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BEMERKUNGEN ÜBER DIE ÜBERTRAGUNGSLIEBE

(*a*) GERMAN EDITIONS:

1915 *Int. Z. Psychoanal.*, **3** (1), 1–11.
1918 *S.K.S.N.*, **4**, 453–69. (1922, 2nd ed.)
1924 *Technik und Metapsychol.*, 120–35.
1925 *G.S.*, **6**, 120–35.
1931 *Neurosenlehre und Technik*, 385–96.
1946 *G.W.*, **10**, 306–21.

(*b*) ENGLISH TRANSLATION:

'Further Recommendations in the Technique of Psycho-Analysis: Observations on Transference-Love'
1924 *C.P.*, **2**, 377–91. (Tr. Joan Riviere.)

The present translation, with a changed title, is a modified version of the one published in 1924.

When this paper was first published (early in 1915), its title ran: 'Weitere Ratschläge zur Technik der Psychoanalyse (III): Bemerkungen über die Übertragungsliebe.' The title of the English translation of 1924, as given above, is a rendering of this. The German editions from 1924 onwards adopted the shorter title.

Dr. Ernest Jones tells us (1955, 266) that Freud considered this the best of the present series of technical papers. A letter written by Freud to Ferenczi on December 13, 1931, in connection with the technical innovations introduced by the latter, forms an interesting postscript to this paper. It was published by Dr. Jones towards the end of Chapter IV of his third volume of Freud's biography (1957, 174 ff.).

OBSERVATIONS ON TRANSFERENCE-LOVE

(FURTHER RECOMMENDATIONS ON THE TECHNIQUE OF PSYCHO-ANALYSIS III)

EVERY beginner in psycho-analysis probably feels alarmed at first at the difficulties in store for him when he comes to interpret the patient's associations and to deal with the reproduction of the repressed. When the time comes, however, he soon learns to look upon these difficulties as insignificant, and instead becomes convinced that the only really serious difficulties he has to meet lie in the management of the transference.

Among the situations which arise in this connection I shall select one which is very sharply circumscribed; and I shall select it, partly because it occurs so often and is so important in its real aspects and partly because of its theoretical interest. What I have in mind is the case in which a woman patient shows by unmistakable indications, or openly declares, that she has fallen in love, as any other mortal woman might, with the doctor who is analysing her. This situation has its distressing and comical aspects, as well as its serious ones. It is also determined by so many and such complicated factors, it is so unavoidable and so difficult to clear up, that a discussion of it to meet a vital need of analytic technique has long been overdue. But since we who laugh at other people's failings are not always free from them ourselves, we have not so far been precisely in a hurry to fulfil this task. We are constantly coming up against the obligation to professional discretion—a discretion which cannot be dispensed with in real life, but which is of no service in our science. In so far as psycho-analytic publications are a part of real life, too, we have here an insoluble contradiction. I have recently disregarded this matter of discretion at one point,[1] and shown how this same transference situation held back the development of psycho-analytic therapy during its first decade.

[1] In the first section of my contribution to the history of the psycho-analytic movement (1914*d*). [This refers to Breuer's difficulties over the transference in the case of Anna O. (*Standard Ed.*, **14**, 12).]

To a well-educated layman (for that is what the ideal civilized person is in regard to psycho-analysis) things that have to do with love are incommensurable with everything else; they are, as it were, written on a special page on which no other writing is tolerated. If a woman patient has fallen in love with her doctor it seems to such a layman that only two outcomes are possible. One, which happens comparatively rarely, is that all the circumstances allow of a permanent legal union between them; the other, which is more frequent, is that the doctor and the patient part and give up the work they have begun which was to have led to her recovery, as though it had been interrupted by some elemental phenomenon. There is, to be sure, a third conceivable outcome, which even seems compatible with a continuation of the treatment. This is that they should enter into a love-relationship which is illicit and which is not intended to last for ever. But such a course is made impossible by conventional morality and professional standards. Nevertheless, our layman will beg the analyst to reassure him as unambiguously as possible that this third alternative is excluded.

