endings or an increased amount of negative affect in their dreams, which is the core dynamic of ED, repressed primary rage. The authors underline that women with ED

are unconscious of their psychological traits, and the authors comment that the dreams of these women could be understood from the compensation function of Jung's Dream Theory (Hall, 1983). Taken together, these results, Brink et al. (1995) suggest that they appear to show the fundamental belief of the dreamer about itself is worthless and bad. These beliefs also contribute to the development and persistence of the disorder (Bruch, 1985).

#### **2.4. Current Study**

Some studies showed that traumatic experiences, neglect, emotional abuse, and maltreatment in the childhood period are frequently reported by people with ED (Allison et al., 2007; Palmisano, 2018b). Since all of these experiences could be experienced as traumatic events by the child, dissociation, which is a natural response to trauma (McWilliams, 2011), is found to be associated with eating disorders (La Mela, 2011; Palmisano et al., 2018a; Palmisano et al., 2018b). Through dissociation, the unpleasant experiences could be kept away from conscious awareness (Van der Kolk et al., 1996), and this dissociated part could contain bits and pieces of "childhood depression" (Bose, 1995, p.401). Dissociation is a "form or variant of repression" (Singer, 1995, p.xviii) and repressed materials, along with the parts of the self that create conflict are stored in the unconscious (Freud, 1962a), and dreams could be a way to reach out to one's unconscious where conflicts, desires and fears are kept (Freud, 1955). Besides possible indirect dissociation and dream content link, there could also be a link between having symptoms and differing dream content. In a study, Rimsh & Pietrowsky (2021) found that the dream contents of patients diagnosed with anxiety disorder significantly differed from the healthy control group in the means of elevated number of characters, negative themes, and decreased friendship interactions and successes. And also early experiences and dream link might be possible as well, as shown by the following study, Selterman & Drigotas (2009) investigated whether dream contents differ depending on the attachment style and found that people with insecure attachment had higher levels of stress, conflict, anxiety, and jealousy in their dreams.

In the current study, our aim is to shed light on the link between disordered eating and dream content. To the best of our knowledge, this is the first study in Türkiye that explores this link. Eating disorder diagnosis and related questions were asked of the participants to create a diagnosed group as well, but the sample size was too small to create group. Also, the nature of the current study depends on self-report, so answers that were given to the diagnosis questions would not be reliable. Moreover, if the study were to only include officially diagnosed clinical samples, then undiagnosed participants with disordered eating would be left out, thus we would fail to reflect the variations in it. Depending on the same reasons, the scope of the hypothesis was kept broader, such that it refrained from hypothesizing specific disordered eating habits and specific dream theme links. Any differences observed for specific themes are exploratively inspected.

This study focused on adults with disordered eating, mainly because adolescence is a period when significant changes related to emotion regulation, identity formation, and cognitive processes, which could affect eating habits and dreaming, could take place. Whereas adulthood is a period when these changes are more stabilized, and a more consistent interpretation of dreams can be done without any developmental variability.

The knowledge gained from the study would also provide benefits for the clinicians who work with the ED. Glucksman (2001) proposes that dreams could be used as a tool during the therapeutic process, such as from understanding the psychic organization of the individual, psychopathology of the one to the predicting transference and resistance. So clinicians would reach to unspeakable unconscious material of the clients with ED or have a tendency to it through their dreams and understand about the dissociated parts and provide material for the client who is unaware of them.

## METHOD

The aim of the study is to investigate whether dream themes of people with disordered eating habits differ from dream themes of people with none or less disordered eating habits. The data consisted of self-reports, and a cross-sectional design was used. The characteristics of sample, the tools provided for the participants, the procedure, and the data analytic strategy are respectively covered in the following sections.

### 3.1. Participants

Inclusion criteria for the current study were voluntarily participating by completing the online survey, and being between the ages of 20 and 60, since adulthood typically starts around the age of 20 and old age starts around 60 (Lachman, 2001). In order to eliminate the confounding effects of adolescence and aging on both eating and dreams, participation was restricted to adults.

A total of 233 participants responded to the online survey. Of these, 5 participants were excluded due to not meeting the age inclusion criterion, and 1 participant was removed due to missing data on one or more research variables.

Additionally, 11 participants reported being diagnosed with an eating disorder; 3 were diagnosed with bulimia nervosa, 2 with anorexia nervosa, 3 with other specified feeding and eating disorder, 1 with unspecified feeding and eating disorder, 1 with pica, and 1 preferred not to disclose the diagnosis. Due to the small size and heterogeneous nature of this subgroup, it was not feasible to include them in the analysis as a separate condition. Including this subgroup would have significantly reduced the statistical power of the study and increased the within-group variability thus limiting the interpretation and reliability of the results. Therefore, these participants were excluded from the final sample.

After excluding 17 participants in total, the final sample consisted of 216 participants with valid responses. The demographic characteristics of the sample are presented in Table

3.1. The age of the participants ranged between 20 and 60, and the mean was 33.48 (SD = 10.40). 167 participants identified themselves as female (78.0%), 47 as male (22.0%), and 2 (0.9%) as non-binary. Due to the very low number of participants who identified as non-binary, they were excluded from analyses that included Gender as a variable.

**Table 3.1. Demographic Characteristics of Participants (N = 216)**

		<i>N</i>	%
Gender	Female	167	77.3
	Male	47	21.8
	Non – binary	2	0.9
Education	Primary School Graduates	2	0.9
	High School Graduates	9	4.2
	Undergraduate Degree Holders	125	57.9
	Graduate Degree Holders	80	37.0
Work Status	Working	163	75.5
	Not Working	53	24.5
Field of Work	Healthcare	54	33.1
	Education	26	16.0
	Engineering	9	5.5
	Finance	7	4.3
	Law	5	3.1
	Other Fields	50	30.7
	Not disclosed	12	7.4

Regarding level of education, the sample consisted of 2 primary school graduates (0.9%), 9 high school graduates (4.2%), 125 undergraduate degree holders (57.9%), and 80 graduate degree holders (37.0%). Due to the very low number of participants with a degree below high school, they were excluded from analyses that included level of education as a variable.

In terms of work status, 163 participants reported working (75.5%) and 53 not working (24.5%). Among working participants, 54 participants reported working in healthcare (33.1%), 26 were in education (16.0%), 9 were in engineering (5.5%), 7 were in finance (4.3%) and 5 were in law (3.1%), 50 participants were working in other fields (30.7%) and remaining 12 participants did not disclose their field of work (7.4%).

The psychosocial background and mental health history of the sample are presented in Table 3.2. Since experiencing a major life event in the last month, such as a move, death of a loved one, or quitting a job, could affect one's eating attitudes and behaviors, it was asked to participants. Among participants, 50 people (23.1%) reported experiencing it, whereas 166 people (76.9%) reported none.

Previous psychological support was asked and among the sample, 150 participants (69.4%) reported had received and 66 participants (30.6%) reported not had received. Among the participants who received support, 98 people (65.3%) applied for multiple reasons, 21 people (14.0%) applied for general reasons and self-recognition, 12 people (8.0%) applied for depression, 11 people (7.3%) applied for anxiety, 4 people (2.7%) applied for relational issues, 1 person (0.7%) applied for trauma, and 3 person (2%) applied for other reason. Participants were also asked whether they had a psychiatric diagnosis; 51 (23.6%) reported having a diagnosis, and 165 (76.4%) reported not having a diagnosis.

Regarding previous and current utilization of psychiatric medication, 136 (63.0%) participants reported not having used none whereas 80 (37.0%) of the participants reported having used at least one type of psychiatric medication. Those who reported having used, 51 (64.0%) used antidepressants, 19 (24.0%) used more than one type, 1 (1.0%) reported using stimulant and/or non-stimulant, and 9 (11.0%) unspecified the medicine used.

**Table 3.2. Psychosocial Background and Mental Health History (N = 216)**

		<i>n</i>	%
Major Life Event	Yes	50	23.1
	No	166	76.9
Previous Psychological Support	Yes	150	69.4
	No	66	30.6
Reason of Psychological Support	Multiple Reason	98	65.3
	General / Self-Recognition	21	14.0
	Depression	12	8.0
	Anxiety	11	7.3
	Relational Issues	4	2.7
	Trauma	1	0.7
	Other	3	2.0
Psychiatric Diagnosis	Yes	51	23.6
	No	165	76.4
Psychiatric Medicine	Yes	80	37.0
	No	136	63.0
Psychiatric Medicine Type	Antidepressants	51	64.0
	Multiple Psy. Med	19	24.0
	Stimulant & Non - st.	1	1.0
	Unspecified	9	11.0

*Note.* Multiple Psy. Med = Multiple Psychiatric Medicine; Stimulant & Non-st. = Stimulant & Non – stimulant

## **3.2. Instruments**

The instruments utilized for the current study are a Demographic Form, Turkish version of the Eating Disorders Examination – 13 Form (EDE-Q-13; Esin & Ayyıldız, 2022), and Dream Themes Scale (DTS; Genç, 2011).

### **3.2.1. Demographic Form**

The Demographic Form was constituted by the researcher. The Demographic Form (see Appendix C) contains 18 questions that aim to gather information about participants age, gender, education level, occupation status, work field, recent experience of major life event, experience of psychological/psychiatric support and the reason, psychiatric diagnosis status, previous and current psychiatric medicine utilization, name and amount of the medicine, ED diagnosis status, time of the ED diagnosis, name of the diagnosis, status for the support for ED, and type of the support.

