Falling in and out of deep sleep
Embodied processes of awakeness and sleep in psychodynamic therapy

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Abstract

Body psychotherapy can offer practical clinical tools, as well as theoretical conceptualisations, for working with transitional states of consciousness, both individual and dyadic. This paper examines sleep as a transformative space, which is mostly unchartered territory for the other, and through developing Bion's reverie (and further influenced by Meltzer's and Klein's work), offers ways of joining the other – in our body – into spaces of sleep and awakening. The work on the threshold of conscious and unconscious processes, which is also known as transliminal (Fassler, Knox and Lynn, 2006), is characterised by dreamlike dissociative states of consciousness during awakeness. In addition, the author explores the function of sleep and sleepiness in the formation of mother-baby attachment system, and therefore at the formative stages of psychotherapy, and attempts to translate these understandings into clinical practice. Alongside the theoretical review, the paper presents a clinical vignette from groupwork, to demonstrate the technique of working somatically with states of sleep.

Keywords: Sleep, shared dreaming, container-contained, transformation, dyadic states of consciousness.

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A. The clock loses its power

In my clinic, I often find myself amidst processes between sleeping and awakening. I find during various therapeutic situations, such as dissociation, where splits occur from the body, the heart (emotional disconnection) the head, or different body organs, it is very difficult to work verbally or interpretatively. We may look at dissociation as an organic state of falling into sleep, in the therapist, client, or both. Sleeping in therapy denotes a sleep, which is qualitatively different to its commonplace occurrence. It is a transitional state between sleep and awakeness – a trasliminal state.

While sleep states of the client and therapist have been widely discussed in psychoanalytic literature (Alexander, 1976; Eshel, 2000; Freud, 1900; Geffner, 2004; Watson, 2003), this paper shall focus on two novel aspects: shared sleep of client and therapist, and techniques for shared-sleeping in treatment as part of a practice of active bodily-reverie. Although drawing from psychoanalytic literature, I focus here on clinical psychotherapeutic applications of shared dreaming. To best understand the ideas

conveyed in this paper, I want to ask you, dear reader, to approach this paper with a dream consciousness, allowing yourself to float in and out, to associate and dissociate, to permit a certain vagueness of understanding.

She's seven or eight, hovering about the house. Light in her steps, her legs are flying about; arms gently raised and softly lowered; mouth opens and closes, singing silently, nonetheless it roams. The bolero plays in her heart, and the ballerina is flying, careful to only step on the carpets, lest she wakes her mum up. It is half past one. One more pirouette, then another; and relevé and plié. It is now twenty to two. The dancer is tired, so she turns the television on. Quietly. What's on the television? There is only one channel; black and white, one takes what's available. It's hard to hear, as the sound is muted; mum should not be awoken. Looking at the clock; two fifteen. She falls asleep in front of the television and wakes with a startle. She turns on the fan, then turns it off; then practices a few more moves. She opens a library book, smelling the old scent of these books, which she hides deep in her bag. These are Romantic novels, "I'm borrowing them for my mum," she lies to the librarian who stares at her questioningly when she takes this book, as well as The Clan of the Cave Bear for the seventh or eighth time; and *Little Women* and *David Copperfield*. The pages are faded from reading. Who reads these books? She wonders. Girls like me? Older women? How come these books pass through so many hands? She is deeply engrossed in her reading, having read fifty pages already and the clock's face shows four thirty. Soon, her heart dances, soon she will wake up.

