Bion's Basic Assumption Groups in the Regimen Treatment of Addictions: Clinical Implications

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This article provides reflection on the potential application of Bion's model of basic assumption groups in patients undergoing midterm inpatient addiction treatment. The clinical implications are discussed in terms of the usability of Bion's model and its possible benefits for patients in regimen addiction treatment, as well as the pitfalls associated with its application in this treatment modality. Despite the highly theoretical nature of this model, clinical experience to date confirms that analysis of the underlying assumptions and associated protomental patterns can provide valuable insights into the nature of the mental and somatic symptoms for which addicted patients come for treatment. On the other hand, this approach places high demands on both the therapist and the patient, and the question arises whether the benefit of the self-knowledge that can be gained in this way is proportionate to the effort expended. In this regard, the short duration of the treatment, the inconsistency of therapeutic interventions, and the semi-open format of the groups proved to be the main pitfalls of applying Bion's model of basic assumptions in the regimen treatment of addictions.

Keywords | Bion – Basic Assumption Group – Work Group – Regimen Addiction Treatment – Group Psychotherapy – Psychoanalysis

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1 INTRODUCTION

The application of group psychotherapy in the treatment of substance use disorders (SUDs) has great merit from both a public health and clinical perspective. From the public health point of view, it helps mitigate the enormous economic costs of treating SUDs while simultaneously affecting the psychosocial framework in which these disorders occur (Yalom & Leszcz, 2005). From a clinical perspective, the possibility of gaining insights into pathological characterological styles that prevent patients with SUDs from achieving healthy intimate contact with other people and contribute to a history of dysfunctional interpersonal relationships, relapse, and a return to substance use can be considered a major benefit of group therapy (Flores & Mahon, 1993). The vulnerability of the self, which is at the core of the character pathology of patients with SUDs, is the consequence of developmental failures and early environmental deprivation leading to ineffective attachment styles (Flores, 2001). Because substance abusers typically suffer from this type of arrested development, they often fail to differentiate, identify, and understand their feelings. Their emotional experience is limited to intense bodily sensations, which in a sober state lead to pain and overwhelm them, so they try to avoid them (Khantzian, 2001). In group therapy for addicts, this tendency can manifest itself through pseudomentalisation, where patients' thoughts remain detached from their personal emotional experience and narratives become ruminative, with an excessive emphasis on detail, resembling intellectualisation or rationalisation (Bateman & Fonagy, 2019). Most recently, pseudomentalisation – a defensive strategy of patients with SUDs against the primary emotion of fear – was addressed as a collective phenomenon resembling the "basic assumption" of W. R. Bion (Esposito et al., 2022).

Although Bion's theory of group processes offers useful insights into the maladaptive dynamics of emotional experience in patients with SUDs, often associated with extreme denial or repression of their feelings (Flores & Mahon, 1993), there is not much literature addressing this topic. Following the current state of knowledge about the applicability of Bion's model in the group therapy of patients in various clinical settings (e.g., Karterud, 1989; Esposito et al., 2022), in this article I will focus on some clinical implications of using Bion's model of working with groups in residential midterm addiction treatment. If we consider vulnerability to addictive behaviour as a way of filling an internal vacuum that helps individuals with SUDs to avert painful affective states stemming from structural deficits in the self (Kohut & Wolf, 1978), we can hypothesise that patients' propensity for pseudomentalisation or other forms of group regression may be an important indicator of the depth of the character pathology of those individuals. The early detection of such regressive interpersonal patterns can have a significant impact on the course and outcome of treatment. In line with this hypothesis, the aims of the work are: 1. to reflect on the practical applicability of the model of basic assumptions from the perspective of the possible benefits for addictology patients undergoing midterm inpatient treatment; 2. to provide reflection on the pitfalls associated with the application of the model in this treatment format. The reflections will be based on the experience of fifty groups conducted with patients of the Department of Addictology, General University Hospital in Prague, specifically the inpatient regimen-based unit for men, in the period January-September 2019.

2 GROUPS AT THE MEN'S UNIT OF THE DEPARTMENT OF ADDICTOLOGY

In addition to regimen therapy, group psychotherapy is the main axis of the therapeutic programme in the inpatient unit for men. It takes place three times a week (90' per session). The patient in the basic treatment format thus completes approximately 39 group sessions during a period of 13 weeks, i.e., almost 59 hours of group psychotherapy. Patients are evenly distributed after their admission into two smaller semi-closed therapeutic groups. Each of these groups is led by two therapists (a man and a woman). Moreover, a joint group is held once every two weeks, where patients from both groups and at least one therapist from each therapeutic couple are present. Although this group model of psychotherapy is technically fixed, the psychotherapeutic interventions differ not only between the two groups, but also in the therapeutic strategies, tactics, and techniques used by individual therapists within each group. For the purposes of this paper, only experiences with groups led by therapists with psychoanalytic and systemic training will be reported.

