

The Sleep of Prisoners: Hypnagogic Resonance and the Vicissitudes of Analyst Sleep

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The title of this paper, *The Sleep of Prisoners*, comes from a play by Christopher Fry, who many consider Britain's most poetic playwright since Shakespeare. Fry's interest was in writing a play to illustrate that differences and conflicts between people "spring often...from the outward amour, the facades behind which we hide our spirits" (Fry, 1951, p. 3). Four male actors play prisoners of war detained in a church turned prison camp, stripped bare except for the pulpit and four wooden beds. By day we see the surface of the men—the outward behaviors and characteristics which distinguish them, one from the other. By night, they sleep and fold into each others' dreams. Each one dreams of himself and the other three as larger than life biblical characters—Cain and Abel, Absalom, David and Joab, Abraham and Isaac, and finally Sadrac, Mesak, and Abendego—four dream stories of relationships laced with trauma, passion, faith, and their accompanying vicissitudes of deception, betrayal, love, loyalty, and redemption. That the play was set in space intended for sacred concentration, but turned into its sacrilegious opposite; that it

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was first performed, not in a theater, but in a country church, in effect blurring *definitions* of reality; that the action of the drama shifted between wakefulness and sleep, challenging *perceptions* of reality; and, finally, that the entire drama layered reality as a topsy-turvy interplay of time, space, content, and person seemed to mirror analytic work and headline the subject of this paper.

One of the foundation stones of analytical psychology is Jung's dictum that analytic work is a *mutually* infecting process. Well before mainstream psychoanalysis had moved toward theoretical models which consider the interpenetrated couple as the basic analytic substrate, Jung was alerting analysts to the intermingling and therefore potential dangers of their profession. His much-quoted caution is probably more alive and relevant today beyond a Jungian bailiwick than it was when he penned it in 1946: "The patient, by bringing an activated unconscious content to bear on the doctor, constellates the corresponding unconscious material in him....The doctor by voluntarily and consciously participating in the psychic suffering of the patient, exposes himself to the oppressing contents of the unconscious and hence, also to their inductive effect....Doctor and patient thus find themselves in a relationship founded on unconsciousness"(CW 16, para. 364). There are many ways to approach the unconscious. One of the most familiar is through sleep, our daily journey to the wisdom of the dream world. Personally and professionally it is usually a welcomed journey, but when it happens in an analytic session with a patient who is alert, animated, and focused on sensitive material, it can be a humiliating and psychologically brutal experience for both parties. This paper is about those brutal and humiliating experiences and about living life in the blurred margins of what we call "reality."

Given the frequency with which analysts I surveyed, including myself, have experienced some form of in-session sleepiness, it is striking how little that frequency is reflected in analytic literature. It does, however, provide frequent fodder for *New Yorker* cartoonists and stand-up comedians. Perhaps the phenomenon of analyst sleep is so common that it is treated as a regularly occurring occupational hazard, to be dis-

pensed with efficiently. We vow to get more sleep, not eat such a big lunch, reduce our afternoon schedule, shift specific patient hours, take it up “later” as a countertransference issue with ourselves, our analyst, and/or supervisor, and return ourselves to that place of “even hovering attention” as quickly as possible, hoping our patient hasn’t noticed our muffled yawn or drooping eyelids. But often they *do* see, especially if the session is conducted face-to-face, rather than on the couch. In my experience, initially they take a “don’t ask, don’t tell” stance, squashing, at least publicly, the bits of affect it engenders.

I want to propose that, given its frequency, analyst sleep is a much-neglected aspect of analytic investigation and, further, that it needs to be seen in a much wider context of mutuality than it has been. I propose that we consider analyst sleep as a form of resonance—a *hypnagogic resonance*—which can provide information vital to the analyzing couple and has been overlooked and underdeveloped therapeutically. By hypnagogic resonance I mean a place of connection with a part of the patient that languishes in a kind of paralytic slumber that the analyst can experience and potentially access in session through the field of sleep. The call to sleep can announce that you might have reached the inner courtyard of a soul that dares not authentically think, feel, or desire. It is the place where differentiation stalled and from where it must reignite. It is a place of *primary process mutuality* in which the analyst can find relevant meaning in its personal manifestations of eidetic imagery, vivid sounds, smells, or various kinesthetic sensations. After considering some of the symbolic aspects of sleep, I will review the relevant literature on analyst sleep and then present some clinical material to illustrate my position.