Excited, she checks the kitchen for cookies and looks for a crossword to solve; choreographing her steps to show mum and it is five o'clock. Shall I knock on the door? Shall I not? To wake her up or not? In her heart she knows she shouldn't, it is never received well. A turn to the right, half a turn to the left, legs wide open, arms high in the air, the face is burning. It is twenty past five. She doesn't understand, it's late. She is also slightly angry. She has been with herself, quietly, for a long time. She doesn't know where her sister is and then decides to go out to the park, to look for her sister. By the time she'd come back, mum would surely be awake. She runs to the park, right behind the house, and there – her sister, sitting on her regular tree, observing life around her. "Come home," she shouts to her sister, "come home." Reluctantly, her sister climbs down from the tree; leaves are decorating her beautiful curls as she climbs down with a newly found walking stick, and both girls skip home. Waiting for mum to open the door. "What time is it?" she asks a neighbour, and he smiles, "Six o'clock." They come in, gently knocking, knowing that mum may not have awoken yet. They open the door to find out that the house is still under a sleeping spell, and dark. They can wait no longer. They barge into her bedroom. "Mummy, mummy," they jump on her bed, "it's five past six." And mother awakes, her eyes are red and duvet's marks weave lattice patterns on her face; her good smell awakes alongside her too. Mum opens the shutters and increases the television's volume. A platter of fruits and cookies is laid on the table by a steaming hot coffee. She and her sisters are singing, taking out some board games to play, and the clock, finally, loses its power.

B. Sleep as a reaction to client's poor associative material

Hazan (2000) divides the literature about sleep in to two groups. In the first, we can find authors postulating the meaning of falling asleep within the transferential context with their clients, such as the "frustrating client", the "non-present client", the "half-alive" client and so on. Ferenczi (1919) related to the client's (and therapist's) falling asleep as a reaction to client's

poor associative material. Ferenczi argues that once we understand that our sleepiness has been a response to the client, our awakening returns. This type of sleep is clinically described by theoreticians as a depersonalization of kind, an extreme dissociative response, a hypnoidal state, a primitive split or an externalization of pathogenic introjects (Brown, 1977; Dickes, 1965; Dickes & Papernik, 1977; Mclaughlin, 1975).

In a second category, we can find theoreticians and clinicians who provide less generic and more specific explanations for sleep. Kelman (1987), for instance, describes himself as feeling sleepy without knowing why until his client shared his childhood difficulty of waking his mother up. Kelman offers the following interpretation: the process began with the client being preoccupied with himself, and the therapist was 'left out', needing to find his way back to the client on a much more primary, primordial fashion. When Kelman almost fell asleep, he in fact identified with the inaccessible mother. This is not a normal transmission of information but instead a first-hand-learning experience, which Kelman termed Forced cognition by resonance, and it took place following a temporary regression of the therapist, and was dependent on the therapist's capacity (and willingness) to identify with processes of loss. Meltzer (in Williams, 2004) similarly relates to countertransference during sleep.

In this paper I focus on the second type of sleep, as a primordial process, one that asks of the therapist, as well as the client, to actively partake in a therapeutic and embodied enactment. It is a search for special dream states, whereupon the therapist dreams of the client while the client concurrently dreams (of himself, the therapist or therapy) during therapy.

C. Sleep as a transformative act

In my childhood fairy tales, heroines often fell into deep sleep (Batelheim, 1980; Renan, 2001). Snow White and Aurora both slept for a long while and were awoken by an external agent. The prince awoke Sleeping Beauty and in Snow White's original story, the seven dwarves refused to give up her beauty and built a glass coffin, placed at the heart of the forest for all the creatures of the wood to enjoy. A prince stumbled upon her and desired to possess her beauty, yet as he tried to load the coffin on his carriage, the coffin fell and broke and the poisonous-apple bite left Snow's body, waking her up (Renan, 2011).

In both stories, the princesses could not be awoken. In Sleeping Beauty, many princes sought Aurora's palace in vain. The thick shrubbery webbed round the castle, gripping it forcefully and freezing it in time, only to open (and this is not a classical interpretation) when the princess was ready to be found[1]. Snow White's glass coffin too was only found when the incubation period was over. The two princes represented the manifestation of the transformative process, its external realization. But what happened during the sleep itself? What was that transformative process the princesses went through and why did they need to sleep so deeply because of it?[2]

Fairy-tale transformation takes place in sleep because the heroine needs to undergo a deep internal process during which the transformation occurs, and only then can the heroine awake into a new reality. The transformative occurrence manifests in the external world but the preceding processes as well as the moment of transformation, are hidden[3]. Sleep allows

[1] Princes too go through transformation during sleep.

[2] In fairytale transformation, the princess' age does not change. Transformation does not interfere with chronological age and the princess is spared the sense of missing our and regret, so common in the clinic (why didn't I do this earlier, my life could have turned out differently). Furthermore, in the real world, transformative processes take time. Sixty-year sleep is a long sleep, too long. I believe that one of the purposes of therapy is to shorten the sleep.

