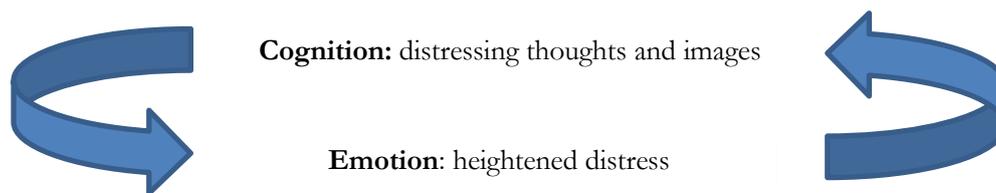


## OCTC PRACTICAL GUIDES

### DISTRACTION & GROUNDING STRATEGIES

Helen Kennerley  
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A common response to upsetting thoughts and images is heightened anxiety or lowered mood - which then fuels the problem cognitions and traps us in distressing cycles that can be really hard to break. We see this over and over again, for example in in panic disorders, worry cycles, hopelessness traps.



The very basic cognitive strategy of distraction rests on the idea that, although we can pay scant attention to several things at once, we can only really attend to one thing at a time. So, if we focus on something neutral or pleasant, we can avoid getting caught up with negative thoughts and urges: we can break out of these cycles.

Distraction can serve two purposes:

- Breaking unhelpful cycles of thoughts or images that might otherwise result in negative moods, increasing preoccupation and so on. This often offers immediate respite. Sometimes it is a temporary solution, giving a person time to recover and marshal their resources, but it sometimes actually results in problem management because of,
- Changing attitudes towards negative cognitions. Instead of getting caught up in them, distraction can help a person achieve distance from them and to see them as 'just thoughts' rather than convincing truths about themselves or the world.

Distraction has been shown to have direct therapeutic benefit both physically and psychologically. For example in pain management (see Koller and Goldman, 2012, for a review of paediatric research) and reducing rumination in depression (Nolen-Hoeksema, 1991).

Research suggests that distraction is more effective than thought suppression in reducing unwanted cognitions (Wenzlaff & Bates, 2000) and that it is more effective when clients devise a positive distraction that is unrelated to their unwanted thoughts (Wenzlaff, Wegner & Klein, 1991). Thus, thinking about something positive is more distracting than trying *not* to think about something negative. This is a general finding – we are more successful if we set out to think about something than if we set out not to think about something. You can easily try this out for yourself – try *not* to think about pink balloons, for example, and your mind will probably fill with pink balloons and you will fail to keep your mind free of them. If, on the other hand, your goal is to think about pink balloons and you try to do this, you will find that you succeed. Furthermore, you can probably manipulate the balloons in your imagination – you can make them rise or fall as you wish or have them explode, for example. This reminds us of the potential control that we have over images.

Distraction techniques include:

- *Physical exercise.* This is particularly useful when a person is so preoccupied that it is very difficult to come up with mental challenges, or with children and adolescents who might be more physically predisposed than psychologically minded. Physical activities can be overt (e.g. going for a run), discreet (e.g. pelvic floor exercises), challenging (e.g. difficult yoga exercises), or mundane (e.g. household chores). The important thing is that they are engaging for your client.
- *Refocusing.* This usually means paying attention to the external environment, and objects or people within it, rather than one's internal world. Patients are encouraged to describe to themselves qualities of the surroundings such as shapes, colours, smells, sounds, textures and so on. The more detailed the description, the more distracting the task will be. *Tracy was nervous on the bus and tempted to get off but she looked out of the window and noted just how many people were wearing hats that day and she noted how the sun was warming her face as it came through the window. She also ran her hands along the edge of her seat and felt the rough velvet of the bus seat. She could just as easily have counted the number of red cars or read different number plates; she could have listened to the sounds of music and conversation within the bus, she could have described to herself the images on the posters which were displayed in the bus – the important thing was that she distracted herself from her worries by paying close attention to her environment.*
- *Mental exercise.* This simply means engaging the mind in mental exercises that might include tasks such as counting backwards in 7s from 1,000, or reciting a poem, or reconstructing in detail a favourite piece of music or scene from a movie. Another effective distraction is a self-created mental image of a place where your client would like to be – a beach, a beautiful garden, a ski slope – whatever appeals to your patient. In order for this to be an effective distraction, the image should be attractive, filled with sensory details and well-rehearsed. Patients might be able to make better use of this sort of distraction by carrying around a book or magazine that will grab their attention, or some photographs of loved ones or a special place that makes the mental image more vivid, or by listening to audio that can distract with either music or talking books.
- *Counting cognitions.* Simply counting troubling thoughts or images can help patients achieve a distance from them and this can break the distress cycle by dampening down the emotional impact of an upsetting cognition. This is achieved because the patients stops paying attention to the *content* and simply counts cognitions with the same attitude one might have to spotting how many pigeons there are in one's neighbourhood: 'There's one ... and another ... oh, and there's another!'