### **3.2.2. Eating Disorder Examination Questionnaire – 13 (EDE-Q-13)**

The original Eating Disorder Examination Questionnaire (EDE-Q) consists of 28 items and was developed by Fairburn and Beglin (1994) in order to measure symptoms of ED and has been found to be a reliable and valid scale in various populations and languages, including Turkish (Yücel et al., 2011). The scale consisted of 4 subscales: Restraint, Eating Concern, Weight Concern, and Shape Concern (Fairburn & Beglin, 1994). However, the analysis run with different population groups fails to support the structure of 4 factors (Rand–Giovannetti et al., 2020; White et al., 2014). This problem led researchers to develop shorter versions of the scale and one of them named EDE-Q-13 and developed by Lev-Ari et al. (2021a) as a 13 item self-report questionnaire with 5 subscales that are Eating Restraint (item no: 1, 2, 3), Shape and Weight Over-Evaluation (item no: 4, 5), Body Dissatisfaction (item no: 6, 7), Bingeing (item no: 8, 9, 10), and Purging (item no: 11, 12, 13). The scale measures participant’s eating habits on the last

28 days and is presented in 7-point Likert style in which 0 is 0 days, 1 is 1-5 days, 2 is 6-12 days, 3 is 13-15 days, 4 is 16-22 days, 5 is 23-27 days and 6 is everyday.

The scale had a positive correlation with the EDE-Q, and Cronbach's Alpha values were found to be .99 for Shape and Weight Over-Evaluation, .89 for Body Dissatisfaction, .92 for Eating Restraint, .89 for Bingeing, and .63 for Purging subscales (Lev-Ari et al., 2021a). Each subscale score is calculated by taking the average of the item scores that belong to that subscale, and the total score of the scale is obtained by computing the mean of the five subscale scores (Lev-Ari et al., 2021a).

Turkish adaptation studies of the EDE-Q-13 (see Appendix D) were conducted by Esin & Ayyıldız (2022) and found to be a reliable and valid scale, in which Cronbach's Alpha coefficient was .89 and criterion validity was proved with other related scales. The Cronbach's Alpha value for the 5 subscales ranged between .75 to .94 (Esin & Ayyıldız, 2022). The Turkish version of the Eating Disorder Examination Questionnaire-13 was used in the current study in order to measure disordered eating habits of the participants.

The Cronbach's Alpha coefficients for the current study was found to be .912, and Cronbach's Alpha for the subscales were as follows: .945 for Eating Restraint, .962 for Shape and Body Overevaluation, .939 for Body Dissatisfaction, .889 for Bingeing, and .668 for Purging.

### **3.2.3. Dream Themes Scale**

The Dream Themes Scale (DTS; see Appendix E) was developed by Genç in 2011 and found to be a reliable and valid scale (Genç, 2011; Genç et. al, 2013). It consists of 29 items, 5 subscales (Negative Themes, Anxiety Themes, Fear Themes, Effects of Experiences, Inhibition Themes) and a 5-point Likert scale (0=never, 4=always). Briefly, the scale measures participant's dreams in the last 6 months in different themes and, the subscales, in detail, measure the following respectively; people who have negative thought content about themselves would expected to have negative themes in the dream, people who have anxiety in their thought content would expected to have anxiety in their dreams, people who have fear in their thought content would expected to have fear in

their dreams and people might have effects of their daily experiences in their dream, the fourth subscale measures it and lastly people who have inhibition in their thought content would be expected to have inhibition themes in their dreams. Some instances regarding the subscales are explained in the following sentences. “I am humiliated/excluded by other people in my dream” is the 24<sup>th</sup> item and an item for Negative Themes. “Anxiety is predominant in my dreams” is the 15<sup>th</sup> item and an item for Anxiety Themes. “I am threatened in my dreams” is the 29<sup>th</sup> item and an item for Fear Themes. “I dream about the things I experience during the day” is the 1<sup>st</sup> item and an item for Effects of Experiences. Lastly, “I dream about the emotions and thoughts that I cannot share with others” is the 10<sup>th</sup> item and an item for Inhibition Themes.

It contains a total of 6 reverse-coded items, 5 of them are in Negative Themes subscale (item no: 2; 7; 12; 13; 19), 1 of them is in Anxiety Themes subscale (item no: 25). The score is calculated by summation of items in each subscale. Negative Themes subscale consists of 8 items (item no: 2; 7; 12; 13; 18; 19; 24; 26) and the possible score range is 0 to 32. The Anxiety Themes subscale consists of 7 items (item no: 3; 8; 14; 15; 20; 25; 27) with 0 to maximum score of 28. Fear Themes subscale consists of 5 items (item no: 4; 9; 16; 21; 29) with a score of 0 to 20. Effects of Experiences subscale composed of 5 items (item no: 1; 6; 11; 22; 28) with a score of 0 to 20. Lastly, the Inhibition Themes subscale consists of 4 items (item no: 5; 10; 17; 23) and scores range between 0 to 16.

The reliability analysis ran by Genç (2011) and .94 was found for Cronbach alpha as an internal consistency coefficient. The Cronbach's alpha for subscales were as follows: .87 for Negative Themes subscale, .86 for Anxiety Themes subscale, .80 for Fear Themes subscale, .77 for Effects of Experiences subscale, and .81 for Inhibition Themes subscale (Genç, 2011). The scale was found to be a reliable and valid scale (Genç, 2011).

The Cronbach's Alpha coefficient of the Dream Themes Scale was found to be .88 in the current study. Cronbach's Alpha for the subscales were as follows: .69 for Negative Themes, .69 for Anxiety Themes, .70 for Fear Themes, .85 for Effects of Experiences, and .58 for Inhibition Themes. The Inhibition Themes subscale, composed of four items, was retained despite a relatively low internal consistency (Cronbach's  $\alpha = .58$ ). Given that this thematic dimension was included on an exploratory basis rather than in relation

to a specific hypothesis, its incorporation aimed to allow for a broader examination of variance patterns across thematic domains. As part of a set of dependent variables analyzed together to detect multivariate differences, this subscale contributed to capturing distinct but potentially overlapping psychological content. In such contexts, where no single dimension is weighted for predictive precision, lower reliability coefficients—particularly for brief subscales—are considered acceptable, as they do not substantially distort shared variance structures or increase Type I error risk (Cortina, 1993; Lance et al., 2006).

### **3.3. Procedure**

After the Ethics Committee's approval (see Appendix A), the study was announced through e-mail and social media groups. The aforementioned measurement tools were organized and administered to volunteer participants via Google Forms. At the beginning of the survey, an Informed Consent Form (Appendix B) was provided to the participants, which briefly explained the study, and they had to check the box in order to continue. The form explained their rights, confidentiality, and storage of the data they would provide, and the aim of the study. After the consent form, they were provided the tools as follows: Dream Themes Scale (DTS), Turkish version of Eating Disorder Questionnaire – 13 (EDE-Q-13), and Demographic Form. Forms were presented in the mentioned sequence to eliminate any possible priming effect. Lastly, as they moved to the final stage, they came across a text that informed them about the seriousness of ED, and Referral Information (see Appendix F) of free health care services to make an appointment in case they suspected an ED within themselves and would like to pursue help.

### **3.4. Data Analysis**

All statistical analyses were conducted using IBM Statistical Package for the Social Sciences (SPSS) version 26. Before the main analyses, preliminary analyses were performed. Descriptive statistics were calculated for the study variables. Additionally, the potential effects of demographic variables and psychological experiences variables on the

dream themes were examined through correlations and variance analyses to determine whether any variable needed to be controlled.

Following these preliminary analyses, a MANOVA was conducted to examine the effects of disordered eating on dream themes. When necessary, relevant demographic variables were included as controls for their potential confounding effects.

For significant multivariate effects, univariate analyses were inspected, and when indicated, post-hoc analyses were conducted. Effect sizes were reported using partial eta squared ( $\eta^2$ ), and significance was evaluated at the .05 alpha level.

## RESULTS

In this section, initially the descriptive statistics of dream themes and disordered eating habits will be presented. Subsequently, preliminary analyses examining the associations between demographic variables and dream themes will be detailed. Finally, hypothesis-related findings on group differences in dream themes as a function of disordered eating will be reported.

### 4.1. Descriptive Statistics of Dream Themes and Disordered Eating (DE)

Dream Themes of the participants were measured via the Dream Themes Scale (DTS). Possible highest score was 32 for Negative Themes, 28 for Anxiety Themes, 20 for Fear Themes, 20 for Effects of Experiences, and 16 for Inhibition Themes. The descriptive statistics regarding the Dream Themes are presented in Table 4.1. The dream theme variables were approximately normally distributed.

**Table 4.1. Descriptive Statistics of Dream Themes (N = 216)**

	<i>Min</i>	<i>Max</i>	<i>Sum Mean</i>	<i>Mean per Item</i>	<i>SD</i>
Negative Themes	3	26	14.99	1.87	4.495
Anxiety Themes	1	21	10.33	1.48	4.461
Fear Themes	0	14	4.79	0.96	3.366
Effect of Experiences	0	19	9.83	1.97	4.516
Inhibition Themes	0	12	5.13	1.28	2.810

*Note.* Sum Mean refers to the average total score per theme. Mean per Item represents the mean score per item, provided for descriptive purposes to account for differences in the number of items.

Given the possible score ranges, the current sample could be described as showing moderate levels of negative and anxiety-related dream themes, and low levels of fear,

inhibition, and experiential impact in their dreams. Fear, inhibition, and the effect of experiences appeared at relatively low levels. When considering the mean scores per item, which normalize for differences in the number of items per theme, negative and dreams reflecting the effects of experiences appeared at relatively higher frequencies, while fear and inhibition remained low relative to other themes.

**Table 4.2. Pearson Correlations Among Dream Themes Subscales (N=216)**

	Negative Themes	Anxiety Themes	Fear Themes	Effects of Experiences	Inhibition Themes
Negative Themes	-				
Anxiety Themes	.44**	-			
Fear Themes	.32**	.76**	-		
Effect of Experiences	-.03	.58**	.47**	-	
Inhibition Themes	.23**	.67**	.68**	.59**	-

*Note.* All correlations are Pearson's  $r$ .  $p < .01$

As shown in Table 4.2, Anxiety Themes were strongly correlated with Fear Themes ( $r = .76, p < .01$ ) and Inhibition Themes ( $r = .67, p < .01$ ). Negative Themes were moderately associated with Anxiety ( $r = .44, p < .01$ ) and Fear Themes ( $r = .32, p < .01$ ), while Effect of Experiences showed weaker associations with most subscales except Anxiety and Inhibition Themes.