[3] Like the ugly duckling story, where a person only realizes his/her beauty and identity when a transformation occurs and is recognized when seeing the already-changed reflection.

the heroine space to develop an inner life, which thereafter fostered change. This process resembles a metabolic internalising, complementary to Klein and Bion, a maternal reverie where the therapist can dream, together with the client, her inner world. Body psychotherapy contributes the concrete shared sleep to the metaphoric and symbolic concepts.

Many psychoanalytic and psychotherapeutic attempts were made to trace those transformative moments. Bion (1961, 1962) dedicated much of his individual and groupwork research to transformation. Bion considered transformative processes as existing in a special state of consciousness, where both client and therapist were deeply immersed in reverie. I shall expand on Bion's work (1962, 1963, 1965) to demonstrate how transformative processes existed in a state of mind of reverie, an in-betwixt state between sleep and awakening. I shall illustrate the practice of bodily-reverie (Pinkas-Samet, 2016a), which uses acts of sleeping and awakening in a physical way, not merely as metaphors.

Reverie, as defined by Bion (1962), is a state of hovering attention – being mindful of all that is around. Ogden (1994) adds somatic awareness to Bion's mentalising work. Bodily-reverie means that I enter a sleep-state alongside my client and be with him there. If I can then generate a process within me, my client stands a better chance of doing the same. We are not relating to linking separateness (what Bion termed as "k"), but instead to sharing a fusion where not only the therapist dreams for the client, but both are undergoing transformation. Both parties seek to expand inner space to create an intersubjective field, and they both do so in their sleep.

I shall look at the bodily meaning of sleep and awakening as part of reverie and exemplify how transformation might take place within sleeping-and-awakening practices and techniques which use body psychotherapeutic principles and practices. Embodied and shared sleeping allows intersubjective resonance and novel intimacy – I am not alone, mum holds my hand as I sleep and she is with me, inside my sleep and my dreams; she takes care of me. Shared sleeping allows the therapeutic dyad to mutually regulate (Carroll, 2009; Rolef Ben-Shahar, 2013a). Such technique would be demonstrated within a training group process.

D. Bionian transformation

> The nearer the analyst comes to achieving the suppression of desire, memory and understanding, the more likely he is to fall into a sleep akin to stupor. Though different, the difference is hard to define.
>
> Wilfred Bion (1970, p. 47).

As a membrane, Bion asks the therapist to absorb into herself (into her body too) everything that takes place in her external environment, all that pulsates. The body offers a laboratory of filtering, processing, digesting, all of these processes allow for an organising intelligence, one which provides a good-enough form to the chaotic, raw, and fragmented material. This organising intelligence is created as a result of slow sinking of materials, until these become precipitations, and thanks to the therapist's ability to leave them be until she gathers them back. Sleep thus allows for material to flexibly move between liminal states, between unconscious and the threshold of consciousness – it is therefore transliminal (Fassler, Knox and Lynn, 2006). Sleep is also a shaper of memories – we organise and form our memories in our sleep (Freud, 1900; Watson, 2003) – as well as the other organisational processes that take place during sleep.

This is not a trivial task. Usually, the gathering happens momentarily and may seem irrelevant, inevitably creating an enactment. The therapist needs to be awake and asleep at the same time: sufficiently asleep to reside in a state of suspended attention and sufficiently awake to note these occurrences. Asleep enough so she is not too reactive, overwhelmed or anxious; awake enough so she could process materials and notice different levels of processes as these occur. Asleep to allow the coming in, leaving out, floating and mobilisation of material without interference, and awake to filter out intolerable toxins, and allow the process to be contained.

Sleep and awakening are physical process. In fact, these are primordial process experienced by the baby. The ability to sustain such connection with the client is nothing but obvious.

It is insufficient to write about sleep and awakening from a theoretical point of view alone. These need to be practiced, and practicing bodily processes should be experienced in the body. Margaret Little (1986) beautifully described how, during her analysis with Winnicott, they have together oscillated between sleep and awakening, facilitating her own birthing processes. They were both in somnolence, neither awake nor asleep, and Winnicott gave birth to himself as her therapist, as well as a surrogate parent. Little needed someone who could experience with her a deeply bodily experience, since birth is a process where the labourer and the baby are deeply intertwined, until they become two separate beings and the umbilical cord is severed.