3 BION'S MODEL OF GROUPS AND THE ADDICTOLOGY SETTING

3.1 Basic assumptions

Bion defines the repeated emotional states of groups as what he calls "basic assumptions". He assumes that within each group there are two separate groups at the same time, i.e., a "work group" and a "basic assumption group". The work group is a functional aspect of the group that has to do with the primary purpose for which the group has met and which it seeks to achieve. In general, this is the part of the group that will maintain a sophisticated and rational level of behaviour. In contrast, he describes a basic assumption group as bearers of silent, subliminal assumptions on the basis of which the work group's behaviour is based.

Bion defined three basic assumptions in this regard: dependence; fight-flight, and pairing. If the group accepts any of these assumptions, they interfere with the task the group is trying to achieve. Bion hypothesised that the therapist's interpretation of this aspect of group dynamics could, despite resistance, lead to gaining potential insights into effective, cooperative group collaboration. The therapist is expected to be able to hold a basic psychoanalytic position, i.e., a position of technical neutrality. He/she should be like a "blank slate" for the patients, limits him-/herself to observing the group's reactions, helping to clarify the respective basic assumptions group, and systematically avoids any directive intervention, other than stressing the group's task of free associations by members, and of

observing the processes emerging in the group setting, and thus creating a ground for the interactions of actors and their free associations. At the appropriate moment, the therapist gradually begins to provide interpretations aimed at revealing unconscious motives for action and transference (Kernberg, 2009; Riegel, 2017).

According to Bion, three groups of basic assumptions can be considered as aggregates of individuals who share the characteristics of one of the representatives of the oedipal situation. However, beyond the oedipal, i.e., neurotic, level of functioning that presupposes the fantasy of "whole objects", Bion, in line with the Kleinian theory of object relations (Klein, 1997), postulated the presence of more primitive fantasies of "partial objects". In other words, with the degree of personality psychopathology, the clarity of these primitive fantasies and defence mechanisms increases and the regression of the group is accelerated. The phenomenon of the regression of the group in this direction can be understood precisely as the tendency of the group to tend to more primitive forms of behaviour, which are typical of a basic assumption group (Bion, 1961).

In group work with patients, it might seem that the group shares one shared assumption, and that everything else, including the emotional states associated with that assumption, is based on that shared assumption. However, Bion does not agree with this premise. From his perspective, emotional states exist inherently in individual members of the group, and on their basis, it is possible to deduce the basic assumptions with which the actors come to the group. These basic assumptions basically echo the phenomena we commonly encounter in individual analyses, in which patients try to separate the good aspects from the bad ones, using different forms of defence mechanisms depending on the level of personality maturity achieved. In the context of a group, the individual, with the support of other members, tries to keep "the good" of the group isolated from "the bad", and finds it difficult to admit that the feeling of feeling better has something to do with the complaints made in the group, or, conversely, that the fact that he/she feels worse is somehow related to the group he/she is currently idealising. In other words, if clinicians work with the hypothesis that the actors of group psychotherapy are united in what they want to achieve (e.g., abstinence), and therefore their emotional states reflect only how they find themselves successful in achieving this goal, they can easily overlook the fact that the individual motives of each patient are subject to completely different principles.

Bion assumes that the basic assumption is present in group therapy as latent, silent, or unspoken. The members of the group behave as if they were aware of that assumption as individuals, but at the same time they are not aware of it as members of the group. As mentioned by French and Simpson (2010), this lack of reflexive awareness is central to Bion's analysis: the adoption by the group of a new [anti-]purpose is 'tacit', and it is adopted unconsciously. The analyst's interpretation then gives meaning to the behaviour of the group, based on an assumption that is not clearly expressed.