In mythology and fairy tale, sleep is most frequently a form of bewitchment which stops all growth. The process of individuation is held in a state of suspended animation until the magic word is said or magic act performed. The bewitched creature remains as he/she was, often an innocent, uncontaminated by the surround of everyday life. Protection at the expense of individuation. By “innocent” I don’t mean one whose existence is limited to purity of heart or a one-sided goodness. Rather, an innocent is a person unawakened to the

fullness of affective life across its erotic and aggressive spectrum. They live in the world but feel as if only on its edges. Connection with self and other is illusive and staccato: the waif whose nose is pressed against the window longing to join the party inside, the stalker who longs to connect but creates only terror and distance. Souls wobbling through everyday life trying to feel grounded. We've each seen it, in some ways we've each lived it. Underneath the stagnant layer of bewitchment there exists a soul bubbling with unrealized fantasy and desire, dormant, fearful, but expectant.

While many bewitchments hold the subject in a state of suspended psychological animation, there is another form of sleep during which dramatic transformation occurs. In the Hebrew Bible, the Hebrew word *tardemah* appears only twice in the *Chumash*, the five books of Moses. It is translated as "deep sleep." The fact that there are other biblical references to sleep that use different words signifying different sleep functions—e.g., as a symbol of spiritual blindness and regression (Jonah); consolidation (Elijah); loss of being—gives a unique significance to *tardemah* sleep.

The two references to *tardemah* sleep both occur in Genesis. The first is from Genesis 2:18: "And God said: It is not good for the human to be alone; I will make a helper corresponding to him. So God formed from the soil every living thing of the field, and every fowl of the heavens and brought each to the human...The human called out names for every [creature]...but there could be found no helper corresponding to him. So God cast a deep sleep [*tardemah*] upon the man and he slept; and God took one of his ribs and closed up the flesh in its place. God built the rib that he had taken from the man into a woman and brought her to the man. The man said: This-time, she-is-it! Bone from my bones, flesh from my flesh! She shall be called woman." Note here that God puts considerable effort into finding a helper for Adam, but a series of attempts fail, much as ours as analysts do as we attempt to experience, understand, and articulate the mind and life of another being, our patient. God only succeeds when parts of the human are taken and refashioned into the Other during sleep, when, out of a fused substrate, difference and attachment emerge.

The second reference is in Genesis 15:12. Much has happened. The humans have been thrown out of the Garden, the first murder has occurred with Cain killing his brother Abel, the world as it was originally constituted has been erased by a flood and repopulated by Noah and his descendants, and the hubris of Babel has shattered the shared speech of humans, creating linguistic confusion. Enter Abram, who, in time, would be renamed and become the first Jew, Abraham. Abram is 75 years old and still childless, God promises him both children as numerous as the stars and land for them to inherit. This marks the moment of the *covenant* between human and divine, the known and the never-to-be known. A partnership is struck. In return for faithfulness and perseverance much will be given. There is a promise and an acceptance—sealed by an animal sacrifice which God directs Abram to make. With the sacrificial fire still smoldering, “a deep sleep [tardemah] fell upon Abram: and behold—a dread! Great darkness fell upon him” (Genesis 15:12). When Abram awakens, God reiterates the covenantal promises, specifying the boundaries of Israel and the time when his descendants would inhabit that land. Here too we can see resemblances to analytic work. For example, as the patient (or analyst) experiences mutuality and intimacy in the analysis, the growing depth and expansiveness of the work may engender a variety of “dread-ful” primitive mental states which threaten progress. If contained within the transference, the “murders,” “floodings,” “thefts,” and “inflations” coagulate, resulting in an ongoing mutuality between two independent subjects—a genuine analytic partnership is established and consistently reaffirmed.

What do these stories tell us about the sleep labeled “tardemah”?

First, it is a sleep which *prefaces the need or desire for partnership*. In the first story God saw that Adam needed company. The animals weren’t enough, God wasn’t even enough. Some biblical sages have suggested that God’s desire to create a helper for Adam was prompted more by a divine self-empathy than by any direct request from the human. God was lonely and created a human in response—perhaps the first instance of the generative effects of empathy! When Adam wakes he is

now a couple; the potential for dialogue has been created while he slept. The movie *Castaway* poignantly portrays this remnant of divine yearning in us as we watch Tom Hanks fashion with bloody hands a basketball face he names "Wilson" in response to his utter loneliness for a "helper corresponding to him." A *de profundis* experience with oneself generates partnership with a created Other. In the Abram story, partnership itself is the created other. Abram and God have made specific promises one to the other in perpetuity. It is also a partnership between two subjects who have a mutual need of each other. Abram needs a protector, God needs to be recognized, that is, seen in the world through their lives.