Disordered Eating (DE) was measured via the Eating Disorder Examination Questionnaire-13, offering a total score as well as separate scores for dimensions of Eating Restraint, Shape & Weight Overevaluation, Body Dissatisfaction, Binging, and Purging; ranging from 0 to 6 with higher scores indicating more severe symptoms.. Table 4.2 presents the descriptive statistics for each subscale and the overall score.

**Table 4.3. Descriptive Statistics of Eating Subscales and Scale (N=216)**

	<i>Min</i>	<i>Max</i>	<i>Mean</i>	<i>SD</i>
Eating Restraint	0	6	2.15	1.98
Shape & Weight Overevaluation	0	6	2.68	2.30
Body Dissatisfaction	0	6	2.84	2.32
Binging	0	6	1.22	1.56
Purging	0	5.67	0.22	0.66
Total	0	5.47	1.82	1.41

Overall, the sample exhibited relatively mild disordered eating patterns. While concerns related to body dissatisfaction and the overvaluation of shape and weight appeared to be the most prominent issues, restrictive behaviors were present to a lesser extent. Episodes of binge eating were infrequent, and purging behaviors were notably rare across the group.

Since the hypothesis of this study pertained to group-level differences rather than scale-level predictions, participants were grouped based on their EDE-Q-13 scores. Normality tests indicated that the total score for disordered eating (DE) deviated significantly from a normal distribution, as evidenced by both the Kolmogorov–Smirnov and Shapiro–Wilk tests ( $p < .001$ ). The distribution of total disordered eating scores showed a moderate positive skew ( $Skewness = 0.552$ ,  $SE = 0.166$ ), suggesting that most participants reported lower symptom levels, with fewer individuals at the higher end. Additionally, the distribution was relatively flatter with lighter tails ( $Kurtosis = -.785$ ,  $SE = 0.330$ ) reflecting less extreme variation in scores as compared to a normal distribution. Considering the qualities of the distribution the DE grouping was made via median-split. Participants with scores below the median of 1.35 were categorized as the “Low Disordered Eating (Low DE) Group” and those with scores equal or above the median were categorized as the “High Disordered Eating (High DE) Group”. Descriptives statistics of the resulting two groups are presented in Table 4.3.

**Table 4.4. Descriptive Statistics of Groups of Disordered Eating Habits (N=214)**

	<i>N</i>	<i>Mean</i>	<i>SD</i>	<i>Min</i>	<i>Max</i>
Low Disordered Eating Group	108	.63	.42	.00	1.33
High Disordered Eating Group	108	3.01	.98	1.37	5.47

#### **4.2. Preliminary Analyses of the Association of Demographic Characteristics with Dream Themes**

Preliminary analyses were conducted to observe the association of demographics with dream themes, and to identify possible controls for the current study. Since there were five interrelated dream themes, to account for potential correlations among them and to reduce the risk of Type I error due to multiple comparisons, Multivariate Analysis of Variance (MANOVA) with the five dream themes as dependent variables and categorical demographic variables (Gender, Education Level, Major Life Event, Psychiatric Diagnosis) as factors and Age as a covariate was conducted. The model was specified to include only the main effects, as the primary aim was to identify potential demographic control variables rather than to test interaction hypotheses. Including interactions or more complex structures was avoided to reduce model complexity and prevent overfitting, particularly given the relatively limited sample size.

The general linear model revealed significant main effects for Gender, Age, and Psychiatric Diagnosis. Table 4.4. presents results of the multivariate analyses conducted to examine the effects of demographic variables on dream themes.

**Table 4.5. Multivariate Effects of Demographic Variables on Dream Themes**

	Wilks' $\Lambda$	$F$	Hyp $df$	Error $df$	$p$	$\eta^2$
Gender	.937	2.617	5	193	.026	.063
Age	.920	3.358	5	193	.006	.080
Education	.955	1.831	5	193	.108	.045
Major Life Event	.991	.354	5	193	.880	.009
Psychiatric Diagnosis	.912	3.737	5	193	.003	.088

Note. N = 203

As displayed in Table 4.5 women scored higher than men across all dream themes. However univariate follow-ups demonstrated that the gender differences were statistically significant only for *Anxiety Themes*,  $F(1, 197) = 4.99$ ,  $p = .027$ , partial  $\eta^2 = .025$ , and dreams reflecting the *Effects of Experiences*,  $F(1, 197) = 9.29$ ,  $p = .003$ , partial  $\eta^2 = .045$ .

**Table 4.6. Means and Standard Deviations of Dream Themes by Gender**

	Women		Men	
	Mean	SD	Mean	SD
Negative Themes	15.16	4.586	14.51	4.032
Anxiety Themes	10.73	4.308	8.89	4.810
Fear Themes	5.01	3.374	4.02	3.193
Effects of Experiences	10.34	4.394	7.77	4.274
Inhibition Themes	5.21	2.889	4.74	2.541

Age, entered as a covariate, was significantly associated with several dream themes. Univariate analyses demonstrated that older age predicted increased *Fear Themes*,  $F(1, 197) = 11.74$ ,  $p < .001$ ; increased *Anxiety Themes*,  $F(1, 197) = 5.03$ ,  $p = .026$ ; and increased *Effects of Experiences*,  $F(1, 197) = 8.74$ ,  $p = .003$ .

Lastly, univariate tests of Psychiatric Diagnosis indicated significant group differences on *Negative Themes*,  $F(1, 197) = 5.68, p = .018$ , partial  $\eta^2 = .028$ ; *Anxiety Themes*,  $F(1, 197) = 13.29, p < .001$ , partial  $\eta^2 = .063$ ; *Fear Themes*,  $F(1, 197) = 8.28, p = .004$ , partial  $\eta^2 = .040$ ; and *Inhibition Themes*,  $F(1, 197) = 8.08, p = .005$ , partial  $\eta^2 = .039$ . As displayed in Table 4.6 participants with a psychiatric diagnosis were higher across all dream themes than those without a diagnosis.

**Table 4.7. Means and Standard Deviations of Dream Themes by Psychiatric Diagnosis (PD)**

	No PD		PD	
	<i>Mean</i>	<i>SD</i>	<i>Mean</i>	<i>SD</i>
Negative Themes	14.56	4.407	16.37	4.543
Anxiety Themes	9.59	4.497	12.73	3.406
Fear Themes	4.30	3.319	6.39	3.027
Effects of Experiences	9.57	4.592	10.69	4.188
Inhibition Themes	4.73	2.770	6.41	2.563

Since psychiatric diagnosis emerged as a factor with a significant main effect on dream themes, its association with disordered eating status was further examined to assess potential overlap. A cross-tabulation of the two binary variables revealed that there was a degree of co-occurrence between disordered eating and other psychiatric diagnoses. This raised the possibility of shared variance attributable to a latent underlying factor, such as general psychological distress or affective dysregulation, which may contribute to both phenomena. A preliminary inspection of Psychiatric Diagnosis (PD) and Disordered Eating (DE) concerning dream themes warranted their interaction to be taken into consideration. Yet, the sample size did not permit reliable testing of interaction effects within a full factorial MANOVA. Thus, grouping the sample into four mutually exclusive categories as (1) No PD – Low DE (n = 89), (2) No PD – High DE (n = 75), (3) PD – Low DE (n = 18), and (4) PD – High DE (n=32) was employed as a statistically

pragmatic alternative. This allowed for the exploration of potential combined and distinct effects while maintaining model parsimony and protecting against inflated error rates and unstable parameter estimates associated with small cell sizes in interaction models. Nevertheless, the unequal sample sizes across these groups should be acknowledged, as they may have influenced the variance estimations and the statistical power of the analyses. While the MANOVA detected pronounced effects, the results should be interpreted with caution considering this limitation.

### 4.3. Dream Themes Differences across Groups by Disordered Eating and Psychiatric Diagnosis

A multivariate analysis of variance (MANOVA) was conducted to examine the dream theme differences across the composite disordered eating (DE) and psychiatric diagnosis (PD) groups. On the basis of preliminary analysis, Gender was added as a factor and Age was added as a covariate to the model. In the present analysis, only the main effects were tested since including interaction terms would have substantially increased model complexity without clear a priori hypotheses and could have reduced statistical power given the available sample size. Box's test of equality of covariance matrices was not significant,  $F(90, 3831.304) = 1.094, p = .257$  indicating that the assumption of homogeneity of covariance matrices was met. The multivariate test results are presented in Table 4.7.

**Table 4.8. Multivariate Test Results for the Effects of Grouping Variable, Gender on Dream Themes**

Effect	Wilks' $\Lambda$	$F$	Hypothesis $df$	Error $df$	$p$	$\eta^2$
Composite DE-PD	.841	2.439	15.000	563.556	.002	.056
Gender	.931	3.013	5.000	204.000	.012	.069
Age	.902	4.428	5.000	204.000	<.001	.098

Analyses revealed that the Composite DE-PD grouping had a significant main effect on the shared variance across dream themes, uniquely contributing to multivariate differences while controlling for Age and Gender. Age and Gender maintained their significance as sources of variance in dream themes, paralleling the preliminary analyses outlined above.

To further explore the effect of Composite DE-PD on each dream theme, univariate analyses were examined. Levene’s test of equality of error variances indicated that the assumption of homogeneity of variance was met for all dream themes. The results of univariate tests are shown in Table 4.8.