Connecting and disconnecting (attuning and misattuning) are therefore bodily processes which are significant in the process of transformation. In therapy, it may happen spontaneously but could also be fostered by the therapist. The capacity to merge, to enmesh into a single unity with the other and then separate, become individual – the movement between separation and individuation, is a crucial tenet in the connection between two people. The process of merging and separating presented here is not Mahlerian (Mahler, 1967) in its developmental essence. I believe that presenting merging as necessarily pathological (or regressive) results from the dread of merging and fusion – the fear of becoming a shared-body, an undifferentiated self. The individual, who is the celebrated unit and end goal of western civilisation, is therefore threatened by cultural perspectives which see the collective and intersubjective as equally important as the individual. Unlike Mahler, I follow the relational view of the processes of merging and separating as continuously occurring and pulsating between each other, rather than unidirectional development from symbiosis to individuality (Aron, 2013; Aron & Bushra, 1988; Carroll, 2009).

In my understanding of the Bionian model, transformation takes place when three elements have changed:

1. The quality of communicated material of the client changes.
2. The therapist changed, following a novel understanding of the world, which changed how she things and feels.
3. The client changed following the therapist's interpretation (both therapist and client invest in expanding their inner space for work).

There are two people in the room, both immersed in the "therapeutic soup". Something then happens, yet it cannot be specifically pointed out, it's impossible to say "it happened exactly such and such". It is a moment which asks for waiting, it is a meditative trance-like state, and it starts with the capacity to courageously sit and admit

that "I have no idea where this is going; I don't know where we would be pulled into and in what form we shall return."

Within this state, we trust that something would happen. And when that something does happen, the quality of communication and of the both persons' material, changes: the client's words, his posture, inner sensations, and thoughts. Concurrently, something changes in the therapist's material – a novel thought will emerge.

There are three possible techniques of working with such reverie. The first is a process of mutual influence – the therapist surrenders to the relationship, and is changed, the field is changed. As something in the client/therapist changes, she attempts to communicate this change verbally and nonverbally to the client. Such nonverbal communication is reverie-resonance, reflecting how the client-therapist relationship manifest in the therapist's reverie, in the thoughts, feelings and sensations she feels. The same resonance phenomenon can happen slightly differently, where the organising intelligence emerges in the room: when time-holes open up within it, something emerges out and into the session. In this case, both therapist and client can sense a different level of intelligence, a third, and are willing to enter it, to allow this intersubjective space influence them. Here, the art of dyadic relationship is in catching that elusive tail, which showed itself for a moment. A third way of working with bodily reverie could be an active technique, instead of merely waiting for the moment to arrive, where I as a therapist am actively surrendering to the process in body and mind, bringing my body into this enmeshed soul despite the fear of merging with the other (annihilation, disease and contamination, and so forth) (Tronick, 1998; 2004), to reiterate – I willingly (and temporarily) submit into our enmeshment.

One of the major fears from directly working with the body is related, in my opinion, to fear of contamination. What would the other pass on to me? While the psyche is not contaminating, the body could be. In Kleinian terminology, we may wonder what would the other inject into me, what toxin would I ingest – or concretely – what if the other person's smell sticks to me? (Becker, 1973; Rick, 2014).

Without expanding on this matter, I still wish to postulate that the archaic fear of working with the physical body might be connected to symbiosis and separation.

Let us turn our attention to the active reverie, where the client's and therapist's body consciously share in the transformative processes. The active reverie illustrated below relates to physical states of consciousness, among these are sleep, stupor and awakening; since it is within this sleep that transformation occurs (and sleep cannot be merely psychic nor can it be solely bodily), where a newness – a novel third emerges into the room, the shared fruit of two people (Rolef Ben-Shahar, 2012; 2013b).

Such sleep cannot be forced; it comes on its own terms. It comes when the two people in the room share a state of consciousness facilitative for such stupor. The deep meaning of reverie is finding yourself in it, and therefore each reverie process also has a mystical element.