Bion assumes that there is a need for security in each of the emotional states associated with the three groups of basic assumptions. However, it may be specific to each of the basic assumptions with which it is inextricably linked. For example, the need for security derived from the basic assumption of dependence is associated with feelings of inadequacy and frustration and is dependent on the attribution of omnipotence and omniscience to one of the group members. This basic assumption can be more easily recognised in individual work with the patient, where the one-to-one setting arrangement amplifies the transference and countertransference pressures arising from the demands that the patient, with the basic assumption of dependence, places on the analyst. Regarding work in a group, Bion states that a clinician usually cannot be manipulated to promote belief in his/her self-omnipotence and omniscience in group members, so that the need for security based on the assumption of dependence is reflected in the group's claim that individual members be omniscient. Similarly, in the case of a group with a fight-flight assumption, the feeling of security is strengthened through the group's claim to courage and self-sacrifice. In short, Bion considers it crucial to pay attention to the combination of emotional states in which a certain feeling (e.g., inadequacy) occurs rather than the feeling itself.

The various feelings that are desirable for an individual cannot be experienced without simultaneous fixation in combination with other, less desirable, and often strongly unpleasant feelings. To satisfy pleasurable feelings (e.g., security), an individual must split off and isolate him-/herself from the group, and his/her inherent tendency to be part of a troop. In other words, the individual will, for example, try to feel secure in the group, but at the same time will try to split off the unpleasant feelings that are combined with the desired feeling of security. He/she will then attribute these unpleasant feelings to other circumstances, such as his/her symptoms.

An example of this behaviour from an addictology setting might be a situation when a group member brings up the topic of craving, saying: "So I might ask how you feel about craving and how you work with it when it comes to you." At that moment, at first glance, it may seem that he/she is coming up with a valuable topic, the content of which certainly belongs to the issue for which he/she came into treatment. However, it depends on whether he/she has a genuine interest in understanding the symptom better through co-patient experience or it is a way of coping with conflicting feelings about not being excluded from the group, in which he/she feels unaccepted, or the group internally devalues and he/she is frustrated by the need to be part of it. The feeling of security is then achieved by transferring the imaginary "expert position" at best to one of the co-patients, who cannot bear the pressure of the claim to omnipotence, at worst, the therapist him-/herself takes the role of omniscient counsellor, exchanging technical neutrality for psychoeducation. In this regard, Bion points out that clarifying the basic assumptions requires a considerable amount of time, while additional time is needed to verify the hypothesis that the experiences that the patient often brings to the discussion as symptoms (e.g., craving) actually reflect his/her need to be in unity with the other members of the group, who share the same need for emotional empowerment, and at the same time with his/her conflict both towards him-/herself and the group.

The question arises of what lies behind the willingness of patients to cooperate in the group. In this regard Bion points out

the fact that the emotional states associated with one basic assumption on the one hand preclude the simultaneous activation of emotional states associated with the other two basic assumptions, but, on the other hand, do not preclude the activation of emotions associated with a so-called sophisticated or work group. Bion assumes that in addition to the above-mentioned conflicts between an individual with a so-called basic group (i.e., a group of basic assumptions) and an individual with him/herself, as a bearer of a basic assumption and a participant in a basic group, there is also a conflict between a group of cooperating individuals at a sophisticated level and individuals in the basic group. While conflicts do not normally occur between basic groups (these are rather seamless alternations of the three basic assumption groups with each other), interventions by work group members can provoke conflict. Because the therapist's interpretations, which are accepted by the group, can also be considered as interpretations (interventions) of the work group, they express recognition of the need of its members to evolve, rather than relying on miracles. The goal of such interventions is to deal with the basic assumptions, using the mobilisation of the emotions of one basic assumption to cope with the emotions and phenomena of another basic assumption. According to Bion, the result of this work is a growing degree of sophistication of the work group. This makes it possible to maintain the more advanced behaviour of group members by suppressing the pattern of emotional expressions associated with a less desirable basic assumption (e.g., fight-flight or pairing), with another, more desirable pattern of emotional expressions associated with, for example, a basic assumption of dependence.