Second, tardemah sleep is *mingled with dread*. Some Bible experts have suggested that in sleep Abram had visions of all his own future sufferings as well as those of his people through the generations, including the *Akedah*, the call to sacrifice of his not-yet-conceived son Isaac and the twentieth-century Holocaust. Taking a more personally oriented psychological perspective, we could say that Abram touches on the more primitive places in his own psyche, ones neither fully known nor consciously experienced—places of encapsulation beyond the purview of cognitions but "dreadfully" sensed. All we know biblically is that God soothed Abram, upon the latter's awakening, by recapitulating the elements of the covenant: "I will be with you...in time, if you remain faithful, this will happen." Although tardemah sleep is never mentioned again, the soothing covenantal promises are repeated many times. This suggests a partnership which must be repeatedly called to mind, we could say "interpreted," to keep it as present as the underlying dread which can erupt with ferocious suddenness.

Third, tardemah sleep *announces the presence of interactional reality*. Although they do not yet understand its ramifications, Adam's vision is now informed by his role as partner of an Other, Abram by his new position as leader of an emerging nation (our posture as analysts by the life of our patients). How one views, thinks about, and moves in the world informed by the Other are different after tardemah sleep from how they were before. The road ahead is not marked by clear direction signs and the atmosphere may be foggy, but the body has evidence

that it is no longer traveling alone. Each must fashion personal meaning from within a new overarching life context.

Fourth and finally, *tardemah* sleep facilitates individuation. It occurs in order to move Adam and Abram forward into their respective life-destinies. It is not meant to inhibit progress, nor does it keep them suspended in a caul of innocence. It is, in fact, the prelude to a more full-bodied, although treacherous, life journey.

I am not suggesting here that all sleep experiences with patients approach the transformational status of *tardemah* sleep. But I do think they all have that potential if they are acknowledged as significant and not tossed off as a form of occupational detritus. Over my years in practice, sleepiness has been an occasional visitor, but, with persistent reflection, supervision, and/or personal analysis, its "shadowy" countertransference implications seemed relatively clear and manageable. Within the past several years, however, its visitations have been striking and dreadful. I found my somnolent bouts dreadful enough to turn toward the initial relief of a goal-directed literature search—the hunt for a quick fix. As I immersed myself in the relevant analytic literature, the positive effects of *tardemah* sleep stood in sharp contrast to the primarily negative and pathological attitude toward reports of analyst sleep, or more accurately, analyst sleepiness. So, with the elements of *tardemah* sleep freshly in mind, let's review that literature along with my own experience of in-session sleepiness.

Literature on Analyst Sleepiness

Analyst sleep/sleepiness rarely commands the central focus of attention in clinical investigation. More often than not it is lumped together with other "symptoms" of countertransference and considered from that larger perspective. Only a handful of published papers report actual examples of an analyst falling asleep on a patient (Eshel, 2001; Renik, 1991; Boyer, 1979.) Perhaps the most famous of these, because of the analyst's celebrity, is Margaret Little's (1985) legendary account of Donald Winnicott's recurrent bouts of sleep during her analysis with him. When sleep is mentioned, it is the analyst's sleepiness or drowsiness that is most frequently cited (Dean, 1957;

Dickes, 1965; McLaughlin, 1975; Brown, 1977; Pacheco, 1980; Alexander, 1981; Wolfenstein, 1985; Kelman, 1987; Rittenberg, 1987; Brenner, 1994; Stein, 1995). For the purposes of this paper I am including all aspects of analyst sleep—from mild forms of somnolent inattention to profound lapses into unconsciousness—under the heading of “analyst sleep.” Given the frequency with which this phenomenon occurs in actual clinical practice, the paucity of written material is quite striking in and of itself. Alexander (1981) and Scott (1975) suggest that in-session sleepiness may elicit feelings of guilt and is, therefore, more “prone to be forgotten.” More plausible, I think, is the fact that analyst sleep is such a humiliating and psychologically brutal experience that few venture forth with public exposure, especially since it once represented an instance of the analyst’s own pathology. This was certainly true in my own case.

Only recently have I wanted to share publicly, outside my supervisory circles, the sudden and dramatic escalation of sleepiness in my own practice. The “what would people think” chatter, combined with fears of aging, kept the situation quite privately contained. But the events in my office guaranteed that one way or another the word had to leak out. With some patients my impulse to yawn began within seconds of their arrival. At first I attributed this to the more typical drowsiness which accompanies ego-driven commentaries and lifts instantly when the patient awakens to a more expanded emotional connection. In most cases this was true. Ongoing personal analysis and supervision helped unearth the endless places of deadness, passivity, terror, and aggression in me which might serve as the hook for somnolence. Such possibilities as professional burnout, defense against intimacy, breakdown, and other personal considerations were entertained. But these explanations, while helpful in some cases, didn’t lift the sleepiness across the board. It was just a more informed sleep! If anything, with a few cases it was getting worse, moving into more alarming territory. These patients were describing evocative material with corresponding affect, and I could barely maintain consciousness. The maw of my yawn threatened to swallow up both of us. It was painful to be in the room, despite my conscious desire to be fully present. The onset of my sleepiness was so