**Table 4.9. Univariate Tests for the Effects of Grouping Variable on Dream Themes**

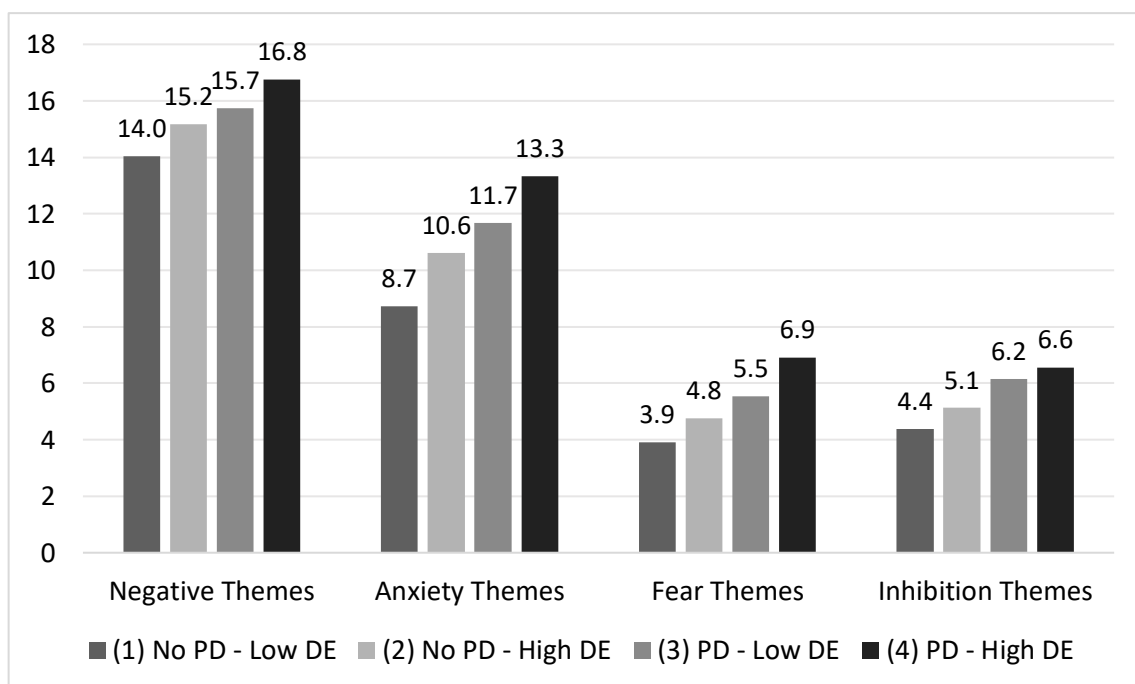
Dream Theme	<i>F</i>	<i>df</i>	<i>p</i>	$\eta^2$
Negative Themes	3.169	(3,208)	.025	.044
Anxiety Themes	9.365	(3,208)	<.001	.119
Fear Themes	5.637	(3,208)	<.001	.075
Effects of Experiences	2.410	(3,208)	.068	.034
Inhibition Themes	4.879	(3,208)	.003	.066

Univariate analyses revealed that the composite DE-PD grouping significantly predicted differences in *Anxiety Themes*, *Fear Themes*, *Inhibition Themes*, and *Negative Themes*. The largest effect was observed for anxiety-related dream content, followed by fear and inhibition themes, each reflecting small to moderate effect sizes. Differences in negative dream themes were also significant, though with a smaller effect size. No significant group differences were found for dream content related to the *Effects of Experiences*.

Figure 4.1 illustrates the means of dream theme scores across groups. It is observed that for all *Negative*, *Anxiety*, *Fear*, and *Inhibition Themes* the ‘PD-High ED’ group had the highest mean and the ‘No PD-Low ED’ group had the lowest mean. As indicated by pairwise comparisons via Scheffe (See Table 4.9.), the difference between the ‘PD-High ED’ and ‘No PD-Low ED’ groups is significant for all themes indicating that participants

experiencing an elevated disordered eating patterns with a co-occurring psychiatric condition reported consistently higher levels of dreams with *Negative Themes* ( $p = .032$ ), *Anxiety Themes* ( $p < .001$ ), *Fear Themes* ( $p < .001$ ), and *Inhibition Themes* ( $p = .002$ ) compared to those with neither condition.

**Figure 4.1. Means of Dream Themes Across Composite PD-ED**



Beyond the contrast between the ‘No PD – Low DE’ and ‘PD – High DE’ groups, several additional group differences reached significance (See Table 4.9.). Participants in the ‘PD – High DE’ group reported significantly higher scores than those in the ‘No PD – High DE’ group on *Anxiety* ( $p = .025$ ) and *Fear Themes* ( $p = .026$ ), suggesting that a psychiatric diagnosis intensifies these themes beyond the effects of disordered eating. For *Anxiety Themes* on the other hand, significant differences were observed between the ‘No PD – Low DE’ and ‘No PD – High DE’ groups ( $p = .036$ ), indicating that disordered eating is

associated with an elevated level of *Anxiety Themes* in dreams, in the absence of a diagnosed psychiatric condition.

**Table 4.10. Pairwise Comparison of Dream Theme Scores between Combined Groups**

		(I)	(J)	I-J	SE	p	95% CI	
							LB	UB
Negative Themes	(1) No PD - Low DE	(2) No PD - High DE		-1.26	0.69	.345	-3.2	0.68
		(3) PD - Low DE		-1.58	1.137	.589	-4.78	1.63
		(4) PD - High DE		-2.72	0.907	.032	-5.27	-0.16
	(2) No PD - High DE	(3) PD - Low DE		-0.32	1.155	.995	-3.57	2.94
		(4) PD - High DE		-1.46	0.929	.485	-4.08	1.16
	(3) PD - Low DE	(4) PD - High DE		-1.14	1.297	.856	-4.79	2.52
Anxiety Themes	(1) No PD - Low DE	(2) No PD - High DE		-1.92	0.651	.036	-3.75	-0.09
		(3) PD - Low DE		-2.89	1.073	.067	-5.91	0.13
		(4) PD - High DE		-4.62	0.855	<.001	-7.04	-2.21
	(2) No PD - High DE	(3) PD - Low DE		-0.97	1.089	.851	-4.04	2.1
		(4) PD - High DE		-2.70	0.876	.025	-5.17	-0.23
	(3) PD - Low DE	(4) PD - High DE		-1.73	1.223	.572	-5.18	1.71
Fear Themes	(1) No PD - Low DE	(2) No PD - High DE		-0.93	0.502	.335	-2.34	0.49
		(3) PD - Low DE		-1.43	0.828	.393	-3.77	0.9
		(4) PD - High DE		-3.01	0.66	<.001	-4.87	-1.15
	(2) No PD - High DE	(3) PD - Low DE		-0.51	0.841	.948	-2.88	1.86
		(4) PD - High DE		-2.08	0.676	.026	-3.99	-0.17
	(3) PD - Low DE	(4) PD - High DE		-1.57	0.944	.429	-4.23	1.09
Inhibition Themes	(1) No PD - Low DE	(2) No PD - High DE		-0.72	0.427	.413	-1.93	0.48
		(3) PD - Low DE		-1.73	0.704	.114	-3.71	0.26
		(4) PD - High DE		-2.18	0.562	.002	-3.76	-0.6
	(2) No PD - High DE	(3) PD - Low DE		-1	0.715	.579	-3.02	1.01
		(4) PD - High DE		-1.46	0.575	.097	-3.08	0.17
	(3) PD - Low DE	(4) PD - High DE		-0.45	0.803	.957	-2.71	1.81

## DISCUSSION

The current study aimed to investigate whether the dreams of individuals with disordered eating habits differ from those without such habits. An online survey, beginning with a consent form and continuing with the Dream Themes Scale, the Eating Disorder Examination Questionnaire-13, and a demographic form, was administered to the participants. Preliminary analyses examining the association between demographic variables and dream themes identified age, gender, and psychiatric diagnosis as significant predictors of variation across dream content. Gender differences were most pronounced for anxiety-related dreams and themes reflecting current experiences, with women reporting higher scores than men. Age was positively associated with fear, anxiety, and experience-related themes, indicating that these aspects of dream content tend to intensify with increasing age. Psychiatric diagnosis was a robust predictor across all five dream domains, with individuals diagnosed with a non-eating psychiatric condition reporting higher levels of negative, anxiety, fear, and inhibition-themed dream content. These findings supported the inclusion of age and gender as covariates in subsequent analyses and motivated a combined grouping approach for psychiatric diagnosis (PD) and disordered eating (DE) status to explore their distinct and interactive contributions to dream themes. The final model with the composite DE-PD grouping, controlling for age and gender demonstrated a significant effect for shared variance across dream themes. Univariate follow-ups showed significant group differences in anxiety, fear, inhibition, and negative dream content, with anxiety themes demonstrating the largest effect. Participants with both elevated disordered eating and a co-occurring psychiatric condition consistently reported the highest levels across all significant dream themes. Additional comparisons indicated that psychiatric diagnosis amplified anxiety and fear-related dream content even beyond the effects of disordered eating alone. Notably, anxiety themes were elevated in participants with high disordered eating in the absence of a formal psychiatric diagnosis, suggesting that eating-related distress alone may be sufficient to shape certain emotional aspects of dream experience.

These findings partially support the initial hypothesis that individuals with elevated disordered eating would exhibit distinct patterns in dream content compared to those without. Disordered eating alone was associated with increased anxiety-themed dream content in the absence of any other psychiatric condition. On the other hand, the presence of a psychiatric diagnosis, especially when in combination with disordered eating emerged as a more robust predictor of variation across multiple dream domains. Thus, the influence of broader psychological distress as captured by psychiatric diagnosis plays an amplifying role in shaping the content of dreams.