It is clear that a psycho-analyst must look at things from a different point of view.

Let us take the case of the second outcome of the situation we are considering. After the patient has fallen in love with her doctor, they part; the treatment is given up. But soon the patient's condition necessitates her making a second attempt at analysis, with another doctor. The next thing that happens is that she feels she has fallen in love with this second doctor too; and if she breaks off with him and begins yet again, the same thing will happen with the third doctor, and so on. This phenomenon, which occurs without fail and which is, as we know, one of the foundations of the psycho-analytic theory, may be evaluated from two points of view, that of the doctor who is carrying out the analysis and that of the patient who is in need of it.

For the doctor the phenomenon signifies a valuable piece of enlightenment and a useful warning against any tendency to a counter-transference which may be present in his own mind.[1] He must recognize that the patient's falling in love is induced

[1] [The question of the 'counter-transference' had already been raised by Freud in his Nuremberg Congress paper (1910*d*), *Standard Ed.*, **11**, 144–5. He returns to it below, on pp. 165 f. and 169 f. Apart from these passages, it is hard to find any other explicit discussions of the subject in Freud's published works.]

by the analytic situation and is not to be attributed to the charms of his own person; so that he has no grounds whatever for being proud of such a 'conquest', as it would be called outside analysis. And it is always well to be reminded of this. For the patient, however, there are two alternatives: either she must relinquish psycho-analytic treatment or she must accept falling in love with her doctor as an inescapable fate.[1]

I have no doubt that the patient's relatives and friends will decide as emphatically for the first of these two alternatives as the analyst will for the second. But I think that here is a case in which the decision cannot be left to the tender—or rather, the egoistic and jealous—concern of her relatives. The welfare of the patient alone should be the touchstone; her relatives' love cannot cure her neurosis. The analyst need not push himself forward, but he may insist that he is indispensable for the achievement of certain ends. Any relative who adopts Tolstoy's attitude to this problem can remain in undisturbed possession of his wife or daughter; but he will have to try to put up with the fact that she, for her part, retains her neurosis and the interference with her capacity for love which it involves. The situation, after all, is similar to that in a gynaecological treatment. Moreover, the jealous father or husband is greatly mistaken if he thinks that the patient will escape falling in love with her doctor if he hands her over to some kind of treatment other than analysis for combating her neurosis. The difference, on the contrary, will only be that a love of this kind, which is bound to remain unexpressed and unanalysed, can never make the contribution to the patient's recovery which analysis would have extracted from it.

It has come to my knowledge that some doctors who practise analysis frequently[2] prepare their patients for the emergence of the erotic transference or even urge them to 'go ahead and fall in love with the doctor so that the treatment may make progress'. I can hardly imagine a more senseless proceeding.

[1] We know that the transference can manifest itself in other, less tender feelings, but I do not propose to go into that side of the matter here. [See the paper on 'The Dynamics of Transference' (1912*b*), p. 105 above.]

[2] ['*Häufig*.' In the first edition only, the word here is '*frühzeitig*' ('early').]

In doing so, an analyst robs the phenomenon of the element of spontaneity which is so convincing and lays up obstacles for himself in the future which are hard to overcome.[1]

At a first glance it certainly does not look as if the patient's falling in love in the transference could result in any advantage to the treatment. No matter how amenable she has been up till then, she suddenly loses all understanding of the treatment and all interest in it, and will not speak or hear about anything but her love, which she demands to have returned. She gives up her symptoms or pays no attention to them; indeed, she declares that she is well. There is a complete change of scene; it is as though some piece of make-believe had been stopped by the sudden irruption of reality—as when, for instance, a cry of fire is raised during a theatrical performance. No doctor who experiences this for the first time will find it easy to retain his grasp on the analytic situation and to keep clear of the illusion that the treatment is really at an end.