sudden and overwhelming I felt I had been drugged. Wilfred Bion (1970) once said that “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” (p. 47). He speaks of a state of reverie where the unconscious material of analyst and patient can meet, a place of safety where images useful for the work can emerge. I think one can find solace and enlightenment in these words only with hindsight. Unfortunately, when this phenomenon began to occur with persistent regularity, I was in the thick of it with barely a glimmer of foresight. It did not feel safe, nor did it have the quality of a familiar creative intuitive reverie. This level of what Jung and Janet call *abaissement du niveau mental* was unfamiliar, but with some patients it was a persistent and troublesome analytic atmosphere. My “private” world was going public.

I took some comfort in the fact that the few clinicians who did consider sleep as their central focus described reactions similar to mine. In 1977, Dennis Brown, a London psychoanalyst, described a sense of “overwhelming paralysis of thought and feeling, accompanied by a wish to withdraw and sleep” (Brown, 1977, p. 483). Murray Stein (1995), the only Jungian analyst I found who published an in-depth report on the phenomenon, describes it more poetically as an interactional field over which the god Somnus reigns: “There the air is heavy with ‘Lethe’s dew’ and a ‘Stygian power’ draws the eyelids forcefully downward. Like Palinarus, the unlucky helmsman of Aeneas’s ship, who is the target of Somnus’s interest ...the analyst may fight valiantly, but perhaps unsuccessfully to resist the compelling force of drowsiness” (p. 69). Stein describes his experience with his patient William: “No matter what time of day or what else of interest might be happening,...William had the hypnotic force with him, and from the first session onward, I had to struggle to keep my eyes open and my hands on the helm of the analytic vessel” (p. 70). In 1985, Wolkenstein, and most recently in 2001, Ofra Eshel, an Israeli psychoanalyst, also described experiences most similar to my own. Wolkenstein (1985) reports finding himself, as did I, trapped between “antithetical imperatives” of “I must go to sleep! I must stay awake!” but then gripped by a sudden, inva-

sive, and overwhelming pull toward sleep: “as if I had been injected with a sleep-making drug” (p. 83). For periods of time Eshel, who was seeing her patient face-to-face, would actually fall into a “deep sleep” after the first 15 minutes of listening and responding. She states that in the last ten minutes, “I would wake up...and become myself again” (Eshel, 2001, p. 548).

On only a few occasions have I been pulled into a momentary detached paralytic sleep. In those instances it is as if sleep itself triggers its opposite, and I return suddenly to that painfully persistent liminal state in which, like Wolkenstein and Stein, I continue my struggle against the force of sleep’s pull. Sometimes, various parts of my body grip and tighten as if alerting me for the need to stand firm, at least in emotional resolve, or keep me from “coming apart.” Unobserved yoga movements bring only temporary relief. Sometimes I feel as if I am wrestling with a powerful but invisible entity, a Jacob-like experience of being caught, as Jung (1911-12/1952) once said, in the back and forth “onslaught of instinct” and an “experience of divinity” (p. 524). At times the struggle is so intense that I begin to sweat. Those of you more inclined toward mutual analysis may be wondering why I didn’t immediately share this intense internal drama with the patient. Such disclosures were always entertained but, in most cases, postponed as premature for both of us.

With only a couple of notable exceptions, the literature on analyst sleep is patient-focused. For example, in his uniquely comprehensive article “The Sleepy Analyst,” McLaughlin (1975) described three types of patients with whom this phenomenon is likely to occur. The most frequent type he calls passive-obsessional and narcissistic character disorders, who use isolation, inactive rumination, concealment, and displacement of affects to control and dull into passivity themselves and the analyst. The next category is borderline and chronic psychotic patients, whose negation of the therapeutic alliance seems to destroy the analyst’s identity and reduce him/her to rage and despair from which he/she retreats to sleep as a defense and narcissistic solution. Finally there are patients whose “character defenses and areas of specific conflict are too similar to those of the analyst or of important transference objects from the analyst’s past” (p. 373). McLaughlin believes this group provides

the most striking and revealing instances of the sleepy phenomenon, as the episodes are more isolated and dystonic, surprise the analyst, and prompt further analysis. I was more interested in this third group because it shifted the etiological search toward the analyzing couple.