The comparison of the current findings with the existing literature will be presented below and discussed in light of psychoanalytic theories and contemporary dream hypotheses. However, before proceeding to these subsections, it is important to note that elevated scores on the EDE-Q-13 indicate increased risk for eating disorder psychopathology. Although the present study was conducted with a non-clinical sample, and most of the existing literature is based on formally diagnosed and specified ED categories (e.g., anorexia nervosa, bulimia nervosa, binge eating disorder), comparisons will still be drawn. These comparisons should be interpreted with caution, considering that the current findings may reflect milder or subclinical expressions of disordered eating rather than full-blown diagnoses.

Another important point is the need to briefly review the content of the subscales in the Dream Themes Scale (Genç, 2011) to clarify the operational definition of each theme. This is particularly relevant, as previous studies may have used different conceptualizations or methods to define and analyze dream content. Presenting this information here will also help avoid repetitive explanations in the subsequent subsections. There are 5 subscales named: negative themes, anxiety themes, fear themes, effects of experiences, and inhibition themes. Based on their content, increased scores on negative themes indicate that the individual rarely experiences positive events such as happiness, success, or being the main character in dreams, and instead frequently experiences feelings of ineffectiveness, helplessness, humiliation, and being discriminated against. Higher scores on the anxiety themes subscale reflect a tendency to dream about searching for lost things, experiencing uneasiness or anxiety, dealing with

serious health concerns, and fearing unknown sources of threat. Occasionally, dreams may also include being with loved ones. Increased scores on the fear themes subscale are characterized by frequent experiences of being watched, becoming a victim of others' malevolence, being threatened, and in some cases, exhibiting aggressive behavior or having exams in dream scenarios. Finally, increased scores on the inhibition subscale indicate that the individual often feels inhibited in dreams, encounters scenarios they would typically avoid during the day, experiences defeat, and has thoughts and emotions they were unable to express in waking life.

These findings will be discussed in detail in the following sections. First, the association of disordered eating with dream themes will be examined in the context of existing literature. This will be followed by interpretations based on contemporary dream theories and psychoanalytic frameworks. Subsequently, the effect of co-occurring psychiatric diagnoses and demographic variables on dream themes will be discussed in the same conceptual order.

### **5.1. Disordered Eating and Dreams**

As outlined above, disordered eating was found to be associated with elevated anxiety in dreams. Furthermore, when disordered eating co-occurred with a diagnosed psychiatric condition, increased levels of negative, fear-related, and inhibition-themed dreams were also observed.

Beginning with the former finding, as previously detailed in the introduction, several studies suggest that individuals with eating disorders experience more negative and emotionally intense dreams compared to healthy controls (Brink & Allan, 1992; Frayn, 1991; Schredl & Montasser, 1999) and even compared to individuals with depression (Dippel et al., 1987). Specifically, women with ED have frequently reported dream themes involving violence, suicidality, being chased, choking, suffocation, distorted body parts, and surreal creatures (Brink & Allan, 1992; Thoma, 1967). Additionally, dream content related to feelings of ineffectiveness, self-hatred, anger, an inability to nourish oneself, or being attacked, observed, controlled, or judged, has been associated with ED

(Brink & Allan, 1992; Brink et al., 1995; Mellen et al., 1993). Other studies have also documented food-related dream imagery, such as food that is aggressive, inaccessible, unsatisfactory, or overwhelming (Levitan, 1981; Selvini-Palazzoli, 1974; Thoma, 1967). Direct comparisons, however, are limited due to methodological differences. Unlike the present study, which did not assess the exact narrative content of dreams, previous studies employed methods such as dream diaries and content analysis (e.g., Brink & Allan, 1992; Dippel et al., 1987; Schredl & Montasser, 1999), which allowed for a more in-depth exploration of dream material. Nevertheless, it could be suggested that if participants with higher disordered eating had dreamt of similar content, they would likely have scored higher on negative-, fear-, and anxiety-themed dream subscales. Yet, in the current study, only anxiety-themed dreams showed a statistically significant difference. Therefore, the findings can be considered partially aligned with the existing literature. This discrepancy may be explained in part by the aforementioned methodological differences. Additionally, the current sample consisted of non-clinical participants without formal ED diagnoses, while earlier studies often involved clinically diagnosed individuals. Having a formal ED diagnosis might influence both the intensity and frequency of negative or fear-related dream content. Moreover, previous studies frequently categorized participants based on specific ED diagnoses—such as anorexia nervosa (Frayn, 1991), bulimia nervosa (Dippel et al., 1987), or included both diagnostic categories (Brink & Allan, 1992; Schredl & Montasser, 1999). In contrast, the current study relied on overall disordered eating scores, combining symptoms such as restriction, bingeing, and purging into a single dimension, rather than analyzing diagnosis-specific patterns.

From a theoretical standpoint, the observed significant and non-significant findings can be interpreted through existing models. The significant difference in anxiety-themed dreams may be explained by the Continuity Hypothesis (Revonsuo, 2000), which posits that dreams reflect waking-life concerns. Individuals with disordered eating habits are often preoccupied with food, body image, and weight. These concerns may remain as persistent thoughts or manifest through restrictive or compensatory behaviors. This ongoing anxiety could be reflected in dream content. Notably, the anxiety-themed subscale includes items related to experiencing serious health problems and general feelings of anxiety, which aligns with the observed finding.

The non-significance of fear- and negative-themed dreams may suggest that these experiences do not significantly differ between individuals with high and low disordered eating habits in their daily lives, potentially resulting in similar dream content. Moreover, participants' conscious and waking-life emotional experiences were not assessed in this study. If such data had been available, these findings could have been interpreted more systematically from the Continuity Hypothesis.

No significant differences were found for inhibition-themed dreams either. One possible explanation is that the study measured overall disordered eating rather than specific behavioral subtypes. From the perspective of the Continuity Hypothesis (Revonsuo, 2000), it would be reasonable to expect significant differences in inhibition-themed dreams particularly between restrictive eaters and those who do not engage in such behavior. However, in the current study, the most prominent subscales were Body Dissatisfaction and Overvaluation of Weight and Shape, rather than behavioral aspects such as purging, or restricting. Therefore, the lack of significance may be attributed to this distinction in symptom focus.

Extending this line of reasoning, some researchers propose that dreams function as a form of self-regulation (Levin & Nielsen, 2009). From this perspective, it could be interpreted that individuals with higher disordered eating habits may struggle with emotion regulation during waking life—a difficulty highlighted in previous studies (Lunn & Poulsen, 2012) and supported by Wooldridge (2022), who found that individuals with ED often experience problems in emotional expression. Thus, this emotional dysregulation may continue in dreams. However, one might expect to observe significant differences in negative- and fear-themed dreams as well, given the well-established link between ED and pervasive negative affect (Brink & Allan, 1992; Heaven et al., 2001), and traumatic history such as abuse, neglect, maltreatment, and bullying (de Oliveira Galvão et al., 2023; Kennedy et al., 2007; Kent et al., 1999; Lie et al., 2019; Striegel-Moore et al., 2002). The fact that only anxiety-themed dreams differed significantly may be due to anxiety being more readily experienced at a bodily level and accessible to conscious awareness, compared to, for instance, worthlessness or ineffectiveness. Similarly, while fear-themed dreams include content related to aggression and victimization, it has been

suggested that individuals with ED tend to dissociate anger (Brink et al., 1995), meaning that emotions not present in conscious awareness during waking life may not appear in dreams either. Additionally, the emergence of anxiety-themed dreams could offer the dreamer an opportunity to mentally rehearse anxiety-inducing experiences and develop more effective coping strategies, as proposed by Revonsuo (2000), Breger (1967), and Greenberg (1970).

From the psychoanalytic perspective, Freud's (1962a) structural model may help explain these findings. According to this model, individuals with disordered eating may experience an internal conflict between the id and the superego—between wish and reality. For example, while the id may wish for food, the superego may evoke body dissatisfaction or guilt. The discrepancy between these opposing forces may give rise to psychological conflict and result in anxiety that is expressed in dreams.

Another possibility is that, as Freud suggested, such dreams -anxiety dreams - serve as a way for unconscious to punish the wish, and he added that these dreams are common in masochistic personalities (Coolidge, 2006). This might imply a masochistic tendency, or a tendency to direct anger inward, in individuals with disordered eating habits.

These results can also be interpreted in light of repression-related processes. Although Freud's theory posits that all dreams are shaped by the transformation of repressed material (Freud, 1955), the overt emergence of anxiety-themed content in this group may reflect a partial failure in the dream-work process or a weakened repression mechanism. It is well documented that individuals with ED tend to exhibit higher levels of dissociation (Palmisano et al., 2018a), which has been conceptualized as a form of repression (Singer, 1995, p. xviii). Accordingly, dissociated material from waking life may re-emerge in dreams with less symbolic filtering.

Moreover, while Freud (1955) suggested that repressed wishes typically appear in dreams in a disguised, symbolic form, he also acknowledged that the accompanying affective tone—such as anxiety—may remain less transformed. In this sense, although the content may be masked, the emotional experience of anxiety may still be consciously felt within the dream. This is especially relevant when considered in relation to the possible

problematic separation–individuation process (Vonwyl, 2000), vague ego boundaries (Bruch, 1973), and the oral character of the symptoms in individuals with ED, which may point to a repressed separation anxiety that is not consciously experienced during waking life but may manifest affectively in dreams.

Continuing with the other themes, the lack of significant differences in negative- and fear-themed dreams raises further questions—especially since the fear subscale contains items that reflect the possible emergence of repressed anger. Starting with the negative themes, the items in this subscale are more directly related to the self, including feelings of incompetence, worthlessness, and helplessness. Such self-referential and affectively intense emotions may be too threatening for the ego to process, even during sleep.

