MAJOR RESEARCH PROJECT

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This project is dedicated to the memory of my grandfather

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The most inspiring, courageous and devoted person I know

SUMMARY OF PORTFOLIO

Section A provides a critical review of the literature pertinent to children's imaginary companions, including definitional issues, historical background, and prevalence. Empirical research concerning the characteristics of children who create imaginary companions is presented, followed by an overview of theories attempting to explain the development and functions of imaginary companions. Empirical research investigating the functions of imaginary companions in normative populations is then reviewed, followed by research into the imaginary companions of children from clinical populations. The review concludes by reviewing the literature into the use of imaginary companions as part of psychological therapy.

Section B provides the findings of a grounded theory study investigating clinicians' understanding of the functions and therapeutic use of imaginary companions for young people accessing Child and Adolescent Mental Health Services. Individual semi-structured interviews were conducted with ten clinicians who had worked therapeutically with a young person presenting with an imaginary companion. Two preliminary models pertaining to functions of imaginary companions, and their use in therapy are provided. The models are discussed in relation to existing theory and research. Clinical implications, methodological limitations, and directions for future research are presented.

Section C provides a critical appraisal of the research methodology and findings, and elaborates on clinical implications and future research ideas discussed in Section B.

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SECTION A

CHILDREN'S IMAGINARY COMPANIONS: A REVIEW OF HISTORICAL AND CURRENT THEORETICAL UNDERSTANDING, RESEARCH FINDINGS, FUNCTIONS AND USE IN THERAPY

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Contents

Abstract

The current review evaluates the extant normative and clinical literature on children's imaginary companions. It begins by outlining the historical context and definitional issues in the area, followed by examining the prevalence estimates for imaginary companions in the general population, and summarising the characteristics of children who create them. The review then briefly evaluates different theoretical understandings of imaginary companions. Their functions in the general population are then explored, leading to a review of the literature investigating clinical populations, including young people with diagnoses of dissociative disorders and Asperger's syndrome. Lastly, the paper reviews two studies exploring the use of imaginary companions as part of psychological therapy, and ends by highlighting directions for future research.

Search Methodology

For literature search criteria and methodology, please refer to Appendix 1.

Introduction

Imaginary companions (ICs), also known as pretend or invisible friends, are developmental phenomena, whose definition, function and prevalence have been debated in the child development literature for decades (Taylor, 1999). Although surprisingly common in young children (Pearson et al., 2001), ICs have received relatively limited research attention until recently, particularly in children experiencing mental health or developmental difficulties. The current review therefore aims to evaluate the extant literature on children's ICs, and addresses definitional and historical issues, prevalence, theoretical understanding, phenomenology and functions in normative and clinical populations, and the use of ICs in therapy.

Definitions

Svendsen (1934) was one of the first authors to publish on this phenomenon and defined an IC as: "An invisible character named and referred to in conversation with other persons or played with directly for a period of time, at least several months, having an air of reality for the child, but no apparent object basis" (p.988).

The above definition excludes types of imaginative play where an object is personified, or a child assumes the role of a person in his/her environment. One argument for this exclusion is that objects in this type of play have a physical existence independent of a child's imagination (Newson & Newson, 1968). Conversely, some authors (Taylor, 1999) have argued that toys can function as ICs, as the experience of imagining an entity is likely to be more vivid if the actual object serves as a prop (Walton, 1990). The distinction between personified objects and ICs is further blurred as parents frequently respond to their child's expression of interest in a particular animal or person by supplying him or her with a toy version of it (Taylor, 1999). With regards to ICs' reality status, most researchers agree that

children are able to recognise that their ICs are not real (Svendsen, 1934; Taylor & Carlson, 1997).

As a result of the above issues, an operational definition of ICs has not been agreed, and research in this area has suffered from the use of inconsistent definitions, with many being over-inclusive (Bouldin & Pratt, 2002). For example, some studies have included transitional objects under the definition of ICs (i.e. physical objects that are postulated to provide psychological comfort in place of the mother-child bond; Winnicott, 1953). Yet the inclusion of transitional objects may lead to inflated prevalence rates, particularly where such objects are not well-elaborated by the child.

Historical background

Early theorists debated whether ICs were developmentally normal or indicative of pathology. For example, Svendsen (1934) argued that ICs were most common in children who were lonely, sensitive, and socially inadequate with their peers. Furthermore, Cohen (1996) described that childcare books of the 1930s advised parents against permitting children to play with ICs as it was believed that they may be the first sign of psychosis. A significant limitation of these early studies was the lack of matched control groups. Since the 1960s, further, controlled research has led to ICs being viewed more positively, as a sign of creativity and mental well-being (Cohen, 1996).

The diverse opinions illustrated above have led to what Seiffge-Krenke (1997) called the 'deficit' versus 'gifted hypothesis'. According to the former, children with a deficit in social skills are especially prone to constructing ICs (e.g. Harter & Chao, 1992). In contrast, the second hypothesis proposes that particularly bright and

creative children are more likely to create an IC (e.g. Meyer & Tuber, 1989; Singer, 1961).

The following section elucidates some of these issues by outlining relevant research findings regarding the prevalence of ICs, and characteristics of children who create them.

Prevalence of ICs

In normative populations, ICs are considered a fairly common, transitory phenomenon with prevalence estimates of 46% in UK children aged 5-12 (Pearson et al., 2001). Research suggests that while the prevalence of ICs peaks at pre-school age (Meyer & Tuber, 1989), they are often present beyond early childhood and sometimes persist into adulthood (Bass, 1983). It is noteworthy that different studies have yielded considerably varied prevalence estimates, ranging from 6% (Harvey, 1918) to 65% (Singer & Singer, 1990), owing to the different definitions and methodologies used (e.g. some studies only interviewing parents about their child's ICs), and the varied age and size of samples.

The characteristics of children who create ICs

Gender and family composition.

With regards to gender, research findings consistently indicate that significantly more girls than boys report having an IC (e.g. Pearson, et al., 2001; Svendsen, 1934). Interestingly, in a study of 152 pre-school children, Carlson and Taylor (2005) found that boys were more likely to impersonate a character, than to create one. Manosevitz, Prentice, and Wilson (1973) found that first-born and only children were more likely to create ICs, which may suggest that children turn to this kind of pretend play when other play partners are less readily available.

Ethnicity.

It is noteworthy that research in this area has been mainly conducted on White-American children. One exception is a study by Mathur and Smith (2007), who investigated the nature of ICs in 43 ethnically diverse, school-aged children. The authors reported a trend for African-American children to be more likely to create ICs compared to children from other ethnic backgrounds. Furthermore, Vietnamese children were significantly more likely to report that their ICs lived in a fantasy location. This study supports the notion that ICs are an important part of the lives of children regardless of ethnicity; however the results should be interpreted with caution, owing to the relatively small sample size and uneven group distributions (i.e. 62.8% of children were from Latin-American ethnic backgrounds).

Intelligence.

While ICs are sometimes considered a sign of intelligence, research in this area has yielded inconclusive results. For example, Meyer and Tuber (1989), who researched ICs in 4-5 year olds, found that children in their sample had a mean IQ of 118 (above average), as measured by the Peabody Picture Vocabulary Test-Revised (PPVT-R; Dunn & Dunn, 1981). However, the small sample size of 18 children questions the reliability and generalisability of the results. In contrast, Manosevitz, et al., (1977), who also used the PPVT-R, found no significant differences in the IQ scores of 84 pre-school children with, and without ICs, with both groups scoring in the average range. However, the authors used parental reports for identifying ICs, which have been found to be less reliable than child reports (Taylor, Cartwright & Carlson, 1993).

Creativity.

With regards to creativity, Schaefer (1969) found that children with ICs are more creative than children without. The author measured literary creativity, in a sample of 800 adolescents, who retrospectively recalled having had an IC in their childhood. However, the retrospective nature of the study may have resulted in recall bias. Furthermore, the definition of ICs was not stated, thus relying on participants' differing understandings of these phenomena, which potentially affected the study's reliability and replicability.

Furthermore, Trionfi and Reese (2009) found that 5 ½ year-old children (n=48) with ICs, told richer narratives about a storybook and a personal experience, compared to children who did not have ICs. However, owing to the correlational design of the study, it is not possible to determine the direction of causality, or whether a third variable can account for this relation.

Conversely, Pearson et al.'s (2001) findings did not support the above assertions. The authors measured creativity in a large sample of 5-12 year old children via the *Uses Task* (Ward, 1968), which required participants to name as many possible uses for four visually-presented everyday objects. They found no significant differences in the creativity scores of participants with and without ICs.

It is clear that the studies cited above operationalised creativity in somewhat different ways, which may account for their inconsistent findings. Furthermore, they all measured creativity using verbal tasks, which may have disadvantaged younger children, or those with a poorer vocabulary.

Social competence.

Harter and Chao (1992) compared 40 pre-school children (mean age=4.26; range: 3-6) with and without ICs, on various domains of competence. The authors

found that children with ICs were rated to be less competent on social domains by their teachers. However, while teachers were blind to the specific hypothesis, they were aware of the general nature of the study. Given that many children openly talk about their ICs (Singer & Singer, 1990), it is possible that teachers had prior knowledge about their existence, thus biasing their reports.

Similarly, in a study of older, middle-school children, (n=152; mean age=12.4 years; range=11.6–14.8), Taylor, Hulette and Dishion (2010) found that those who currently had ICs, received more negative nominations from peers than children with past ICs and children who had never had an IC.

Conversely, Gleason (2004) compared the personal relationships of 88 children with and without ICs (mean age=4.5; range 3.6-5.7), defined as both those with 'invisible friends' and those with personified objects. The ratings were provided by peers with whom the child rarely played, as it was hypothesised that the child's friends were less likely to provide negative ratings.

The author found no differences in the ratings of children with ICs and those without, in terms of social competence and peer acceptance. However, children with 'personified objects' received more negative nominations than children with 'invisible friends' and controls, perhaps owing to the more visible nature of their interactions. However, Gleason's (2004) sample consisted of an unevenly small number of children with ICs (n=11), compared to those without, thus adversely affecting the statistical power of the study.

Emotional and behavioral difficulties.

Bouldin and Pratt (2002) hypothesised that children who experience high levels of anxiety may create ICs to help them deal with this emotion. They compared the levels of anxiety and specific fears in 72 children with, and without ICs (mean age=6; range: 3.2-8.7) using parent-rated measures, such as the Revised Children's Manifest Anxiety scale (RCMAS; Reynolds & Richmond, 1985). Although the parents of children with ICs reported significantly higher anxiety scores on the RCMAS, they fell within 1 SD of normative scores, and were not clinically significant. No differences with regards to specific fears were found between children with, and without ICs. One limitation of this study is that only parent-ratings of anxiety were administered. Research indicates that parent-child agreement for anxiety symptoms is often modest, which questions the validity of using these measures (Muris, Meesters & Spinder, 2003).

Taylor et al. (2010) also investigated the relationship between having an IC, and the long-term outcomes for middle-school children at risk of problem behaviours. At risk children were identified using parent, teacher and self-report ratings on the Child Behaviour Checklist (Achenbach, 1991). At the end of the six-year follow-up, children who had ICs in middle school showed greater positive adjustment on a multiple-indicator adjustment construct. However, only 13 of the 152 children had ICs, thus reducing the statistical power of the study.

In sum, findings from the normative literature point to the lack of an operational definition of ICs, varied prevalence rates, and inconclusive findings regarding the relation of ICs to intelligence, creativity, social competence, emotional and

behavioural problems. The findings also indicate that ICs are found across cultures, and are more common in girls, and only children.

Having considered the historical, definitional and phenomenological aspects of ICs, the next section turns to theories that attempt to specifically conceptualise this phenomenon, notably developmental and psychoanalytic theories.

Theoretical Understanding

Developmental Theories

Developmental theorists such as Piaget (1962) have viewed ICs as a normal part of cognitive development, connected with the capacity for symbolic play (i.e. imaginative play in which children substitute one object for another, or afford objects attributes that they do not have; Watson & Zlotlow, 1999).

Piaget (1962) proposed that pretend play can help a child assimilate reality and engage in role reversal, helping to advance perspective-taking and 'theory of mind'. More specifically, he asserted that ICs serve to help children communicate and cope with a range of difficult emotions, explore their environment, develop new skills, and support the process of individuation.

While Vygotsky (1978) did not specifically comment on ICs, he viewed pretend play as creating a zone of proximal development. He regarded fantasy play as a window into the areas of competence that a child is striving to master, but are still out of reach, or as a way of fulfilling unattainable desires.

The above theories emphasise the role of ICs in cognitive development. Notably, they have drawn their conclusions largely from researching small samples of

typically-developing children, and do not account for the reasons why only some children develop these capacities through ICs.

Psychoanalytic Theories

Psychoanalytic writers have conceptualised ICs as serving defensive functions, allowing a child to cope indirectly with difficulties and overwhelming emotions (Freud, 1968). For example, Nagera (1969) believed that they prevented problems in young children from developing into 'specific diseases' through supporting the development of autonomy and ego integration, embodying ego ideals, and enabling a child to deal with fears in an adaptive way.

Freud (1968) and Fraiberg (1995) believed that ICs served to support superego development by acting out impulses. For example, they proposed that children may internalise parental/adult values by scolding their companion for unacceptable behaviour.

Benson and Pryor (1973) adopted the theoretical frameworks of Winnicott (1953) and Kohut (1971) to propose an understanding of ICs as 'self-objects': something or someone subjectively experienced as part of the self. A 'self-object' serves a developmental function, protecting the child from 'narcissistic injury by soothing, mirroring and reflecting the child's sense of perfection' (p. 464).

In sum, psychoanalytic theories propose that, in many children, ICs are an aspect of self, symbolically located outside the self. Through interacting with ICs, a child may experiment with aspects of his/her ongoing social and emotional development, or defensively 'act out' feelings deemed unacceptable by others, or by the child's

emerging superego, thus acting as an intermediate step between external control and a fully-developed superego structure.

While these theoretical assertions are consistent with different schools of psychoanalytic theory, they have not been supported by empirical research. Furthermore, where clinical case studies have been used to illustrate theory, the nature of presenting problems was often unclear (e.g. Nagera, 1969). Where psychiatric diagnoses were stated, it was ambiguous whether the mere presence of an IC was considered sufficient to warrant diagnoses. Benson and Pryor (1973) give an example of a child who was hospitalised and consequently diagnosed with schizophrenia due to "excessive reliance on an IC" (p. 460).

Although approaching from different epistemological positions, psychoanalytic and developmental theories appear to be conceptualising the functions of ICs somewhat similarly. For example, whilst developmental theories conceptualise ICs as supporting the process of individuation, psychoanalytic theories describe their role in superego development. However, developmental theories appear to emphasise ICs in the context of cognitive development, whilst psychoanalytic theories highlight their role in social and emotional development.

Next, the research findings into the proposed functions of ICs in normative populations are outlined.

Functions in Normative Populations: Research Evidence

Much of the research in this area has been conducted by Taylor and colleagues who carried out semi-structured interviews with pre-school US children (Taylor, Cartwright & Carlson, 1993; Taylor et al., 2004; Carlson & Taylor, 2005). However,

Hoff (2005) has criticised some of Taylor's conclusions based on the questionable reliability and validity of pre-school children's self-reports. Garbarino and Scott (1992) have argued that before the age of 10, children have not reached a developmental level where their verbal accounts are as reliable as those of adults. Taylor has acknowledged that these tendencies are to be expected, and that young children are likely to create new details about their ICs every time they think about them.

Companionship

Taylor (1999) proposed that the primary reason why children from normative populations develop ICs is for fun and friendship, with companions reflecting the child's idiosyncratic interests, and often being closely modelled on playmates of the child's own age, gender, and size.

Communication

Taylor (1999) proposed that ICs may be helpful as a means of communication. Both Newson and Newson (1976) and Piaget (1962) provided examples of children using their ICs to express emotions in a way that negates their potential negative impact on others. More specifically, Piaget described a situation in which his daughter, when upset with him, would talk out loud about the mean father of her IC, Marecage: "Marecage has a horrid father. He calls her in when she's playing....her mother chose badly" (Piaget, 1962; p. 53).

Preserving Self-esteem

In line with psychoanalytic theory, ICs can serve as 'scapegoats'**,** as a way for a child to avoid blame and preserve self-esteem, whilst internalising parental expectations.

Hoff (2005) investigated the characteristics and functions of ICs in 26 ten-year-old children. In addition to functions relating to companionship and communication, Hoff elaborated on the self-esteem enhancement functions of ICs. She provided examples of children using ICs to externalise difficult aspects of self. For example, one boy who feared going to school, explained that he was unable to go, since his Gremlin IC was "too chicken" to go with him.

Integrating Aspects of Self

Some children in Hoff's (2005) study used their companions as a way to extend aspects of their personality, by having companions of the opposite gender, or with opposite characteristics. For example, one boy had two male companions with different personalities, one who was tough and rebellious with orange hair, and one who was old-fashioned and dressed in a suit and bow tie. Hoff proposed that working through the opposite characteristics of their ICs may aid children to integrate their positive and negative features into more lasting self-dispositional traits.

Competence

In line with developmental theories, Harter and Chao (1992) found that many children create ICs in order to achieve feelings of competence and mastery. For example, a child may create an IC that is helpless or incompetent, making the child feel better in comparison. Conversely, by creating a companion that is exactly the opposite, i.e. extremely competent, a child may acquire a powerful ally to bolster his/her self-esteem. Some gender differences regarding this function were found, with girls being significantly more likely to create a particularly incompetent IC, while boys were more likely to create a companion more competent than themselves. The authors proposed that these differences may reflect children's emerging awareness

of gender-role stereotypes in self-development (i.e. girls taking a more nurturing role).

Overcoming Fears and Restrictions

Taylor (1999) asserted that ICs can help children overcome specific fears: she provided an example of a child who had developed a fear of ghosts, and proceeded to create a friendly, ghost IC.