If I give another example from practice here, the willingness of patients to leave the level of symptoms and to become more involved in group dynamics increased especially when one or more members with a deeper personality psychopathology appeared in the group. These patients organised rather at the borderline level generally tended to form basic groups based on a fight-flight assumption (less often on pairing), trying to alter the basic assumption of dependence held by more neurotically organised individuals. Increasing tension between members of the work group and the dependence basic assumption group created pressure (often potentiated by the therapist's interpretation) that prevented both groups from being adversely affected by the emotional states of the fight-flight basic-assumption group. Not surprisingly, such moments in the groups I refer to have become rather rare. Bion points out that in such moments one can simultaneously see the strength of the emotions associated with the basic assumption of dependence (i.e., fear and belief in the omnipotence of one of the members) and the vigour and vitality mobilised by the intervention of the work group. It is as if human beings are aware of the painful and often fatal consequences of action, which cannot be substantiated by an adequate understanding of reality, and at the same time their need to find the truth, as criteria for evaluating their discoveries. In other words, developments in the work group are largely dependent on the state of mind of individual members. If the members of the work group are overly controlled by the fear of inadequacy typical of members of a basic group with an assumption of dependence, their willingness to empirically (i.e., by their own experience) verify the nature of the group deity (i.e., the therapist) is severely limited. In such a case, in the group of addicted patients, the work group regressed more often to the level of a dependence basic assumption group, which manifested itself in resignation and desperate devotion to the magical belief that an omnipotent member was found in their ranks, able to face the destructive forces of the fight-flight basic assumption group. If their faith was not fulfilled, it was possible to observe within the group a gradual alteration of the dependence basic assumption group into a fight-flight basic assumption group, which confirms Bion's premise of the impossibility of the parallel coexistence of two basic assumption groups at one moment.

3.2 Protomental matrices

Taking advantage of the clinical situation illustrated above, I consider it appropriate to mention that Bion elaborates on his model when he comes up with the theory of so-called "protomental matrices" to clarify the impossibility of the coexistence of two groups of basic assumptions. According to Bion (1961), the basic assumption is a more organised unit of emotional states, which the individual/group can consciously express, and as such requires a higher mental ability to organise and differentiate. In contrast, the protomental phase is a non-differentiated basis[1] of all the basic assumptions with the ability to affiliate emotional states to their differentiated forms (i.e., dependence, pairing, fight-flight). In a situation where the work group formed an imaginary coalition with a dependence basic assumption group (i.e., a group with the capacity to develop from a protomental state to a state of basic assumption that allows the clinician to perceive psychological phenomena), the other two basic groups with the assumptions of pairing and fight-flight remained "trapped" in the preoperative protomental phase. However, the power of the emotional states of individuals with deeper personality psychopathology caused the development of a fight-flight basic assumption, which subsequently became dominant in the group, as the hitherto active assumption of dependence regressed to the preoperative phase.

Although these are largely hypothetical considerations about possible intrapsychic processes, which, even according to Bion, require more thorough verification within larger groups of patients with various types of mental, possibly psychosomatic diseases, one can agree with the statement that the protomental phase in an individual is only part of the protomental system. To understand the complexity of the protomental phenomena, it is therefore necessary to examine individuals within the dynamics of the group as a whole. From this perspective, the regression of a basic group with an assumption of dependence could be perceived as a manifestation of "group disease", where symptoms of anxiety and low self-confidence led to decomposition under the pervasiveness of the aggression of the fight-flight basic assumption group. Such a constellation thus offers the analyst several interpretive strategies; either those that could target the anxiety of the dependence basic assumption group, leading to surrender, or those addressing the anxiety of the fight-flight basic assumption group, leading to the need to omnipotently control the entire therapeutic space.

1 | In this sense, non-differentiation means primarily the inability to separate physical sensations from mental experiences.

4 DISCUSSION

Regarding the stated goals of this work, i.e., reflection on the practical applicability of the model of basic assumptions from the perspective of the possible benefits for addictology patients undergoing midterm residential treatment, and a reflection of previous experience and pitfalls associated with applying the model in this treatment format, Bion's argument that I find essential is that the concept of protomental systems, together with theories of basic assumptions, can provide a unique way of looking at physical illnesses, especially psychosomatic disorders or diseases that are part of psychosocial medicine or those in which the dynamics of the patient's social relationships play a significant role in their origin and course (Bion, 1961). I believe that the issue of addiction is undoubtedly a good example of the illnesses listed above. To achieve a comprehensive picture of not only addictive disorders, the aetiology of which is usually an amalgam of many interacting factors without the ability to reliably determine the ratio of psycho-social and bio-hereditary components (e.g., West, 2013), it is necessary to think about the system of basic assumptions both from the point of view of the mental illness (i.e., protomentally) and that of the physical illness (i.e., protophysically). According to Bion's theory, protomental and protophysical phases are states in which the physical and mental are undifferentiated. If the disease, in this case addiction, manifests itself first on the physical level, we can be sure that there is also a reciprocal psychological component that creates a natural counterpart. This reciprocal part can then be observed, for example, in the form of a basic assumption of dependence. Nevertheless, it cannot be clearly perceived as either a cause or a consequence of a physical illness (Bion, 1961).