Regarding fear-themed dreams, a similar interpretation can be made. Repressed anger might be so overwhelming for the ego that it does not appear in the manifest content, is not remembered upon waking, or disrupts the dream itself by triggering anxiety. In this context, it is also possible that what appears as anxiety in dreams may represent displaced or disguised expressions of repressed aggression. This interpretation aligns with Freud’s theory of dream censorship (Auchincloss, 2015), which posits that threatening unconscious material is often distorted, disguised, or excluded from conscious dream recall. Alternatively, anger-related content may be so thoroughly repressed or dissociated that it remains inaccessible even in dreams. Another possibility is that, these emotions such as worthlessness or fear are already part of the conscious experience of individuals in both groups and thus are not repressed. If these emotions are consciously accessible, they may not produce significant differences in dream themes across groups.

Another non-significant finding was related to inhibition-themed dreams. Upon closer examination, the items in this subscale (Genç, 2011) appear to reflect socially and morally constrained behaviors (e.g., item 23: “The things I hesitate to do during waking life appear in my dreams”; item 20: “Emotions and thoughts I don’t share with people appear in my dreams”), and also resemble superego functions (e.g., item 5: “I am inhibited while trying to do something in my dreams”). The absence of group differences in this theme may suggest that such content reflects broadly shared societal and moral constraints, rather than conflict-based repressive dynamics specific to eating pathology.

Bion's (1962) concept of the alpha function offers a meaningful lens through which to interpret these findings. Research suggests that individuals with eating disorder symptoms may have experienced emotionally insufficient caregiving in early life (Allison et al., 2007), which might have limited opportunities for the development of a stable reflective function. In such contexts, raw emotional experiences—what Bion referred to as beta elements, including fear, hunger, or restlessness—may not have been consistently transformed into thinkable, manageable experiences through the caregiver's containing (alpha) function. When this transformation is not adequately modeled or internalized, individuals may remain more vulnerable to the direct impact of unprocessed affect. Bion (1962) suggested that without the alpha function, one cannot dream or think symbolically. Thus, the very presence of dreams reflects a degree of psychic processing. However, the dominance of anxiety-themed dreams in the disordered eating group may indicate limitations in this function, as anxiety represents a more raw, beta-like emotional state. Bion (1962) also emphasized that emotions in waking and dreaming life are not fundamentally different; rather, they are shaped and transformed by the alpha function. In this sense, dreams provide an opportunity to process and contain otherwise overwhelming affect. The significant differences observed in the current study may be understood in light of these ideas: individuals with eating disorder symptoms—or, in this case, disordered eating habits as a milder or subclinical form—have been shown to experience more negative affect (Heaven et al., 2001; Brink & Allan, 1992), and such emotions may be reflected and worked through in dream content. However, one might have expected significant differences in fear- and negative-themed dreams, as well, if the alpha function was impaired to a certain degree. In this regard, the current findings may suggest a partial limitation of the theory's explanatory power for the full range of emotional dream themes observed.

Fairbairn's (1994) theory suggests that, dreams reflect what is taking place in the endopsychic structures. These structures are composed of internalized object relations that result from early relational experiences (Fairbairn, 1994). In cases of emotional trauma or neglect, which was highlighted in several studies conducted with eating disordered patients (Kent et al., 1999; Kennedy et al., 2007), the ego might split into distinct parts, including the libidinal ego - that is attached to the exciting but unavailable

object – and the antilibidinal ego – in conflict with a rejecting object. The heightened scores of anxiety-themed dreams might mark the anxiety aroused from the conflict between libidinal ego and antilibidinal ego in one's psyche, or the dominance of one structure. The absence of significant differences in negative-, and fear- themed dreams may suggest that certain affective states – particularly those related to aggression or internalized devaluation- are more deeply repressed or integrated within the endopsychic structures. As such, they may not emerge as distinct or consciously accessible content in dream reports, unlike the more conflict-laden anxiety aroused by tensions between split ego structures.

From Jung's perspective, dreams serve a compensatory function and convey messages to the self in order to maintain equilibrium between the conscious and unconscious mind (Hall, 1983). Anxiety-themed dreams, in this sense, may signal the need for the dreamer to confront anxiety-provoking experiences as part of personal growth. For instance, items within the anxiety subscale include themes such as searching for lost objects or being separated from loved ones. These motifs may symbolize a call from the unconscious to leave what had been tightly hold. According to Jung, such dreams support the individuation process by highlighting aspects of the psyche that are underdeveloped or unacknowledged in waking life (Hall, 1983). In relation to the non-significant findings, the lack of difference in inhibition-themed dreams might be explained by the fact that individuals with disordered eating may already engage in inhibitory behaviors in their daily lives, such as food restriction or attempts to suppress weight gain. Therefore, these themes may not appear as prominently in dreams, having already been integrated into conscious experience.

Similarly, the absence of significant differences in fear- and negative-themed dreams may indicate that the associated emotions—such as fear, worthlessness, or vulnerability—are consciously experienced during waking life and thus do not require symbolic representation in dreams. This interpretation aligns with the compensatory model, which suggests that dreams express unconscious material that is lacking or suppressed in the conscious self, rather than what is already acknowledged.

However, the presence of anxiety-themed dreams—assuming that anxiety was consciously experienced during the day, like other emotions—may reflect that this affect was not sufficiently processed or integrated in waking life. In line with Jung’s model, the dream may serve to compensate not for the absence of awareness per se, but for the lack of emotional containment and understanding. In this sense, even if anxiety was consciously felt, its unresolved or fragmented nature may still trigger compensatory expressions in dream content. If anxiety was not consciously experienced, then the compensatory function would fully account for its emergence in dreams.

## **5.2. Additional Observations on the Role of Co-occurring Psychiatric Condition**

The current study provided a chance to observe the additional effect of psychiatric diagnosis on dream themes as well. To the best of the researcher’s knowledge, no prior study has specifically examined the dream content of individuals with both disordered eating behaviors and psychiatric diagnoses. However, one important limitation of the current study is the lack of information regarding the specific nature of psychiatric diagnoses reported by participants. Given that the diagnoses could range from mood and anxiety disorders to personality disorders or even psychotic conditions, it is not possible to draw precise conclusions about how each diagnostic category may have influenced dream content. However, based on prior literature, comorbid psychiatric conditions in individuals with disordered eating are most commonly related to anxiety disorders (Swinbourne & Touyz, 2007) and trauma-related disorders (Mitchell et al., 2016; Trottier & MacDonald, 2017). Therefore, the interpretation offered here is tentative and should be viewed as a general, hypothesis-driven consideration rather than a diagnosis-specific explanation.

The current study found that participants with both a psychiatric diagnosis and high levels of disordered eating reported significantly more anxiety- and fear-themed dreams compared to those with high disordered eating but no psychiatric diagnosis. Previous literature has shown that individuals with psychiatric conditions tend to experience dreams that differ both qualitatively and quantitatively from those of healthy controls.

Although a significant difference was also observed in the present study, the specific nature of this difference does not entirely align with prior findings.

For example, individuals with anxiety disorders have been found to experience dreams with a greater number of characters, more negative content, and reduced success or social interaction compared to healthy individuals (Rimsh & Pietrowsky, 2021). While some of these features overlap with what is captured in the "negative themes" subscale used in the current study, no significant group differences were observed in that subscale. This discrepancy may be attributed to the unspecified nature of the psychiatric diagnoses in the present sample, as noted earlier. Another possibility lies in methodological differences, as prior studies often utilized content analysis rather than structured self-report scales.

However, other findings in the literature do support the significance of fear and anxiety in the dream lives of individuals with psychopathology. For instance, alexithymia—often associated with emotional processing difficulties in disordered eating—has been linked to increased nightmare frequency (Obrebska & Rohoza, 2021). Additionally, while not a formal diagnosis, childhood trauma has been associated with higher nightmare frequency and distress (Mathes et al., 2022), as well as greater overall psychopathology and more severe nightmare content (Duval et al., 2013). These findings may be particularly relevant given the established links between eating disorders and trauma history, and the conceptual overlap between nightmares and the fear- and anxiety-themed dreams assessed in the current study.

Turning to the additional impact of psychiatric diagnosis from a psychoanalytic perspective, it is notable that all individuals in the relevant comparison were already exhibiting a symptom—namely, disordered eating. However, the presence of a psychiatric diagnosis appears to amplify the emotional intensity of dream content, as evidenced by the significant increase in anxiety- and fear-themed dreams.

This finding can be interpreted through Freud's psychoanalytic framework, particularly his theories of dream formation and defense mechanisms. On one hand, Freud (1955) suggested that dreams are formed from repressed and conflict-laden material, which is

typically disguised through dream-work processes to evade the internal censor. Despite this transformation, the ego remains partially active during sleep. On the other hand, Freud (1962a) explained that while defense mechanisms serve an adaptive purpose, their chronic overuse or failure can lead to psychological disturbances. In individuals with psychiatric diagnoses, the ego's capacity to manage unconscious conflict through repression or disguise may be compromised. As a result, the dream content may appear less symbolized and more emotionally raw—manifesting as fear and anxiety themes, as seen in the current study.

Taking this interpretation one step further, these dream themes may also be understood through Freud's (1962a) structural model. Although the specific psychiatric diagnoses of participants were unknown, diagnostic criteria generally depend on the individual's level of psychological distress and degree of functional impairment. When psychological functioning deteriorates, individuals may experience a downward drift—an erosion of adaptive capacity. In such cases, the demands of the external world persist, as emphasized by the superego, but the ego may no longer possess sufficient strength to mediate between internal needs and outer expectations. The resulting conflict—between the superego's demands and the weakened ego's limited regulatory capacity—may give rise to inner tension that is enacted symbolically through dreams.

From Kohut's (2009) self-psychological perspective, the increased frequency of anxiety- and fear-themed dreams among individuals with psychiatric diagnoses can be interpreted as symbolic expressions of the dread of self-fragmentation. These dreams may reflect the psyche's attempt—particularly through its more intact structures—to metabolize and contain overwhelming psychological threats. Dream imagery thus becomes a vehicle for working through experiences that cannot be fully processed in waking life, helping to preserve a sense of cohesion and continuity in the face of internal disintegration.

