The analysis of fantasy is a prominent aspect of the work of psychoanalytic treatment. For historical reasons dream interpretation has received the lion's share of our professional interest in fantasy, but every analyst is aware that daydreams, reveries, conscious imagery and flights of fancy can provide significant grist for the treatment mill. The expectation is that bringing into focus the unanalysed meanings, the wishful musings embedded in fantasies of whatever nature will further strengthen the ego's hold on reality. But in the course of analysis with many patients a specific hidden fantasy eventually unfolds which not only has a fixed content noteworthy for its similarity from patient to patient, but which becomes the basis of a significant resistance to treatment.

The fantasy is a simple and familiar one: it is the wish to have all of one's needs met in a relationship hallowed by perfection. Two invariable features of this fantasy make it a thing apart both in its effect upon the patient's life and in its influence on the analysis. The first aspect has to do with the patient's position in respect to the fantasy: it is always passive, always tied to the conviction that somewhere in that great, unbounded expanse called the world is a person capable of fully meeting one's needs. The wish is to be cared for so completely that no demand will be made on the patient except his capacity for passively taking in. The second aspect, a corollary of the first, is the subjective experience of the patient that this fantasy touches on the deepest issues of one's life and that indeed one's very survival may depend upon its preservation. To maintain the fantasy intact, to search endlessly for its fulfilment in every relationship becomes the patient's raison d'être. To give up the fantasy is to give up everything, to lose the primary source of comfort (the idealized object), even one's sense of meaning. It is as if the fantasy provided a self-definition: without it there is no existence and the world becomes a place without hope. One can sense the black and white, all-or-nothing quality of this formula, as if on the other side of the ideal there lurked some horror. If one cannot maintain what is good, then one is left only with what is bad; the danger is that the ideal object can become a persecutory one.

The first appearance of the fantasy is likely to occur within the transference when the patient—usually with considerable affect—reveals his high expectations of the analyst. While it is true that most works on psychoanalytic technique point to what the patient expects to 'get' from the analyst in the way of love, what has not been conveyed in these accounts is the fact that lying behind this wish is a highly developed, intransigent life-influencing fantasy that may be revealed only piece-by-piece. To allow the fantasy to be seen in its entirety, even assuming it were totally available to consciousness, may require an act of faith in the analysis not easily attained, since typically the patient views the fantasy as an area of vulnerability, expecting it to come under attack as ridiculous or unrealistic. The patient may be intellectually aware of the presence and meaning of the fantasy, but this fact in no way influences its hold on his life, for to give it up is to open oneself to what may seem a destructive world.

Implicit in the fantasy is the notion that such a blissful state was at one time actual but now has been lost. Perhaps it is just such experiences that represent the anlage for the notion of Paradise. Is it possible that 'the Fall', if it is a metaphor referring to the loss of the oceanic pleasures of infancy, represents nothing more than a developmental stage in us all, namely separation from the all-giving mother is that eviction from Paradise that sets off—at least in
The importance of the optimal emotional availability describe this period of made more conspicuous by its contrast to the relationship between the mother break autonomy development intertwined, lines of growth which may indeed get out of that one can detect in the around him. Most importantly Mahler can expect the emergence of psychotic child and, in particular, the symbiosis and his ministering reactions, a unresponsiveness to outside stimuli. This state of lumpishness gradually glides into a new patterning of normal autistic DEVELOPMENTAL ISSUES patients. any particular kind of pathology, it is likely to be seen more starkly in infantile, narcissistic and schizoid wish to be loved and the fear of rejection. So while it is true that the appearance of the like the women in my sample, keep them on a developmental level noteworthy for its preoccupation with the reveal prominent separation anxiety. Both men and women are similarly afflicted, though (again in my own experience) men reveal prominent castration problems which deprive them of a motivation for resolving oedipal problems which deprive them of a motivation for resolving oedipal conflict and, like the women in my sample, keep them on a developmental level noteworthy for its preoccupation with the wish to be loved and the fear of rejection. So while it is true that the appearance of the fantasy is not limited to any particular kind of pathology, it is likely to be seen more starkly in infantile, narcissistic and schizoid patients.

Mahler et al. (1975) spell out the phases of the separation-individuation process. They speak first of a child's normal autistic phase, a time when the baby is more likely to be asleep than awake, a time of relative unresponsiveness to outside stimuli. This state of lumpishness gradually glides into a new patterning of reactions, a symbiotic phase, in which speculatively we assume the child does not differentiate between himself and his ministering mother, seeing her largely as an extension of his own needs. 'The essential feature of symbiosis is hallucinatory or delusional somatopsychic omnipotent fusion with the representation of the mother and, in particular, the delusion of a common boundary between two physically separate systems' (p. 45). If the child later in life is hit hard enough by anxiety or trauma to set off a regression to this stage of development, one can expect the emergence of psychotic symptoms.

Even before six months of age, the baby begins to show developmental movement from symbiosis to differentiation, leading to a process of 'hatching', permitting the baby to become more alert to what is going on around him. Most importantly Mahler et al. (p. 63) indicate that the processes of separation and individuation that one can detect in the child's behaviour by the end of the first year run along different, though clearly intertwined, lines of growth which may indeed get out of phase with each other. Individuation is reflected in the development of a host of ego functions having to do with reality-testing and its dependence on perception and autonomy, while separation is connected with boundary functions and most importantly with the capacity to break free from mother even if only for short periods of time before returning to her reassuring presence.

Sometime before the end of the second year of life, the child's locomotion allows him to move away from mother at will, but this separation may bring about a concomitant increase in the quantity of anxiety. The relationship between the child's capacity for separateness and the need for the mother's love is a close one, made more conspicuous by its contrast to the child's former 'toddler's indifference' to the mother. Mahler et al. describe this period of development as the phase of rapprochement. 'One cannot emphasize too strongly the importance of the optimal emotional availability
of the mother during this subphase. ... We ventured the hypothesis that it was among those children whose separation reactions had been characterized by moderate and ego-filtered affects in which the libidinal valence (love instead of aggression) predominated that subsequent development was more likely to be favorable' (p. 77).