When devising distraction exercises, remember to do this collaboratively and with the following in mind:

- The exercise must suit the person. For example, mental arithmetic and a beach image would not be effective for someone who hates mathematics and is allergic to sand. Your patient will only be able to engage in distraction if the exercise is readily accessible and attractive. Build on a person’s interests and strengths.
- Patients might need several techniques to use under different circumstances. For example, tasks need to be discreet in a public place, whilst in private they can be more overt; physical strategies can be most accessible when a person is highly preoccupied, and mental strategies more usable at lower levels of preoccupation.
- Distraction can be used in behavioural experiments to test predictions such as ‘I can’t stop thinking about x’, or ‘I cannot get the worries out of my head’.
- Distraction will be counter-productive if used as a long-term avoidance or safety behaviour. If your patient develops a belief that he is only coping because he uses distraction, rather than building up confidence that he can take command of his problems, then distraction will be of limited benefit and could actually undermine his confidence.
- Often distraction does not fundamentally change the unhelpful cognition, so it is not necessarily a good strategy for the long term: hence the need for the other strategies that CBT embraces.

Once distraction has been used, debrief. This is crucial to establish

- whether or not its successful application is as a *coping strategy* or as a *safety behavior*, and
- to re-formulate and assess if you need to progress beyond distraction.

*Janice experienced occasions when she felt trapped and immobilized by panicky thoughts. Recently she had experienced this at work, when it stopped her from completing a report that was urgent, at home, where she found herself so preoccupied that she failed to get ready for a social event and in the street when she couldn’t rid herself of catastrophic thoughts and she wandered aimlessly. Janice said that sometimes she simply needed respite from panicky thoughts so that she could “think straight and make a plan.” A repertoire of distractions gave her the mental break that she needed. Her chosen strategies embraced her interest in gardening, and love of reading as well as her ability to run for several miles (see below). A person with different interests and abilities would generate a different list of physical and mental distractions.*

*Janice’s distraction repertoire*

	<i>At home</i>	<i>At work</i>	<i>In public</i>
<b><i>Low-moderate panic</i></b>	<i>Read my novel (keep it on my phone for easy access)</i>  <i>Plan the garden : go out and work on it if I can</i>	<i>Read my novel (keep it on my phone for easy access)</i>  <i>Look at the pictures of National Trust gardens that I keep on my phone: imagine walking through them.</i>	<i>Try to remember the plot of my novel and talk myself through it</i>  <i>Imagine walking through a beautiful garden</i>

	<i>Sing along to pop music: dancing helps, too</i>	<i>Review my calendar and my "to do" list</i>  <i>In a meeting : make notes of what's being said</i>	<i>Listen to pop music through earplugs</i>  <i>Walk!</i>
<b>High level panic</b>	<i>Go out for a run if possible</i>  <i>Walk to the Garden Centre</i>  <i>Watch something easy and entertaining on the internet.</i>	<i>Take a walk to the canteen or go for a lunch time run</i>  <i>Work through the puzzle magazine in my drawer</i>  <i>In a meeting: doodle</i>	<i>Describe what I can see: whatever is in shop windows / the number of red cars or people carrying handbags etc.</i>  <i>Count down from 100 in multiples of 7</i>