The significantly elevated inhibition-themed dream scores observed in participants with both a psychiatric diagnosis and high disordered eating can be interpreted through Freud's (1955) theory of repression. The inhibition subscale includes items that reflect this dynamic, such as hesitating to act on desires during waking life or experiencing blocked actions in dreams. In this case, it may not be that repression has entirely failed, but rather

that the ego is still actively attempting to repress distressing material. However, due to the increased psychological burden, this effort becomes more visible in the dream content. The emergence of inhibition in dreams may thus reflect the ego's ongoing but strained efforts to contain internal conflict, resulting in symbolic expressions of restraint and inner tension during dreaming. Jung's concept of the compensatory function (Hall, 1983) may also offer a meaningful perspective on this specific finding. From this viewpoint, inhibition-themed dreams could be interpreted as the unconscious sending a message to the self—that further repression or restraint is psychologically necessary in order to restore internal balance. In other words, while the ego may still be actively engaging in repression, the unconscious may simultaneously support this defense by symbolically reinforcing the need to hold back certain impulses or conflicts through dream content.

Last but not least, no significant differences were found in dreams reflecting the effects of experiences. This finding is consistent with Skancke et al.'s (2014) research, which suggests that the extent to which waking life events are incorporated into dreams may vary across individuals and yield inconsistent results. If there had been a systematic difference between the groups, it would likely have been reflected in their mean scores.

This result also aligns with Revonsuo's (2000) Continuity Hypothesis, which proposes that waking-life experiences naturally flow into dreams. As Freud (1955) similarly emphasized, the appearance of "day residues" in dream content is a universal phenomenon.

Finally, the current findings do not support Hobson and McCarley's (1977) activation-synthesis hypothesis, which claims that dreams result from random neural firings without meaningful psychological content. If that had been the case, no systematic group differences in dream themes would have emerged, as observed in the present study.

### **5.3. Demographic Characteristics and Dreams**

In the present study, age and gender were initially included as control variables in the main model. Both emerged as significant predictors of several dream themes, suggesting that these demographic factors independently influence dream content.

Specifically, the current study found that as age increased, participants reported more anxiety- and fear-themed dreams, as well as more dreams reflecting the effects of experiences. In line with these findings, Domhoff (2010) suggested that dreams in early life tend to reflect themes related to gender and individuality. However, it remains unclear whether the age-related differences observed in the current study are directly linked to changes in personal identity or broader developmental shifts in self-perception, especially since the specific dream content was not known.

Regarding gender differences, the study revealed that women reported significantly more anxiety-themed dreams and dreams reflecting the effects of experiences compared to men. Similarly, previous studies have highlighted gender-based variations in dream content. For example, Zheng et al. (2024) found that men and women differ in their use of language in dreams in ways that mirror their waking-life communication styles. Earlier research has also reported gender differences in the frequency of aggressive content, family-related scenes, and nightmares (Cappadona et al., 2021).

However, in the current study, significant gender differences emerged only in anxiety and experience-related dream themes. One possible explanation is that women tend to report higher levels of anxiety than men (Pigott, 1999), and this heightened affective state may be more likely to surface during dreaming. Furthermore, in relation to the incorporation of waking-life experiences into dreams, it is possible that women are more inclined to repress their drives, even during sleep. As a result, latent dream thoughts may become symbolically expressed through manifest content, such as mundane or day-residue elements.

Importantly, the observed associations between psychiatric diagnosis, disordered eating, and dream themes remained significant even after accounting for the effects of age and gender. These findings further highlight the importance of controlling for fundamental demographic variables, such as age and gender, in future studies exploring the relationship between psychopathology and dream content.

#### **5.4. Clinical Implications**

Dreams provide a path to the one's unconscious material. In the literature, it was well-established that eating disorders are related to adverse childhood experiences, such as neglect, several kinds of abuse, maltreatment, that occurred during pre-verbal period and could not be expressed through words in the session room but rather displayed through somatic symptoms as in the eating disorders. It is also shown that these individuals tend to dissociate more, and known to repress emotions, so these emotions might not come to the session room for years since they are not experienced in conscious awareness. Through the dreams, clinicians could tune in to hear the repressed material, and provide a space to talk about them and interpret what could not have been put into the words. In Bion's (1962) terms, could facilitate the internalization of alpha function for client, with client's beta elements.

Although current study was not conducted with a clinical sample, the disordered eating habits could imply a tendency toward the ED. The findings suggest that clinician should be aware of repressed and unspeakable emotions of the clients with disordered eating habits.

#### **5.5. Limitations and Directions for Future Research**

The present study has several limitations that should be considered when interpreting the findings. First, the sample consisted of non-clinical participants, and disordered eating tendencies were assessed through self-report measures rather than structured clinical interviews or formal diagnoses. As a result, the findings may not fully reflect the experiences of individuals with clinically diagnosed eating disorders.

Additionally, the scale used to assess disordered eating had no established cut-off score, and groupings were determined based on the distribution within the sample. This may have influenced the strength and validity of group-based comparisons. Moreover, the four groups created by combining psychiatric diagnosis and disordered eating levels differed substantially in sample size. This unequal distribution may have affected variance

estimates and statistical power, and results indicating pronounced effects should therefore be interpreted with caution.

Psychiatric diagnoses were also based solely on self-reports and were neither validated through clinical interviews nor specified in terms of diagnostic categories. This may have led to misclassification or underreporting, and also limiting the ability to contextualize the results in light of existing literature.

The study employed a cross-sectional design, which set an obstacle to the establishment of causal relationships between disordered eating and dream themes. Observed associations should therefore be interpreted with caution.

Data were collected via an online survey, which may have introduced biases such as social desirability or varying levels of participant attention. Furthermore, the frequency of dream recall was not controlled for, which may have influenced the number and variety of reported dream themes. Participants who tend to recall dreams more frequently may have provided more detailed responses, potentially affecting the results.

Additionally, the sample was female in majority, which may limit the generalizability of the findings to other gender groups.

Despite these limitations, the current study has several notable strengths. The inclusion of both disordered eating and psychiatric diagnosis as intersecting variables allowed for a more comprehensive view of how comorbidity may shape dream content. Furthermore, the stepwise control of demographic and clinical variables such as age and gender ensured that group differences in dream content were not confounded by these factors.

To the best of researcher's knowledge, this is the first study to examine the intersection of disordered eating and dream themes in a non-clinical population, making it a new contribution to the existing literature.

Future studies should aim to include clinically diagnosed participants and larger, more diverse samples. Including tools that evaluate dissociation and repression could deepen our understanding of the internal processes related to disordered eating and dreaming. Given the well-established association between trauma and eating disorders, future

research would benefit from collecting data on participants' trauma histories and familial relationships. Additionally, collecting dream data through dream diaries and conducting studies in controlled laboratory settings could improve data richness and scientific precision.

## CONCLUSION

The present study aimed to examine whether individuals with disordered eating habits experience different dream themes compared to those without such habits. In light of the sample characteristics, psychiatric diagnosis was included as an additional variable, since it was found to significantly affect dream themes. This allowed for comparisons across four groups based on the combination of disordered eating and psychiatric diagnosis.

The findings showed that participants with both a psychiatric diagnosis and high disordered eating habits reported more negative-, anxiety-, fear-, and inhibition-themed dreams compared to those with no psychiatric diagnosis and low disordered eating habits. Participants with a psychiatric diagnosis and high disordered eating also reported significantly more anxiety- and fear-themed dreams compared to those with no diagnosis and low disordered eating. Furthermore, participants with no psychiatric diagnosis but high disordered eating reported significantly more anxiety-themed dreams compared to those with no diagnosis and low disordered eating.

Regarding demographic variables, older participants reported more anxiety-, fear-themed dreams and dreams reflecting the effects of experiences. Also, women reported more anxiety-themed dreams and dreams reflecting the effects of experiences compared to men.

Framed within psychoanalytic theory and contemporary dream research, these findings highlight the potential of dream analysis as a means of accessing unconscious emotional processes. Despite the exploratory nature and methodological limitations of the study, the use of a four-group design offers a novel contribution to the literature and provides a foundation for future research on the clinical relevance of dream content in psychotherapeutic settings.

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## **APPENDICES**

### **Appendix A. Result of the Evaluation by the Ethics Committee**

Result of the Evaluation by the Ethics Committee is available in the printed version of this dissertation

## **Appendix B. Informed Consent Form**

### **Bilgilendirilmiş Onam Formu**

Bu çalışma İstanbul Bilgi Üniversitesi Klinik Psikoloji Yüksek Lisans Programı öğrencisi Ceren Özkan tarafından Doç. Dr. Alev Çavdar danışmanlığında yüksek lisans tezi kapsamında yürütülmektedir. Bu çalışmanın amacı, kişilerin yeme tutumları ile rüyaları arasındaki ilişkiyi anlamaktır.

Bu çalışma kapsamında ilk olarak katılımcılardan yaklaşık 10 dakika sürecek bir anket cevaplama ve ardından bir bilgi formu doldurması istenecektir.

Bu araştırma bilimsel bir amaçla yapılmaktadır ve katılımcı bilgilerinin gizliliği esastır. Formlara verdiğiniz cevaplar kaydedilirken isminiz sorulmayacak ve kişisel bilgileriniz kaydedilmeyecektir. Bu bilgiler yalnızca araştırmacının ve tez danışmanının erişimi olan şifreli bir dosyada ve şifreli bir bilgisayarda tutulacak, anonim veri saklama yükümlülüğüne bağlı olarak 5 yıl boyunca dışarıdan erişime kapalı olarak muhafaza edilecektir.