But, in those patients who cling to the golden fantasy, precisely the opposite seems to be the case; if we think, as Mahler et al. do, of a sense of separateness as an intrapsychic achievement, then the fantasy makes clear that this goal has not been reached. Instead, these patients characteristically remember mother as unavailable during the critical period of individuation-separation; and just as the content of the golden fantasy appears with remarkable consistency from patient to patient, so it seems to be linked with an emotionally charged 'memory' of the mother's loss. Predictably our patients connect mother's decathexis with the simultaneous appearance of a new sibling. But in some instances the mother's alleged turning away from the child may be experienced differently. One patient described a mother so invested in her own self-reflexions that she spent long periods of time locked in the bathroom writing a daily journal; in the meantime, the patient felt herself abandoned, ignored and unloved. In another instance a patient remembered her mother explaining that when the new baby arrives, she must be a 'big girl' and do things for herself—undoubtedly an expression of a young mother's efforts to encourage some increased self-sufficiency in the older child in the face of the increased demands a new baby brings. But the child heard the message as a declaration of separation, as an indication that henceforth she must stand on her own as an autonomous being with no comforting mother to turn to. Similarly a young male patient in his late twenties carried with him the conviction that in his moving to a new home, his mother's arrangement of placing his sisters together in a bedroom near her own while giving him a room alone at a distant end of the house represented a critical loss of a mother who seemed to understand and be interested only in girls.

In each case the perception of mother's unavailability came at that moment in the child's development when he was suffering from a heightened awareness of the anxiety associated with separation and its consequent depression. Just as the child out of his own needs is attempting to get closer to mother, so she is seen as pulling away to favour her own preoccupations. Such experiences take on a particular drama for the patient, raising the question as to whether what we know to be the idealization of the relationship with mother before the separation is not paralleled by an exaggeration of mother's rejection during and following the separation. The idealized mother becomes the vilified mother. Yet, through the analysis the mother's turning away seemed on the surface not as critical as the patient felt it to be, and it seemed clear as well that such mothers had not actually abandoned their roles, but on some level had continued to be caring and nurturing. Yet the trauma for the child and the resultant fantasy constructions are clear enough.

In any event, what the child experiences as an unbridgeable distance leads to his preoccupation with mother and with continued, even desperate efforts to find some basis of reclaimed intimacy. As a result it becomes difficult for the child to invest libido in any other relationship. It is as if the mother's felt withdrawal fixed the anxiety in the child's mind. Such conflicts over separation can be reactivated in later life, especially at those moments when the patient is expected to function separately—when the spouse is away out of some necessity, when the analyst is absent, or when the appearance of some new responsibility underscores the need for the patient to act independently. It is at these moments that the patient is in danger of regressively repeating the behaviour of the rapprochement phase of development, meeting what is experienced as frustration, and leading finally to the reactivation of the golden fantasy as the regressive solution to the fear of separation. It was Freud (1930) in discussing the nature of oceanic feeling who pointed out that the preservation of all of the earlier stages of childhood and infancy can occur only in the mind of the patient. It is my position, based on this model, that the structures of the mind are simply those that involve the process of thinking, and the thinking one does about his own mind is based on fantasy.
THE FANTASY AS A SOURCE OF RESISTANCE

As the fantasy emerges in the course of treatment and its place at the core of the patient's life becomes evident, the issue of resistance to change inevitably becomes the focus of the analytic work. The management of this resistance is crucial to the treatment outcome, for unless it can be resolved in the sense that the patient can give up the attachment to the fantasied all-fulfilling primary object by replacing it with more realistic introjects, not only will the analysis be incomplete, but probably the patient will never attain satisfactory object relationships.

The resistance itself takes on different guises. One of the most common forms is acting out; and while such behaviour is often seen as a reaction to the neutrality of the analyst, leading the patient, often revengefully, to demonstrate that the gratification he cannot obtain within the transference is available outside it, what may be missed in this behaviour is its underlying motive of protecting the fantasy against the analytic work. With a reckless abandon the patient may become involved in an affair, in an extramarital relationship, or in a homosexual liaison, all of which are ways the patient is saying to the analyst, 'I do not need you, I will replace you with someone who will give me what I want in the relationship with you but which you refuse to allow.' But on another level, and one probably closer to the core of the patient's illness, is the conviction that the analyst intends to rob the patient of his fantasy, to destroy the needs expressed in the fantasy, and to leave the patient with nothing but a stark and intolerable reality. In metaphorical terms the fear is that the analyst will bring about 'the Fall'.

[Patient A.:] I realize now that this fantasy goes way back. I have always felt there is a remote person somewhere who would do everything for me, somebody who would fulfil every need in some magical, fairy-like manner and see to it I would be able to get whatever I want without putting out any effort for it. The most important part is that I don't have any responsibility for anything. I realize there are strong sexual feelings in this fantasy. I have never lived without all this stuff being there in the background. I don't know if I can. It's easy for me to feel that you want to take it from me. I know it can't be fulfilled, that no one is capable of doing it, but that makes me feel depressed. I don't know if I can live without it—just a world of reality seems so drab, so lifeless, and offers me nothing to keep me going. I even have some feeling I won't be able to breathe. It's scary.