Winnicott (1960) explains his concept of being as an axis alongside which early experiences of mother-baby take place; being together in a place without urges as a precondition for development of agency. Thus, the sleep of a therapist is sharing-in-being with the client, and sleep can be not only a shared field for exploration of dreaming, but also of becoming, becoming which unravels tissues and tendons from its bodily origins. But what about shared sleeping? Shared-sleeping, albeit carrying sexual connotations, has more to do with a dyadic state of consciousness (Tronick et al., 1998) than with sexuality.

It does not necessitate physically sleeping next to each other, but allowing someone else into a place which is usually isolated.

In discussing mutual regression, Lewis Aron (1988) relates to regression where both client and therapist enter a mutually-dependent relationship. Within this regression the therapeutic dyad emulates a mother-baby (or parent-baby) attachment system, and both parent and child are in a special state of consciousness. I consider the mother's sleep next to her baby as a special sleep, through which the mother constitutes the child's identity within her; she takes a rest from her baby, yet at the same time processes him within her sleeping experience, absorbing his smells and breaths, experiencing his movements in her dreams, gets to better understand which he cries. The same is true for the baby.

Many psychoanalytic processes (Freud's drive theory, Kleinian projection and introjection, Bion's Container-contained concept and more) could be seen as expressions of biological mechanisms. Classic psychoanalytic technique attempt to find words for the bodily container. But what about the other direction, from the psychology to the physiology? How can I, as an adult, trace primordial bodily processes and what can I understand from them? Can we deduce from the experience itself, from the affect and not just from the memory thereof?

E. Waking up and awakeness in groupwork – a clinical vignette

The following vignette is taken from a training group in its first stages of forming, or in Bion's (1961) language, in its pre-mental stage – undifferentiated and dissociative. I wish to illustrate how working between sleep and awakening could be done with disintegrative structures and how somatic practices can be used for such therapeutic processes.

For a group engaging in bodywork, the group-body is of utter importance. The body of the group is the point of attachment, a source of comfort as well as a reference for personal enquiry and an axis of exploring relationships.

During the first stage of building a group, our group-body has yet to develop and the personal body is scared too, wishing to disconnect while also seeking connection. During classes, and within the bodywork we can see all the extremes: the obedient body that executes every directive and the dissociated body sitting still and unable to move. We notice the responsive body and the placating body, the frozen body and the body parts which arrive scattered into the work, while other parts are left behind. Frequently, while doing deep regressive work there is neither body nor mind nor a distinction between the two. All we can do is go to sleep; adopt a sleeping posture and breathe the group inside, just like a baby and his mother, smelling our environment, evaluating the space which expands or contracts around us.

Upon waking up, it is very difficult to speak. The group is still immersed in a schizoid experience, disconnected, and sharing many dissociated elements. The speech is fractured, distant. Different body movements, organs are moving disharmoniously, scattered, a sense of embarrassment and sleepy helplessness. The body is rigid, pulling down, back into gravity. Nearly everybody yawns. The only verbal reports are of dizziness and headaches, not feeling the personal body, fear and anxiety expressing in respiratory difficulty or contraction, narrowing down of the self.

I ask them to lie down once more. Each trainee tries to sleep on the floor, as close as possible to the ground, and while adopting a posture he or she can sink into. I ask them to sink, to drop down and sink and collapse into this posture, to surrender into the ground, to merge with that which is underneath, to let go, "can you melt into the ground? Can you deeply sink into the self or into the ground? To fall asleep, to doze off, to nap, to be and not to be, to sleep".

A long time passes.

I ask them to slowly leave that posture into a new, calming movement. A repetitive movement, possibly an obsessive-compulsive movement, the same balance and rhythm and size[4]*. An emergent movement, starting from inside.*

One by one. Distant apart. Like organs spread in the room. one is rocking, the other singing to himself; one strokes his head and face repeatedly, another one rocks her leg; one person is praying, and another is hitting himself.

There they stay for a long hour, repeating that movement time and again until I ask them to cease; to enter the basic posture, to collapse into the self, to get lost and rest.