While this type of categorization is often intellectually interesting, I didn't find that it had heuristic value in my practice. In an interactional model of mutuality the patient cannot be considered apart from "this particular" analyst. Borderline, narcissistic, or obsessional personality features and behaviors occur in any long-term relationship with oneself or an other. The fact that sleep cuts across categorical types, at least in my own practice, suggested that it might be more helpful to focus, not on categorization, but on introspection and symbolization.

In a letter to Clifford Scott in 1954, Donald Winnicott, whose experience with it was hardly theoretical, wondered whether sleep was the "right word" for this type of event, noting that it seems "to be more in the nature of a depersonalization or an extreme dissociation" (Rodman, 1987, p. 56). It has also been argued that sleeplike states of patients or analysts during treatment are hypnoid or hypnotic states and not ordinary sleep. They are repetitions of childhood hypnoid states that occurred as a defense or refuge from intolerable feelings resulting from traumatic overstimulation and abuse (Dickes & Papernik, 1977; Dickes, 1965). Ferenczi (1919/1980) considered the analyst's dozing as an unconscious withdrawal reaction "to the emptiness and worthlessness of the associations" and his awakening "at the first idea of the patient's that in any way concerns the treatment" (p. 180). Racker (1968) considered it a "mutual withdrawal"—the analyst's "talionic response" to the withdrawal of the patient (p. 130). Others place it at the door of certain patients' tenacious resistance and the analyst using sleep to "further avoid the frustrating nature of the situation" (Alexander, 1981, p. 49; Dean, 1957). Brown (1977) suggests that recurrent drowsiness is a "response to the patient not being present in some important sense" (p. 490). By a process of projective identification, the analyst feels depleted or half-alive, and thus disoriented and out of touch with the basis of what is most alive, or would be most alive at that time if the patient

were truly there" (p. 470). In effect, this interpretation suggests that something akin to a "black hole" *absence* is pulling the analyst into sleep. Said differently: "If the patient were really there, I'd be awake."

Carrying forward the theme of splitting, Murray Stein (1995) hypothesizes that the patient's ego-defense creates a state of dissociation within and a wall of somnolence without to "ward off the unwanted and intolerable intrusions." He senses a "much darker purpose...that cannot be completely written off to defense....A defense pretends to protect and sustain the individual's life, to have an adaptive function. But Somnus enters the scene with sinister, not benign intent. He wants Palinarus to drown; he wants death" (p. 76). In his case example, Stein, following the interactional model of analytical psychology, traces an archetypal thread to the "hook" in himself which catalyzed the projective identification. He finds it in "a mutual mother complex" (p. 85). At no time did Stein comment directly to his patient on the nature of the sleepy analytic field, nor did he use it to make transference interpretations, arguing that such presentations would be "premature...and break the spell." He suggests that, when the analytic field is constituted by strong features of the autistic-contiguous position, as it was with this patient, the analyst go with the patient "into the underground caverns and simply observe what is there before reporting it to any part of the personality in treatment" (p. 82).

Ofra Eshel (2001), the most recent "sleepy analyst" to appear in the literature, moves, like Stein, in the direction of the mythopoetic to illustrate her somnolent bouts. She is also planted solidly in the interactional ground of the psychoanalytic community. She sees it as the mirrored reflection of her patient's "petrifying dissociation." In her case example, sleep was like the Perseus-like mirror-shield which allowed her to approach and overcome the Gorgon Medusa without looking directly at her. In sleep Eshel and her patient, Clari, were interconnected, each in her own way, getting in touch with, experiencing, knowing, containing, and influencing unknown, dissociated, unthinkable aspects of being and relating. Early trauma led to Clari's coercive dissociation of self-experience, cognitive-affective paralysis, and profound sense of absence. These central elements of

her inner world were now projected onto Eshel in a new kind of dissociation in the conjoint entity of her and me, an “entity of ‘togetherness’” (Eshel, 2001, p. 556). “Now the experience of being inside a dissociative, blank process was occurring in me—a vicarious self state dissociation thus detaching and distancing it from her while she observed from without” (p. 557). Stein and Eshel use different theoretical languages, but there is a commonality in the direction of their discourse.

Resonance—The Missing Piece

In reviewing the literature I gained a comforting collegiality with those few other victims of Somnus willing to go public with their struggles. Comfortable, but not yet satisfied. Even though sleep as countertransference was being used in a therapeutic way, as Jung originally suggested, analyst sleep was more often than not considered a defense—used to ward off some “x”. Although I can’t give clear reasons, the explanations I found in the literature did not seem complete. It seemed as if I was searching for a missing piece which would be known only when found.