One can see in Patient A.'s comments all of the elements of the golden fantasy—the wish to be totally gratified in a manner that underscores the patient's passivity and by someone who remains nameless and faceless but is somehow always present to assume responsibility and meet every need. The regressive implications are clear, and just as the infant could not live without being fed, so the patient is convinced she may not live and breathe without the nurturing fantasy. Usually before coming into treatment such patients have been through repeated efforts to establish a relationship that seems to promise a fulfilment of the fantasy. Indeed, it is likely that such patients seek out an analysis precisely because of its promise of a regressive experience, and because the frequency of contact with the analyst and the potential length of the treatment all contribute to the patient's notions that the analysis at last will magically meet the requirements of the fantasy. (No doubt, there are also patients who avoid treatment or seek out a superficial, largely supportive therapeutic relationship as a way of protecting the fantasy from any serious scrutiny).

Patient A. came to treatment after her marriage had proved a failure, and once she sensed that the work of treatment did not involve a remote and faceless 'somebody' behind the couch assuming full responsibility for her needs, she actively put herself in the position of being 'swept off her feet' by a business associate of the husband's whom she had earlier described as a 'remote man'. She flew to another city to meet him for the first time alone, and in the hotel room together on that first night, something happened that convinced her she had found the answer to her dreams. As they lay together in bed, her partner made no attempt at sexual intercourse, but simply held her close to him, whispering to her that he would always take care of her. In contrast the analysis is cast as a 'drab and lifeless' confrontation with reality, as an effort to 'analyse everything to death', leaving her with nothing. The flight into the affair was to prevent that

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robbery, to find confirmation for the validity of the fantasy and to keep herself from changing.

Parenthetically, one can see in this instance how the fantasy represents a powerful force in the selection of a sexual object. In the case of another patient, who was torn between the marriage proposals of two eligible men, her decision was finally based on a simple incident that occurred one evening as she was dining out with one of her suitors. During the course of the meal, her escort picked up a morsel of food from his plate and spooned it into her mouth. She found this act of caring so gratifying, so compelling in its promise of a regressive fulfilment in the relationship that her indecision was ended. (I am indebted for this vignette to Dr Gertrude Ticho.)

In most instances it is not difficult to understand the real motives lying behind the acting out, since the patient's ability to judge the realistic aspects of a relationship obviously meant to be a replacement for the analyst is virtually nil. For instance, Patient A.'s headlong flight from the analysis, impulsive and desperate as it was, left her no room for assessing how little this relationship offered her, or how her partner later began to exploit her with his own demands and empty promises. This need to keep the fantasy intact, to defend it against analytic incursions, has seemed to me a more significant threat to analytic success than whatever other motives may fuel the acting out. This comment is not meant to preclude analytic work on whatever other meanings become apparent in regard to the patient's behaviour, such as revenge or a turning away from the analyst as the patient felt turned away from by others, or a projection of the patient's envy on to the analyst, seeing him as wishing to destroy something good the patient possesses. Rather, it is a matter of recognizing that the patient's motives reflect a hierarchy of values.

The resistance may take another form just as intransigent as the first. In this instance the patient enters analysis with the same hope of finding within the treatment the realization of the fantasy, but instead of experiencing the frustration of the analyst's neutrality, he persists in believing that it is only a matter of time until he can find the key to unlock the bounty he is certain the analyst is keeping in reserve for him—another form of maintaining the analyst as an ideal object. Whatever the analyst says in the treatment hour is listened to not from the standpoint of its content but as a blissful experience of being comforted by the analyst's voice, of finding solace in its soothing tones, in being warmed by the analyst's closeness with all of its implications for succourance.

Patient B., a young man in his twenties, had a recurrent dream which he would recall in the analysis at those moments of wishing for a special closeness with the analyst.

Dream:

I am in this space—a nothingness—with no darkness but a diffuse light as if I am on an infinite plane in a kind of foreverness. In the dream it was like walking through air where everything is white, but the air has some kind of resistance to it like gelatin. There is a corollary dream of being with my mother in some sort of space but with a sense of rooms and soft carpeting—but all with a colourlessness—whiteness. My mother is only a shape or a presence and I'm very small. It's like getting away to some place where everything is sufficient.

This dream with its emphasis on space and whiteness recalls Lewin's (1948) discussion of the dream screen, a symbol for the mother's breast, the wish for a closeness with her that, as the patient makes clear, would fill him up but at the same time would require nothing of him. Typically this patient could not hear my interpretation of his dream; my voice seemed to him to become more distant as if I were far away from him. Rather than listening to the meaning of my words, he was instead overcome with an impulse to reach back across the couch to touch me, to regain the closeness he felt was slipping away. In one sense the patient was conveying through his action how difficult it is to grow up. He was convinced that his only hope in the analysis was to regress to the position of the baby to be taken care of. His wish to touch me was not an instance of identifying with me as the analyst, nor was it an expression of his wish to learn from the analytic situation. Rather it was the expression of his desire not for analytic interpretations but for unstinting care. And the reason why he could not listen to the interpretations or explore their meaning was that he would then be led to the discovery that the fantasy of my 'maternal sufficiency' was
false, that the wish to be cared for completely could not be realized. Paradise could indeed be lost.

When the fantasy is aroused, as in the example of Patient B., it fosters a predictable regressive pull on the patient's self-conceptions. In effect the fantasy acts to deskill the patient, causing such phrases to come to the patient's mind as 'I can't do it', or 'I can't handle it', or 'I don't know how'. In this sense the fantasy keeps the patient from identifying with the analytic task, from moving ahead with his own psychic development or from testing his own strengths and abilities. Thus the real work of the analysis is of no importance to the patient; he resists it by concentrating on his own fantasied expectations of perfect fulfilment and waits for the analyst to respond to the charming child within him who needs for his satisfaction only to be tended and loved in his helplessly passive state—not to be made to think or work or reflect or even understand or listen. These are active tasks which can only lead to painful confrontations but never, in the patient's view of the analytic relationship, to any satisfaction of the fantasy.