Similarly, Hoff (2005) found that some children used ICs as a means to maintain control and alleviate negative emotions in difficult or frightening situations. She presented the example of a girl who had learnt about her mother's miscarriage and 'revived' her younger sibling by creating an imaginary sister, as a way to deal with the loss.

Additionally, Taylor (1999) argued that the most central traits of an IC often relate to overcoming pervasive restrictions in a child's life. For instance, Singer and Streiner (1966) compared 20 children with visual impairments to 20 matched controls and found that almost all of the visually-impaired children had an IC who could see.

However, similar patterns have not been replicated in hearing-impaired children (Singer, 1993).

While most of the empirical studies in this area have not been explicit in their theoretical foundations, there appears to be considerable overlap with the above functions and the assertions of psychoanalytic and developmental theories, albeit expressed in different linguistic terms.

The above research suggests that feelings of incompetence, which may be difficult for children to accept, appeared to be located outside the self, and projected

into ICs, thus boosting self-concept. Furthermore, affect regulation appeared to be an important function, achieved by displacement, or by locating difficult/unacceptable feelings in ICs. Moreover, ICs seemed to be used to negotiate aspects of self-development, and the development of morality, through helping young people to internalise parental expectations.

With the above in mind, the following section of the review will explore research into the phenomenology and functions of ICs in clinical populations.

Imaginary Companions in Clinical Populations

At present, there is a dearth of research investigating the phenomenology and functions of ICs in clinical populations. Whilst a categorical separation is likely to be misleading, as many of the functions described above may also apply to children with mental health and developmental difficulties, some researchers have proposed notable differences between the ICs of clinical and normative samples (Trujilo, Lewis, Yeager & Gidlow. 1996).

The only specific clinical population where research on ICs has been carried out involves young people with a diagnosis of Dissociative identity disorder (DID): a condition in which a person displays multiple distinct identities, which regularly take control of his/her behaviour, and are associated with an inability to recall important personal information (DSM-IV-TR, American Psychiatric Association, 2000). However, research in this area is surrounded by controversy, mainly owing to the questionable reliability and validity of DID as a psychiatric diagnosis (Pope, Oliva, Hudson, Bodkin, & Gruber, 1999).

Trujilo et al. (1996) compared the ICs of 23 boys in a US residential treatment facility (mean age=10.6; median=10) to 23 controls. All of the participants had experienced severe sexual, and/or physical abuse and neglect, and six of the 23 met the DSM criteria for a DID diagnosis. The authors found both similarities and differences in phenomenology and functions reported.

The six boys diagnosed with DID reported a significantly larger number of ICs compared to controls (6.5 versus 2). Furthermore, their ICs were described as strong and powerful characters (e.g. a policeman) with complex roles, such as “keepers of memories and secrets” (p.384), and imaginary family members, including sometimes taking the role of abusers. The authors suggested that for these children, protective functions predominated, such as ICs bearing pain and abuse and helping the boys cope with life stressors. This function appears similar to the functions described in normative populations, in terms of projecting difficult emotions and experiences onto ICs, although the content of these experiences is likely to have been significantly more distressing for this clinical population.

However, differences compared to the control group transpired where the ICs of participants diagnosed with DID were described as feeling subjectively outside their control, incongruent with their wishes, and occasionally malevolent (e.g. ‘leading’ a child to self-harm). Furthermore, the boys in this sample reported that they perceived their ICs as particularly vivid, and that they often ‘slipped into’ their ICs’ personas.

One methodological limitation of this study related to the small number of participants with DID diagnoses. Furthermore, the two groups of participants were not matched in terms of demographic variables, other than age, which limits the reliability and replicability of the findings, i.e. the reported differences in the nature of

ICs may partially reflect social and cultural differences. Additionally, the above findings cannot be generalised to girls with DID. It is possible that the functions described by girls may differ, considering some of the gender differences reported previously (e.g. Harter & Chao, 1992).

Lastly, caution should be employed when interpreting Trujilo et al.'s (1996) findings, owing to the controversy surrounding DID generally, and the specific difficulty in diagnosing this condition in younger people, i.e. one of the DSM-IV-TR exclusion criteria for diagnosing this disorder in children, is that symptoms cannot be attributed to imaginary friends or other fantasy play.

Further research in clinical populations is limited to a handful of case studies of children with a diagnosis of Asperger's syndrome (Adamo, 2004), a pervasive developmental disorder, characterised by difficulties with social communication and interaction, and restricted, repetitive patterns of behaviour and play (DSM-IV-TR, APA, 2000).

For example, Attwood (2008), using clinical observations, proposed that children, particularly girls, with Asperger's syndrome, often create ICs and imaginary worlds as a substitute for real friends, and in order to feel understood and successful. Furthermore, he asserted that although the girls' interaction with their ICs may superficially resemble that of typically-developing girls, it often lacks reciprocity and is overly controlling. Additionally, Attwood (2008) stated that in this clinical population, ICs are often likely to persist into adolescence, as illustrated by the following case study, conducted in Italy.

Adamo (2004) described the psychoanalytic treatment of a 14-year-old boy with a diagnosis of Asperger's syndrome. The boy, "Salvo", was an only child, who was described by his teachers as isolated and lacking positive relationships with his classmates. His parents reportedly experienced difficulties with expressing emotions, and the family's narrative was characterised by stories of death and illness. Salvo introduced the therapist to a number of his vivid ICs who had been present since the age of eight. Interestingly, he did not mention their reality status until much later on in therapy. The author believed these characters mainly served the function of self-protection, advising and supporting Salvo in the role of superego auxiliaries. Adamo also proposed that, similarly to the functions reported in normative samples, the companions sometimes served as play partners and "receptacles for the boy's incompetent parts" (p.291).

In sum, research into the phenomenology and functions of ICs in young people from clinical populations is limited to a narrow range of presentations, namely DID and Asperger's syndrome. While the validity of research in this area is compromised by methodological weaknesses, psychiatric controversy, and the use of informal clinical observations, it highlights both similarities and differences in the functions of ICs, compared with normative populations. The main differences related to the tendency of the ICs in these clinical populations to feel subjectively out of a child's control, act against his/her manifest wishes, or be perceived as malevolent in intent.

Having considered the available literature on the phenomenology and functions of ICs in two clinical populations, the review will now examine the extant literature on their potential use as part of psychological therapy.

Use of Imaginary Companions as Part of Psychological Therapy

There are two case studies focussing on the use of ICs as part of therapy.

In the study cited above, Adamo (2004) described how Salvo's ICs often acted as protective parental figures, including at times, the therapist herself. Adamo stated that she felt confronted by a constant dilemma in therapy. She felt that the ICs performed crucial functions for Salvo by: "protecting him from an unbearable sense of emptiness, un-connectedness and deadness; they provided him with the closeness and continuity that he seemed unable to find in his relationships, but at the same time, being constantly present and under his control, they interfered with the possibility of establishing relationships with human beings" (p. 276). The therapist also reported struggling with her reluctance to challenge the reality of Salvo's companions, while also being aware of the risk of colluding with his impaired reality-testing.

As therapy progressed, and the therapeutic relationship seemed to gain importance for Salvo, his ICs faded away and were replaced by meaningful peer relationships.

This case study demonstrates the potential value of creatively utilising a child's IC as part of clinical formulation and treatment. It is illustrated by rich clinical material grounded in a specific social and systemic context. However, the interactions reported by the therapist are likely to be influenced by her psychoanalytic theoretical orientation, which may lead to bias (Yin, 1989). Furthermore, as pertinent to all case studies, the findings and therapeutic intervention described may not be appropriate, or generalisable to other clinical contexts.

The only other publication on this topic is a Japanese study on the role of ICs in promoting the psychotherapeutic process (Sawa, Oae, Abiru, Ogawa, & Takahashi, 2004). The authors presented three cases (two adults and one adolescent) whereby ICs were utilised in therapy.

The first case described a 21-year-old woman with diagnoses of conversion disorder, and bulimia nervosa. Her IC first appeared during primary school and was an older woman, who offered advice and counsel. The advice was usually helpful, however, sometimes the IC appeared to act against her wishes. In such cases, the woman reluctantly, still followed her advice. She also reported that at times, when she condemned herself for needing to see a therapist, the IC encouraged and supported her to continue to attend. During therapy, it appeared that the therapist gradually began to replace the IC in an advisory and supportive role.

The second case described a 27-year-old man with a diagnosis of conversion disorder, aphonia (the inability to speak) and an episode of partial amnesia. Similarly, his IC had persisted from childhood, first appearing after a conflict with his father. In the therapeutic relationship, the IC reportedly acted as an intermediary between the therapist and patient, and articulated thoughts that the patient had suppressed or was unable to express directly.

The third case involved a 15-year-old girl diagnosed with conversion disorder. As a young child she had reportedly begun to suppress her feelings of anger when scolded by her parents. In this instance, the IC was not benevolent and appeared to urge the girl to hurt herself and others. Although she had attempted to refuse to follow the IC's instructions, she was often unable to resist, and as a consequence had self-harmed. The therapist was able to obtain insight into the emotions she had

difficulty expressing, by closely examining the characteristics of her IC. When the therapist empathised with, and validated her emotions, the girl was able to draw parallels between the IC's behaviour, and her own feelings of anger.

While this study highlights the explicit use of ICs as part of the therapy process, two of the illustrative cases were based on work with adults, and all of the psychological problems described were severe, dissociative disorders.

Finally, the two studies described above illustrate single cases outside the United Kingdom. While their results may not be generalisable to other populations and cultures, they highlight the potential benefit of incorporating ICs as part of psychological therapy. Furthermore, the studies also raise the possibility of using ICs to evaluate treatment outcome: i.e. as the clients in these cases were able to use therapy to re-integrate externalised aspects of self, their need for ICs seemed to diminish.

Summary and Future Directions

This review presented a synopsis of the available literature on ICs, highlighting the historical context, and lack of operationalised definitions. Different theoretical understandings of ICs, drawn from the mainstream developmental and psychoanalytic literature were also evaluated.

The normative literature regarding the characteristics of children who create ICs pointed to mixed findings, with many studies emphasising similarities, rather than differences in children with, and without ICs, resulting in lack of clarity about what leads a child to develop an IC. Studies from normative populations suggested that ICs are fairly common in young children and can serve a number of useful functions,

such as companionship, affect regulation, projection of unacceptable aspects of self, and communication of difficult emotions and experiences.

With regards to clinical populations, the review highlighted the methodological and conceptual limitations in the extant literature, and lack of consistent, and integrated theoretical understanding of the roles that ICs may play in young people experiencing mental health and developmental difficulties. Furthermore, while the review highlighted a number of similar functions to normative populations, some of the findings indicated that the ICs of young people from clinical populations may be qualitatively different: more vivid, feeling subjectively out of a child's control, and acting against a child's wishes, occasionally in an overtly hostile way.

Lastly, while ICs seem to be a relatively common childhood phenomenon, literature on their potential use as part of assessment, formulation, treatment and evaluation of psychological therapy is particularly sparse. Nonetheless, the two case studies presented indicate that utilising ICs as part of the therapeutic process may be clinically useful, firstly in understanding the nature of a client's difficulty, and secondly, through incorporating them into the therapeutic process as a presence to support psychological growth.

The following areas for further research arise from this review:

1. Prevalence of ICs in children from different clinical populations.

   This area of research could identify whether ICs are more common in children experiencing difficulties, and whether particular psychological problems increase their likelihood.

2. Roles/functions of ICs in young people from clinical populations.

This area of research would identify overlap and differences of functions between young people from normative populations, and those experiencing psychological or developmental problems. This may inform clinical assessment, formulation, and future interventions.

3. The potential therapeutic role of ICs in clinical practice.

Specifically, clinicians' understanding and incorporation of ICs in their practice, children's responses to this, and the impact of utilising ICs as part of the therapy process, warrant further investigation.

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MAJOR RESEARCH PROJECT

SAVINA WACHTER, BSc Hons

SECTION B

EMPIRICAL PAPER

IMAGINARY COMPANIONS: CLINICIANS' OBSERVATIONS OF THEIR FUNCTIONS AND USE IN THERAPY WITH YOUNG PEOPLE REFERRED TO CAMHS

WORD COUNT: 7992

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

Contents

Abstract

Imaginary companions represent a common childhood developmental phenomenon, to date, largely neglected in the clinical literature. The present grounded theory study investigates the functions and therapeutic use of imaginary companions in a clinical population, by interviewing clinicians working therapeutically with young people accessing Child and Adolescent Mental Health Services. Participants were 10 UK clinicians, most practising as child clinical psychologists. Clinicians reported that imaginary companions served a number of fundamental functions, including serving as a communication aide, a secure attachment figure, proving mastery over a child's world, and acting to maintain stability in the environment, and in a child's self-image. Imaginary companions were utilised by most clinicians as part of engagement, and to gain insight into young people's difficulties. Depending on their salience, and congruence with young people's self-image, imaginary companions were used as therapeutic allies, to aid perspective-taking, and as a way to manage the intensity of interactions with clinicians. Imaginary companions were not therapeutically utilised by a sub-section of clinicians, owing to their perceived low salience, and to clinical risk issues. The findings are discussed in relation to existing theory and research, and methodological limitations, implications for clinical practice, and directions for future research are provided.

Introduction

Definition and Historical Context

While many children engage in pretend play, and may endow a toy with a stable personality, some young people[1] create imaginary companions (ICs). Svendsen (1934) defined an IC as an invisible character, with whom a child regularly interacts, but which has no apparent reality basis. The above definition excludes imaginative play where an object is personified, or a child assumes the role of someone in his/her environment. Although some authors (e.g. Taylor, 1999) have argued that objects can sometimes serve as ICs, in order to avoid over-inclusion, the present study utilises Svendsen's (1934) definition.

The extant literature is characterised by a lack of consensus regarding the definition, function and prevalence of ICs (Taylor, 1999). Early theorists were divided as to whether ICs were developmentally normal or indicative of pathology. Since the 1960s research has led to ICs being viewed as a relatively benign and common childhood phenomenon (Cohen, 1996). In fact, a large-scale UK study found that 46% of children aged 5-12 reported having an IC (Pearson et al., 2001).

Characteristics of Children Who Create ICs

Research regarding the characteristics of children who present with ICs has yielded mixed findings. For example, some studies have found that children with ICs are more intelligent and creative (Meyer & Tuber, 1989); whereas others have failed to replicate these findings (Pearson et al., 2001).

[1] Henceforth, for the purpose of this paper, the terms 'children' and 'young people' are used interchangeably

Research findings seem more consistent in terms of gender and family structure: ICs appear to be more common in only children (Manosevitz, Prentice, & Wilson, 1973), and in girls (Carlson & Taylor, 2005).

Theoretical background

Developmental theories.

Developmental theories have conceptualised ICs as a normal part of cognitive development, associated with the capacity for symbolic play.

Piaget (1962) believed that pretend play can help children assimilate reality and engage in role-reversal, helping to advance perspective-taking and theory of mind. He also proposed that ICs serve to help children communicate, cope with difficult emotions, develop new skills, and support the process of individuation.

While Vygotsky (1978) did not specifically comment on ICs, he viewed pretend play as creating a "zone of proximal development", i.e. a window into the areas of competence that a child is striving to master; or a way of fulfilling unattainable desires.

Notably, the above theories have drawn their conclusions from researching small samples of typically-developing children, and do not account for why only some children develop these capacities through ICs.

Psychoanalytic theories.

Psychoanalytic writers have conceptualised ICs as serving primarily defensive functions (Freud, 1968), and supporting superego development (Fraiberg, 1995). Furthermore, Benson and Pryor (1973) adopted the theoretical frameworks of

Winnicott (1953) and Kohut (1971) to propose an understanding of ICs as 'self-objects', functioning to protect children from 'narcissistic injury by soothing, mirroring and reflecting the child's sense of perfection' (p. 464).

Interestingly, ICs appear to have been neglected in attachment theory (Bowlby, 1969). However, in object-relations theory, parallels may be drawn between ICs and transitional objects - physical objects postulated to provide psychological comfort in place of the mother-child bond (Winnicott, 1953). Thus ICs may be understood as constructs through which a child can experience love and containment without the threat of separation (Burlingham, 1945).

The above theoretical assertions have generally not been supported by empirical research evidence. Where clinical case studies have been used to illustrate theory, the nature of children's presenting problems/diagnoses have not been well defined (e.g. Nagera, 1969).

Functions of ICs in Normative Populations

Research into the functions of ICs in children from normative populations suggests that they can serve a number of beneficial functions. Taylor (1999) proposed that the primary reason why children develop ICs is for friendship, with ICs often reflecting a child's idiosyncratic interests. ICs have also been found to help children achieve feelings of competence and mastery (Harter & Chao, 1992).

Additionally, Taylor (1999) found that ICs are used to practice recently acquired knowledge and social skills. Children may also use them as a way to avoid blame and maintain self-esteem, whilst internalising parental expectations (Hoff, 2005). Hoff also provided examples of children using ICs to both express, and alleviate difficult emotions.

Functions of ICs in Clinical Populations

There is a dearth of research investigating the functions of ICs in clinical populations. Whilst a categorical separation is likely to be misleading, some researchers have proposed notable differences in the functions of ICs between clinical and normative samples (Trujilo, Lewis, Yeager & Gidlow, 1996)

The only clinical population, in which research on ICs has been carried out, is with young people with a diagnosis of Dissociative Identity Disorder (DID). Trujilo et al. (1996) found that boys diagnosed with DID described their ICs as powerful characters with complex roles, who never functioned solely as playmates. Protective functions were found to predominate, such as ICs bearing pain and abuse. Conversely, some ICs were perceived as feeling subjectively outside of participants' control, and were occasionally malevolent.

Caution should be employed when interpreting Trujilo et al.'s (1996) findings, owing to the small sample size, and the questionable reliability and validity of diagnosing DID in young people (Pope, Oliva, Hudson, Bodkin & Gruber, 1999).

With regards to other clinical populations, research is limited to a handful of case studies and clinical observations of children with a diagnosis of Asperger's syndrome (i.e. Adamo, 2004). Attwood (2008) proposed that children with this condition often create ICs as a substitute for real friends, owing to social communication difficulties.