A little reflection enables one to find one's bearings. First and foremost, one keeps in mind the suspicion that anything that interferes with the continuation of the treatment may be an expression of resistance.[2] There can be no doubt that the outbreak of a passionate demand for love is largely the work of resistance. One will have long since noticed in the patient the signs of an affectionate transference, and one will have been able to feel certain that her docility, her acceptance of the analytic explanations, her remarkable comprehension and the high degree of intelligence she showed were to be attributed to this attitude towards her doctor. Now all this is swept away. She has become quite without insight and seems to be swallowed up in her love. Moreover, this change quite regularly occurs precisely at a point of time when one is having to try to bring her to admit or remember some particularly distressing and heavily repressed piece of her life-history. She has been in love, therefore, for a long time; but now the resistance is beginning to make use of her love in order to hinder the continuation of

[1] [In the first edition only, this paragraph (which is in the nature of a parenthesis) was printed in small type.]

[2] [Freud had already stated this still more categorically in the first edition of *The Interpretation of Dreams* (1900*a*), *Standard Ed.*, **5**, 517. But in 1925 he added a long footnote to the passage, explaining its sense and qualifying the terms in which he had expressed himself.]

the treatment, to deflect all her interest from the work and to put the analyst in an awkward position.

If one looks into the situation more closely one recognizes the influence of motives which further complicate things—of which some are connected with being in love and others are particular expressions of resistance. Of the first kind are the patient's endeavour to assure herself of her irresistibility, to destroy the doctor's authority by bringing him down to the level of a lover and to gain all the other promised advantages incidental to the satisfaction of love. As regards the resistance, we may suspect that on occasion it makes use of a declaration of love on the patient's part as a means of putting her analyst's severity to the test, so that, if he should show signs of compliance, he may expect to be taken to task for it. But above all, one gets an impression that the resistance is acting as an *agent provocateur*; it heightens the patient's state of being in love and exaggerates her readiness for sexual surrender in order to justify the workings of repression all the more emphatically, by pointing to the dangers of such licentiousness.[1] All these accessory motives, which in simpler cases may not be present, have, as we know, been regarded by Adler as the essential part of the whole process.[2]

But how is the analyst to behave in order not to come to grief over this situation, supposing he is convinced that the treatment should be carried on in spite of this erotic transference and should take it in its stride?

It would be easy for me to lay stress on the universally accepted standards of morality and to insist that the analyst must never under any circumstances accept or return the tender feelings that are offered him: that, instead, he must consider that the time has come for him to put before the woman who is in love with him the demands of social morality and the necessity for renunciation, and to succeed in making her give up her desires, and, having surmounted the animal side of her self, go on with the work of analysis.

I shall not, however, fulfil these expectations—neither the first nor the second of them. Not the first, because I am writing not for patients but for doctors who have serious difficulties to contend with, and also because in this instance I am able to trace the moral prescription back to its source, namely to

[1] [Cf. pp. 152–3.]

[2] [Cf. Adler, 1911, 219.]

expediency. I am on this occasion in the happy position of being able to replace the moral embargo by considerations of analytic technique, without any alteration in the outcome.

Even more decidedly, however, do I decline to fulfil the second of the expectations I have mentioned. To urge the patient to suppress, renounce or sublimate her instincts the moment she has admitted her erotic transference would be, not an analytic way of dealing with them, but a senseless one. It would be just as though, after summoning up a spirit from the underworld by cunning spells, one were to send him down again without having asked him a single question. One would have brought the repressed into consciousness, only to repress it once more in a fright. Nor should we deceive ourselves about the success of any such proceeding. As we know, the passions are little affected by sublime speeches. The patient will feel only the humiliation, and she will not fail to take her revenge for it.