While the unfolding of the golden fantasy may take several months of analysis, most patients come finally to a full explication of its dimensions and its central importance in their lives. In these instances, the processes of resistance seem largely focused on the relationship with the analyst as an ultimate if not immediate source of gratifying the patient's wishes. But in other patients, the resistance occurs around the disclosure of the fantasy and the conviction that once the fantasy is exposed, the patient will be placed in a vulnerable position. This reaction is based on the low valuation but high cathexis the patient places on his own needs. Indeed, the needs for a passive and regressive fulfilment associated with the fantasy appear to the patient as bad, repulsive, and paradoxically as evidence of an unlovability. In this judgement the patient is revealing an unloving superego or the voice within himself of an insufficiently introjected parent. The fear is that, once the analyst discovers the existence of the fantasy and its attendant needs, the analyst will be so repelled by the patient's greedy, infantile self as to be forced to reject him. Since this idea is unacceptable, the patient will commonly turn it around, rejecting the analyst and the analytic work, devaluing his interpretations and pulling away from the therapeutic alliance before the analyst has the opportunity, as the patient expects, to treat him in the same derogatory manner.

Patient C., a young married woman with three children, was initially delighted about being assigned to a male analyst because it meant that something special would now happen, something sexual, something more gratifying than she had ever before experienced. But as it became clear that the golden fantasy was lurking behind these expressions of the positive transference, as we moved more closely to the regressive significance of her wishes, she regarded such revelations as placing her in a dangerously vulnerable position and began to entertain the idea that I would terminate the analysis. The unearthing of the fantasy occurred largely through dream interpretation; I appeared in several of her dreams as a fatherly teacher who would finally break through the strictures of my role as educator (analyst) to enter into a sexual relationship with her that for the first time in her life held the promise of total fulfillment. But because such wishes towards me were not safe, she began to pull back from the analytic work, attempting to withhold material from me. Further dreams in which a paternal figure 'vandalized' or destroyed her sexual wishes pointed up the projective nature of her destructive feelings about me. She treated her husband as she felt I was treating her—seducing him into closeness and into revealing his needs for her only to frustrate and abandon him as she felt abandoned by me—and all for the same reason; that is, she was repelled by the open expression of his needs just as she was convinced I would find her demands intolerable.

She reported a sexual experience with her husband that provided further insight into her resistance to the analysis. On the occasion in question her husband had climaxed early, but he hid this fact from her and attempted to continue intercourse. When she became aware of what had happened, her feeling was that he had 'exposed' her, had humiliated her and left her feeling 'put down'. What was exposed was her own needs which she could tolerate only so long as they were hidden behind his need for her. Ironically, she was angry at her husband for concealing his orgasm from her when in effect it was she who wished to conceal something from him. She felt he was uncaring and merely acting towards her in a mechanical fashion rather than her seeing that both his hiding his orgasm from her and his efforts to continue with intercourse were evidences of his wish to gratify her and of his caring rather than uncaring attitude toward her. Similarly in the analysis her conviction was that I would expose.
her fantasy for complete gratification only to use it against her, to belittle her, to devalue her in a way that would deprive her of the fantasy and leave her with nothing. It was just such motives which probably lie at the base of the patient's need to devalue the analyst, to control him, be one-up on him and to beat him to the interpretive punch.

One might think that if the wished-for closeness could be brought nearer reality, the patient might find some relief from his painful yearnings. But, for many patients, the promise of fulfillment turns bewilderingly into a threat. The seriousness of this danger as it appears in the patient's perception of his relationships with others seems based on what has transpired developmentally during the separation-individuation phase of growth. While the fantasy about total fulfillment and complete gratification may be conspicuously influencing the patient's transference interactions and accounting for the varying patterns of resistance described here, it is not simply the fear of annihilation through abandonment—so typical of the symbiotic phase of development—that may account for the patient's fears. As the child begins to move away from mother, to engage not simply in a physical separation from her but to develop some intrapsychic sense of an autonomous self, the danger becomes one of being drawn back into the symbiotic relationship, of becoming re-engulfed, caught once again in a fusion that threatens to blot out one's separateness. It is not surprising, then, that patients may experience fantasies of suffocation when, in later life, events conspire to trigger these reactions from early childhood.

Patient D. reported that she had recently become more conscious of her distaste for sexual contact with her husband. On the last occasion of intercourse with her husband, she was deeply troubled by his reminding her of her mother. This episode brought to her mind still another occasion in which she awakened in the middle of the night to find herself having intercourse with her husband who was kissing her in such a manner that she could not get her breath. The idea of being suffocated at mother's breast, with its accompanying panicky feeling, returned to her as it had on other occasions. She began to experience a sense of fusion with her husband, but once she realized she could control the situation which she realized was not life-threatening, she was able to allow herself to give in to the passivity of being 'fed' by her husband, celebrating as a result her 'greatest orgasm'. Her feeling was that at last her needs were being met, that the golden fantasy could become a reality. But her association to these two events in the analytic hour brought her back to early memories of her mother telling her not to breast-feed her baby in bed because she would roll over and suffocate it. She thought as well of the death of her baby sister and her concerns that her mother in some way contributed to that death, thinking that baby sister's being buried in a box also meant suffocation.

Such revelations are likely to reaffirm the patient's fear that closeness is dangerous unless, as in the case of her husband's smothering kisses, she could reassure herself that she could bring the experience to an end when she wished. One may see in this material the origins for a patient's need to control relationships, and to discover that the golden fantasy itself, for all of its apparent passivity, is a means of controlling and manipulating the environment to meet one's own needs, serving as it does a double purpose: to recapture or re-enter Paradise but in a way that results in no loss of autonomy. Typically patients oscillate between these two positions, at one moment fearing the fusion and the loss of boundaries implied in closeness, and at other moments wishing for oneness with an all-giving, all-fulfilling maternal figure.