Again they get up into the movement; not playing with it yet – that would come later – but merely exploring it, checking how it touches other body organs, wondering about its foundation and its direction, what does it feel like? What organs tire first? What is this experience like? And again, back to the basic posture.

We practice sleep and awakeness like a baby, who conducts a basic exploration of his body – moving his limbs about, opening and closing his fist, rocking his body, searching for a posture for sleep, so that he may internalise his experiences.

What makes my body relax? What regulates me? What happens within those states of rest which are part-doze, part-sleep, part-daydreaming? What happens from entering the posture until I go back to rest? Perhaps this is an attempt to explore foetal positions, repetitive movements as a ritual; perhaps we explore our basic needs, both connected and disconnected, conscious and unaware of our surrounding.

I let go from trying to understand, from observing. I too am lying there, searching for my posture within this group atmosphere. I want to feel the group inside of me. I want to fall asleep in it and wake up within it, to absorb the group's precipitations into my body. I practice with the group, sometimes I observe from outside and at other times going in, coming in and out, I am in the group and the group is in me.

The emphasis in this work is experience rather than words or emotions. Such experiential onus is paramount to body psychotherapeutic practices, wishing to track primary processes through the body (this is supported by the work of Daniel Stern, 2004; Ramberg, 2006). These are hour-long practices which are repeated for about two months. After two months we seek to explore the experience differently – we work with our movements with another person, in front of a small group, until at the end the group creates the group-body, one which shares movements and organs of its own. This group-body is not just an epistemological body; it is body acting as such in the world.

I ask the participants of the group to pair up. We practice shared sleeping. We practice a few types of shared sleep. At first, each one sleeps by the other, practices the repetitive movement next to the other; in effect – conducting his or her own private ritual next to the other. The partner watches; she may watch silently or listen to the voices that emerge in her or she may imitate the other in her own body or through the movements that emerge from her. Sometimes these are micro-movements, and they may regulate the other. Sometimes these are mirror movements, reflecting the other what he is doing right now. At other times, these are complementary movements which connect fragmented, unsequenced movements. Sometimes these are different movement's altogether, bodies dialoguing among themselves, a question and

[4] Not unlike Tustin's (1981) ritualistic shapes.

a reply, bodies expressions, forms (Keleman, 2012). Slowly, one is immersed in the world of the other; I practice this repetitive movement next to the other and something of my movement is ingested by him. His movement changes from my own, and my movement - from his. We slowly synchronize into a shared, wordless movement. Perhaps this is not synchronization, but a third, novel movement.

We may also simply sit by one another and breathe together. I listen to his breaths and come back to mine. And again. And again. Sometimes I am with my breathing cycles alone, sometimes only with the other's.

We practice entering sleeping positions next to one another, and waking up. We wake into each other, and go back to sleep. Each time, sleeping changes, the other enters my sleep, dreams become enmeshed.

We could have thereafter spoken about the dyadic sleep we shared, but we elect not to. We do not seek to prove that we shared similar experiences or that we shared thoughts. The presence next to the other in such an intimate ritual like sleep suffices. It is transformative – I do not sleep alone, I do not wake alone from my sleep, be it from a dream or a nightmare. Someone is there, with me, in my sleep, sharing his sleep with me. Within this process, part of the transformation is a creation of shared sleep, something new was created.

Discussion

I postulate that these processes are active bodily-reverie, pre-cognised (and pre-linguistic) processes and nonverbal which exist and operate in our body. I further believe that these processes form part of the body's language (Bucci, 2001, 2011) and that we don't exactly understand how repeating these processes serve our understanding of them, but that within the bodily practice, they offer both the capacity to tolerate early experiences in our body and are facilitative in constructing a shared, intersubjective, body.

1. **Tolerating early experience:** internalizing unconscious bodily processes: movement patterns, bodily organizations, familiarity with my somatic-self and its language (Pinkas-Samet, 2016a, b).

   The capacity to tolerate early experiences in the body and examine them from inside is an expression of bodily-reverie, since it allows for understanding that has no words for shared bodily experiences, or bodily expressions of the self as manifesting, and reflecting the other. It is like being deep in meditation and at the same time physically being inside the other. The physical aspects allow us to explore, understand and experience such processes from inside, from within our body. This is more than cognitive understanding, as our body experiences early pre-mental states afresh. By experiencing these we may repeat and heal early processes of closeness and distance, symbiosis and separation.