Use in Therapy

Adamo (2004) described the psychoanalytic treatment of a 14-year-old boy with Asperger's syndrome (AS), whose ICs were hypothesised to serve the function of superego auxiliaries, protective parental figures, and repositories for his "incompetent parts" (p.291). As treatment progressed, and the therapeutic

relationship seemed to gain importance, the ICs reportedly faded away and were replaced by meaningful peer relationships.

Sawa, Oae, Abiru, Ogawa and Takahashi (2004) reported on the treatment of two adults and one adolescent, where ICs were directly utilised by therapists to promote the psychotherapeutic process. In one case, the IC acted as an intermediary between the therapist and patient, whilst in another, examining the characteristics of the IC facilitated insight into the patient's difficulties.

Although inherently limited in terms of generalisability, these case studies raise the possibility of using ICs to gain insight into clients' difficulties, and as a possible measure of treatment outcome: i.e. as clients re-integrated externalised aspects of self through therapy, the need for their ICs seemingly diminished.

Rationale for the Present Study

The extant literature is characterised by a paucity of research, and lacks an integrated theoretical understanding of the roles that ICs play in the psychological development of children from clinical populations. While there appears to be some overlap with normative populations, the findings indicate that the ICs of young people from clinical populations may be qualitatively different.

Furthermore, literature on ICs' use as part of psychological therapy is particularly sparse. Nonetheless, the two case studies presented indicate the potential utility of incorporating ICs as part of the therapeutic process.

The present study aimed to investigate the functions and therapeutic use of ICs for young people accessing Child and Adolescent Mental Health Services (CAMHS), through conducting interviews with clinicians. Although a quantitative approach may

be useful in the future, the dearth of extant literature indicates that a qualitative method may be an appropriate initial step in adding to the research base. It is hoped that the findings would facilitate the development of theoretical knowledge of the functions of ICs in young people experiencing mental health and developmental difficulties, as well as inform clinical practice with regards to working therapeutically with this phenomenon.

Research Questions

The present study aims to address the following research questions:

1. What are clinicians' hypotheses regarding the functions of ICs for young people receiving psychological therapy?
2. What are clinicians' experiences of utilising ICs in therapy?
3. How does the use of ICs appear to impact on the course or conduct of therapy?
4. What are clinicians' observations regarding the transformation of ICs, in terms of function and salience, during the course of therapy?

Method

Participants

Participants comprised 10 UK clinicians with 1.5-30 years of experience working with young people. Most were practicing as Child Clinical Psychologists and two as Systemic Therapists. Participants' demographic data (Appendix 2) and information regarding corresponding cases discussed during interviews (Appendix 3) are appended, in order to situate the sample.

Ethical Considerations

Ethical approval for the study was granted by the *Canterbury Christ Church (Salomons) Research Ethics Committee (*Appendix 4). The study adhered to the British Psychological Society (BPS) and Health Professionals Council (HPC) code of ethics and conduct (BPS, 2006; HPC, 2004).

Design

The study adopted a non-experimental, qualitative design using a semi-structured interview schedule. Semi-structured interviews consist of open-ended questions, and allow new questions to be asked, following an interviewee's response. This interview method facilitates the generation of rich data, required for grounded theory (GT; Charmaz, 2006), the chosen methodology for this study.

Procedure

Participants were recruited through placing adverts (Appendix 5) on the mailing lists of a number of professional forums: the Paediatric Psychology Network; the Association of Family Therapists; the British Association of Child Psychotherapists; the Clinical Psychologists working with Looked-after and Adopted Children National Network, and the British Association of Play Therapists. The researcher also e-

mailed the study advert to Child Psychotherapists and Child Clinical Psychologists whose details were published on the BPS website.

Interested clinicians, including those who did not meet the criteria to participate (i.e. those who had not worked with a child presenting with an IC in the last 5 years), were invited to distribute the study advert to other clinicians, as part of a snow-ball sampling strategy (Coolican, 2009). Participants were interviewed either face-to-face or via telephone.

To ensure confidentiality, cases were discussed without revealing identifying information and pseudonyms were used to preserve anonymity. Where clinicians were interviewed about current cases, they sought verbal consent from parents before agreeing to participate.

To ensure informed consent, the purpose and procedure of the study were discussed, and participants' right to withdraw at any time was highlighted (Informed consent form: Appendix 6).

The interview schedule was based on the research questions (Appendix 7) and each clinician was interviewed about a single case. A pilot interview was conducted with one participant, who commented on the language, structure, and content of the interview. Feedback was positive and the questions were reported to adequately address the research topic.

Each interview lasted between 30-45 minutes. All interviews were audiotaped and transcribed by the principal researcher. Although most questions remained similar throughout the interviews, some were adapted in accordance with GT methodology.

Following each interview, additional questions were answered, and participants were provided with a Debriefing Form (Appendix 8).

Data Analysis

Data were analysed using constructivist GT (Charmaz, 2006), which emphasises the subjective interrelationship between researcher and participant, and the co-construction of reality and meaning (Pidgeon & Henwood, 1997). Qualitative methods are considered suitable in exploring areas about which little is known (Stern, 1980). GT, with its focus on theory generation, seemed relevant for the present study, considering the paucity of research, and limited theoretical conceptualisations of ICs in clinical populations.

Coding in GT links raw data with theory generation (Charmaz, 2006), and consists of three main stages:

1. Line-by-line or incident-by-incident coding. To ensure understanding and immersion in the data, the first four interviews were coded line-by-line.

2. Focussed coding, where the most salient codes developed from the first stage were placed into broader codes. Constant comparison of codes was carried out to ensure the data were coded correctly (Charmaz, 2006).

3. Theoretical coding, which allowed the researcher to begin relating codes to each other (Charmaz, 2006) and develop a theory from the data. Throughout the process, memos were written and used to inform the theory development (Appendix 9).

Quality Assurance

Extensive quotations from participants' transcripts are used throughout the results section, thus increasing the credibility of data (Williams & Morrow, 2009). Where material has been omitted, blank square brackets are used. Numbers (Participant 1-10) are used to identify participants' quotations.

Respondent validation (Appendix 10) was obtained through e-mailing a summary of the results to participants (Appendix 11), to determine whether the emerging theory was representative of their interviews.

Research supervisors were consulted regularly, and cross-checked the coding of transcripts, and generation of the resultant GT. A colleague of the researcher coded a section of an interview transcript to provide an independent audit of the coding (Elliott, Fischer, & Rennie, 1999). No major discrepancies were found.

The researcher kept a reflective diary (Appendix 12), and sought to maintain awareness of how her previous experiences working with children, although helpful in sensitising her to the data, could also mean that she shared some of participants' assumptions.

Results

IC Functions

All categories, sub-categories and related codes are listed in Appendix 12.

Figure 1:Clinicians' views of IC functions

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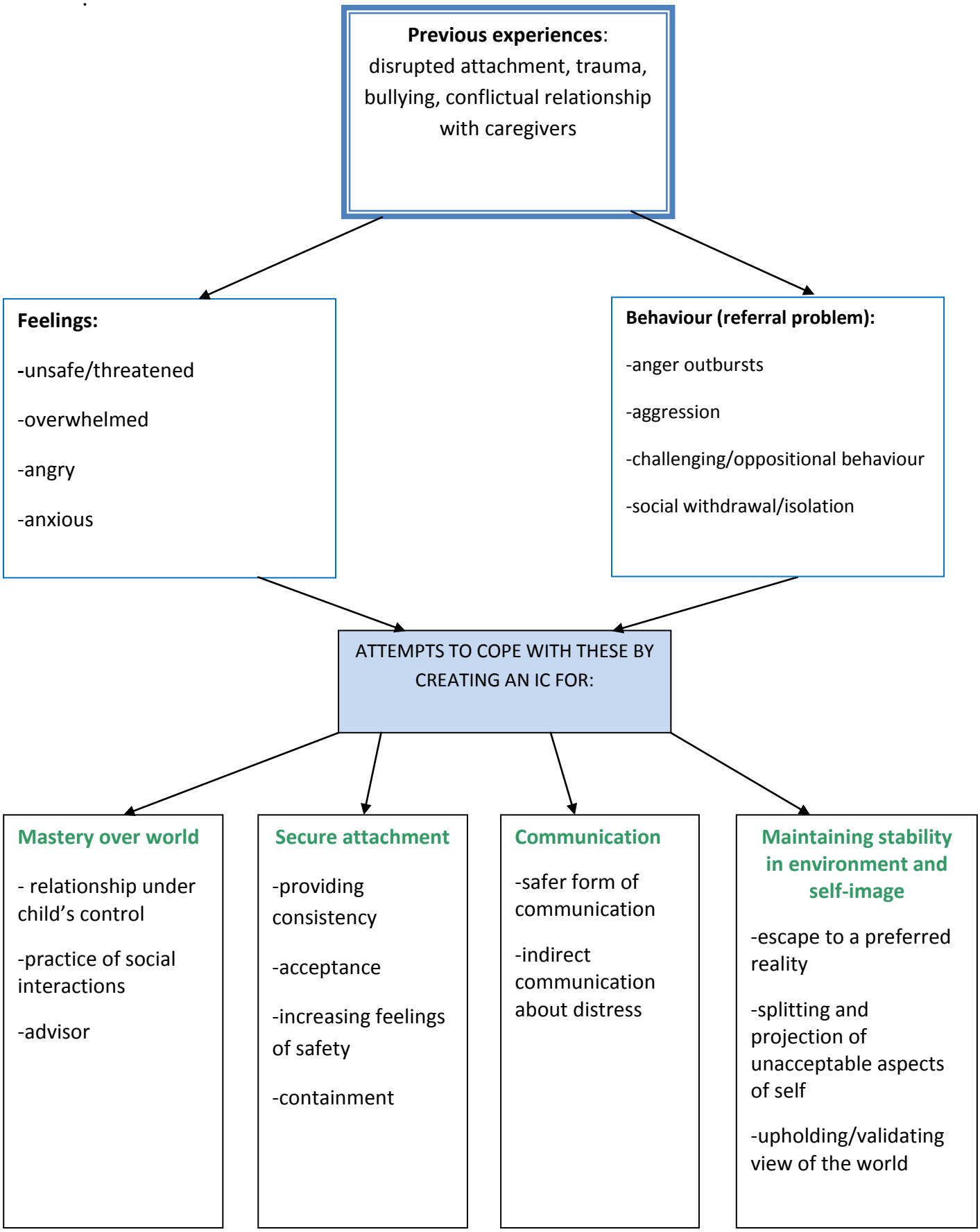


Summary of model.

Figure 1 summarises the model of ICs' functions developed from the GT analysis of clinicians' responses. The model attempts to bring together the relationship between young people's early experiences, resultant problematic emotions and behaviours, and the creation of an IC, as an attempt to cope with these difficulties. This was achieved through ICs serving as communication aides; secure attachment figures; supporting children to gain mastery over their world, and maintaining stability in an otherwise chaotic environment, and consistency in self-image. The model and specific examples of each category are presented below.

Creation of ICs.

Many young people had reportedly experienced separation from their parents, due to *parental physical, mental illness*, *substance abuse*, or *domestic violence*; and some spent significant time in *foster care*. Clinicians hypothesised that these experiences had led to young people *feeling unsafe*, *anxious, angry*, and resulted in problematic behaviours such as *aggression* and *isolation* from peers. The creation of ICs appeared to be one key way of coping with these difficulties.

The ICs in this sample were not based on toys, or well-known fictional characters, but appeared to be creatively engineered to meet the specific needs of a child (Appendix 3: number and forms of ICs): In most cases, the IC's characteristics and functions seemed directly related to the difficulties experienced. For example, an 8-year-old boy, who had changed numerous foster placements, had constructed the following protective character:

"He had blue hair...and was a big, furry and cuddly character...he listened to the child and sounded like a comforting character...kind of like a safe haven." (Participant 7, line 43-45).

In most cases ICs were reported to play a central part in young people's lives:

"They were present in every context. They were in the classroom with her. She spoke to them on the way to school [], when she got home they would be there. They were here in the therapy room... [] they were around all the time" (Participant 2, line 95-98).

The main categories relating to functions of ICs, as identified by clinicians, are described in the following section.

Function 1: Mastery Over the Child's World.

Many young people's ICs reportedly served to provide mastery and control over an environment lacking in predictability. The sub-categories relating to this function are described below.

IC providing a relationship under the child's control.

Several children had experienced unsuccessful social relationships. They appeared to cope with feelings of confusion and inadequacy by creating a relationship with their IC, which was affirmative, predictable, and under their control:

"She was very lonely, very isolated. [] She struggled in how to make friends, so her socialising skills were perhaps a bit lacking. She said that the ICs always did what she wanted them to do. I guess it's not so easy with real friends... but she very much wanted to be in control" (Participant 2, line 203-207).

Practicing Social Interactions.

A related role, particularly for children with communication difficulties, involved practising desired social situations. Their interactions with ICs appeared to function as a means of learning social rules and achieving mastery over social interactions, which were otherwise difficult to manage. Furthermore, they seemed to be an imaginative compensation for feelings of failure with peers. For example, a 5-year-old girl meticulously planned and practiced tea parties with her IC, 'the Ball':

> *"There was a lot about parties, having a party with the Ball...talking to it about who she'd invite from class and who she wouldn't invite, depending on how things were going at school. But the Ball was always invited to the party and a part of the planning stage"* (Participant 3, line 34-38).

Advisor.

Another sub-category relating to mastery, involved ICs acting as advisors, offering guidance and counsel, in situations where an adult role model was not available. In the following quote, a clinician describes the IC of a 10-year-old boy, who had difficulties relating to his parents:

> *"He was not an adult friend...but a mature, sensible voice that helped him to feel safe, but also one that he would listen to... like another voice that was not his parents, but was sensible"* (Participant 10, line 83-85).

Function 2: Secure attachment figure.

Several young people were looked-after, or had relationships with their caregivers which did not appear to provide stability and safety. Thus, one of the most frequently reported roles of ICs appeared to be that of an attachment figure.

Providing consistency.

Many young people's environments were characterised by chaos and unpredictability, for example, owing to frequent changes in caregivers. In such cases, clinicians reported that an IC seemed to function as an externalised other, a consistent figure upon whom the child could rely:

> *"He was moving from placement to placement, with a sort of sense of him being rejected or abandoned repeatedly by both his parents and subsequent foster placements. Bob (IC) was one of the few stable things in his life, [] perhaps unlike his parents. In fact, he was the complete opposite, always there when he needed him, like a shadow almost"* (Participant 7, line 32-37).

Providing Unconditional Acceptance.

The majority of young people appeared to have experienced rejection, or lack of understanding from their caregivers, peers, and at times, professionals. The following quotes provide examples of ICs serving as unconditionally accepting figures:

> *"He was there for him no matter what he did or said."* (Participant 6, line 108).

> *"Mum didn't know how to be with her, play with her, didn't know how to...be a mum really. So I feel that was their role...somebody for her, who accepted her, because she didn't have anybody, in that way"* (Participant 2, line 216-218).

Increasing feelings of safety.

In some cases, ICs functioned to help young people feel safe and protected, by being vigilant for signs of danger in their environment. One 10-year-old boy, who had

experienced severe bullying, had an IC with large eyes and ears, who lived in the walls:

> *"He was quite a useful little companion for him, because it was an extra pair of eyes and ears for him".* (Participant 10, line 58-60).

Containment.

For some children who had had traumatic experiences, ICs seemed to serve as 'containers' for distress and anxiety, by assuming the child's difficult emotions without becoming overwhelmed, and communicating them back in a validating way. In the following quote, a clinician describes the IC of a boy who had experienced domestic violence and possible sexual abuse:

> *"He had been around since the domestic violence, and was there for him as someone to witness what he was witnessing, alongside him. [] I guess the IC was... someone who shared his distress, maybe someone who validated his reaction to what had happened"* (Participant 6, line 122-125).

Function 3: Communication.

Many clinicians reported that ICs served to aid communication. The relevant sub-categories are expanded below.

Expressing difficult emotions in a safer way.

Clinicians reported that young people often used their ICs to express emotions, perceived to be unacceptable, by projecting them on to their IC. A clinician hypothesised about the function of a girl's 7-year-old 'ghost' IC:

> *"Because the IC was at an age when this girl was in care, the IC was talking about things that she wouldn't have said herself []. It was allowing her to*

express angry feelings, and the loss, confusion and pain she was in...It made it safe for her" (Participant 5, line 79-83).

Indirect communication about distress/difficulties.

Clinicians reported that children used their ICs to communicate indirectly about the difficulties they were currently experiencing. One 10-year-old girl, who had a conflictual relationship with her mother, and was bullied at school, talked about her IC, 'Susan', during therapy:

"... [] she pointed that Susan was up there, on the light. And then there was this silence, and she went over, and banged the chair with her hands, and she said sadly: 'Susan has fallen off the light, she's fallen down and she's dead. It's because all these nasty people were coming after her. And [] Susan's mummy, didn't look after her, didn't protect her, didn't care for her.' She stared at the chair, it was so...dramatic!" (Participant 2, line 128-142).

Function 4: Maintaining stability in environment and self-image.

This category involved young people utilising ICs to escape to an imaginary world, when their reality appeared to be unbearable; to maintain a stable self-image, or to validate their view of the world.

Escape to a preferred reality.

Several children, whose life circumstances were unendurable and distressing had created ICs, in order to 'escape' into a preferred reality:

"She was left to her own devices a lot [], so she created these companions...sometimes I thought because her real world was so...difficult []. So

she escaped to this imaginary world, with these imaginary people, where she could do the things she wanted to do, be how she wanted to be, and nobody would give her a hard time. [] I guess that way, she didn't have to think so much about her real world and things she wasn't happy about" (Participant 2, line 222-228).

Splitting of unwanted parts of self and acting out unacceptable impulses.