When architects get stuck on spatial relationships they often flip the forms, switch to a layout exactly opposite the current one. Even though all the elements are the same, the oppositional flip shifts the perspective. It can make all the difference. That’s what happened when I serendipitously stumbled upon some data. I learned that in the animal kingdom the infectious quality of the phenomenon of yawning was one the animal behaviorists attributed to a primitive form of bonding. I yawn, you yawn, we meet in our physicality—on the common ground of our animal natures. We are *present* to each other, affected by each other’s existence—a resonance which manifests in physical form in the body. But a resonance with what? My patients weren’t asleep, I was! Not so. Not if we hold to a model of interpenetrating mutuality. Not if we consider the dynamics of protective defense described by such eloquent clinical theorists as Donald Kalsched (1995), Herbert Rosenfeld (1965), and Donald Winnicott (1960). I was not only *not* alone in that state but in contact with a primitive and powerful aspect of the patient.

Consider the dynamics of defense. However we choose to label the elements, there is at least a dynamic triad in operation in any protective system of defense—the *defense* in one of its many mercurial forms, *that which prompted the reemergence of the defense*, and *that which needs to be defended*. If we hold onto our model of mutuality and flip the dynamic of defense to its logical opposite, we have a different perspective on the same configuration. It is not a dynamic of defense, but a dynamic of resonance. Not an absence, but a presence. A resonance of presence experienced in sleep. That which needs to be resonated with is the dormant, somnolent core of the patient, now present, announced in the body of the analyst through a form of symmetrical identification (Matte Blanco, 1975). That which prompted the reemergence of the resonance is the activated desire of the analyst to see and understand the patient, merged with the patient's unspoken, unconscious desire to be seen—a deep yearning of which they themselves may be consciously unaware. Whether conscious or not, “if,” as Bion (1970) once remarked, “the analyst can take certain steps that enable him to ‘see’ what the patient sees, it is reasonable to suppose that the patient has likewise ‘taken steps’ to ‘see’ what he sees” (p. 40). Or, we might say with Jung: *Vocatus non vocatus Deus aderit* (Bidden or unbidden God will be present).

Before we travel any further into explication I want to describe more of the clinical landscape. The druglike sleep I experience is not restricted to interactions with patients of a particular diagnostic category or social class. Diagnostically the patients cut a wide swath, but they did have several things in common: 1) as children none of them were permitted to describe fully or demonstrate freely their inner experience, especially its assertive or aggressive aspects; 2) their expression of authentic experience was either punished, ignored, or incorporated by a powerful “other”; 3) they were born with what I can describe as a “too muchness” of energy and substance for their biological family nest to contain; 4) they were “parentified children,” forced into care-taking responsibility roles well before their time; 5) they experienced trauma in early childhood in the form of parental emotional abuse or neglect, psychological abandonment, and/or familial betrayal; 7) each one

also had a poignant experience with sleep per se or a sleeplike dissociation. We will look at two of them and see how sleep crept into our work together.

Clinical Illustrations

Ellie was a 46-year-old, married, childless artist who, for the two years before treatment began, was unable to produce any new work. She was the middle child of seven siblings and looked considerably different in coloring and demeanor, which earned her the label of “weird one.” She left the family enclave in her early twenties to pursue an advanced degree. By the third session I knew something “weird” had also entered the room. Almost every time Ellie came in the same phenomena would occur: interesting material presented with appropriate affect and me doing all I could to stave off sleep. My in-session notes were often illegible, with more resemblance to hieroglyphics than writing. At the fourth session Ellie reported symptoms of a panic attack driving to the session. The panic attacks proved situation-specific to her analytic sessions. Ellie was terrified by her sense of being “out of control,” especially behind the wheel of a car. Within a month the panic attacks had switched venue. They came directly into the room. In the middle of one session Ellie reported a sense of being “dissociated,” with pieces of herself flying off and her conscious mind getting wiped out. She thought it might be helpful if she could lie on the couch instead of sitting upright. Many patients associate analytic work with a prone position on “the couch.” I think Ellie’s move to assume that position symbolized her unconscious desire for the grounding function of deeper psychological work. During this time and the months which followed, I began my search for the various interpretations of analyst sleep, including my own counter-transference issues. Although my own introspection, analysis, and supervision provided many interesting ways to understand a particular clinical moment, none of them seemed to account for the ferocity of the reaction.