2. **Constructing a shared-body** (for the purpose of shared-dreaming, Rolef Ben-Shahar, 2014a, b)

   Building a shared body may assist unconscious survival goals of the group, as Bion argues (1965), but the bodily expressions of the group construct a different kind of a group, one that can lean against intimate processes, which reflects the other and is reflected by the other physically. As a group, the shared group moves as one, as a unified bodily entity. A bodily group has power and meaning in the world – the individual may experience him or herself as a part of something bigger, not just psychically but through

his body. He is an organ of something, he breathes for someone, he does not exist as a shared body without the other, he needs the other and the other needs him. Thus, the relationship weaved in such a group and within the people of the group, are based on intimacy. As such, they teach us about being together. As I hope to have demonstrated, I believe that body psychotherapy techniques can significantly contribute to the formation and sustaining of intersubjective processes.

F. The clock loses its power

The clock loses its power.

And tomorrow is a new day, one without transitional moments between waking up and awakeness, but instead falling into deep, autistic sleep, which offers no transformative moments, which offers no way out.

But this dancing girl would forever remain. A girl who does not stop moving, as if she attempts, with her own small body, to enliven all that is dead in this world.

BIOGRAPHY

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REFERENCES

Alexander, R. P. (1976). On patient's sleep during the psychoanalytic session. *Contemporary Psychoanalysis*, *12*, 277-291.

Aron, L. (2013). *Monsters, ghosts and the undecidables: Mutual vulnerability.* Paper presented at the Individual and the Group in the Space of Mutual Vulnerability, Tel Aviv.

Aron L. and Bushra, A. (1988). Mutual regression: Altered states in the psychoanalytic situation. *Journal of the American Psychoanalytic Association, 46*: 389-412.

Becker, E. (1973). *The Denial of Death.* New York: The Free Press.

Bettelheim, B. (1989). *The Uses of Enchantment: The Meaning and Importance of Fairy Tales.* New York: Vintage Books.

Bion, W. R. (1961). *Experiences in Groups,* London: Tavistock.

Bion, W. R. (1962(. *Learning from Experience.* London: Tavistock.

Bion, W. R. (1963). *Elements of Psycho-Analysis.* London: Heinemann.

Bion, W. R. (1965). *Transformations.* London: William Heinemann.

Bion, W. R. (1970). *Attention and Interpretation.* London: Tavistock.

Brown, G. (1977). Drowsiness in the countertransference. *International Review of Psychoanalysis, 4*:481-492.

Bucci, W. (2001). Pathways of emotional communication. *Psychoanalytic Inquiry, 21,* 40-70.

Bucci, W. (2011). The interplay of subsymbolic and symbolic processes in psychoanalytic treatment: It takes two to tango - but who knows the steps, who's the leader? The choreography of the psychoanalytic interchange. *Psychoanalytic Dialogues, 21*(1), 45-54.

Carroll, R. (2009). Self-regulation: An evolving concept at the heart of body psychotherapy.

In L. Hartley (Ed.), *Contemporary Body Psychotherapy* (pp. 89-105). Hove: Routledge.

Dickes, R. (1965). The defensive function of an alerted state of consciousness: A hypnoid state. *Journal of the American Psychoanalytic Association, 13*: 356-403.

Dickes, R. & Papernik, D.S. (1977). Defence alterations of consciousness: Hypnoid states, sleep and the dream. *Jornal of the American Psychoanalytic Association, 25*: 635-654.

Eshel, O. (2000). Who's sleep is it anyways? Or exploration in the dark [Hebrew]. *Sihot*, *14*(3): 174-186.

Fassler, O., Knox, J., Lynn, S. J. (2006). The Sleep Experiences Survey: Hypntizability, absorption, and dissociation. *Personality and Individual Differences, 41,* 675-684.

Ferenczi, S. (1919). On falling asleep during analysis. In: J. Rickman (Ed.). *Further contributions to the theory and technique of psychoanalysis* (pp. 249-250). London, Hogarth Press, 1950.