Just as little can I advocate a middle course, which would recommend itself to some people as being specially ingenious. This would consist in declaring that one returns the patient's fond feelings but at the same time in avoiding any physical implementation of this fondness until one is able to guide the relationship into calmer channels and raise it to a higher level. My objection to this expedient is that psycho-analytic treatment is founded on truthfulness. In this fact lies a great part of its educative effect and its ethical value. It is dangerous to depart from this foundation. Anyone who has become saturated in the analytic technique will no longer be able to make use of the lies and pretences which a doctor normally finds unavoidable; and if, with the best intentions, he does attempt to do so, he is very likely to betray himself. Since we demand strict truthfulness from our patients, we jeopardize our whole authority if we let ourselves be caught out by them in a departure from the truth. Besides, the experiment of letting oneself go a little way in tender feelings for the patient is not altogether without danger. Our control over ourselves is not so complete that we may not suddenly one day go further than we had intended. In my opinion, therefore, we ought not to give up the neutrality towards the patient, which we have acquired through keeping the counter-transference in check.

I have already let it be understood that analytic technique

requires of the physician that he should deny to the patient who is craving for love the satisfaction she demands. The treatment must be carried out in abstinence. By this I do not mean physical abstinence alone, nor yet the deprivation of everything that the patient desires, for perhaps no sick person could tolerate this. Instead, I shall state it as a fundamental principle that the patient's need and longing should be allowed to persist in her, in order that they may serve as forces impelling her to do work and to make changes, and that we must beware of appeasing those forces by means of surrogates. And what we could offer would never be anything else than a surrogate, for the patient's condition is such that, until her repressions are removed, she is incapable of getting real satisfaction.

Let us admit that this fundamental principle of the treatment being carried out in abstinence extends far beyond the single case we are considering here, and that it needs to be thoroughly discussed in order that we may define the limits of its possible application.[1] We will not enter into this now, however, but will keep as close as possible to the situation from which we started out. What would happen if the doctor were to behave differently and, supposing both parties were free, if he were to avail himself of that freedom in order to return the patient's love and to still her need for affection?

If he has been guided by the calculation that this compliance on his part will ensure his domination over his patient and thus enable him to influence her to perform the tasks required by the treatment, and in this way to liberate herself permanently from her neurosis—then experience would inevitably show him that his calculation was wrong. The patient would achieve *her* aim, but he would never achieve *his*. What would happen to the doctor and the patient would only be what happened, according to the amusing anecdote, to the pastor and the insurance agent. The insurance agent, a free-thinker, lay at the point of death and his relatives insisted on bringing in a man of God to convert him before he died. The interview lasted so long that those who were waiting outside began to have hopes. At last the door of the sick-chamber opened. The free-thinker had not been converted; but the pastor went away insured.

[1] [Freud took this subject up again in his Budapest Congress paper (1919*a*), *Standard Ed.*, **17**, 162–3.]

If the patient's advances were returned it would be a great triumph for her, but a complete defeat for the treatment. She would have succeeded in what all patients strive for in analysis —she would have succeeded in acting out, in repeating in real life, what she ought only to have remembered, to have reproduced as psychical material and to have kept within the sphere of psychical events.[1] In the further course of the love-relationship she would bring out all the inhibitions and pathological reactions of her erotic life, without there being any possibility of correcting them; and the distressing episode would end in remorse and a great strengthening of her propensity to repression. The love-relationship in fact destroys the patient's susceptibility to influence from analytic treatment. A combination of the two would be an impossibility.

It is, therefore, just as disastrous for the analysis if the patient's craving for love is gratified as if it is suppressed. The course the analyst must pursue is neither of these; it is one for which there is no model in real life. He must take care not to steer away from the transference-love, or to repulse it or to make it distasteful to the patient; but he must just as resolutely withhold any response to it. He must keep firm hold of the transference-love, but treat it as something unreal, as a situation which has to be gone through in the treatment and traced back to its unconscious origins and which must assist in bringing all that is most deeply hidden in the patient's erotic life into her consciousness and therefore under her control. The more plainly the analyst lets it be seen that he is proof against every temptation, the more readily will he be able to extract from the situation its analytic content. The patient, whose sexual repression is of course not yet removed but merely pushed into the background, will then feel safe enough to allow all her preconditions for loving, all the phantasies springing from her sexual desires, all the detailed characteristics of her state of being in love, to come to light; and from these she will herself open the way to the infantile roots of her love.