So in Patient D., she could experience the dangers of closeness and suffocation in intercourse, but at the same time often wept at the end of intercourse, much to her husband's puzzlement and consternation. At the conclusion of their sexual activity, she would be overwhelmed with sadness and loss, convinced that her husband's withdrawal from her somehow spelled the end of his efforts to 'feed' her, to fulfill her, thus leaving her abandoned and peculiarly without hope that the good and giving aspect of their relationship could ever be restored. Indeed it later developed that her alleged distaste for sexual contact was an effort to avoid the depression that swept over her when the husband was 'done' with her and 'turned away' from her—an event that seemed to repeat for her the pain of mother's similarly 'turning her back' on her.

The reason the child invents in his own mind such 'turning away', since he is innocent of the complexity of the adult (especially parental) motivations, is that the needs the child longs to have met have served, instead, to drive the loved one away. The child thus is led to view his own needs as bad, and their discovery or exposure as
tantamount to rejection. This course of events is played out again in the analysis, a situation most likely to stimulate such thoughts in the patient because, unlike any other of the patient's relationships, the analysis will have a definite ending resulting in a separation from the analyst that is implied in its very beginnings. This fact becomes a source of pain for the patient who can see the termination only as a rejection and resists the exposure of the core fantasy in part to stave off the inevitable.

Another subtle but powerful form of resistance to the analysis deriving from the presence of the golden fantasy is linked to a characteristic feature of certain patients: while they are on an endless search for a fulfilling experience, they seem unable to make use of the loving relationships around them. Their hunger for attention, love, succourance and gratification would lead one to believe that they exist in a depriving, rejecting environment, but often the opposite is the case. It is not unusual to discover that their spouses are obviously invested in their well-being, their families are ready to comfort them, their friends are able to be understanding and helpful, but these giving, loving relationships are held at arm's distance and appear to the patient as unsatisfactory or as falling short of the expectations embodied in the fantasy. The envy the patient feels for his giving analyst obviously lies behind such reactions, leading the patient to turn from idealization to vilification of the object. But there is also another reason. It is as if committing oneself to a relationship or to accepting what is offered or available represents an admission that the fantasy cannot be realized. To decide to work at a particular relationship is to confirm the fact that the fantasy is dead (or that Paradise is lost) or that what was once within one's grasp is forever gone. Thus, what the patient has in hand is willing to let go in the interests of looking endlessly for new possibilities, searching for the one person who will at last fulfill him so completely that he will experience the longed-for bliss the fantasy promises. The idealized primary object persists and the patient cannot be brought to replace it with other object relationships. For a short time the patient may find in another person the hope of realizing the fantasy, but usually such contacts are not enduring due to the patient's tendency to spoil or derogate them as soon as he decides his expectations will not be satisfied from this new quarter. The ensuing sense of frustration often leads the patient to believe that it is not the inability of the other person to meet his unrealistic fantasy expectations but an unwillingness and a turning away which repeats in the patient's mind the early turning away of the mother. Such patients are thus highly vulnerable to rejection, seeing in every frustration of the fantasy evidences of malevolence or vengefulness. This view is likely to be a projected one, since in reality it is the patient's unwillingness to make a commitment to a relationship not only because of envy but additionally because of its implications for destroying the fantasy.

All of these relationship paradigms find their way into the transference, setting up a resistance to viewing the analyst as a helping person or developing a therapeutic alliance. The patient begins to view the aim of the analysis as one of coercing him to renounce the fantasy with all of its hopes and expectations, thus leaving him with nothing.

Patient E., a young woman of 20 who was hospitalized after several years of self-destructive involvement and drugs and sexual promiscuity, came from a family where both parents had behaved towards her seductively and in subtle ways encouraged her acting out. She began psychotherapy with a young male resident, immediately erotizing the relationship and attempting to break down the doctor's efforts to maintain an appropriate professional distance. She was willing to work in the psychotherapy as a way of pleasing the resident; she would bring dreams to him, become reflective for him, even mend her ways for him until after several months of such adaptiveness the doctor took a vacation of several weeks' duration, unfortunately scheduled for the same time her hospital counsellor planned to be away. During their absence the patient sought out a former hospital staff member who took the patient into his apartment, offering her comfort in her loneliness and enough alcohol to allow her to rationalize her going to bed with him. Her parents, who had never wholeheartedly supported her treatment, offered her enticements to return home which became more forceful as her feelings of abandonment increased. Upon the doctor's return, she called him at two o'clock in the morning before the resumption of their hours together to inform him she was quitting treatment to return home. Though he persuaded her to attend a few further sessions to talk about the basis
of her decision, he was not successful in rekindling her interest in psychotherapy. The premature loss of
this patient to the treatment process was chalked up to her anger about his absence and to the
negative influence of the parents. And while these factors were no doubt important, the clinical
evidence points to the presence of the now familiar fantasy as the deciding issue in her behaviour.
From early childhood she had been led to believe that she was someone special whom the parents
would indulge with promises of total fulfilment, often in the form of sexual gratification. Her later
self-indulgences in drugs and promiscuity were efforts to find the bliss that seemed always to elude
her. Once again her hopes were raised by an accepting young doctor whose skill and attainments in
knowing what troubled patients needed certainly equipped him in her eyes to meet all her
expectations. She was willing to please him, work for him, convince him she was ready for his
rewards, but instead he cast her aside; he left on a vacation where she could imagine his having fun
with others, while she was left helpless to deal with her own loneliness and was unable to control his
comings and goings.

This rejection she experienced as a threat to the integrity of the fantasy, and under these circumstances the
patient's resistance to the regressive pull of the parents' renewed promises became weakened. Her efforts to find
a substitute for the absent doctor in the former staff member and her phoning the doctor at the early morning hour
shortly after his return suggest not only an impulsivity but considerable anger and aggression. These elements of
her behaviour can properly be viewed as self-destructive, an assessment consonant with so many aspects of her
history; but my point is that this self-destructiveness, this weakening of her reality-testing, this disruption of a
significant relationship are all in the interest of protecting the underlying primitive, grandiose fantasy that
someplace, somewhere she will find total fulfilment. In the face of what she saw as the doctor's rejection, her
hope of fulfilment with him had been killed. To recommit herself to the therapy would have been the equivalent
of admitting to herself that the fantasy had no continuing reality.