Clinical practice confirms how difficult it is for patients themselves to postulate hypotheses about the origin of their addiction, and yet it is often impossible to avoid the impression that some patients are more similar than others. In this case, I do not mean the elemental similarities of life stories in the sense of an aggressive father-submissive mother, etc. I mean rather a way of overall behavioural self-presentation, which can be more clearly manifested in group therapy through interpersonal interactions. Their careful analysis can offer an excursion into the intrapsychic specificity of the individual. The use of the model of basic assumptions in residential treatment of addictions can be useful for mapping protomental, or alternatively protophysical precursors of the symptomatic accompaniment of this multifactorial disease. With its primary focus on the here-and-now interactions and their underlying unconscious motives, it resembles Yalom's interactional group psychotherapy (Yalom & Leszcz, 2005). From this perspective, only the confrontation with the arrogance and individualism of the members of the fight-flight basic assumption group will help provide a better understanding of the tendency to surrender and decompensation of the members of the dependence or pairing basic assumption group as a hypothetical consequence of reviving the protomental experiences of patients with e.g., an aggressive, abusive father and a helpless mother who is unable to provide the desired safety and protection against the pervasive anxiety at a given moment. The appropriately chosen interpretive strategies of the analyst can, in such moments, help restore faith in the competence of the therapist (mother), who can act as an extended ego, with which it is to some extent possible to identify within the work group, and thus support patients' curative process of building healthier self-confidence.

Since the involvement of the patient in one of the basic assumptions is not only inevitable, but also involves sharing emotions that are discrete in nature and often separate from each other, it is practically impossible for the therapist to determine why and under what circumstances one or another of the basic assumptions is activated (Karterud, 1989). I believe, in the case of residential addiction treatment, that the situation is even more complicated for at least two very practical reasons. The length of the treatment should be considered the first problem. The therapeutic space in the standard treatment length of 13 weeks seems to be too short for a meaningful detection of the prevailing basic assumptions, which, and thus I come to the second problem, can change very often, because the therapeutic group is semi-opened. Newly arrived patients significantly influence the group atmosphere, which often leads to a characteristic tendency to superficiality and rather formal cooperation. Since the arrival of new members disrupts the internal cohesion of the group, the tendency to pseudomentalise can be seen as a natural defensive reaction against the fear of external threat. Unlike pseudomentalisation as a regressive phenomenon associated with non-mentalising thinking, characterised by certainty about mental states and a disconnection between emotional experience and social cognition (Esposito et al., 2022), in this case it is an iatrogenically induced condition that does not allow any interpretation in the realm of basic assumptions.

Those above-mentioned factors explain why midterm residential treatment may not offer enough space to allow patients to embed awareness of their typical pathological characterological styles for their reliable application in everyday life. In the better case, it will become an imaginary tasting or a hint of direction, which may become inspiring for patients in any further psychotherapeutic work on themselves. In the worst case, transference anxiety, potentiated by the technically neutral attitude of the analyst, becomes all too threatening and confusing for patients in the group, as it targets the facilitation of patients' free speech and autonomy is in direct contrast to meeting the expectations and rules of the regimen treatment. If this anxiety is not sufficiently worked through, in an extreme case, the degree of resistance can lead to the consolidation of the group and its reversal against the analyst in the context of a negative therapeutic reaction (Horney, 1936). However, in my experience, this phenomenon is especially probable if the group has worked differently so far. In this context, the inconsistency of therapists in the way of leading groups, not only in terms of content, but especially therapeutic techniques, proved to be another threatening factor. While Bion's concept offers a comprehensive, theory-based interpretive framework that becomes binding on the way an analyst works, predominantly eclectic techniques that are used in integrative approaches are used randomly, often according to the therapist's current idea, and with relatively low demands on continuity. I believe both approaches can be useful in certain circumstances, but in the work reported here, their combination proved to be explosive.

To mitigate the potentially negative effects of applying Bion's model, a therapist's primary focus on protomental matrices – connected with early psychotic anxieties (Klein, 1997), rather than on interpretations of basic assumptions – is suggested for use in midterm residential addiction treatment. The therapist's capacity for empathetic echo-based reflections, resembling Prouty's Pre-Therapy (Prouty, 2007), can support the creation of a therapeutic alliance, which in subsequent therapy could help group members to see their anxieties and associated defences as understandable reactions related to, and because of, unmet developmental needs for self-object responsiveness, which are repeated in the here-and-now interactions in the group (Flores & Mahon, 1993). However, this goal seems attainable in a closed group of patients, where, in the spirit of Bion's basic "not-knowing" attitude (Simpson & French, 2001), the therapist limits him-/herself to occasional, short interventions targeting the patients' current mental states and emotions, rather than verbal contents, all this while strictly observing group boundaries, which confirms the conclusions of Esposito et al. (2022) in relation to the issue of pseudomentalisation in the group therapy of patients with SUDs.