There is, it is true, one class of women with whom this attempt to preserve the erotic transference for the purposes of analytic work without satisfying it will not succeed. These are women of elemental passionateness who tolerate no surrogates. They are children of nature who refuse to accept the psychical

[1] See the preceding paper [p. 150].

in place of the material, who, in the poet's words, are accessible only to 'the logic of soup, with dumplings for arguments'. With such people one has the choice between returning their love or else bringing down upon oneself the full enmity of a woman scorned. In neither case can one safeguard the interests of the treatment. One has to withdraw, unsuccessful; and all one can do is to turn the problem over in one's mind of how it is that a capacity for neurosis is joined with such an intractable need for love.

Many analysts will no doubt be agreed on the method by which other women, who are less violent in their love, can be gradually made to adopt the analytic attitude. What we do, above all, is to stress to the patient the unmistakable element of resistance in this 'love'. Genuine love, we say, would make her docile and intensify her readiness to solve the problems of her case, simply because the man she was in love with expected it of her. In such a case she would gladly choose the road to completion of the treatment, in order to acquire value in the doctor's eyes and to prepare herself for real life, where this feeling of love could find a proper place. Instead of this, we point out, she is showing a stubborn and rebellious spirit, she has thrown up all interest in her treatment, and clearly feels no respect for the doctor's well-founded convictions. She is thus bringing out a resistance under the guise of being in love with him; and in addition to this she has no compunction in placing him in a cleft stick. For if he refuses her love, as his duty and his understanding compel him to do, she can play the part of a woman scorned, and then withdraw from his therapeutic efforts out of revenge and resentment, exactly as she is now doing out of her ostensible love.

As a second argument against the genuineness of this love we advance the fact that it exhibits not a single new feature arising from the present situation, but is entirely composed of repetitions and copies of earlier reactions, including infantile ones. We undertake to prove this by a detailed analysis of the patient's behaviour in love.

If the necessary amount of patience is added to these arguments, it is usually possible to overcome the difficult situation and to continue the work with a love which has been moderated or transformed; the work then aims at uncovering the patient's infantile object-choice and the phantasies woven round it.

I should now like, however, to examine these arguments with a critical eye and to raise the question whether, in putting them forward to the patient, we are really telling the truth, or whether we are not resorting in our desperation to concealments and misrepresentations. In other words: can we truly say that the state of being in love which becomes manifest in analytic treatment is not a real one?

I think we have told the patient the truth, but not the whole truth regardless of the consequences. Of our two arguments the first is the stronger. The part played by resistance in transference-love is unquestionable and very considerable. Nevertheless the resistance did not, after all, *create* this love; it finds it ready to hand, makes use of it and aggravates its manifestations. Nor is the genuineness of the phenomenon disproved by the resistance. The second argument is far weaker. It is true that the love consists of new editions of old traits and that it repeats infantile reactions. But this is the essential character of every state of being in love. There is no such state which does not reproduce infantile prototypes. It is precisely from this infantile determination that it receives its compulsive character, verging as it does on the pathological. Transference-love has perhaps a degree less of freedom than the love which appears in ordinary life and is called normal; it displays its dependence on the infantile pattern more clearly and is less adaptable and capable of modification; but that is all, and not what is essential.

By what other signs can the genuineness of a love be recognized? By its efficacy, its serviceability in achieving the aim of love? In this respect transference-love seems to be second to none; one has the impression that one could obtain anything from it.