By now it should be clear that if the patient harbours the conviction that by having every need met, he can
arrive at some state of perfect contentment, then this notion must be linked in his mind with other evidences of
magical thinking. The patient must view the analyst as omnipotent, capable of miraculous powers of healing and
caring, endowed with a god-like perfection. While in some patients, as we have seen, such an idealization of the
analyst is quickly shattered by the patient's projections, in others the conviction of the analyst's perfection is so
tenaciously held that the patient screens out of his awareness whatever contradicts his magical notions. What is
more disconcerting to such patients is any evidence of the analyst's humanness, particularly any perception that
the analyst might suffer or have feelings of stress or sorrow or hurt. Not only does the patient ward off such
perceptions, but he strongly resists any interpretations that would help him see how the analyst's human
limitations threaten the satisfaction, if not the very existence, of the fantasy.

Patient F. correctly inferred that my reason for wishing to change our scheduled hour was to permit
me to attend the funeral of the child of a hospital staff member. He agreed readily to the shift in the
time, but the next day he began the hour by commenting on his callousness, his taking me so much for
granted, his inconsiderateness in not thinking himself I would wish to attend the funeral. But he also
wished not to know what I was going through in regard to my own feelings. The fact that he had for the
moment come face to face with the probability that I was suffering from some degree of grief, that
indeed I was a real person with real feelings, caused him to see my emotions as an intrusion. It was as
if I had suddenly become a burden to him, as if he might be expected in some way to take care of me.
He fell into a confused state as a way of hiding his anger from me. His irritation was based on the fact
that I was there to care for him, to meet his needs, not to make demands upon him. 'I want you to care
for me in this analysis. I want your superior skill to tell me everything in one day that will short-cut
the pain of the work in here. How unfortunate to have a human being as an analyst. I had even hoped
you might cure me of this cold.' These comments spoke clearly to his disappointment in discovering I
was no miracle worker and to his unwillingness to deal with the blow this discovery delivered to the
fantasy. His response was to tell me how he had thought of changing around my office furniture, which
was of course his wish to change me, to rearrange me into a more perfect

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COUNTERTRANSFERENCE ISSUES

When the presence of the golden fantasy plays a central role in the pathology of the patient, it is predictable that one of the patient's primary motives in seeking treatment is the hope that the fantasy will be fulfilled. For such patients psychoanalysis, as mentioned earlier, may have considerable appeal. On the face of it, the patient may view the various dimensions of psychoanalysis—the frequency of contact, the length of treatment and the presence of a regressive experience—as offering more closeness, more caring, more likelihood of the analyst's taking responsibility for understanding and meeting the patient's desires than in any other relationship, while the only requirement of the patient is that he lie passively on the couch. The patient's discovery that the work of analysis does not square with these views precipitates one or more of the several forms of resistances already recounted. But when the patient's wish to protect the fantasy against any analytic incursion leads to intense efforts to break down the barriers between patient and analyst, where the fulfillment of emotional needs is presented as a matter of life and death, needs so exquisite in their urgency that only an ogre could deny their gratification, it is not surprising that the analyst is placed under unusual countertransference pressures. The countertransference reactions of the treater may have as many permutations as the patient's resistance, but I will limit myself to a few examples.

The primary danger for the analyst is that the plaintive patient may arouse in him fantasies of rescue. These fantasies in turn may trigger off a counter-acting-out. The analyst's move in this direction may on the surface seem minimal or insignificant, but the patient whose life is geared towards satisfying his fantasied wishes will seize on the smallest signal as a promise of the fulfillment to come. The analyst's mis-step may be nothing more than too quickly changing an appointment hour without inquiring into the patient's purposes, or an unthinking social response in reaction to a piece of patient flattery regarding his appearance, his dress, a new fixture in the office, or a too ready acceptance of the notion that an encounter outside the hours was entirely coincidental. A patient going through an episode of considerable emotional distress may tearfully appeal to the treater for some concrete evidence of his concern or to extend the hour or to be allowed on leaving to touch the analyst's coat.

My recent reading brought me serendipitously upon this description of the beginning of treatment (Khan, 1971). The author is describing a thirty-year-old female patient who came to him for help after three unsuccessful efforts at psychoanalysis with three different analysts. Khan writes:

She told me how with her first analyst things had gone wrong because eventually her psychic pain had been so acute and unassuageable in the sessions that he had felt compelled to hold her hand. This had very nearly degenerated into physical intimacy between them. But what had finally broken down the treatment there was that she took an overdose of sleeping pills and was very critically near to death, but was saved. After this, the analyst had referred her to a colleague (p. 255).

Is it too much to surmise that a pain so 'unassuageable' that it brought the analyst to feel 'compelled to hold her hand' was derived from a fantasy of how her acute pain could be relieved by a totally caring, completely fulfilling relationship? The analyst 'felt compelled' to act rather than interpret her plight (the compulsion of rescue), leading him nearly to engage her in a full-blown sexual experience from which we can surmise he somehow managed to pull back—but not without serious repercussions. The patient, now rejected, who had been led to expect that an adoring analyst would at last fulfil her fantasied yearnings was left only with death as a solution to her frustration and as a revenge on the depriving analyst.