During one particularly torporous session I asked Ellie directly if the notion of sleep held any meaning for her. Associations, largely related to her father, emerged. Father used to play a game called “sleeping Indian”: “The game was

to go to sleep. You won if you went to sleep the quickest. One day I realized what that meant and I didn't want to play anymore. He just wanted to be rid of us." Another memory related to sleep was particularly poignant: "When my father drove for any distance one of us children always had to be with him so he wouldn't fall asleep while driving." As she told this, she felt into the danger of such a situation and the enormous responsibility it placed on the children and was shaken to the point of sobbing for several minutes. Prior to this incident Ellie did not experience any anger toward her father or her family. Now it began to emerge.

Henry was a 63-year-old attorney, prominent in the civil right movement in the 1960-70's. He had one biological older brother and a younger stepbrother. His father, who was the love of his mother's life, abandoned the family when Henry was born, returning to his native country where he came from a wealthy, celebrity family. The parents never legally married. Mother was left to support herself and her sons, which she did by fortune-telling and renting rooms. Henry considered his mother a clairvoyant who heard voices and saw visions. She blamed Henry for the loss of her lover and berated him continually throughout his life for his looks, his intellect, his lack of talent, and his inability to "be a man." School life and the plaudits he received for his obvious giftedness kept him afloat emotionally and psychologically. Henry was most fully engaged when he was in a controlling leadership position. The stories of his early life were replete with heroic trials, none of which ever captured his mother's attention. Since early childhood Henry felt despised by his mother. Her frequent criticisms and demeaning comments left him feeling humiliated and ashamed. He considered his life oriented toward getting approval and staying one step ahead of failure.

Sleep crept into this analysis slowly. However, its appearance was no less dramatic for me than the experience with Ellie. About a year into the analysis Henry was describing his relationship with his mother. He said: "Sometimes when I looked at my mother I was looking right through her." I heard this sentence as I would an early morning alarm bell and realized I had been in a kind of hypnogogic state for some minutes.

During those moments of somnolence Henry was looking through me as he had looked through his mother, but the conscious Henry didn't know that. He was on the couch facing away from me. I felt humiliated and ashamed. Two sessions later I was infected by sleep from the very beginning of the session. Its intensity was similar to the discomfort I experienced with Ellie. This time he caught me: "What's wrong?" he asked. "I don't know," I replied, "but something is off. I'm off and I don't know why yet." And then I found myself blurting out from my stupor, "Do you?"

I was astonished at what I considered my ineptitude and stupidity. This was a man who used mental musings as an emotional defense and here I was, at this traumatic moment, asking him to think! After a few seconds of quiet reflection he said, "No,...well maybe...If I show what I want, *they* back off," referring to the women in his life, which at that moment included me-in-sleep. He recounted an experience he hadn't recalled in years. It happened in front of an audience of 500 when he and a respected adversary were debating a political issue: "I could hear everything, see everything, but he wasn't there." This led to associations of care-taking and responsibility, of unearned respect, of paternal abandonment and maternal betrayal which were uttered between deep sobs. For the first time he also raged at me with tears running down his face: "I'm sick of people not giving back, not having a conversation...they don't give back...like my mother." My sudden "blurting" was something his mother would never do. Wrapped in our mutual state of humiliation and abandonment, I had respectfully asked a question. In other words, I had recognized Henry and welcomed his mind. After this event the atmosphere of the sessions had the feel of a more authentic partnership.

In both cases I directly addressed sleep—with Ellie it was planned, with Henry it hatched out in its own time.

Further Reflections on Sleep and Resonance

Analyst sleep is a countertransference phenomenon, one among a wide spectrum of images, affects, behaviors, enactments, and the like which are birthed in the midst of analytic relationships. We in the Jungian community are privileged

to have been warned from the very beginning that analytic work demands mutual “psychic infection” in which the analyst takes in one or another aspect of the patient’s psyche and through which unconscious material relevant to the patient could emerge (CW 16, paras. 358, 365). Jung called countertransference “a highly important organ of information” for the analyst (CW 16, para. 163). I think that what we face in *any* countertransference experience is the invitation to explore the link between “instinct” and “divinity,” to use Jung’s language, ushered in by a relational connection between the analytic couple and reaching beyond them. Those involved in mother-infant observation—and I especially point to the current work of Jungian analyst Brian Feldman (2000, 2003)—see these linkages come alive on video tape. When the tapes are viewed, audience members often fall into states of emotional defense or resonance depending upon their own internal complexes. Feldman (2003, personal communication) has recorded sleep patterns of the maternal-infant couple which illustrate sleep as a function of defense as well as resonance. These patterns may well parallel the dynamics at work in the analytic dyad.