Freud, S. The Interpretation of Dreams,(1900). *The Standard Edition of the Complete Psychological Works of Sigmund Freud,* The Hogarth Press and the Institute of Psychoanalysis, London, 1958.

Geffner, A. H. (2004). "To sleep, perchance to dream" ... on the couch: The interpersonal nature of dreams and other dissociative processes - a case illustration. *Psychoanalytic Dialogues, 14*(1), 139-162.

Hazan, Y. (2000). On the patient's sleep in psychotherapy [Hebrew]. *Sihot, 14*(3): 187-198.

Keleman, S. (2012). Forming an embodied life: The difference between being bodied and forming an embodied life. *International Body Psychotherapy Journal, 11*(1), 51-56.

Kelman, H. (1987). On resonant cognition. *International Review of Psychoanalysis, 14*: 111-123.

Little. M. (1985). Winnicott working in areas where psychotic anxieties predominate. *Free Associations 3*: 9-41.

Mahler, M. S. (1967). On human symbiosis and the vicissitudes of individuation. *Journal of the American Psychoanalytic Association, 15*, 740-763.

Mclaughlin, J. T. (1975). The sleepy analyst: Some observations on states of consciousness in the analyst at work. *Journal of the American Psychoanalytic association, 23*: 363-382.

Ogden, T. H. (1994). The analytic third—working with intersubjective clinical facts. *International Journal of Psychoanalysis, 75*, 3-20.

Pinkas-Samet, S. (2016a). Psychic fragments and changing bodies: Theoretical and clinical applications of bodily-reverie. *Pending Publication.*

Pinkas-Samet, S. (2016b). Other people's movements: Ethnologic perspectives on motoric armouring in body psychotherapy. *Pending Publication.*

Ramberg, L. (2006). In dialogue with Daniel Stern: A review and discussion of The Present Moment in Psychotherapy and Everyday Life. *International Forum of Psychoanalysis, 15*(1), 19-33.

Renan, Y. (2011). *The Poisonous Apple: The Heroine in European Fairytales* [Hebrew]. Hakibbutz Hameuchad.

Rick, M. (2014). The therapist's body as a platform for analytic in-depth work. *Sihot* [Hebrew]. 28(2):1-9.

Rolef Ben-Shahar, A. (2012). The relational turn and body psychotherapy III: Salsa lessons and the emergent self. In C. Young (Ed.), *About relational body psychotherapy* (pp. 155-178). Stow: Body Psychotherapy Publications.

Rolef Ben-Shahar, A. (2013a). A cup, grasping my fingers. *Somatic Psychotherapy Today, Spring 2013,* 40-42.

Rolef Ben-Shahar, A. (2013b). The self-healing forest: Between self-regulation and dyadic regulation. *Body, Movement and Dance in Psychotherapy, 9*(1), 16-28.

Rolef Ben-Shahar, A. (2014a). Bodies intertwined - short cuts. *Somatic Psychotherapy Today, 4*, 20-24,78.

Rolef Ben-Shahar, A. (2014b). *Touching the Relational Edge - Body Psychotherapy.* London: Karnac.

Stern, D. N. (2004). *The Present Moment in Psychotherapy and Everyday Life.* New York: Norton.

Tronick, E. Z. (2004). Why is connection with other so critical? The formation of dyadic states of consciousness and the expansion of individual's states of consciousness: Coherence governed selection and the co-creation of meaning out of messy meaning making. In J. Nadel & D. Muir (Eds.), *Emotional Development - Recent Research Advances* (pp. 293-316). Oxford: Oxford University Press.

Tronick, E. Z., Bruschweiler-Stern, N., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Nahum, J. P., Stern, D. N. (1998). Dyadically expanded states of consciousness and the process of therapeutic change. *Infant Mental Health Journal, 19*(3), 277-353.

Tustin, F. (1981). *Autistic States in Children.* London: Routledge & Kegan Paul.

Watson, D. (2003). To dream, perchance to remember: Individual differences in dream recall. *Personality and Individual Differences,* 34, 1271-1286.Winnicott, D. (1960). The theory of the parent-child relationship, International Journal of Psychoanalysis, 41:585-595.