When we hear of therapists who have given in to the patient's seduction, who have in a sense become victims of the patient's fantasy, and who rationalize their behaviour on grounds of becoming the beloved object for the patient, thus providing a psychological feeding through the sexual act, we are witnessing the power of the fantasy to overwhelm the therapist's ego. The rationalizations can be dismissed; not even a therapist can be that altruistic. It goes without saying that such countertransference gratifications destroy the treatment; acting-out on the part of the patient has never been successfully treated by acting-out on the part of the therapist.
A second form the countertransference may take is perhaps less flamboyant but just as insidious in its effect on the treatment. As the needs of the fantasy for total fulfilment and care work their way into the transference, the analyst may begin to feel that he cannot handle the patient's overwhelming demands. He may begin to feel inadequate, immobilized, deskilled, in effect controlled by the patient's fantasy. These are reactions the patient is likely to be feeling about himself but, by instilling them into the analyst, he temporarily rids himself of the discomfort and the anxiety they may cause. If the analyst gets caught in this countertransference trap—or what more accurately might be called a counterprojective identification—his tendency is to wish to escape the patient, a reaction likely to repeat the patient's past or fulfill the patient's prophecy that his needs are bad, that the analyst will be repulsed by his greediness and in the end will abandon him. The ultimate in countertransference reactions to the patient whose needs appear too overwhelming or demanding is the analyst's falling asleep.

Such reactions are the result of the analyst—for whatever internal reason—taking the fantasy expressions of the patient as if they were concrete realities rather than psychological issues to be clarified and interpreted. The patient's continued insistence that he is not getting enough, that what the analyst has to offer is worthless, that urgent needs are not being met, that he is getting worse with every hour of treatment, that the analyst must be holding back because he has nothing to give, is himself empty, or, if not inadequate to the task of fulfillment then veneful and sadistic in his frustration of the patient, all represent a persistent assault on the analyst. It is not surprising that such patients may arouse discomfort and anxiety in the analyst, along with a wish to get out of the line of fire or to engage in therapeutic manoeuvres which keep the work of the treatment on a superficial level, avoiding the hard and painful labour of disembowelling the fantasy and confronting its interpersonal implications, its infantile wishes, its narcissistic core and its destructive influence on the patient's life choices.

It would be easier to settle for an incomplete analysis, to be satisfied with partial results, making it appear that what is actually a problem in countertransference is a problem in diagnosis. Rather than admit to himself that he is made too uncomfortable or is too threatened by the patient, the analyst instead tells himself that the patient's ego can go no further. The problem is that the patient often conspires in this countertransference manoeuvre, since he, too, may be willing to settle for a partial result rather than have the valued fantasy 'exposed and destroyed'. Often such patients will be referred to an analytic colleague as a way of getting out of the countertransference bind. Shifting the patient to another analyst may sometimes have good results if the new analyst is not intimidated by the patient's history. The danger in such transfers is that the patient, in finding what promises to be a new source of fantasy fulfilment, may fire up all the unrealistic hopes and demands and the cycle begins all over again.

Finally, one must not forget that the repeated emphasis which the patient gives to his needs for fantasy gratification may touch upon the unanalysed fragments of the analyst's own golden fantasy, may through their insistence sink shafts into the analyst's own unconscious. The hope is that the analyst can allow this stimulation of his own regressive wishes to be utilized positively in the treatment, to allow him to discover that he is not so distant from his patient as he may at first have assumed. But if the patient's tapping into his own buried needs succeeds in threatening the analyst's equilibrium, he may react to the patient's fantasies in the way of countertransference, treating the patient with the same constriction, condemnation and intolerance for self-indulgence he feels he should be imposing on himself. Or the analyst may be seen as a third party who comes between the patient and his fantasy, creating a triangular situation from which the analyst may try to escape by looking upon the fantasy as a thing to be studied microscopically and thus lose sight of the fact that the fantasy is also about the analytic relationship. In this manner he may move so far from where the patient is in his treatment or become so easily identified by the patient as the rejecting mother, or so radically sever the empathic ties which in a sense are the connective tissues of the treatment, that the analytic process can only founder.
CONCLUDING ISSUES

Even in patients for whom the golden fantasy has assumed larger than life proportions, its full dimensions may not be fully or immediately revealed in treatment. Since the analyst may be observing only the derivatives of the fantasy, he may miss its significance as a central determining factor in the life choices of the patient, choices which can affect the course or even the culmination of the analysis itself.

In the earlier description of the analyst who felt 'compelled' to hold the patient's hand and later to go even further in expressions of his 'caring' for her, his reaction makes it clear that he was not in touch with the underlying fantasy propelling the patient into such demandingness. What one sees in this incident is the power of the patient's fantasy in controlling relationships, inducing resistance to treatment, arousing countertransference reactions in the analyst, and ultimately destroying not only the effectiveness of treatment but nearly the patient's own life. And what one can also see is the patient's desire for repetition rather than a desire for growth. All three analytic experiences of this patient left the fantasy untouched; it remained alive to be played out again in other relationships.

As in the case in this example, patients often give hints about the presence of the fantasy in the assumptions they make about treatment. The intensity of the wish to be fulfilled becomes so large in the patient's mind that it seems overwhelming and in danger of overpowering others with its strength. Further, the conviction that such intense needs will be condemned as bad leads the patient to view their exposure as dangerous and as ending inevitably in rejection and abandonment.

The resolution of this dilemma for some patients is turning to a world beyond this one for the ultimate in fulfillment, extending what is already magical thinking into mystical experience and allowing the fantasy now to masquerade as religious faith, or to embrace a platonic, nostalgic religion that denigrates the world, the here and the now, in favour of some ultimate salvation full of promises. The common element in this permutation of what by now is a familiar theme is that the world is too limited or already spoiled as a source of gratification, or that it is simply to be endured as a source of unrelenting frustration until one is finally rescued by an idyllic union with an idealized all-giving, all-loving, god-like figure. The symbiotic nature of this fantasy parallels the effort of many patients to satisfy their needs for limitless love through achieving a sense of oneness with the object. One patient described a recent experience with her lover:

I get into a skewed thing where 80 per cent of the time is spent talking about him. That happens a lot with men. What I do when that goes on is to live out vicariously through what he is saying to me. It's as if when I listen hard enough or get into the other person enough, then I'll get something for myself. This guy I was with told me his aunt said she loved him. He made it seem like such a big thing. I wouldn't tell anybody about a thing like that. Maybe that's because what actively happens to me I don't see as being good—not worth anything. So I try to get something from somebody else—like this guy—by listening to him tell about himself. That seems so much more important than what happens to me. Maybe I set it up that way, so I'm hardly anything in the relationship—plus the other thing of my wanting to use the other person as much as I see him wanting to use me.

