that which is personal to the therapist. In order to make this distinction, at the time of the clinical episode quoted, I suggested we might speak of a 'diagnostic response' as compared with a 'personal countertransference' (Casement 1973).

Boredom as communication

Example 4.2

For some months, in the course of a long analysis, I found myself regularly feeling bored by one particular male patient. I silently explored this as fully as I could to see if my feelings were simply some personal countertransference to my patient, as a transferential object, thinking here of countertransference in the sense described by Reich (1951). But even after this self-scrutiny, my feelings of boredom continued to occur in many of the sessions with this patient.

When I monitored this boredom more closely, I came to recognize I was responding to the fact that the patient was not relating to me. He seemed to be speaking to himself, as if I were not present; but this was not the whole of it. The patient treated me as physically present but emotionally absent. He was assuming that I was not interested, although this was not normally how I felt towards him. I could then see that the quality of his relating to me was as if to someone whose interest he could not engage, or who was unwilling to be engaged. This offered me a fresh clue.

What then stirred in me was a clear image of this patient at the time when he had been in a mental hospital. He had told me how his mother used to visit him regularly. She claimed to be concerned, and yet she continued to rationalize why her son had to remain in hospital. (He would have been allowed home if his parents had been prepared to look after him.)

The patient's presence in hospital was due to a prolonged agitated depression. This in turn was largely activated by the family's readiness to close ranks against this child, who

had come to feel that life was not worth living. The parents did not seem to be prepared to let themselves be in touch with, or to be touched by, the patient's depression and despair – or by his need to be allowed home, rather than being left indefinitely in a mental hospital until he was 'better'. The parents were wanting to ignore the main reason for their son being left there. This was because he had nowhere else to go other than to his home, where his parents felt that they would not be able to cope with him in this chronic state.

With this re-activated memory as my cue, I began to wonder whether my patient might be re-enacting with me the empty relating that he had so often sat through while he remained in hospital. He had talked *at* his mother, who had barely listened. His mother, in her turn, had talked *at* him rather than *to* him.

When I began to re-focus my listening to the patient, in this new context, I could recognize many other indications which confirmed this impression. I became able to point out to the patient how he was speaking to me, as if he did not expect me really to be interested or to be ready to take seriously anything he said. I wondered whether this may have been how it used to be during his mother's visits to him in the hospital, which sounded as if they had been just as empty of meaningful relating.

Once I had been able to interpret this emptiness in the transference, the patient began to speak to me and to relate to me in a way that began (for the first time) to be invested with meaning. The transference stopped being a shallow relating, as if to a physically present but emotionally absent mother. Instead, the patient began to relate to me as to someone who was emotionally as well as physically present; and I stopped being troubled by boredom when I was with him.

An experience of projective identification

Although I had struggled to understand the concept of projective identification from what I had read about it, as in

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