Many children reportedly used ICs as a repository for all the personal qualities and emotions that they perceived to be unacceptable, thereby seeking to preserve a benign sense of self, with difficult aspects located outside the self. At times ICs acted out aggressive and destructive wishes, so that the young person would not have to take responsibility for the consequences. Some clinicians perceived this function as maintaining the child's difficulties, and a barrier to solving their difficulties:

"She mentioned a ghost, a little 7 year-old girl, and that the ghost was telling her to do these things, like hit her little brother. [] It was splitting off a part of herself, not allowing her to work through some of the angry feelings that she had, I guess she felt it wasn't safe to do that herself" (Participant 5; line 91-95).

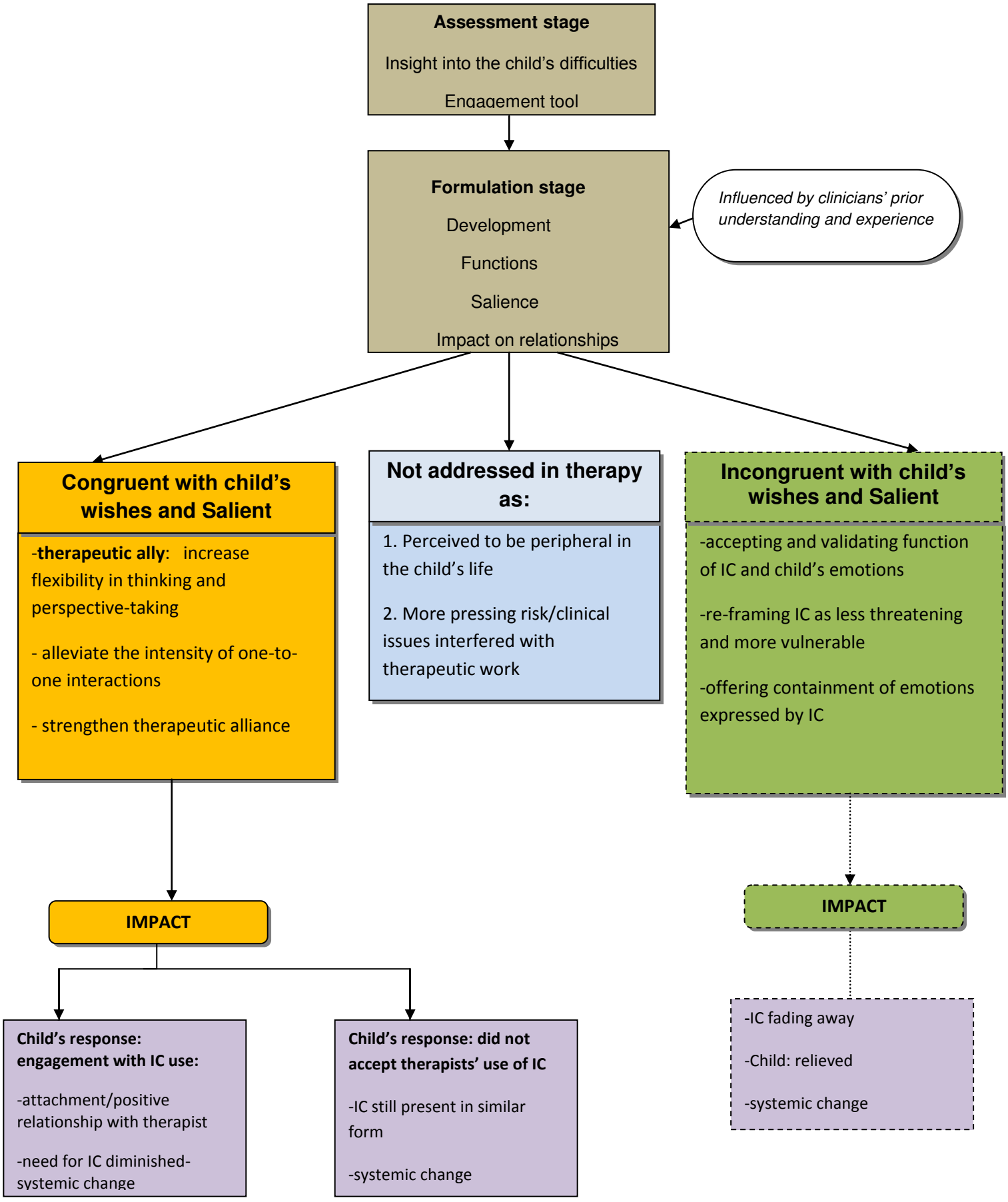
Validating the child's view of the world.

Clinicians reported that some ICs appeared to serve the function of upholding a child's view of the world and validating his/her actions. For example, a 10-year-old girl had created an IC poodle called 'Cherry', which acted to confirm her negative views towards men:

“Well, her main problem was this hatred towards men and boys. And Cherry had said some things about boys to her, validating her negative view and justifying being mean to them....her belief that men were really bad was reinforced by the actions of Cherry and the other poodles, who went on killing them” (Participant 1, line 93-98).

Use in Therapy

Figure 2: Clinicians' experiences of IC use in therapy



Summary of model.

Clinicians reported using ICs as a way of engaging young people and gaining an insight into their difficulties. Consequently, clinicians appeared to build hypotheses around ICs' initial creation, functions, salience, and systemic impact, which influenced the decisions about utilising ICs in therapy. In sum, when ICs were hypothesised to be salient in a child's life, clinicians incorporated them in therapy. In cases where ICs were assessed to be benign and congruent with a child's self-image, they were used to aid perspective-taking, communication and establish a positive therapeutic relationship. Conversely, when an IC was incongruent with a child's wishes/self-image, the clinician validated and re-framed it as a less threatening figure.

The following section elaborates upon the preliminary model of ICs' use in therapy.

Assessment.

Most clinicians had prior knowledge about a child's IC, either through discussion with parents, or from information specified in the referral letter. Thus, several clinicians reported addressing ICs as part of assessment:

Engagement tool.

Clinicians stated that engaging some children in therapy would have been challenging, if not impossible, had they not initially expressed interest in their ICs. Some clinicians did this by including ICs in young people's genograms.

One clinician described her difficulties engaging a girl diagnosed with AS, who initially did not respond to questions, or make eye contact, unless she was asked about her imaginary poodle world:

"It was quite clear from the first session that we needed to work with the poodles to work with her. It was the only way to engage her, so I remember hanging on to it very quickly" (Participant 1, line 136-139).

Insight into a child's difficulties.

Clinicians reported that asking questions about young people's ICs facilitated a better understanding of their difficulties. In the following quotes, a clinician describes the insight she gained through a girl's drawings of her imaginary poodle world:

"Because she didn't have many friendships, it was about relating to the poodles and learning about her social world from them" (Participant 1, line 143-146).

The girl reportedly had difficulties accepting that she was entering puberty, which were also elucidated through her IC drawings:

"She was developing sexually quite early...It was quite painful for her to accept. [] Our first inkling about it was when she drew 'Cherry', and on her dress, there were heart patterns, which were quite strategically placed, and covered particular body parts" (Participant 1, line 121-125).

Formulation.

The majority of clinicians utilised young people's ICs to hypothesise about their presenting problems. More specifically, they considered:

a) how the need for the IC had arisen, and whether it was dynamically related to a particular event in the child's life:

"There had been particular crises in the family, physical illness, hospitalisation...[] which meant that the girl had to spend periods of

separation with the grandparents, and I realised that this coincided with the development of the IC" (Participant 9, line 29-33).

b) The roles/functions of an IC, as described in the previous section.

c) The salience of an IC in a young person's life:

Clinicians' decisions about the level of involvement of ICs in therapy seemed, in part, influenced by their formulation regarding their salience in a child's life.

d) The impact of a young person's interaction with their IC on other relationships:

Several clinicians reported taking into account the systemic impact of a child's relationship with their IC, which informed their use in therapy:

"It became an issue between her and her mum. Her mum would be telling her to stop having the ICs []. So there was a lot of conflict between them about it. Even walking to school in the morning, her mum would get irate with her, because she was talking to the ICs" (Participant 2, line 233-237).

Influence of clinicians' previous experiences with ICs on formulation.

Clinicians' formulations appeared to be influenced by their previous experiences of ICs, either relating them to their own children's ICs, or to having had one personally. Based on these experiences, several clinicians reported perceiving ICs as "*pretty innocent*", and something that *"fades when it's no longer useful"*.

Some clinicians' previous experiences, however, led them to consider ICs to be quite rare:

"In my experience most children do not present with ICs" (Participant 8, line 29).

The perception of ICs as a rare phenomenon appeared to relate to less positive expectations about their roles, and some apprehension about how a child with an IC would present:

> *"I remember thinking, I don't know very much about this"* (Participant 2, line 68).

> *"I thought ok, what are we going to get here!"* (Participant 4, line 55).

Intervention.

Whether, and how, clinicians utilised ICs appeared to depend on the perceived salience of an IC, its congruence with a child's wishes, and clinical risk issues.

IC not addressed in therapy.

Three clinicians reported that they did not attempt to utilise a child's IC as part of interventions. When it was hypothesised that an IC was not particularly salient for a child, it was less likely to be involved in therapy:

> *"I think I would have used him more, had the boy brought him more obviously to work with. I would only use it, if it became apparent that it was quite prominent".* (Participant 8, line 108-111).

A further reason related to the complexity of a case, particularly where child protection issues were at play. These took priority over the therapeutic work, and therefore the IC's involvement:

> *"I didn't go into it as much as I wanted to, as there were safeguarding issues, which were more pressing."* (Participant 4, line 178-180).

IC: Salient and benign.

Six clinicians formulated ICs as salient, and congruent with a child's self-image. In such cases, ICs were incorporated in therapy as follows:

Fostering trust through acceptance of IC.

The ICs of several children were perceived negatively by others in their system. They were often described as an *"area of conflict for the family",* or a *"cause for concern"* by schools. Some parents forbade their children to interact with their ICs, particularly at school, owing to concerns about ridicule from their peers. It appeared that clinicians took a contrasting approach to young people's ICs, by showing curiosity and acceptance:

> *"I don't know if it made it easier for her because I was happy for them to be there. Whereas her mum was very clear: 'You don't talk about them, you don't talk to them![] She loved coming. I think therapy was a safe place where she could talk about her ICs, and be accepted for having them"* (Participant 2, line 191-195).

This approach seemed to foster trust in clinicians, allowing opportunities for further use of ICs.

Therapeutic Allies.

ICs were often utilised as therapeutic allies to help young people increase their flexibility in thinking, generate alternative responses, or aid perspective-taking:

> *"What does Billy (IC) think about this?"* (Participant 6, line 87).

> *"If you were stuck, could you ask Toby (IC) what you could do?"* (Participant 10, line 98-99).

ICs were also used as a bridge between the child and the clinician, allowing them to address issues indirectly:

> *"We would ask the young girl, before she settled down to play with this little companion, whether she could convince her that maybe tidying the room might be a good idea."* (Participant 9, line 138-141).

Managing the intensity of interactions.

Several young people in the sample had difficulties with social communication. Clinicians reported using children's ICs to alleviate the intensity of interactions, by directing questions to the companion:

> *"Billy (IC), how do you think 'Johnny' (client pseudonym) would feel about spending the next session in the play room, without his mum?"* (Participant 6, line 141-143).

Impact.

The impact of ICs' use on therapy outcomes seemed to depend upon the extent to which young people engaged with the particular strategies employed by clinicians.

Not accepting clinician's use of ICs.

In some cases, young people spontaneously discussed ICs; but did not engage with clinicians' specific attempts to involve ICs in therapy:

> *"She found it hard when I tried to bring them in []. Sometimes when you are working with children, you try to get them to take a different perspective, like: "What would your friend do?" But when I said that to her, she'd [] say: "Oh but they are just imaginary!"* (Participant 2, line 247-252).

In cases where young people did not accept clinicians' attempts to utilise their IC, the salience, and function of the IC did not change in any significant way through the course of therapy. However, it is important to emphasise that the presence of the IC at the end of therapy was not perceived as a negative outcome by clinicians, and some would have considered an IC's 'disappearance' to be detrimental for a child's well-being:

> *"I wouldn't have wanted to 'kill off' the Ball in any sense, as I saw it as serving a very useful function."* (Participant 3, line 169-170).

In cases where children did not engage with clinicians' use of their ICs, the focus of interventions involved addressing the systems around the child.

Systemic change.

Several clinicians reported that a significant aspect of their role involved supporting the systems around young people. Some described liaising with families and school, which resulted in a better understanding of the child' behaviour and improved relationships:

> *"I don't know if I could hand-on-heart say that anything meaningful changed about her, I think other people's way of relating to her changed."* (Participant 1, line 230-232).

In one case, family liaison resulted in a parent, who had recently experienced bereavement, seeking help for her own difficulties:

"When mum was breaking down into tears because she wasn't able to play with her daughter, [] and sometimes couldn't even tolerate being around her, she realised that it was partly her own difficulty, not just 'Mary'" (Participant 2, line 267-271).

Engagement with clinician's use of IC.

In several cases where a young person engaged with the clinician's use of an IC, the salience of the IC reportedly changed. It seemed that, aspects of self previously externalised into ICs, had become integrated into young people's developing personalities:

> *"I understand he is fading now, the friend. I think his sense of containment is such that he doesn't perhaps need him anymore. He has almost absorbed that person into himself"* (Participant 10, line 100-103).

IC: Salient and malevolent.

In one case, an IC was reportedly experienced as going against a young person's wishes, and out of her control: an 11-year-old girl, who had spent several years in foster care, and had recently been re-united with her birth mother. She had presented with aggressive behaviour towards her young half-brother, and stated that her IC, a 7-year-old "ghost", was telling her to hit him. The clinician reported that she seemed agitated by the IC's presence and asked him to *"make it go away".* The intervention was based on the clinician's hypothesis that the IC was a projection of the girl, aged 7-8, when she was first taken into foster care.

> *"Rather than see it as a monster, like it was initially presented, we re-framed it as a child, who was lost and angry, looking for containment of her anger, and for someone to look after her"* (Participant 5, line 116-118).

The clinician validated and verbalised the emotions the IC expressed, which the girl herself had found difficult to own.

> *"I re-framed the IC as 7-8 year-old child, looking for a real home. I said to her that in our clinic, we often work with 7-8 year-old children, looking for safety and understanding, and that the IC could stay here, with us, and that we would look after her. And that's when she went away!"* (Participant 5, line 111-116).

It seemed that once the girl no longer needed to express her emotions through this medium, the IC faded away.

> *"She wasn't sad about the IC disappearing; in fact, she thanked me for making it go away"* (Participant 5, line 130-131).

The clinician also reported that part of the intervention was systemic, and included sharing his formulation of the IC's function, which he reported brought about *"an improved relationship with her mother".*

Discussion

The present study investigated the functions and therapeutic use of ICs for young people accessing CAMHS. In the following section, the main categories are discussed in relation to existing theory and research.

Functions of ICs

ICs appeared to play a central part in the lives of the young people in this sample, and functioned as a means to cope with difficult experiences and emotions. The ICs did not take the form of toys or well-known characters, but appeared to be dynamically created to fulfil a child's unmet needs. Their main roles revolved around meeting social, emotional and developmental needs, and maintaining stability in a chaotic environment, and self-image.

Mastery over the child's world.

Many young people's environments seemed to lack the conditions necessary to establish a secure sense of selfhood and mastery. The findings suggested that ICs facilitated the acquisition of social competencies through a safe, non-judgemental interaction. This finding resonates with Piaget's (1962) assertion that children use ICs to develop new skills. Furthermore, rehearsing social interactions with ICs relates to Vygotsky's (1998) notion of practicing skills within a child's zone of proximal development, where the role of the more competent adult or peer appears to be fulfilled by ICs. Furthermore, the advisory role of ICs could be linked to psychoanalytic ideas of 'superego auxiliaries', or helpful aspects of self (Adamo, 2004).

The finding that half of young people had confirmed or queried AS diagnoses supports Attwood's (2008) observation that children with this difficulty are particularly likely to develop ICs, as they long to make friendships, but lack the necessary skills. Furthermore, a key feature of their play is a need to control the activity. This resonates with the current study's findings, i.e. when attempts to make friends have been unsuccessful, some children seemed to develop ICs, so that social interactions could take place, but remain under their control.

Moreover, it may be that children with AS create ICs owing to difficulties with understanding others' social cues and mental states (Attwood, 2005). This difficulty becomes less pertinent in interactions with ICs, where the companion's behaviour is ultimately under the child's control. It raises the interesting question of whether children are using theory of mind (ToM) abilities when interacting with ICs, as suggested by some developmental theories (Piaget, 1962; Fein, 1975), or whether difficulties with advanced ToM skills may contribute to the creation of an IC.

Secure attachment figure.

This category has not been previously discussed in the literature. An exception is the sub-category of increasing safety, discussed by Trujillo et al., (1996) and Adamo (2004), who found that the ICs of boys diagnosed with DID and AS were predominantly protective parental figures.

With regards to the remaining sub-categories, Bowlby (1973) proposed that attachment-related events, such as loss and abuse, can lead to modifications of internal representations, which affect a child's strategies for processing thoughts and feelings. Several young people in this study had reportedly experienced early

disruptions in attachment, or had conflictual parental relationships. Thus, the creation of an IC could reflect an adaptive alternative to the self-regulatory processes that would normally be fulfilled by a secure attachment figure (Hofer, 2006), similarly to transitional objects (Winnicott, 1953). This is illustrated by the capacity of ICs to provide containment, without the threat of separation (Burlingham, 1945). Consequently ICs appeared to receive the emotional communication of children without becoming overwhelmed, and to communicate it back (Bion, 1963), thus providing young people with permission to experience, regulate and express a range of affects.

Communication.

The communicative role of ICs was identified as a prominent category. Although this function of ICs is emphasised in the normative literature (Piaget, 1962; Taylor, 1999), it appeared that for this group of children, who experienced social communication and emotion regulation difficulties, their ICs were the only safe way to express them, either by indirectly discussing their ICs' difficulties, or through ICs expressing emotions/impulses perceived to be unacceptable.