5 CONCLUSION

In this article, I have attempted to reflect on the potential use of Bion's model of basic assumptions in patients undergoing midterm residential addiction treatment. Although this is a highly theoretical model, my experience to date confirms that the analysis of basic assumptions and associated protomental patterns can provide valuable insights into the nature of the mental and somatic symptoms with which these patients come to treatment. On the other hand, it is an approach that places high demands on both the therapist and the patient, and the question arises whether the benefit of the self-knowledge that can be obtained from this approach is proportional to the effort expended. From the point of view of clinical practice, it is necessary to keep in mind that the experience with psychotherapy is highly variable in patients entering the regimen treatment of addiction. The method of group work presented here presupposes a certain readiness for the specifics of the psychoanalytic approach, not only on the part of the patient, but also of the therapeutic team within which it is to be applied. In this regard, the short duration of the treatment, the inconsistency of the therapeutic interventions, and the semi-open format of the groups proved to be the main pitfalls of applying Bion's model of basic assumptions in this treatment format. However, if the therapist succeeds in his or her attempt to create an empathetic atmosphere of interaction that promotes understanding of the self and the self in relation to others, Bion's concept of basic assumptions, and especially protomental matrices, can lay the foundations for long-term therapy to help group members understand the ways in which their psychological vulnerability can lead to their drug use and addiction.

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REFERENCES

Bateman, A. W., & Fonagy, P. (2019). *Handbook of mentalizing in mental health practice.* American Psychiatric Publishing.

Bion, W. R. (1961). *Experiences in groups and other papers.* Tavistock.

Esposito, G., Formentin, S., Marogna, C., Sava, V., Passeggia, R., & Karterud, S. W. (2022). Pseudomentalization as a challenge for therapists of group psychotherapy with drug addicted patients. *Frontiers in Psychology, 12,* Article 684723. https://doi.org/10.3389/fpsyg.2021.684723

Flores, P. J. (2001). Addiction as an attachment disorder: Implications for group therapy. *International Journal of Group Psychotherapy, 51* (1), 63–81. https://doi.org/10.1521/ijgp.51.1.63.49730

Flores, P. J., & Mahon, L. (1993). The treatment of addiction in group psychotherapy. *International Journal of Group Psychotherapy, 43* (2), 143–156. https://doi.org/10.1080/00207284.1994.11491213

French, R. B., & Simpson, P. (2010). The 'work group': Redressing the balance in Bion's Experiences in Groups. *Human Relations, 63* (12), 1859–1878. https://doi.org/10.1177/0018726710365091

Horney, K. (1936). The problem of the Negative Therapeutic Reaction. *The Psychoanalytic Quarterly, 5* (1), 29-44. https://doi.org/10.1080/21674086.1936.11925271

Karterud, S. (1989). A study of Bion's basic assumption groups. *Human Relations, 42* (4), 315–335. https://doi.org/10.1177/001872678904200403

Kernberg, O. F. (2009). Psychoanalytic group psychotherapy: The Transference-Focused Psychotherapy (TFP) model. Weill Medical College of Cornell University [unpublished manuscript].

Khantzian, E. J. (2001). Reflections on group treatments as corrective experiences for addictive vulnerability. *International Journal of Group Psychotherapy, 51* (1), 11–20. https://doi.org/10.1521/ijgp.51.1.11.49729

Klein, M. (1997). *Envy and gratitude and other works 1946–1963.* Vintage.

Kohut, H., & Wolf, E. S. (1978). The disorders of the self and their treatment: An outline. *The International Journal of Psychoanalysis, 59* (4), 413–425.

Prouty, G. (2007). Pre-therapy: The application of contact reflections. *American Journal of Psychotherapy, 61* (3), 285–295. https://doi.org/10.1176/appi.psychotherapy.2007.61.3.285

Riegel, K. D. (2017). Transference-focused psychotherapy (TFP): On the way for change in personality organization. *Psychiatrie, 21* (2), 78–86.

Simpson, P., & French, R. (2001). Learning at the edges between knowing and not-knowing: 'Translating' Bion. *Organisational and Social Dynamics, 1* (1), 54–77.

West, R. (2013). *Models of addiction.* EMCDDA.

Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). Basic Books.