Countertransference reactions like sleep put us at the core of archetypal psychology in our daily professional practice. Consider Jung’s (1981) statement that “the *via regia* to the unconscious...is not the dream but the complex, which is the architect of dreams and symptoms” (para. 310). It is a powerful statement, the clinical implications of which are slowly emerging. Through countertransference experiences we are, and must be, affectively challenged, infected, and subsequently inoculated. Affect is the emotional resonance of the complex, and the complex is the embodied resonance of the archetype in daily life. God in the details! But I don’t think that, until quite recently, we in the Jungian community have given it the *royal* status it deserves. The detailing and amplification of transference-countertransference phenomenon became what seemed to be the “handmaiden” to the amplification of dreams and myths. Perhaps that’s because it is devilishly difficult to sort out what belongs to me and what belongs to “thee” when the “Thee” of the psyche is so vast. Perhaps it’s because, despite what he said, Jung did not find his own royal road there but turned to more

universal and symbolic forms of introspection. He was captivated more by the psychology of the transference within a person than between an analyzing couple.

Even though he was referencing an inner struggle, Jung did teach us that “engaging with” is often more vital than “sorting out.” What does that actually mean in a therapy session? What does it look like to “hold the opposites” in a state of psychic infection in front of our patients, find meaning in it, and translate that hypothesized meaning into “language,” not always spoken, which helps expand consciousness? Jung (1963) gave us a glimpse in *Memories, Dreams Reflections*:

I did my best not to lose my head, but to find some way to understand these strange things. I stood helpless before an alien world, everything in it seemed difficult and incomprehensible. I was living in a constant state of tension; often I felt as if gigantic blocks of stone were tumbling down upon me. One thunderstorm followed another. I was frequently so wrought up that I had to do certain yoga exercises in order to hold my emotions in check. But since it was my purpose to know what was going on within myself, I would do these exercises only until I had calmed myself enough to resume my work with the unconscious. As soon as I had the feeling that I was myself again, I abandoned this restraint upon the emotions and allowed the images to speak afresh. (p. 176)

As I consider my work with Ellie, Henry, and other patients during periods of somnolence, those words became more and more familiar...and, I might add, yoga more important!

Jung was essentially alone with himself, not in a therapy session with patients, when this was happening to him. But I suspect we have all experienced such moments in our offices. If we take Jung’s ideas seriously we are never really alone in our selves or in the universe. If we open ourselves to it we are always fluctuating between what we know and what frightens us, what does not feel part of us. Sleep takes us into the primal realms of human existence. When it occurs in session, analyst

sleep may be viewed as a form of primary process mutuality which the analyst can use to formulate meaning for the analytic couple. As we move toward sleep, more evidence of primary process influences begin to appear. We see fleeting images, sniff aromas, hear amplified sounds, experience kinesthetic sensations. These manifestations can be “held,” as possible sources of helpful analytic information. In several cases in my practice images or words which occurred to me during my bouts of sleepiness matched unreported dream images the patient encountered on previous nights; odd phrases or melodies matched their “favorite” book titles or meaningful songs. How one deals with primary process material in a session will depend on the insight and skill of the each analyst. There are no formulas, only guideposts leading toward the unexplored territory of analytic mutuality. While I have no doubts that some forms of analyst sleep are a defense against one’s own conflicts or the patient’s states of being, they can also be seen as forms of synchronicity, acausal connections and links between the physical state of the analyst and more authentic, but dormant, aspects of the patient.

In *Symbols of Transformation*, Jung (1911-12/1952) cautioned us to use vigilance lest we “fall into a state of sleep when faced with a primal experience of differentiation” (p. 500n). But differentiation is a foundation stone in the path toward individuation. So, when sleep begins to beckon in sessions now, I consider it a gift, a synchronistic event, linking “inner” and “outer,” “same” and “other,” patient and analyst in a potentially transformative moment of mutual experience—a *tardemah* moment. The attempt to open the gift is difficult work that pushes at the boundaries of clinical understanding. Visionaries in psychology like Jung, Bion, and Matte Blanco keep trying to tell us that we and the universe are of a Whole—which we must continue to try to understand, but never will. In one sense, then, we are all prisoners of sleep. One of the characters in the Christopher Fry play (1951, p. 62) I referred to at the beginning of this paper describes poetically what I think explorations into the vicissitudes of sleep and other countertransference phenomena are all about and why they take analyst and patient to the edge and beyond:

Dark and cold we may be, but this
 Is no winter now. The frozen misery
 Of centuries, cracks, begins to move,
 The thunder is the thunder of the floes,
 The thaw, the flood, the upstart Spring.
 Thank God our time is now when wrong
 Comes up to face us everywhere,
 Never to leave us till we take
 The longest stride of soul men ever took.
 Affairs are now soul size.
 The enterprise
 Is exploration into God...

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