Maintaining stability in environment and self-image.

The last category could be summarised as functions relating to children's sense of instability in their environment, and threats to sense of self. These were managed by either 'escaping' into a more tolerable imaginary reality, or placing unacceptable feelings/impulses into ICs.

This first finding confirms Taylor`s (1999) and Hoff's (2005) suggestions that ICs can aid children to overcome pervasive restrictions in their lives by helping them

escape into a world where they feel safe, and in control. Although in most cases this function appeared to be adaptive, it resulted in withdrawal from the real world, which in the longer-term may have prevented young people from forming other meaningful relationships.

The remainder of sub-categories strongly resonate with psychoanalytic theories which propose that ICs help children to indirectly cope with emotions and impulses perceived to be unacceptable (Freud, 1968). Some ICs also seemed to relate to Benson and Pryor's (1973) notion of 'self-objects', validating young people's world views, and maintaining self-esteem, by embodying negative aspects of personality. At the same time, ICs seemed to allow children to remain sufficiently connected to these externalised aspects of personality to prevent disintegration, and loss of self.

It is noteworthy that the ICs in this sample took a variety of forms (e.g. persons, objects, animals) and numbers, ranging from a single companion, to a whole imaginary world. Whilst it seemed that ICs' phenomenology could be dynamically related to a child's difficulties, and shed light on definitional issues, it is not within the scope of this study to fully elucidate this issue.

Use in Therapy

To the author's knowledge, this is the first study to investigate the therapeutic use of ICs from an 'outsider' perspective; the other two publications on this topic were by clinicians who used ICs as part of their own practice (Sawa et al., 2004; Adamo, 2004).

Clinicians' formulation of ICs' impact on children's sense of self appeared to resonate with psychoanalytic notions of 'ego-dystonic' and 'ego-syntonic' constructs

(Fenichel, 1946). In cases where ICs were hypothesised to be 'ego-syntonic', or acceptable to the child's sense of self, clinicians utilised them as therapeutic allies.

The actual strategies employed by clinicians could be conceptualised from different theoretical frameworks. For example, the use of ICs to increase flexibility in thinking resonates with cognitive theory and cognitive-behavioural interventions (e.g. Friedberg & McClure, 2002).

Previous research (Adamo 2004; Sawa et al., 2004) has considered the disappearance of an IC at the end of therapy as a positive outcome, implying the integration of aspects of self, previously placed into an IC. In some cases, the present study confirmed this finding. However, in other cases, the salience of ICs did not change through therapy, which was not necessarily a negative indication of therapy outcome. Young people often remained in environments where it was not necessarily safe to challenge their defensive use of ICs, and where systemic interventions were more appropriate.

Clinicians' interventions in this area could be understood within Bronfenbrenner's (1979) ecological systems theory, which considers a child's development in the context of a system of relationships that form his/her environment, e.g. family and school. Where relevant, clinicians liaised with parents and schools to support their understanding of young people's difficulties, and sometimes shared their formulation regarding IC functions.

Lastly, in one case an IC was perceived to act against a child's wishes and feel subjectively out of control, i.e. ego-dystonic. Although theoretical saturation in this category was not reached in the present study, it resonates with Trujilo et al.'s (1996)

finding that the ICs of children diagnosed with DID felt outside their control, and acted malevolently. In this case, the clinician used the IC to validate emotions which were difficult to express, and re-framed the IC as a vulnerable aspect of the child, which reduced the need for the IC to fulfil this function.

Clinical Implications

The results of this study indicate that young people experiencing mental health and developmental difficulties may create ICs as an adaptive way to cope with a range of problems. Particularly where ICs are salient, clinicians may need to incorporate them as a way of engaging young people, and gain insight into their difficulties, through examining ICs' characteristics, and interactions.

When an IC is formulated as congruent with a child's wishes, it may be helpful to utilise it to strengthen the therapeutic alliance, and introduce flexibility in thinking and feeling. Furthermore, for children with AS, using ICs to communicate indirectly may make interactions more manageable.

Clinicians' intervention would most likely require a different approach, in those cases where a young person presents with an IC, who seems to act against his/her wishes. In such cases, supporting a child to find alternative strategies to cope with their emotions may be necessary.

Successful treatment outcome cannot simply be equated with the re-introjection of an IC as a result of therapy. Many ICs played useful functions which would otherwise remain unfulfilled. Therefore the 'disappearance' of an IC may leave young people with fewer coping strategies to manage distress. An idiosyncratic approach, balancing an IC's useful functions with its effect on social relationships may be valuable.

Lastly, offering psychoeducation and sharing formulations with parents and schools about an IC's functions may be useful to achieve systemic change.

Future Research

To the author's knowledge, this study is the first of its kind in the UK, and as such, replication would be useful.

Furthermore, in addition to clinicians, it may be important for future research to interview young people from a clinical population, and their parents about their understanding of ICs' functions.

An unexpected finding of this study related to the high proportion of young people with social communication difficulties, who presented with ICs. This finding has interesting implications for social imagination and ToM understanding in AS. A study exploring in more detail the interaction between children with AS and their ICs, could potentially inform future diagnostic criteria for this disorder, in terms of whether creating an IC utilises social imagination abilities.

Clinicians reported that the ICs of some young people faded away as therapy progressed. It would be interesting for a future study to establish whether ICs return after treatment has terminated, or whether therapy helps young people to enduringly internalise the useful aspects of their ICs.

Although attempts were made to recruit participants from other professions, (e.g. child psychotherapists), unfortunately these efforts did not materialise. However, it would be useful for a future study to obtain the perspective of child psychotherapists, as their use of ICs may differ, owing to divergent theoretical perspectives.

Methodological Limitations

One of the main limitations of this study concerns utilising clinicians' perspectives to identify IC functions. Although this method provided rich data, it relied on clinicians' memory, interpretation, and construction of functions, which would have been influenced by their perceptions, theoretical orientation, and previous experiences. These were then further influenced by the researcher's own previous experience and expectations. Although quality assurance methods were used to manage this issue; it is acknowledged that participants' and researcher expectations may have influenced the resultant GT.

Furthermore, this study may have been affected by self-selection bias, as it is likely that clinicians who had successfully utilised ICs in therapy were more likely to take part in the study.

Conclusions

This study aimed to investigate the functions and therapeutic use of ICs for children with mental health and developmental difficulties. The findings indicated that ICs in this population sample served some similar functions to normative populations. Strikingly, some differences were also found, for example, ICs serving as secure attachment figures. Most clinicians were able to effectively use ICs therapeutically, as an engagement tool, to gain insight into young people's worlds, and formulate their difficulties. Furthermore, clinicians utilised ICs as therapeutic allies, and as a way of evaluating therapy outcome. Although some methodological limitations of the study were identified, it is a first step in highlighting young people's adaptive use of ICs to manage significant emotional and behavioural difficulties, and their potential therapeutic utility.

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MAJOR RESEARCH PROJECT

SAVINA WACHTER BSc Hons

SECTION C: CRITICAL APPRAISAL

WORD COUNT: 1973

A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

July 2011

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Contents

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

Undertaking this project has been an enriching experience, but also a steep learning curve. The skills I learnt reflected the wide range of abilities required throughout the different stages of the research process. These included selecting a feasible topic, writing a research proposal, obtaining ethical approval, carrying out a thorough literature review, recruiting participants, choosing an appropriate methodology, and analysing qualitative data. In the following section, some of these aspects are reflected upon in more detail.

The Salomons ethics approval process was rigorous and required preparation and flexibility in adapting my project when my initial idea to interview parents and children was not approved, owing to the time-frame that would have been required. In future, I hope to acquire more experience of the NHS ethics approval system, which is likely to be necessary for future research projects.

Another skill learnt related to managing the difficulties in recruiting participants, which were initially approached with some naivety. Overcoming this challenge led to a better awareness of the level of effort, organisation, and flexibility required to obtain a sufficient number of participants to reach saturation in most categories. For example, as participants were busy clinicians, reminder e-mails and considerable flexibility in terms of time and location, were often required when arranging interviews.

Undertaking this project also developed my skills in designing and carrying out semi-structured interviews, which are reported to be suited to grounded theory (Starks & Trinidad, 2007). It emphasised the importance of piloting an interview schedule to ensure that the responses elicited addressed the research questions posed. Furthermore, I learnt the importance of asking interview questions in an open, neutral way, so that I did not lead participants in a particular direction.

Additionally, I developed my understanding of different qualitative methods in order to select the appropriate method for the study. GT was chosen as it reflected the focus on my research questions on process, rather than the hypothetico-deductive focus on hypothesis testing, more typical of quantitative methods (Coolican, 2009). Although other methodologies, such as Interpretative Phenomenological Analysis (IPA), which focuses on participants' lived experience, were considered, GT was chosen for two reasons. Firstly, GT allowed for participants to construct their understanding of the experiences of children with whom they were working, whereas IPA focuses on participants' own direct experiences. Secondly, GT is better suited to developing theoretical constructs, examining relationships between them, and constructing a conceptual model.

Furthermore, I developed my awareness of how adopting a different epistemological position could influence the way a research project is conducted. I had to make a decision about whether to adopt a realist or a social constructivist GT framework. GT originally adopted a realist epistemology (Glaser & Strauss, 1967), which proposes that there is a truth to be discovered, and is more akin to a positivist quantitative perspective. In contrast, I chose to adopt a social constructionist

epistemology which argues against the existence of an objective truth and proposes that “all knowledge is derived from looking at the world from one perspective or another” (Burr, 1995, p.6). The reasons for this decision were based upon my own epistemological position regarding how knowledge is acquired. Furthermore, as a trainee clinical psychologist, my previous experience working with children in a clinical setting was likely to have influenced my interpretation of the data, thus offering an “interpretative portrayal of the studied world” (Charmaz, 2006, p.10).

By adopting a social constructivist stance, I also learnt to acknowledge the potential bias and assumptions that could influence the research process. My initial interest in this research area was related to my fascination with children’s creativity, and undoubtedly influenced by having had an IC myself as a child. Therefore, I was aware of the likelihood of projecting my experiences onto the data. Dey (1999) criticises GT and highlights the possibility that authors may just end up finding what they are looking for. I tried to reflect upon this possibility by being explicit about my initial expectations in relation to the results. One obvious assumption was reflected in my belief that ICs can be effectively utilised in therapy, and it seemed that participants largely shared this view. This realisation led me to theoretically sample cases where ICs were not utilised in therapy. My further attempts to increase data credibility were through keeping a research diary, supervision, and respondent validation (Williams & Morrow, 2009).

The data analysis stage was challenging owing to the substantial amount of data, and the uncertainty of “whether I am doing it right”, which most likely reflected my inexperience with qualitative analysis. However, through remaining focussed,

rigorous, systematic, and always returning to the data, I learnt to synthesise significant quantities of data in order to construct meaning and reach a level of understanding, which was both coherent and theoretical.

The theoretical coding of the data was challenging as I was concerned about it being influenced by existent theoretical terms. I found writing theoretical memos particularly helpful at this stage (Charmaz, 2006). Another strategy which I learnt in this process was to ask questions of categories to clarify their relationship to each other. These included thinking about the intervening conditions between causes and consequences, contexts within which a category emerges, and whether a category is a contingency (Strauss & Corbin, 1990). Consequently, I found that the level of abstraction of the categories increased progressively, allowing the generation of the two preliminary models.

If you were able to do this project again, what would you do differently, and why?

Considering the context of this project as a doctoral dissertation, which involved a limited time-scale and particular requirements, it would have been difficult to conduct this project in a significantly different way. Nonetheless, I considered the following aspects of the project in this section:

I initially aimed to include clinicians from a variety of professions in the sample, including child clinical psychologists, systemic therapists, child psychotherapists, and play therapists. However, the final sample largely comprised clinical psychologists. The sample constitution may be party attributed to my background, as a trainee clinical psychologist, which may have meant that clinicians from similar backgrounds felt more encouraged to respond to the advert. It may have been possible to obtain

participants from a wider range of professional backgrounds through presenting the project at conferences, and multi-disciplinary meetings. However, this approach would have required obtaining multi-site NHS approval, a time-consuming approach, with no guarantee of obtaining a wider range of participants.

Within a longer time-frame, it may have been valuable to interview children and/or parents about IC functions in order to achieve participant triangulation. Triangulation is the combination of two or more data sources, investigators, methodological approaches, theoretical perspectives, or analytical methods within the same study, and is used to increase the credibility of data analysis (Kimchi, Polivka, & Stevenson, 1991). However, although data source triangulation was not within the scope of this project, investigator triangulation was utilised, which in this case involved using more than one coder. Banik (1993) proposes that coding, and verifying the interpretation of data by multiple analysts serves not only to "amplify the findings and increase validity, but also adds to reliability" (p. 49). Two transcripts were coded by the principal research supervisor, and by a peer researcher, who had no prior knowledge of the project. Similar initial codes and categories were found among raters without prior discussion or collaboration with one another, which lended greater credibility to the resultant GT (Denzin, 1970).

In GT, theoretical sampling is used to ensure that categories have full and saturated definitions. At the same time, Corbin & Strauss (2008) recognise that total saturation is unlikely to be achieved, and therefore a more realistic aim is to ensure that the categories are developed sufficiently for the purposes of the study. Although it would have been useful to recruit more cases where an IC acted against a child's

wishes in order to reach saturation in this category, attempts to achieve this were unsuccessful. This could reflect the rarity of such IC presentations, or clinicians' limited success in working with them. Nonetheless, this category was included in the preliminary model, as it was internally coherent, and the type of IC presentation reflected previous research findings.

Clinically, as a consequence of doing this study, would you do anything differently and why?

The research findings indicated that young people experiencing mental health and developmental difficulties may create ICs as an adaptive way to cope with a range of problems, and that ICs can be effectively utilised in therapy in a number of ways.

Although ICs appeared to play an important part in young people's lives, I would not necessarily advocate asking a young person whether they have an IC as a routine part of assessment, as this could be perceived to be intrusive by a child, who may not be ready to share this information. However, where a clinician is aware of an ICs' existence, or a young person spontaneously brings it up, it may be clinically useful to enquire, in a curious and accepting way about the IC, in order to engage young people, and foster a strong therapeutic alliance.

Furthermore, having had a specialist placement working with children with autism spectrum conditions, I can appreciate the value of engaging children with these types of difficulties indirectly through their ICs, owing to their difficulties with social communication.

When building a hypothesis about a young person's problems, I think it would be important to consider the functions an IC may be playing: i.e. whether it is an

adaptive response to adverse circumstances and a creative approach to meeting unmet needs, and/or whether it is maintaining a child's difficulties. In most cases, it appeared that ICs were an adaptive response, however I think it would be clinically useful to tease out the positive and negative aspects of IC interactions. For example, while some ICs appeared to help children to escape to a preferred reality when their own lives were experienced as intolerable, this also appeared to result in young people withdrawing socially, thus preventing the formation of potentially supportive relationships.

With regards to utilising ICs in therapy, I would be careful about imposing therapeutic strategies or questions (e.g. perspective-taking questions), which do not fit in with a child's construct of their IC, and would try to find out sufficient information about an IC's characteristics before attempting to utilise it in a particular way.

Lastly, if appropriate, I would consider offering psychoeducation to parents and schools around ICs, and the functions they may be serving, particularly if interactions between a child and an IC are a cause for concern for parents or schools.

If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

Around half of young people described by clinicians had confirmed or queried diagnoses of Asperger's syndrome (AS). This finding raises questions about whether interacting with an IC utilises social imagination, and theory of mind (ToM) abilities. Taking into account that one of the diagnostic criteria for AS relates to difficulties with social imagination, this avenue of research could have implications for the diagnostic criteria for this condition.

A quantitative study, using a between-subjects design could compare the ToM abilities of a sample of young people with AS and ICs, and those with an AS diagnosis, who do not have an IC. The ToM task used in such a study would need to be appropriate to the developmental stage of young people who take part. For example, whereas a second-order ToM task involving a participant reasoning about what one person thinks about another's thoughts (e.g. the "Sally-Anne" task; Wimmer & Perner, 1983) may be suitable for younger children, it would not be appropriate to use this task with older children with AS, owing to ceiling effects (Ozonoff, Rogers, & Pennington, 1991).

Additionally, a future quantitative study could investigate the proportion of children with AS who present with ICs, compared to a control group of children from a normative sample, in order to find out whether ICs are more common in children with this condition. If ICs are indeed more common in children with AS, they can potentially be incorporated in designing treatment protocols for children with these difficulties.

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MAJOR RESEARCH PROJECT

SAVINA WACHTER BSc Hons

SECTION D

APPENDICES

A thesis submitted in partial fulfilment of the requirements of

Canterbury Christ Church University for the degree of

Doctor of Clinical Psychology

July 2011

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

APPENDIX 1: Section A Search Methodology

The electronic databases PsychINFO, CINAHL, Cochrane, MEDLINE, Pubmed Central, ASSIA, Web of Science, ScienceDirect and Google Scholar were searched between 02.08.09 and 31.05.11 initially using the following terms:

1. *Imaginary companion(s)/imaginary friend(s)/ pretend friend(s)*

These terms were searched with no time limitation initially owing to the limited extant literature in the area. The search yielded 219 articles in English. The references (including abstracts and book chapters) generated were scanned to extract studies focussing on the following four areas, which were deemed most pertinent to the literature review in the area:

1. Theoretical understanding of imaginary companions
2. Prevalence of imaginary companions
3. Characteristics of children with imaginary companions (including intelligence, creativity, gender, family composition, psychopathology)
4. Functions of imaginary companions

The studies deemed most relevant to the above areas were included in Section A.

Once this search was completed, another search combining the following key terms was conducted:

1. Imaginary companions/friends AND functions/roles AND psychopathology/clinical/mental health
2. Imaginary companions/friends AND therapy

Attempts were made to select studies where the functions of imaginary companions for children from clinical populations, and their potential to be used in therapy could be assessed. Therefore, the following were excluded:

1. Studies focussing on the role or use of ICs in adults.
2. Theoretical publications only, with no clinical case examples or research in clinical populations.