The patient describes an important interaction that transpires between herself and a person she has chosen to fulfill the fantasy. The patient melds into the experiences of her erstwhile lover, feeling one with him, feeding off him, attempting to fill the emptiness and to find some sense of worth. On another level, her comment is a metaphor of the analysis and, indeed, she had previously described to the analyst a frightening sense of losing boundaries with her surrounding world, a loss of distance that strongly suggested that something had gone awry with the developmental process of separating from the primary object.

And yet, as in this woman's case, she also begins to feel that the wish for fusion is undone by her perceiving the object's efforts to exploit her. The person chosen to fulfill the fantasy suddenly seems aiming only at selfishly fulfilling his own needs. In the end the patient feels demeaned and used. While it is true, as the patient indicates, that she 'sets it up that way', choosing partners preoccupied with their own egocentric aims, it is nevertheless likely that her view of her partner contains all the elements of a projection. What the patient wishes is to use somebody to meet her own needs without
giving in return or having any requirements made of her. The fantasy is itself a piece of exploitation, excluding as it always does any evidence of a mutual give-and-take in a relationship. The fantasy, in other words, is a singularly naked expression of that very egocentricity the patient is so ready to ascribe to the object. What is missing in this picture is not only any evidence of mutuality but a sense of self-respect that allows the patient a mature confidence in the fact she has something worthwhile to offer and that indeed she can engage in a giving intimacy with another person without feeling depleted or robbed.

The patient's efforts to fulfill the fantasy through an experience of fusion can probably be traced to the early symbiotic relationship to the mother, a condition Searles (1973) describes as 'a thoroughly adoring, contented oneness' (p. 248). From the genetic standpoint, the fantasy is a derivative of the pre-ambivalent period of development. Searles believes that patients such as I have been describing assume in their analysis the role of the therapist—not out of a competitive sense of one-upmanship, but out of a deeper need to fill the gaps in the internal representation of their own limited, ego-fragmented mothers. This view may be a way of dignifying what I have seen in these patients as taking the role of the mother, not only with the analyst but with numerous others as well, out of a wish to be treated by the mothering figure as the mother is treated. Again, in this interaction the roles of self and other—of giving mother and receiving infant—may not at all times be distinctly defined.

My purpose in this study has been the modest one of drawing attention to an aspect of the patient's internal world that often has far-reaching implications genetically and significant consequences therapeutically. I have not attempted to assign any particular diagnostic labels since, I believe, the fantasy as I have described it is sufficiently ubiquitous, at least in our own culture, to cut across various forms of pathology. In my own treatment of patients whose object relationships are in large part defined by the golden fantasy, I have believed with Searles that the analyst must immerse himself at first in the fantasies of the patient, to steep himself in the infantile wish-fulfilling world of the patient, in the hopes that through the patient's identification with him or through the patient's growing ability to utilize him as a model, the analyst can serve as a bridge between the patient's fantasy and reality. This process cannot be hurried. Battering at the patient's defences and resistances against giving up the fantasy can, especially early in the analysis, turn the analyst into an alien force attempting to destroy a portion of the patient's valued self.

What frequently happens when the fantasy becomes fully conscious and the patient begins to develop some appreciation for the way it influences his life (e.g. in acting out), is that the patient often develops a dialogue within himself in which one side of the self takes the role of wishing to be free to indulge in the fantasy, free to immerse oneself in a passive gratification experience, while another side of the self takes the role of the parental figure who wishes to bring constriction to bear on the infantile self, to control it, discipline it and force it into a position of renunciation (Searles, 1977). The struggle in the analysis is to keep this conflict inside the patient and relentlessly confront the patient with his efforts to project one side or the other of these self representations on to the analyst.

A further treatment issue, as Kernberg (1975) and others have made clear, is that the patient who suffers from the kind of separation-individuation problems implied in the golden fantasy often cannot tolerate the analyst as a separate, independent person. There is not only the need to pull the analyst into a symbiotic relationship as a way of repeating the past (Kohut, 1968), but there is also a developing and destructive envy of the analyst expressed in part by the patient's devaluation of the analyst's capacity to give or to help or to understand. This tactic can only leave the patient more empty and therefore more willing to turn back to the fantasy as a highly valued form of promised gratification. For the patient with severe narcissistic character problems, this issue may be less resolvable in part because one may be dealing more with fixation than regression.

The giving up of the fantasy, or finding other ways to satisfy it, is clearly a prerequisite to emotional growth and to any movement in the
direction of a meaningful individuation, but the relinquishment of the fantasy is dependent on the intensity of the patient's idealizations. The longing for the idealized mother embedded in the fantasy must finally come together with what we have seen as the other side of the fantasy, that is, the image of the mother as aggressive, incorporating and dangerous. It is this process that allows the patient to shift from the fantasy to an acknowledgement of what the analyst has to give and what the real world has to offer. This shift, as we know, will not be all of a piece, but will involve an oscillating pattern of regression and growth until in the end, if all goes well, the patient can discover that the mother's goodness can allow the patient to separate from the mother and at the same time keep her inside, a paradox that permits the patient to see the fantasy for what it is—an impotent imposturing of the impossible.

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