Let us sum up, therefore. We have no right to dispute that the state of being in love which makes its appearance in the course of analytic treatment has the character of a 'genuine' love. If it seems so lacking in normality, this is sufficiently explained by the fact that being in love in ordinary life, outside analysis, is also more similar to abnormal than to normal mental phenomena. Nevertheless, transference-love is characterized by certain features which ensure it a special position. In the first place, it is provoked by the analytic situation; secondly, it is greatly intensified by the resistance, which dominates the situation; and thirdly, it is lacking to a high

degree in a regard for reality, is less sensible, less concerned about consequences and more blind in its valuation of the loved person than we are prepared to admit in the case of normal love. We should not forget, however, that these departures from the norm constitute precisely what is essential about being in love.

As regards the analyst's line of action, it is the first of these three features of transference-love which is the decisive factor. He has evoked this love by instituting analytic treatment in order to cure the neurosis. For him, it is an unavoidable consequence of a medical situation, like the exposure of a patient's body or the imparting of a vital secret. It is therefore plain to him that he must not derive any personal advantage from it. The patient's willingness makes no difference; it merely throws the whole responsibility on the analyst himself. Indeed, as he must know, the patient had been prepared for no other mechanism of cure. After all the difficulties have been successfully overcome, she will often confess to having had an anticipatory phantasy at the time when she entered the treatment, to the effect that if she behaved well she would be rewarded at the end by the doctor's affection.

For the doctor, ethical motives unite with the technical ones to restrain him from giving the patient his love. The aim he has to keep in view is that this woman, whose capacity for love is impaired by infantile fixations, should gain free command over a function which is of such inestimable importance to her; that she should not, however, dissipate it in the treatment, but keep it ready for the time when, after her treatment, the demands of real life make themselves felt. He must not stage the scene of a dog-race in which the prize was to be a garland of sausages but which some humorist spoilt by throwing a single sausage on to the track. The result was, of course, that the dogs threw themselves upon it and forgot all about the race and about the garland that was luring them to victory in the far distance. I do not mean to say that it is always easy for the doctor to keep within the limits prescribed by ethics and technique. Those who are still youngish and not yet bound by strong ties may in particular find it a hard task. Sexual love is undoubtedly one of the chief things in life, and the union of mental and bodily satisfaction in the enjoyment of love is one of its culminating peaks. Apart from a few queer fanatics, all the world knows

this and conducts its life accordingly; science alone is too delicate to admit it. Again, when a woman sues for love, to reject and refuse is a distressing part for a man to play; and, in spite of neurosis and resistance, there is an incomparable fascination in a woman of high principles who confesses her passion. It is not a patient's crudely sensual desires which constitute the temptation. These are more likely to repel, and it will call for all the doctor's tolerance if he is to regard them as a natural phenomenon. It is rather, perhaps, a woman's subtler and aim-inhibited wishes which bring with them the danger of making a man forget his technique and his medical task for the sake of a fine experience.

And yet it is quite out of the question for the analyst to give way. However highly he may prize love he must prize even more highly the opportunity for helping his patient over a decisive stage in her life. She has to learn from him to overcome the pleasure principle, to give up a satisfaction which lies to hand but is socially not acceptable, in favour of a more distant one, which is perhaps altogether uncertain, but which is both psychologically and socially unimpeachable. To achieve this overcoming, she has to be led through the primal period of her mental development and on that path she has to acquire the extra piece of mental freedom which distinguishes conscious mental activity—in the systematic sense—from unconscious.[1]

The analytic psychotherapist thus has a threefold battle to wage—in his own mind against the forces which seek to drag him down from the analytic level; outside the analysis, against opponents who dispute the importance he attaches to the sexual instinctual forces and hinder him from making use of them in his scientific technique; and inside the analysis, against his patients, who at first behave like opponents but later on reveal the overvaluation of sexual life which dominates them, and who try to make him captive to their socially untamed passion.