This search yielded 1 empirical study, and 3 case study publications.

APPENDIX 2: Participant Demographic Data

Participant Number	***Job Title***	***Specialty***	***Ethnicity***	***Number of years experience working with children***
1	Clinical Psychologist	CAMHS Tier 3	White European	4.5
2	Clinical Psychologist & Systemic Psychotherapist	CAMHS Tier 3	White Irish	21
3	Clinical Psychologist	CAMHS Tier 3	White European	12
4	Systemic Psychotherapist	CAMHS Tier 2	White Irish	20
5	Systemic Psychotherapist	CAMHS Tier 3	White Scottish/Irish	18
6	Clinical Psychologist	CAMHS Tier 3	White Other	1.5
7	Clinical Psychologist	CAMHS Tier 2	White British	2.5
8	Consultant Clinical Psychologist	CAMHS Tier 3	White British	30
9	Consultant Clinical Psychologist	CAMHS Tier 2	Asian Indian	22
10	Consultant Clinical Psychologist	CAMHS Tier 2	White British	20

APPENDIX 3: Corresponding cases additional data

Participant Number (corresponding case discussed in interview)	***Age***	***Gender***	***Ethnicity***	***Referral Reason***	***Number of siblings***	***Diagnoses***	***Family circumstances***	***Imaginary Companion(s) form and number***
1	10	Female	White British	Aggressive behaviour	1	Asperger's Syndrome	Nuclear family	Imaginary poodle world; One main imaginary companion: pink poodle called 'Cherry'
2	10	Female	White British	-strange behaviour at school -isolation -problematic relationship with mum	none	none	Single parent household	Three main imaginary companions: two girls similar to client ('Susan' and 'Lilly') and one older man, with the same name as client's grandfather
3	5	Female	White British	-anger outbursts	1	possible ASD diagnosis	Single parent household	One imaginary companion: invisible red ball called 'The Ball'
4	4	Female	Black African	-anger outbursts -witnessed domestic violence	5	none	Single parent household	One male human imaginary companion (name not shared with therapist)
5	11	Female	White British	-aggressive behaviour towards brother -"seeing things that were not there"	1	none	Previously looked after child in foster home. Recently moved back with birth mother	One imaginary ghost girl, 'Lucy', aged 7-8
6	7	Male	White British	-Anger outbursts -Witness of domestic violence	None	Asperger's syndrome	Previously looked after Child -currently living with birth mother	One imaginary male friend, called 'Billy', short with spiky hair

7	8	Male	White British	-attachment problems -challenging and oppositional behaviour	1 (no contact)	Oppositional defiant disorder	Looked After Child (fostered)	One imaginary companion: big, fluffy, blue imaginary creature called 'Bob'
8	12	Male	White British	-PTSD after witnessing domestic violence -anxiety and difficulties controlling anger	1	PTSD ASD	Living with birth mother and stepfather	One imaginary companion: A blue, round blob, who wore a white shirt
9	6	Female	White British	-separation anxiety -temper tantrums	none	none	Nuclear family	-one imaginary companion: A little girl called 'Talia' who was the same age as client and looked similar
10	10	Male	White British	-anger outbursts -behavioural difficulties	2	Asperger's syndrome	Nuclear family	One imaginary companion: an Elf with large ears and eyes who lived in the walls, called 'Toby'

APPENDIX 4: Salomons Research Ethics Committee Approval

This has been removed from the electronic copy.

APPENDIX 5: Study Advert

INVITATION TO TAKE PART IN A RESEARCH STUDY

I am a Trainee Clinical Psychologist based in Salomons, Tunbridge Wells. For my final year thesis, I am interested in researching the possible roles that imaginary companions may play in children/adolescents from a mental health outpatient population and to obtain an understanding of clinicians' observations and experiences of utilising this phenomenon as part of their clinical work. An imaginary companion has been defined as:

> *"An invisible character named and referred to in conversation with other persons or played with directly for a period of time, at least several months, having an air of reality for the child, but no apparent object basis"*

I am interested in talking to clinicians who have worked with a young person with an imaginary companion within the last 5 years. From the respondents who identify that they have worked with this phenomenon and are interested in being interviewed about it, the first 10-20 will be contacted to take part. This will involve a telephone/face-to-face interview (according to your preference) lasting between 45-60 minutes and focussing on the possible roles of the imaginary companion(s) in the identified case. I am also hoping to obtain an in-depth understanding of clinicians' experiences of working therapeutically with imaginary companions.

If you are clinical psychologist, child psychotherapist, family therapist, or play therapist interested in participating, please e-mail me on the following address: sw283@canterbury.ac.uk

or write to me at:

Savina Wachter

Clinical Psychology Department

David Salomons Estate
Broomhill Road

Royal Tunbridge Wells, Kent, TN3 0TG

APPENDIX 6: Informed Consent Form

Informed Consent for Participants

Title of Research: Imaginary Companions: Clinicians' experiences and observations of functions and use in therapy

Name of researcher: Ms Savina Wachter

Name of supervisors: Dr Jane Ware and Ms Linda Hammond

Affiliation: Department of Clinical Psychology, Salomons, Canterbury Christ Church University

Purpose of data collection: Doctoral Research Project

Contact address: Salomons, David Salomons Estate, Broomhill Road, Southborough, Tunbridge Wells, Kent, TN3 0TG

Description of research: Imaginary friends (or companions) are very vivid, often invisible characters with which many children interact during their play and daily activities. Nearly half of UK children between the ages of 5-12 have an imaginary companion at some point in their lives.

The present study aims to investigate the possible roles that imaginary companions may play in children/adolescents from a mental health outpatient population and to obtain an understanding of clinicians' observations and experiences of utilising this phenomenon as part of their clinical work.

Research Procedure: The procedure involves a telephone/face-to-face interview lasting between 30-45 minutes and focussing on possible roles of the imaginary companion(s) in the identified case as well as obtaining an understanding on clinicians' experiences of these phenomena. The interview will be audio-taped.

Please read the statements below, then sign and date the form if you consent to participate.

I understand that:

- My data (questionnaires, audio tapes and transcripts) are being collected as part of a doctoral research project.

- My data will be kept in a locked filing cabinet within the psychology department at Salomons for a period of at least five years. Transcripts produced from my interview will be password protected.

- My data will be kept confidential and an identification code will be used instead of my name to ensure anonymity. Only the named researcher and named research supervisors will have access to my data.

The only circumstances in which confidentiality would be broken are:

1. If you had said something to the researcher which raised concerns about the safety of yourself and/or other people.
2. If you said something to the researcher which raised concerns about your clinical practice, or that of your colleagues or other professionals or services.

- The interview will take approximately 30-45 minutes to complete and will be audiotaped.
- Direct quotations from my interview may be used in the final manuscript
- My participation in this research is voluntary and I have the right to withdraw from the study at any time and for any reason, without prejudice.
- I will be able to obtain general information and/or a summary about the results of this research by contacting the researcher on the address provided above.
- I am giving consent for my data to be used for the following purposes (please tick one box below).

☐ Research project only (i.e. only used for the purposes of the present study)

☐ This research project and also for further professional publications, in which case my data will be kept securely in a locked filing cabinet for at least 5 years following any relevant publications.

- Any questions I have about my participation have been answered.

If you have any questions about the above, please ask the researcher before you sign.

Print Name: _____

***Signed:* _____**

***Date:* _____**

Please note that this form will be kept separately from your data

Thank you for your time

APPENDIX 7: Interview Schedule

- Please give me some background about this child/young person (without revealing any identifying information).
- When and how did you first find out about the child's imaginary companion?
- Did the child refer to the imaginary companion by a specific name?
- To your knowledge, was the imaginary companion based on a character, a real person that the child knew or was it completely made-up?
- Was the imaginary companion ever around during therapy sessions? How did you know?
- Do you know whether the imaginary companion was around in other contexts such as home, school etc? Were they around only when the child was alone or also when others were present?
- How did the child play and interact with the imaginary companion in therapy?
- What were your first thoughts when you find out about the child's imaginary companion?
- What is your understanding of imaginary companions in general? (additional question added after interview 3: Do you have any personal experience with ICs?)
- What do you think the role or purpose of the imaginary companion was for this specific child?
- In your work together, did you refer to or try to utilise the imaginary companion in any way?
- If yes, how did you do this and how did the child respond?
- If not, was there anything specific consideration that stopped you from doing so?
- (additional question added after pilot interview: What was the general outcome of the therapy?)

APPENDIX 8: Debriefing form

Debriefing Form for Participants

Thank you for taking part in the research project. The purpose of this study is to establish some of the roles of imaginary companions in children and adolescents receiving treatment for mental health difficulties. The second part of the project also aims to obtain a better understanding of clinicians' experiences of working with these phenomena. It is hoped that the findings from the research will contribute to theoretical knowledge of the roles of imaginary companions in this population. In addition, it is hoped that the findings will inform clinicians' practice with regards to working with this childhood phenomenon as part of therapeutic engagement and treatment.

As part of this study you were required to reflect on your clinical work, which may have raised difficult or sensitive issues. If this is the case, it may be useful to seek out appropriate clinical supervision.

If you have any questions or comments about this research, please feel free to contact Ms Savina Wachter at the following address: Salomons, David Salomons Estate, Broomhill Road, Southborough, Tunbridge Wells, Kent, TN3 0TG or to e-mail sw283@canterbury.ac.uk.

If you are interested in this area of research, you may find the following text useful:

Taylor, M. (1999). ***Imaginary companions and the children who create them*****. New York: Oxford University Press.**

Finally, thank you again for taking part in this project.

Best Wishes,

Savina Wachter

APPENDIX 9: Theoretical Memos

The memos presented below were selected to demonstrate the progress of my thinking about the emerging theory. ** are used instead of participant initials, in order to maintain anonymity. Some memos are typed out from a Memo notebook to improve legibility.

1. Initial category development examples

19th November, 2010

Both ** and ** describe cases, where there has been a disruption in relationship with parents. For ** there was domestic violence, then fleeing to a refuge. Later on, losing stepfather and difficult relationship with mother. For ** again, domestic violence, foster case, possible CSA. I wonder whether ICs were serving some kind of attachment function, where this was not fulfilled by parents. There seemed to be a lot about soothing, containment, acceptance, safety...something constant in an otherwise chaotic life. Could this be linked to meeting an unmet attachment need, or is it more about a response to an unsafe environment, or need for safety?

30th January, 2011

After initial coding of ** interview, and comparing it with **, the ICs in both cases (and *maybe in the case of the girl with Asperger's) seemed to serve, what in psychoanalytic* literature could be described as defensive functions. In ** the IC is was blamed, or *'scapegoated' for something that the girls herself did. In **, the IC 'tells' her to hit her* stepbrother. For **, the ICs act to maintain her perceptions of men, by confirming, or validating her negative view. It is interesting that the ICs went as far as to tell her to try and

*'poison' xxxxx, albeit with pink ink? ** talked about avoiding personal responsibility. This* seems to link to psychoanalytic constructs of IC acting to maintain self-esteem, so that unacceptable *impulses are not part of/owned by the child. Benson & Pryor's self objects? Can this be linked with **'s IC which acted as a way to help the girl escape from her* unbearable reality? I guess both can be seen as defensive functions, maybe when there is no escape, or no way to make the current situation better. So maybe IC was acting to maintain *stability in the environment? In **'s transcript, that definitely seemed to be the case.*

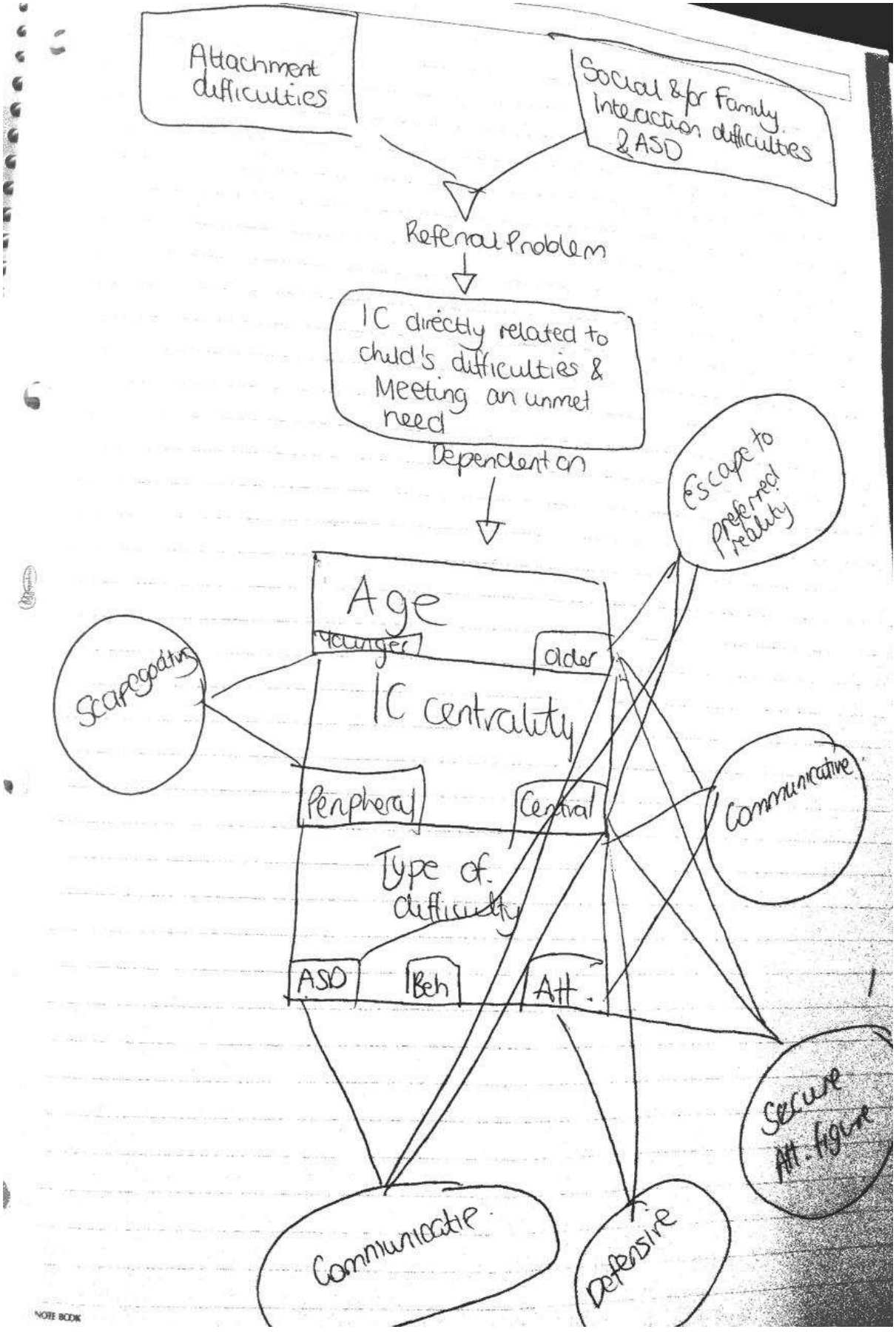
2. Example memos regarding the emerging theory

February and March 2011

The following memos demonstrate the progress of my thinking regarding the model of IC functions. Initially I wondered whether these functions could be understood as falling on a number of different continua, including age, type of difficulty and IC salience:

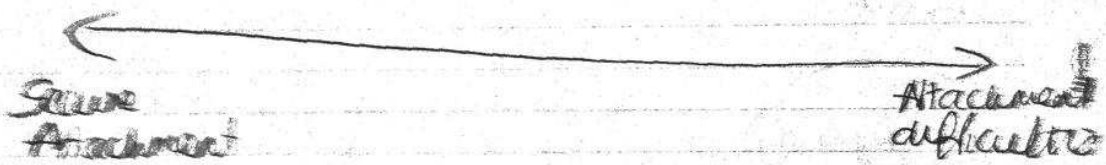
Extract of memo, 12 March 2011

How does age interact with function and pathology of IC? It seems that when IC is an ever-*present part of child's life at an older age (10*-12) it seems to have functions that are less positive? Perhaps more complicated functions. As the child becomes older, does the IC become more important? Perhaps a continuum could illustrate this theory...


Attachment difficulties
Social &/or Family Interaction difficulties & ASD
Referral Problem
IC directly related to child's difficulties & Meeting an unmet need
Dependent on
Age
Younger
Older
IC centrality
Peripheral
Central
Type of difficulty
ASD
Beh
Att.
Escape to preferred reality
Scapegoating
Communicative
Secure Att. figure
Communicate
Defensive
NOTE BOOK

The functions of IC seemed to depend on where the IC fell on certain continuums. Firstly, the age of the child. Certain functions seemed to be more salient for younger children, particularly the projection, scapegoating function.

Secondly, depending on how central the IC was in a child's life, certain functions were more likely to occur. For children where the IC seemed to be prescriptive in the child's life, the function seemed related to meeting vital unmet needs. E.g. such as safety, protection, containment



Many children were LAC & for them their ICs provided a key attachment figure, s/o who was consistent accepting the child no matter what & trustworthy & there

or had ambivalent rels with parent

Furthermore where children's difficulties or env't did not support effective communication, the children creatively used their ICs to do this

This idea was later revised:

29 March 2011

*Having gone back through the transcripts, I don't feel as if some of the conti*nua I initially *thought were relevant, match the data, particularly age. There doesn't seem to be enough in* the data to associate particular functions, with younger or older children, with the exception *of 'blaming the IC for something the child had done',* which seems to be more relevant for younger children. I initially thought that mastery functions may be more relevant for the *younger children, but this didn't seem to be the case.*

30th March 2011

It does seem that previous experiences, as opposed to <u>type</u> of difficulty seem to be related to the creation of an IC? Most ICs seem to be completely made-up, not based on a character. Perhaps they are meeting needs more than just play/companionship? They seemed to be *made up in such a way to meet the child's specific needs as opposed to* the ones based on a character, which seem an extension of play?