Bu çalışmaya katılmak tamamen isteğe bağlıdır. Çalışmaya katılmanın üzerinizde herhangi bir olumsuz etki yaratması beklenmemektedir. Ancak yeme tutumlarınıza ya da rüyalarınıza dair soruları cevaplamak bazı katılımcılar için rahatsız edici olabilir. Katılmayı kabul ettiğiniz takdirde çalışmanın herhangi bir aşamasında onayınızı geri alma ve çalışmadan ayrılma hakkına sahipsiniz. Çalışmayı yarım bıraktığınız durumda verdiğiniz bilgiler araştırmaya dahil edilmeyecektir.

Araştırmayla ilgili bilgi almak, soru sormak veya yorumlarınızı paylaşmak isterseniz, araştırmacı Ceren Özkan ile iletişime geçebilirsiniz.

Eğer araştırmaya katılmaya onay veriyorsanız, aşağıdaki bölümdeki madde için onay kutucuğunu işaretlemeniz yeterlidir.

Bu alıřmaya tamamen gnll olarak katılıyorum. Bana anlatılanları ve yukarıdaki aıklamaları anladım. alıřmaya katılmayı ve verdiđim bilgilerin bilimsel amalı yayın, rapor ve sunumlarda kullanılmasını kabul ediyorum.

## Appendix C. Demographic Form

(Questions with forced response is marked with “\*”).

\*Yaşınız: .....

\*Cinsiyetiniz: .....

\*En son mezun olduğunuz okul: (ilkokul) (ortaokul) (lise) (lisans) (lisansüstü)

\*Çalışıyor musunuz? (evet) (hayır)

Çalışıyorsanız, mesleğiniz? .....

\*Son bir ay içinde büyük bir hayat değişikliği yaşadınız mı? (taşınma, işten ayrılma, sevilen birinin kaybı vb.): (evet) (hayır)

\*Daha önce psikolojik veya psikiyatrik yardım aldınız mı? (evet) (hayır)

Evet ise, hangi nedenle/nedenlerle başvurduunuz? (kaygı) (depresyon) (ilişkisel sebepler) (travma) (genel/kendini tanıma) (diğer)

\*Aldığınız bir psikiyatrik tanı var mı? (evet) (hayır)

\*Daha önce psikiyatrik bir ilaç kullandınız mı? (evet) (hayır)

Evet ise lütfen ilacın/ilaçların adını ve dozunu belirtin. ....

\*Halen kullandığınız bir psikiyatrik ilaç var mı? (evet) (hayır)

Evet ise lütfen ilacın/ilaçların adını ve dozunu belirtin. ....

\*Aldığınız bir yeme bozukluğu tanısı var mı? (evet) (hayır)

Evet ise, tanıyı ne zaman aldınız? .....

Yeme bozukluğu tanınız var ise lütfen aldığınız tanıyı işaretleyin. (Pika) (Ruminasyon Bozukluğu) (Kaçınan/Kısıtlayıcı Gıda Alım Bozukluğu) (Anoreksiya Nervosa) (Bulimia Nervosa) (Tıkınırcasına Yeme Bozukluğu) (Tanımlanmış Diğer Beslenme ve Yeme Bozuklukları) (Tanımlanmamış Diğer Beslenme ve Yeme Bozukluğu)

Yeme bozukluđu tanınız var ise, herhangi bir yardım alıyor musunuz? (evet) (hayır)

Yardım alıyorsanız, yardım türünü belirtin. ....

## Appendix D. EDE-Q-13

### YEME BOZUKLUĞU DEĞERLENDİRME ÖLÇEĞİ (EDE-Q-13)

Aşağıdaki sorular sadece son dört hafta (28 gün) ile ilgilidir. Lütfen her soruyu dikkatlice okuyunuz. **Aşağıdaki ifadeleri son 28 günün kaç gününde deneyimlediyseniz o kadar gün sayısını işaretleyiniz.** Lütfen tüm soruları yanıtlayınız ve her soru için bir yanıt seçiniz.

EDE-Q-13	Son 28 günün kaç gününde...	0	1-5	6-12	13-15	16-22	23-27	Her gün
1.	bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için yediğiniz yiyecek miktarını kasıtlı olarak sınırlandırmaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)							
2.	bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için sevdiğiniz herhangi bir yiyeceği beslenme düzeninizden çıkarmaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)							
3.	bedeninizin şeklini veya vücut ağırlığınızı değiştirmek için yemenizle ilgili belirli kurallara (örneğin, kalori sınırlandırması)							

	uymaya çalıştınız? (Başarılı olup olmadığınız önemli değildir.)							
4.	vücut ağırlığınız, kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi?							
5.	bedeninizin şekli, kendiniz hakkındaki düşüncenizi (yargınızı) etkiledi?							
6.	vücut ağırlığınızdan memnun değildiniz?							
7.	bedeninizin şeklinden memnun değildiniz?							
8.	başka insanların alışılmadık miktarda fazla olarak tanımladıkları kadar (şartlara göre) yemek yediniz?							
9.	yemek yemenizle ilgili kontrolü kaybetme hissine kapıldınız (yemek yediğiniz sırada)?							
10.	aşırı yeme atakları yaşadınız (örn. alışılmadık miktarda fazla yemek yediniz ve o sırada kontrolü kaybettiğinizi hissettiniz)?							

<b>11.</b>	bedenizin şeklini veya vücut ağırlığınızı kontrol etmek için kendinizi kusturdunuz?							
<b>12.</b>	bedenizin şeklini veya vücut ağırlığınızı kontrol etmek için müshil (bağırsak çalıştırıcı) kullandınız?							
<b>13.</b>	vücut ağırlığınızı, bedeninizin şeklini veya vücut yağ miktarınızı kontrol etmek veya kalori yakmak amacıyla “takıntılı” ya da “zorlayıcı” biçimde egzersiz yaptınız?							

## Appendix E. Dream Themes Scale

### RÜYA TEMALARI ÖLÇEĞİ

Aşağıda kişilerin hatırlayabildikleri rüyaları ile ilgili çeşitli ifadeler yer almaktadır. Sizden beklenen son altı ay içinde hatırlayabildiğiniz rüyalarınız ile ilgili her bir ifadeyi dikkatlice okuduktan sonra bu durumu ne sıklıkta yaşadığınızı 0'dan 4'e kadar sıralanan puanlardan size uygun olan seçeneğe işaretleyerek belirtmenizdir.

	Maddeler	Hiçbir zaman (0)	Ara Sıra (1)	Orta Derecede (2)	Sıklıkla (3)	Her Zaman (4)
1	Gün içerisinde yaşadıklarım rüyalarım girer.					
2	Rüyalarımda güzel olaylar başımdan geçiyor.					
3	Rüyalarımda kaybettim/unuttuğum bir şeyleri arıyorum.					
4	Rüyalarımda başkalarından bana kötülük geldiğini/geleceğini görüyorum.					
5	Rüyalarımda bir şeyler yapmaya çalışırken engelleniyorum.					
6	Gün içerisindeki duygusal durumum rüyalarımaya yansır.					
7	Rüyalarımda yapmaya çalıştığım şeylerde başarılı olduğumu görüyorum.					
8	Rüyalarımda olanlar karşısında tedirginlik yaşıyorum.					

9	Rüyalarımnda imtihan edildiğimi görüyorum.					
10	İnsanlarla paylaşamayacağım duygu ve düşüncelerim rüyalarımna girer.					
11	Günlük hayatımnda çözmeye çalıştığım problemlerle ilgili rüyalar görüyorum.					
12	Rüyalarımnda gelecek ile ilgili planlarımın gerçekleştiğini görüyorum.					
13	Rüyalarımndaki olayların içerisinde başrolde/en önemli kişi ben oluyorum.					
14	Rüyalarımnda sağlığımla ilgili ciddi problemler yaşadığımı görüyorum					
15	Rüyalarımna endişe duyguları hakimdir.					
16	Rüyalarımndaki olayların içerisinde agresif davranışlar sergiliyorum.					
17	Rüyalarımnda mağlup olduğumu/yenildiğimi görüyorum.					
18	Rüyalarımnda başımdan geçen olaylar karşısında çaresizlik yaşıyorum.					
19	Rüyalarımnda kendimi mutlu/sevinçli olarak görüyorum.					
20	Rüyalarımnda sebebini bilmediğim bir şeylerden korkuyorum.					
21	Rüyalarımnda birileri beni izliyor.					
22	Gün içerisinde aklımdan geçen önem vermediğim düşünceler rüyalarımna girer.					
23	Uyanık yaşantımda yapmaya çekindiğim şeyleri rüyalarımnda yaptığımı görüyorum.					

24	Rüyalarımnda diğer insanlar tarafından aşağılanıyorum/dışlanıyorum.					
25	Rüyalarımnda sevdiğim yakın olduğum insanlarla beraberim.					
26	Rüyalarımnda olanların içerisinde kendimi yetersiz hissediyorum.					
27	Günlük hayatımda bana korku veren şeyleri rüyalarımnda da gördüğüm olur.					
28	Yakın bir geçmişte yaşadığım önemli olaylarla ilgili rüyalar görürüm.					
29	Rüyalarımnda tehdit ediliyorum.					

## **Appendix F. Referral Information**

Yeme bozuklukları şiddetine baęlı olarak ciddi boyutlara ulaşabilen psikiyatrik rahatsızlıklardır. Eęer böyle bir durumdan şüpheleniyorsanız, en yakın zamanda bir psikiyatr ile görüşmenizi öneririz.

Bulduğunuz bölgeye baęlı olarak devlet hastaneleri ya da şehir hastanelerinin "Ruh Sağlığı ve Hastalıkları (Psikiyatri)" bölümlerinden randevu alabilirsiniz. Randevu için Merkezi Hekim Randevu Sistemi'ne internet aracılığıyla ([www.mhrs.gov.tr](http://www.mhrs.gov.tr)) ya da telefon ile 182'yi tuşlayarak ulaşabilirsiniz.