The lay public, about whose attitude to psycho-analysis I spoke at the outset, will doubtless seize upon this discussion of transference-love as another opportunity for directing the attention of the world to the serious danger of this therapeutic method. The psycho-analyst knows that he is working with highly explosive forces and that he needs to proceed with as much caution and conscientiousness as a chemist. But when

[1] [This distinction is explained below, p. 266.]

have chemists ever been forbidden, because of the danger, from handling explosive substances, which are indispensable, on account of their effects? It is remarkable that psycho-analysis has to win for itself afresh all the liberties which have long since been accorded to other medical activities. I am certainly not in favour of giving up the harmless methods of treatment. For many cases they are sufficient, and, when all is said, human society has no more use for the *furor sanandi*[1] than for any other fanaticism. But to believe that the psychoneuroses are to be conquered by operating with harmless little remedies is grossly to under-estimate those disorders both as to their origin and their practical importance. No; in medical practice there will always be room for the '*ferrum*' and the '*ignis*' side by side with the '*medicina*';[2] and in the same way we shall never be able to do without a strictly regular, undiluted psycho-analysis which is not afraid to handle the most dangerous mental impulses and to obtain mastery over them for the benefit of the patient.

[1] ['Passion for curing people.']

[2] [An allusion to a saying attributed to Hippocrates: 'Those diseases which medicines do not cure, iron (the knife?) cures; those which iron cannot cure, fire cures; and those which fire cannot cure are to be reckoned wholly incurable.' *Aphorisms*, VII, 87 (*trans.* 1849).]

APPENDIX

LIST OF WRITINGS BY FREUD DEALING MAINLY WITH PSYCHO-ANALYTIC TECHNIQUE AND THE THEORY OF PSYCHOTHERAPY

[*The date at the beginning of each entry is that of the year during which the work in question was probably written. The date at the end is that of publication; and under that date fuller particulars of the work will be found in the* Bibliography and Author Index.]

1888 *Introduction to the translation of Bernheim's *De la suggestion* (1888–9)
1892 *'A Case of Successful Treatment by Hypnotism' (1892–93*b*)
1895 *Studies on Hysteria*, Part IV (1895*d*)
1898 'Sexuality in the Aetiology of the Neuroses' (last part) (1898*a*)
1899 *The Interpretation of Dreams*, Chapter II (first part) (1900*a*)
1901 'Fragment of an Analysis of a Case of Hysteria', Chapter IV (1905*e*)
1903 'Freud's Psycho-Analytic Procedure' (1904*a*)
1904 'On Psychotherapy' (1905*a*)
1905 *'Psychical (or Mental) Treatment' (1905*b*)
1910 'The Future Prospects of Psycho-Analytic Therapy' (1910*d*)
1910 '"Wild" Psycho-Analysis' (1910*k*)
1911 'The Handling of Dream-Interpretation in Psycho-Analysis' (1911*e*)
1912 'The Dynamics of Transference' (1912*b*)
1912 'Recommendations to Physicians Practising Psycho-Analysis' (1912*e*)
1913 'On Beginning the Treatment' (1913*c*)
1914 'Fausse Reconnaissance ("déjà raconté") in Psycho-Analytic Treatment' (1914*a*)
1914 'Remembering, Repeating and Working-Through' (1914*g*)
1914 'Observations on Transference-Love' (1915*a*)

* These papers are concerned only with hypnotism and suggestion.

1917 *Introductory Lectures on Psycho-Analysis*, Lectures XXVII and XXVIII (1916–17)
1918 'Lines of Advance in Psycho-Analytic Therapy' (1919*a*)
1920 *Beyond the Pleasure Principle*, Chapter II (1920*g*)
1923 'Remarks on the Theory and Practice of Dream-Interpretation' (1923*c*)
1926 *The Question of Lay Analysis*, Chapter V (1926*e*)
1932 *New Introductory Lectures on Psycho-Analysis*, Lecture XXXIV (last part) (1933*a*)
1937 'Analysis Terminable and Interminable' (1937*c*)
1937 'Constructions in Analysis' (1937*d*)
1938 *An Outline of Psycho-Analysis*, Chapter VI (1940*a*)