The difficult past experiences in ** transcript seem to be related to the referral problem, i.e. witnessed domestic violence >>>hyper vigilance and aggressive behaviour>> IC acting out unacceptable behaviour ?

This also seemed to be the case for **: domestic violence, numerous foster placements>>>IC fluffy, friendly blue creature>>>secure attachment?

APPENDIX 10: Example of respondent validation

Hi Savina,

Having looked through the summary, it resonates well for me despite my limited experience of imaginary friends in clinical work. However, there were bits that more strongly resonated, particularly in light of the experience I discussed with you. It related to the attachment function an imaginary friend may have for a child, particularly the unconditional acceptance and feeling of safety. In terms of the communication, the projections into the imaginary friend resonated mostly, rather than any overt verbal expression of difficulties. Providing mastery over a child's world, with emphasis on the ability to engage in a relationship which the child controls was also a noticeable and salient component.

I must admit that therapeutically, the imaginary friend served mainly to contribute to formulation. However, it did also serve as an anxiety-reducing coping strategy. As for the implications, I agree wholeheartedly and feel that this is an often under-utilized aspect of working with children in CAMHS.

Hope this is helpful. Let me know if you need anything more.

APPENDIX 11: Summary of findings for participants and Salomons ethics panel

Summary Report: June 2011

Imaginary companions: Clinicians' observations of their functions and use in therapy with young people referred to CAMHS

Whilst research shows that imaginary companions represent a common childhood developmental phenomenon, to date, they have been largely neglected in the clinical literature. The present grounded theory study investigated the functions and therapeutic use of imaginary companions in a clinical population, by interviewing clinicians working therapeutically with young people accessing CAMHS.

Methodology

The sample consisted of 10 clinicians. Participants were recruited through placing the study advert on numerous professional forums. Eight participants were practicing as Child Clinical Psychologists and two were practicing as Systemic Psychotherapists. Data were gathered using semi-structured interviews, and analysed using grounded theory.

Findings

1. Clinicians' views on imaginary companions' functions

Clinicians reported a relationship between young people's early experiences, resultant problematic emotions and behaviours, and the creation of an IC, which appeared to be an attempt to cope with difficult experiences. This was achieved through ICs serving the following functions:

1. ***Providing mastery over the child's world:*** Many young people's companions reportedly served to provide mastery and control over an environment lacking in predictability. More specifically they served to:

    a) Provide a relationship under the child's control. This was particularly found for children with social communication difficulties.

    b) Help a child to practice social interactions

    c) As an advisor, offering guidance and counsel, in situations where an adult role model was not available

2. ***Secure attachment figure:*** This role seemed to reflect the fact that many of the young people had experienced disruptions in attachment. More specifically, this role related to imaginary companions serving to provide:

    a) Consistency

b) Unconditional acceptance

c) Containment

d) Feelings of safety

3. ***Communication:*** Imaginary companions seemed to allow young people to express difficult emotions in two ways:

   a) Expressing difficult emotions through placing/projecting them into imaginary companion

   b) Using imaginary companions to indirectly communicate about own difficulties, e.g. “my imaginary companion is sad, because she is being bullied”.

4. ***Maintaining stability in environment and self-image:*** These ‘defensive’ functions fell into three sub-categories:

a) Using imaginary companions to ‘escape’ into a preferred reality, when young people’s lives were perceived as difficult, or unbearable.

b) Using imaginary companions to ‘split-off- unwanted parts of self and act out impulses.

c) Validating or upholding a child’s view of the world

2. <u>Use in therapy</u>

Most clinicians utilised imaginary companions in therapy in some way:

1. **In assessment:**

   a) As an engagement tool

   b) To gain insight into young people’s difficulties

2. **In formulation** clinicians considered:

   a) How imaginary companions developed

   b) Their functions

   c) Their salience

   d) And their impact on other relationships

When ICs were hypothesised to be salient in a child’s life, they tended to be incorporated in therapy. In three cases, imaginary companions were not incorporated in the intervention, owing to their low salience, and to clinical risk issues, which took precedence over the therapeutic work.

When imaginary companions were assessed to be benign and congruent with a child’s sense of self, they were used as therapeutic allies, to aid perspective-taking, to strengthen the

therapeutic alliance, and for children with communication difficulties, to manage the intensity of interactions.

In one case, an imaginary companion was experienced subjectively as outside a child's control, and acting against her wishes. In this case, the clinician validated the emotions the companion was communicating, and re-framed it as a less threatening figure, which led to it fading away.

Implications for practice

The results of this study indicate that young people experiencing mental health and developmental difficulties may create imaginary companions as an adaptive way to cope with a range of problems. Particularly where imaginary companions are salient, clinicians may need to incorporate them as a way of engaging young people, and gaining an insight into their difficulties, through examining a companion's characteristics, and interactions.

When an imaginary companion is formulated as congruent with a child's wishes, it may be helpful to utilise it to strengthen the therapeutic alliance, and introduce flexibility in thinking. Furthermore, for children diagnosed with ASD, using imaginary companions to communicate indirectly, may make interactions more manageable.

Evaluating treatment outcome through imaginary companions may be more complex than the companion simply fading away as a result of therapy. Many imaginary friends played useful functions which would not otherwise be fulfilled. Therefore the disappearance of an imaginary companion may leave young people with fewer coping strategies to manage their distress.

Lastly, clinicians may find it useful to share their formulation of an imaginary companion's functions with parents and schools, in order to support a better understanding of a child's difficulties.

APPENDIX 12: Excerpts from Research Diary

December 2008: MRP idea

A lecturer came to present to us today, and mentioned imaginary companions, and how they are an under-researched area. I was thinking whether this might be a fruitful avenue to research? I am particularly interested in whether imaginary companions are in any way related to trauma. I need to find out how common they are, and what research has been done in clinical populations, in order to decide whether this is a feasible idea.

February 2009

Things seem to be taking shape now. I had a meeting with Linda, who seemed very enthusiastic about the idea of researching the prevalence and functions of imaginary companions in a clinical sample. I guess my assumption is that for children that have experienced trauma, imaginary companions could be a way of coping.

We also thought it might be useful to investigate whether, and how, imaginary companions can be used in therapy? This seems like it would involve a mixed methodology. Linda thought that my initial idea to focus on post-traumatic stress disorder will be difficult to implement, and suggested going more general (i.e. Clinical population or children accessing CAMHS) due to the lack of research in the area.

April 2009

I now finally have an external supervisor. Jane is very interested in the idea, but concerned about whether I will be able to obtain enough participants in terms of children and parent dyads from a clinical population. We also talked about methodology. It seems that the qualitative aspect of the project would need to be carried out using either grounded theory or IPA. Jane has used IPA before and said that it may be suitable for clinicians' experiences. I think that grounded theory may be more challenging to conduct, but also more useful in terms of actually developing a theory.

December 2009

I had my IRP review today. The panel thought my ideas were interesting, but that that investigating the prevalence of imaginary companions in clinical populations was too ambitious, and beyond the scope of a doctoral-level project. They also suggested that it was not within the scope of the project to interview children and parents, as I would have to obtain multi-site NHS approval, which will be very challenging and time-consuming considering the sample I am interested in. I am quite disappointed, as I believe that children's perspectives could be valuable in obtaining a better understanding of imaginary companion functions. However, I also don't want to embark on a project, which I won't be able to complete. I need to think about how else the project can be conducted.

January 2010

Jane, Linda, Sue and I had a meeting to try and think about how the project could be conducted. We thought that interviewing clinicians about their understanding of imaginary companion functions, and the use of imaginary companions in therapy will be a useful avenue as an initial step in building the research-base. I guess it would be important to acknowledge that the functions I obtain will be based on clinicians' own understanding, and therefore constructed, and not necessarily a reflection of an "objective truth", if there is indeed such a thing. With regards to use of imaginary companions in therapy, there seems to be minimal research out there, so I feel quite hopeful that my study will be able to make a useful contribution in this field.

February 2010

I have ethics approval for the project! Really happy! I spoke to Jane and we thought it would be important to conduct the pilot interview as soon as possible to see whether the questions I have devised adequately match the research questions.

End of May 2010

Carried out the pilot interview today. I was amazed by how knowledgeable and experienced this clinician was. She felt that the questions were really appropriate, and the language and style was neutral and prompted further thinking. I already have some quite interesting data regarding the development of an imaginary companion being related to a particular crisis in the family, so that's something to think about further. I am slightly worried as the responses from the adverts haven't been as good as I expected. I am surprised at the number of clinicians who responded and said that they've never worked with a child who presented with an imaginary companion. This doesn't seem to match the prevalence rates...I wonder whether children are being quite secretive about their imaginary companions in this kind of setting, or whether clinicians are not asking those questions?

October 2010

After transcribing the first four interviews, and doing the initial coding, it seems that all clinicians I have interviewed so far have used imaginary companions in therapy quite successfully, and in many cases very creatively. I wonder if this could be related to self-selection issues...could it be that only clinicians who work with imaginary companions in therapy successfully are coming forward. I think I might try and interview some clinicians who didn't use imaginary companions in therapy and try and understand the processes at play better. It seems that imaginary companions are being used in quite a CBT way a lot of the time, clinicians are asking a lot of perspective-taking questions. I wonder if child psychotherapists might use them differently...need to try and see if I can get any psychotherapist participants.

December 2010

I have carried out eight interviews now, and I think I have reached saturation on all, but one of the categories. The only category which I don't think is saturated is the case where the imaginary companion was acting against the girl's wishes; this is the only case where the

imaginary companion seems more malevolent. I will try and recruit another participant who has come across this...I wonder how common it is.

There seems to be a lot of overlap between clinicians so far with regards to functions, many imaginary companions serving some kind of attachment function, and every participant has talked about imaginary companions being used to communicate indirectly, sometimes to express difficult emotions and impulses. The other category which seems really salient is about difficult emotions and impulses being placed in, or acted out by an imaginary companion.

The 'Use in Therapy' categories hang together really well otherwise, I have an idea already about what that model could look like.

February-March 2011

I've finished transcribing all the interviews I have now. Jane and I looked at all the transcripts and notes I'd made, and think that saturation can be reached in most of the categories. I just need to link them together now to produce an actual model!

I also need to consider the one clinician who talked about an imaginary companion going against a girl's wishes and feeling out of her control. I haven't had much luck recruiting more clinicians in this category. Although I do still think it would valid to include this case, as it's quite internally coherent and does seem to be represented in the literature. I need to speak to supervisors about this. Maybe I can ask Sue to consult on the grounded theory aspect of it.

End of May 2011

Wow, a week of meetings! Have met with Jane, Linda and Sue this week to finalise the preliminary models. The model about use in therapy seems to hang together really well, and made sense to all the supervisors. The model of functions also seems to fit well with the data, although I wonder whether there is more to IC functions than 'meeting an unmet need'. The more defensive functions seem to be maintaining stability, which I guess is also an unmet need, but I wonder whether some of this needs to be re-phrased to be clearer.

June 2011

Completely immersed in the write up now, so haven't had much time for the diary. Feels difficult to select quotes that are most relevant, as there are a lot I could pick from. Difficult to know whether I've selected the right one, as I feel I am more familiar with the model, and wondering whether quotes will be clear to readers who are not familiar with the area. Section B is already much over the word count, so I need to be more selective with quotes and more succinct with describing the theory.

APPENDIX 13: Audit trail: Quotes, Initial Codes Categories and Sub-categories

Quote	***Initial and focussed codes***	***Sub-categories***	***Categories***
"His mother and father, he was taken away from them" *"It had been a pretty difficult time for the parents, which meant that the child had to spend periods of separation with the grandparents"* *"Not knowing where her real family was"*	Separated from parents	Disrupted attachment	**Previous difficult experiences**
"This is an 8-year old boy, who was in a foster placement" *"She had spent long periods in care"* *"He was a looked-after child"*	Looked-after		
"*He then went from placement to placement, and no placement lasted longer than 12 months. "* *"He was taken out of her custody, and returned to her custody, so there was quite a lot of to-ing and fro-ing"* *"...he was moving from placement to placement"*	Frequent changes in carers		
"The mother was an alcoholic, and there were issues of neglect" *"There had been physical illness in the family, hospitalisation"* *"The mother suffered from post-natal depression"*	Parental ill-health		

"*she talks about having suffered from depression and using Prozac on and off throughout the years"*			
"*There was domestic violence"* *"He had witnessed and experienced domestic violence and there was some indication that he had experienced childhood sexual abuse"* *"He came to see me because he'd witnessed some domestic violence"* *"He was abusing alcohol and that's when...at that time he would be abusive towards the mother...physically abusive and I guess emotionally abusive.*	Witnessed domestic violence Sexually abused Witnessed physical and emotional violence	Trauma	
"Bullying was an issue" *"They were mostly concerned about her being bullied and how the other kids perceived her"* *"...they made the child feel foolish"* *"She had been bullied, mainly bullied by boys"* "*...there was some bullying from a boy at school who was picking on her and calling her names, which she was quite upset by*" *"They physically bullied her, pushed her around, and she didn't like touch"* *"...they had singled her as the weird one"* *"She was very unhappy at school, no friends, nobody liked her, they all thought she was very odd"* *"those kids immediately picked up on it...and they gave her a hard time"*	Bullied Made to feel inadequate Verbally bullied Physically bullied Singled out Picked on by other children	Bullying	

"They spoke a lot about the difficulties they were having with him" *"She was very angry towards the mother, and she'd be screaming: "I hate her!", and that mother always just wanted her to clean her room, she was always cross with her and never, never, played with her"* *"They reported a lot of conflict between all of them really"*	Difficult relationship with parents Anger towards mum Disappointment towards mum Conflict in family	Conflictual relationship with parents	
"He was incredibly distressed...always looking around, going to the corner of the room" *"She would just really, really cling to her mother at first"*	Vigilant for danger Unsafe Clingy	unsafe/threatened	**Unmanageable Emotions**
"It was difficult for her if other children tried to talk to her, and if they tried to touch her, it was too much!" *"She said that her problems were too much for her to handle on her own"*	Touch too intense Social interactions difficult Problems too overwhelming	overwhelmed	
"She was very angry towards the bullies, but I guess that's justifiable" *"Her main problem was this hatred towards boys."* *"I guess she was very angry towards the mother"* *"He had difficulty controlling his anger* *"He seemed very wound up"*	Angry at bullies Hatred Angry at mum Unmanageable anger Uptight	angry	

"...a very anxious, isolated girl..." "*He was feeling more anxious"* *"He was experiencing issues with anxiety"* *"She came across as shy... and just anxious"* *"She was a terrified-looking child..."* *"I think he wanted help to feel calmer"*	Feeling anxious Shy and fearful Panicked Need to feel calmer	anxious	
"The main problem appeared to be anger tantrums" *"She would also have sort of tantrums, for want of a better word, outbursts of anger".* *"...his explosive behaviour was really difficult for the family"* *"He had a lot of anger outbursts, that was the main behaviour that people were concerned about...so tantrums, throwing things, breaking toys."* *"He had issues with anger...difficulty controlling his anger".*	Outbursts of anger Acting out Explosiveness and difficulty controlling anger Temper tantrums Difficulties controlling anger	Anger outbursts	**Behaviours (Referral Problem)**
"The girl had thrown the computer across the nursery, and it had broken" *"When she'd go for it, she'd really go for it...quite aggressive, fists and all"* *"She was hitting her two-year old brother"* *"She had tried to poison her teacher with pink ink"* *"She had recently become quite verbally abusive to other children..."*	Damaging property Physically aggressive Physically aggressive to brother Dangerous behaviour Verbally aggressive	Aggression	

"The parents were having difficulties because she didn't like rules, she'd stamp her feet and say that she didn't want to go to bed, or whatever the issue was." *"There was some quite oppositional behaviour with his foster mum, quite a lot of arguing and defiance on this boy's part".* *"There were some issues with him being really difficult and manipulative at home..."*	Difficulties accepting parental authority and rules Oppositional and defiant behaviour Behaviour challenging to parents	Challenging and Oppositional behaviour	
"She was isolating herself a lot" *"She was quite withdrawn at times, would spend a long time on her own in the playground"* *"She was very withdrawn, and difficult to engage"* *"She was very lonely, very isolated. She didn't have many friends and she struggled in how to make friends, so her socialising skills were perhaps a bit lacking"*	Isolated from others Socially withdrawn Withdrawn and disconnected Socially isolated from peers	Social withdrawal/isolation	
"She said that the ICs always did what she wanted them to do. I guess it's not so easy with real friends... but she very much wanted to be in control." *"It was a way of getting social interaction, they provided her with friendships, but ultimately everything Cherry and the other poodles did was under her control".* *"This child didn't really have many friends, and Billy was someone he could talk to and play with, without feeling rejected or being bullied".* *"It sometimes acted as a companion, like a sibling, but without the pressure of having to compete for the parents' attention."*	Friendship under child's control Controllable and manageable social interaction Safe and controllable friendship Friendship under child's control	Relationship under child's control	**Mastery over world**
"*There was a lot about parties, having a party with the Ball...talking to it about who she'd invite from class and who she wouldn't invite, depending on*	Practicing desired social situations	Practice of social interactions	

how things were going at school. But the Ball was always invited to the party and a part of the planning stage". *"I did actually wonder if the IC's name was a boy's name from school that he hoped to be friends with"*	Helping plan social events Practicing of social situation		
"*He was not an adult friend...but a mature, sensible voice that helped him to feel safe, but also one that he would listen to... like another voice that was not his parents, but was sensible".* *"It was a voice that he listened to, and accepted".* *"We were able to have his friend there almost as a conscience...a positive development and a more mature voice"* *"I think he did seem to ask his IC sometimes, instead of his mum or friends, like someone a bit wiser."*	IC offering counsel and advice A respected voice Mature conscientious voice	Advisor	
"He was moving from placement to placement, with a sort of sense of him being rejected or abandoned repeatedly by both his parents and subsequent foster placements. Bob (IC) was one of the few stable things in his life, always there for him, perhaps unlike his parents. In fact, he was the complete opposite, always there when he needed him, like a shadow almost". *"The IC for him was certainly something that was stable, and there for him throughout a lot of those difficult experiences."* "*Her mum...I did feel wasn't available to her at all"*	Providing stability and consistency that's missing from parental relationship Providing stability in difficult circumstances Unavailable parental figure	Providing consistency	**Secure attachment figure**
He was there for him no matter what he did or said."	Completely accepting	Providing unconditional acceptance	

"Mum didn't know how to be with her, how to play with her, didn't know how to...be a mum really. So I feel that was their role...somebody for her, who accepted her, because she didn't have anybody, in that way" *"...someone to listen to him, to whom he could say how he feels, without dismissing him or feelings threatened, someone accepting."* *"It was a completely non-critical voice"*	Accepting and available Listening and accepting Accepting voice		
"He was quite a useful little companion for him, because I think the hearing and sight... it was an extra pair of eyes and ears for him". *"He said that Billy looked out for him, made sure he was ok"*	Providing protection IC guarding and protecting	Increasing feelings of safety	
"He was a comforting and reassuring figure" *"He had been around since the domestic violence, and was there for him as someone to witness what he was witnessing, alongside him."* *"I guess the IC was... someone who shared his distress, maybe someone who validated his reaction to what had happened."* *"It was a way of self-soothing...like it was around more when he was worried, or distressed"* "*I think it was also a manifestation of a benign presence that replicated some aspects of the parental relationship…you know, being around, being contained. She said that it was taking care of her while she slept."*	Providing comfort Providing containment of difficult emotions Containing distress Validating reaction to distress Containing anxiety and distress Serving as aspect of parent Containing and comforting	Providing containment	

"Because the IC was at an age when this girl was in care, the IC was talking about things that she wouldn't have said herself. It was allowing her to express angry feelings, and the loss, confusion and pain she was in...It made it safe for her." *"They were an outlet for those emotions that she couldn't express in any other way,"* *"I did find that, in therapy, when things were potentially difficult, he would say:"Billy things this is stupid" or "He's annoyed with you".* *"I think Billy was able to vocalise things that were too difficult for this child, so I think Billy would be often feeling angry, or annoyed."* *"It was another means of communication."* *"I think she felt guilty about the negativity, and the angry part of her...so maybe it felt safer having this Ball character to express it."*	Expressing difficult emotions Expressing unacceptable emotions Expressing difficult thoughts and feelings in a safe way Expressing negative emotions Communicating Expressing negative emotions in a safe way	Expressing emotions in a safe way	**Communication**
"She pointed that Susan was up there, on the light. And then there was this silence, and she went over, and banged the chair with her hands, and she said sadly: 'Susan has fallen off the light, she's fallen down and she's dead. It's because all these nasty people were coming after her. And the mummy, Susan's mummy, didn't look after her, didn't protect her, didn't care for her.' She stared at the chair, and it was so...dramatic!" *"I think there was something about flagging up a need for help...like "my problems are too much for me to handle on my own...so I've got my IC here to help me"* *"It would kind of assert what it felt and what it wanted for her, in a way that perhaps she didn't."* *"She referred to it, like the Ball's thoughts on things… like her friends"*	Communicating through IC about own distress Flagging up and communicating that child not coping IC voicing difficulties that child could not voice IC voicing difficulties IC communicating distress	Indirect communication about difficulties/distress	

"The things he wasn't able to say, or the emotions he didn't feel able to feel, Billy felt" *"There were certain patterns, in terms of if someone pushes her at school, this would be reflected by the poodle Cherry, pushing a boy back in the poodle world. The poodles used to do things that boys did to her."*	ICs indirectly communicating about child's own difficulties		
"She was left to her own devices a lot of the time, so she created these companions...sometimes I thought because her real world was so...difficult, and not really what she wanted. So she escaped to this imaginary world, with these imaginary people, where she could do the things she wanted to do, be how she wanted to be, and nobody would give her a hard time." *" I guess that way, she didn't have to think so much about her real world and things she wasn't happy about"* *"I think that possibly it was a way of escaping what was going on in the real world"* *"It was somewhere where she was happy, in her imaginary world, with her imaginary friends"*	IC helping to escape real world IC helping to escape reality IC helping go to a world where child feels accepted IC helping to escape difficulties in real world Escape to preferred world	Escape to a preferred reality	**Maintaining stability in environment and self-image**
"She mentioned a ghost, a little 7-year old girl, and that the ghost was telling her to do these things, like hit her little brother. *It was splitting off a part of herself, not allowing her to work through some of the angry feelings that she had, I guess she felt it wasn't safe to do that herself"* *"She often didn't own her own anger. The Ball was holding the anger for her a lot of the time, which I suppose isn't ideal."* *"It seemed as if the companion was invested with all the…difficult, negative behaviour that the child was finding it difficult to cope with."* *"It seemed like it was an unwanted*	IC acting out unacceptable impulses Unacceptable qualities placed into IC as safer Anger being placed in IC IC invested with unacceptable qualities	Splitting of unacceptable aspects of self through projection	

part of self, rather than a complete other" *"Particularly where there were misdemeanours involved, then the IC became a repository of all the things the child had done"* *"They were acting on her desires of what she would have liked to happen what she would want to do, but couldn't"* *"It seemed a safe way of distancing his feelings and projecting them onto someone else"*	IC containing unacceptable aspects of self IC scape-goated for child's misdemeanours ICs acting out wishes Placing difficult feelings into IC		
"Well, her main problem was this hatred towards men and boys. And Cherry had said some things about boys to her, validating her negative view and justifying being mean to them....her belief that men were really bad was reinforced by the actions of Cherry and the other poodles, who went on killing them" *"Everything the poodles did was to reinforce her belief system, and everything that Cherry did was to reinforce her beliefs".* *"I think it maintained her negative beliefs about friendships, other children"*	IC validating belief system IC reinforcing negative beliefs ICs reinforcing existing beliefs IC reinforcing beliefs about social relationships	Upholding/validating view of the world	

Use in therapy

"Because she didn't have many friendships, it was about relating to the poodles and learning about her social world from them." *"She was developing sexually quite early...It was quite painful for her to accept, and we did talk to her about it quite a lot. Our first inkling about it was when she drew 'Cherry', and on her dress, there were heart patterns, which were quite strategically placed,*	Learning about difficulties though ICs Insight about distress difficult to verbalise through IC	Insight into the child's difficulties	**Assessment**

and covered particular body parts." *"It impacted on therapy in that it helped me to understand more of what my patient was trying to tell me, and how I could help her"*	Learning about child's difficulties through IC presentation		
"It was quite clear from the first session that we needed to work with the poodles to work with her. It was the only way to engage her, so I remember hanging on to it very quickly." *"The only way to get any direct dialogue with her was by asking her what she was by asking her to draw her ICs and commenting on the drawings"* *"But I do remember that talking about the IC seemed to be the way to engage her, she was very difficult to engage in conversation, there was no eye contact."* *"I think the IC helped a lot, especially in engaging him."*	IC only way to engage child IC useful for establishing initial rapport Engagement tool for child that was difficult IC helpful in engagement	Engagement tool	
"It was the only way to engage her!" *"There had been particular crises in the family, physical illness, hospitalisation...which meant that the girl had to spend periods of separation with the grandparents, and I realised that this coincided with the development of the IC".* *"I tried to understand it in terms of a stable figure in his life that developed as a result of a chaotic early life, rejection, abandonment"* *"I tried to understand what the meaning of the IC's presence was, why it had developed, where it had come from"*	IC development related to difficult period in child's life IC creation related to distressing early experiences Hypothesising about IC's development	Development	**Formulation**

"Because it was so predominant in the sessions, it was also very predominant in our formulation"	IC salient for child	Salience	
"Well we drew Bob in his genogram, which was interesting because I asked him to include all the key figures in his life"	IC key figure in child's life		
"They were around in all contexts"	IC present in all contexts		
"She was certainly talking about Cherry and the other poodles all the time"	Important for child		
"It was around in many different contexts, but particularly in therapy and at school I think"	Hypothesising about IC's presence in different contexts		
"It became an issue between her and her mum. Her mum would be telling her to stop having the ICs, or send them away. So there was a lot of conflict between them about it. Even walking to school in the morning, her mum would get irate with her, because she was talking to the ICs."	IC hypothesised to have negative impact on parental relationship	Impact on other relationships	
"It had become an area of conflict for the family...because the parents, and particularly the siblings would sometimes belittle the existence of this friend, they'd say "it's just imaginary" and make the child feel foolish for having this friend"	IC perceived as area of conflict for system		
"It was a source of ridicule for the siblings, which was obviously concerning"	Siblings teasing child for having IC		
"The parents were a bit dismissive, but also concerned and slightly worried because he still had this friend. Mum said: "It was acceptable at 3-4ish but he really should have grown out of it by now"	Parent exasperated by IC presence into adolescence		
"Other people didn't understand, they thought she was mad"	Negative perception of child's IC		
"I don't think it helped him to be accepted you know, in the school context. It was an unusual type of IC, not just like a mini-me, it was this thing that lived in the walls...so I tried	Unusual IC perceived negatively by school peers		

to think about how it was affecting his relationships" *" She was very unhappy at school, no friends, nobody liked her, they all thought she was very odd, very strange because she was talking to all these imaginary friends all the time"* *"Mum was very cross with the ICs and told her not to speak to them and for them to go away and not to be there. Yeah, I mean mum saw them as a problem"*	Peers rejecting child owing to interactions with IC Mum concerned about interactions with IC		
I think my understanding is probably based on my own experience of having one as a child" *"I guess because I've had the experience of having one, I always thought they were quite normal, so in that sense my lay understanding of they would be that they are something to make play more interesting"* *"I think they are pretty innocent I guess...they can be helpful and serve a function useful for a child"* *"I think they are quite prevalent in young children...and at some point or other they just fade away, when they are no longer useful I guess"* *"I had one myself growing up, so I see them as fairly common, and you know...normally fun"* *"One of my own daughters had ICs when she was younger, so I knew it was pretty common and wasn't perturbed by it"* *"I'd never come across it before, so I thought:"Oh what are going to get here"*	Understanding influenced by previous experience of IC as a child IC normal part of childhood Serving useful function for children ICs prevalent in early childhood ICs disappear naturally when they have served their function Understanding influenced by having an IC as a child Acceptance of ICs influenced by previous experience Lack of experience with ICs Hesitancy Lack of previous	Impact of clinicians' previous experiences on formulation	

"I remember thinking...I don't know very much about this! I never had one! *"I didn't know much about it, so I was a bit confused and had several hypotheses in my mind...I didn't know if it was some sort of potential...psychotic delusion"*	experience with ICs Lack of experience and concern about IC meaning IC as part of psychotic presentation		
"I didn't go into it as much as I wanted to, as there were safeguarding issues, which were more pressing." *"I feel that the child protection issue had the biggest impact on how the therapy progressed"*	Risk issues preventing IC use Child protection issues impacting on course of therapy	Clinical risk issues	**Not addressed in therapy**
"I think I would have used him more, had the boy brought him more obviously to work with. I would only use it if it became apparent that it was quite prominent" *"It didn't crop up that much really"*	IC not salient for child so not used Child not bringing up IC in therapy	Not salient	
"I don't know if it made it easier for her because I was happy for them to be there. Whereas her mum was very clear: 'You don't talk about them, you don't talk to them! *"She loved coming. I think therapy was a safe place where she could talk about her ICs, and be accepted for having them"* *"Well, first of all I think it was important that I didn't deny that his friend existed..so I think he felt I was accepting of what he brought"* *"I tried not to be too challenging of the IC, which I think helped us establish a good alliance"*	Clinician accepting of ICs brought to therapy Therapy providing accepting environment to discuss ICs Clinician acknowledging IC existence Clinician not challenging reality of IC Positive effect of this on therapeutic alliance	Fostering trust through acceptance of IC	**Salient and Congruent**

"I think we did try to use the poodles in terms of when we were trying to introduce flexibility in her thinking" *"We asked her: "How could Cherry help you?" The girl really liked video games and as part of the exposure work we took her to a video game shop, where we anticipated there would be a lot of men and boys. Rather than just going in and stabbing everybody, you can't get the game if you do that. Cherry was quite important in how she could help, coming up with alternative strategies, like she could keep a look-out"* *I would ask "What does Billy think about this?"* *"What would Billy say?"* *"If he was feeling very angry, I'd say: "What would Billy do if he was feeling angry?"* *"If you were stuck, could you ask Toby what you could do"*	ICs used to augment number of options IC used to generate more adaptive coping strategies IC used to aid perspective taking IC used to help generate alternative coping strategies	Therapeutic allies	
"We would ask the young girl, before she settled down to play with this little companion, whether she could convince her that maybe tidying the room might be a good idea." *"Billy, how do you think 'Johnny' (client pseudonym) would feel about spending the next session in the play room, without his mum?"* *"I think eye contact in particular was difficult for this girl, and she preferred to answer through the IC"*	Obtaining co-operation through using IC in mediating role Using IC as mediator IC acting as bridge between child and therapist Interaction through IC preferred owing to social communication difficulties	Managing intensity of interactions	
"I tried to emphasise that children are allowed to be angry about what's happened to them and be accepting to those emotions she was bringing"	Therapist accepting of emotions IC was expressing	Validating IC function	**Salient and acting against child's wishes**

"Rather than see it was a monster, like it was initially presented, we re-framed it as a child, who was lost and angry, looking for containment of her anger, and for someone to look after her." *"I re-framed the IC as 7-8 year old child, looking for a real home. I said to her that in our clinic, we often work with 7-8 year-old children, looking for safety and understanding, and that the IC could stay here, with us, and that we would look after her. And that's when she (IC) went away!"*	IC re-framed in a less threatening form IC re-framed as vulnerable aspect of child IC re-framed as child at younger age Clinician offering to 'look after' vulnerable IC Understanding child's communication	Re-framing IC	
"She found it hard when I tried to bring them in. Sometimes when you are working with children, you try to get them to take a different perspective, like: "What would your friend do?" But when I said that to her, she'd sort of cop out of it and say: "Oh but they are just imaginary!"She was able to step out of it. *"I tried to use it, but I was not very successful. I tried to talk about her friend and she sort of looked at me a bit blankly, and didn't answer"* *"But when it came to 'Live'...going to process and commenting on the Ball...then she didn't seem quite so happy to go there. I don't know whether that's because maybe she was partly aware of the construct that it was...that if she was talking to me on that level and she knew it wasn't there, it would be uncomfortable and....perhaps sticking to description was safer"*	Not going along with clinician's use of IC Child not comfortable with clinician's use of IC Child not engaging with clinician's use of IC Child uncomfortable with use of IC as knew it wasn't real Preference for own use of IC	Not accepting clinician's use of IC	Impact
"I suppose I wouldn't have wanted to kill of the Ball in any sense as I saw it as having a useful function" *"It was still very much a part of her life"*	IC needed to serve useful function IC still present	No change in IC presentation	

"They still remained there, and they were still important to her" *"Billy was definitely still there, I included him in my ending letter"* *"Perhaps they were a bit less present therapy went on, She did still refer to them and talk to them though, they were definitely still there.*	IC remaining salient IC still present ICs somewhat less present ICs till salient		
"Yeah, I think he relied on him a little bit less, he was definitely less of a feature towards the end of therapy." *"I think he was able to vocalise his own emotions a little bit more, so he may have needed Billy less for that particular purpose."* *"He talked about him spontaneously less towards the end of therapy"* *"I think that there seemed to be less of a need for it. She didn't seem as interested in it"* *"Some additional needs were being met therefore reducing the possibly the need for the IC to be held on to"* *"I understand he is fading now, the friend. I think his sense of containment is such that he perhaps doesn't need him anymore, he has almost absorbed that person into himself"*	Decreased reliance on IC IC less needed Child more able to express emotions IC less salient in therapy IC less needed IC less needed as therapy meeting unmet needs IC fading Useful aspects of IC internalised	IC fading away	
"We did have a few school meetings; we talked about transition and things like that.. and I do think that the school were a bit more understanding after that" *"I don't know if I could hand-on-heart say that something meaningful changed about her, I think that other people's relating to her changed".* *"Mum was always in the sessions so mum's thinking and understanding was probably more affected, same with school.*	School liaison improving understanding Therapy impacting on other systems Therapy improving mum's and school's understanding of difficulties	Systemic impact	

"So working with the systems seemed to be more effective to shift things"	Systemic impact of treatment		
"When mum was breaking down into tears that she wasn't able to play with her daughter, and sometimes couldn't even tolerate being around her...she realised it was partly her, and not just Mary"	Therapy highlighting mum's difficulties		
"And she also came to understand why Mary had the ICs"	Therapy helping parent to understand child's use of ICs		
"Her relationship with her biological mum and stepdad improved quite a lot as a result of our work"	Therapy having positive impact on parental relationships		
"We also managed to help the parents see this little companion more playfully, to create opportunities for the parents and this child to interact together differently"	Therapy having a positive impact on parent's understanding of IC		
"I tried to legitimise the IC with the school staff as well"	School liaison having positive impact on school's understanding of IC		
"His behaviour at home was still difficult, but the parents had a much better understanding of it"	Therapy having a positive impact on parental understanding of child's difficulties		
"School improved enormously, because they really tried to understand people with ASD better"	School liaison resulting in improved understanding of ASD presentation		
"The family dynamics were improved by them just understanding him a bit better and enlisting the support of voluntary organisations"	Positive systemic impact		
	Obtaining additional support		
"I think the systems started to work better around him, rather than we "fixed him", we just helped the systems around him to accommodate him"	Positive impact on systems understanding of child		

APPENDIX 14: Example Uncoded Transcript

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APPENDIX 15: JOURNAL SUBMISSION GUIDELINES

Child: Care, Health and Development

The multidisciplinary journal - incorporating Ambulatory Child Health

Official journal of BACCH, Swiss Paediatric Society and ESSOP

Edited by:
Stuart Logan

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