*Judy tried out her strategies and realized that she needed to refine her ideas – for example, when she was in public and very panicky, it was impossible for her to count backwards from 100 in multiples of 7 – so she abandoned this and opted for a less demanding (but very absorbing) task of trying to walk as her childhood ballet teacher had taught her, being aware of keeping upright and positioning her feet carefully. These changes are necessary in order make the strategies sufficiently “bespoke”.*

*She found that simply breaking the cycle of panicky thoughts often gave her enough relief to be able to put her concerns to one side and get on as normal. Just knowing this reduced her anxiety levels because she became less afraid of being afraid. There were times, however, when her concerns returned and so she developed specific strategies for catching, focusing on and reviewing problem cognitions.*

## Grounding strategies

These are simply elaborations of distraction technique that can be helpful in managing intrusions and urges (Kennerley, 1996). The intention is to “ground” a person back in the present if they are dissociated for time, or to “ground” them in a pleasant or safe place-in-mind if they are distressed and have the urge to hurt themselves or others.

Grounding strategies generally need to be rehearsed very frequently if they are to successfully combat dissociation and urges and, like all distraction strategies, they are more likely to be engaging if they represent something that interests the patient.

Below are some simple grounding strategies:

- **Imagining a ‘safe place in mind’.** You can build on the power of distracting images by helping your patient elaborate one or more into a vivid mental picture of somewhere that your patient feels safe and/or soothed. There are three things which really help make the image work: encourage your patient to (i) make the image as full of sensory experiences as

possible: sounds, sights, physical sensations and so on; (ii) make it somewhere that the patient enjoys thinking about; (iii) make it active, have a routine to follow such as walking through a beautiful city if there are good memories of that place or follow all the necessary stages in making cake if your patient enjoys baking – this will help them keep engaged with the image. You really do need to encourage patients to create an appealing image and not just one that you both think should work. For example, there would be little point in a keen cyclist who hated the sensation of sand between his toes imagining “walking bare-foot along a tropical beach” as his soothing image, it just wouldn’t work and he would have far more success imagining himself cycling along on a particularly satisfying route.

- **Imaging and creating a safe or strong position:** Our body responds to emotion - if we feel depressed we tend to slump and if we feel anxious we tend to cower, for example. Interestingly, our emotions also respond to our bodies - if we adopt a confident position we tend to feel more confident and if we smile we tend to feel more cheerful. Thus it can be very helpful to aid patients in developing “grounding positions”, postures that convey the emotions that they need to feel. Thus, fearful patients might benefit from practising a confident posture, the submissive patient an assertive stance and so on. This practice is often enhanced by also considering shapes and colours and temperatures and it can be productive to ask questions like: “If you were feeling confident and good about yourself what colour might your ‘feel’, where would it be in your body, what shape would it take?” When asked this, one patient replied: “When I stand tall and feel in control, strong and in command of my anger, the colour in me is blue. It’s a cool misty blue that descends from my head, displacing all the red anger.”
- **Using pleasurable and soothing smells.** Smell can be very powerful in triggering emotions and patients can use this to their advantage if they find a scent that is really meaningful in a positive way. You could check out perfumes, aftershaves and familiar smells such as fresh coffee, cinnamon, vanilla etc. When your patients find something effective, help them develop ways of making it accessible. For example one patient carried a little bottle of rose oil as this took her back to her wedding day and filled her with joy and hope, another carried around coffee beans which made him feel “grown up” and thus stronger, another carried a cedar wood ball because the smell was a soothing reminder of happy days in his grandfather’s house.
- **Using grounding objects:** These are portable objects that distract and then cue the patient to find the safe or soothing place-in-mind. They are not “lucky charms” and should not be used in that way. Grounding objects can be quite mundane - pebbles, key rings, hankies, a friendship bracelet, for example. The key is in finding an object (or two) that immediately generates the message that your patient needs to rehearse be it: “I’m loved”, “I can do”, “I am safe” “I have achieved” and so on. Sometimes the object has a scent that makes it even more potent.  
*For example, the patient above fixed a wooden cedar ball to his key chain so that it was always with him. When it was in his pocket he could simply hold it and the shape of it immediately triggered a mental picture that reminded him of his grandfather’s house (which was also the subject of his safe-place-in-mind image). If he took out the cedar ball, the smell ensured that he was transported back to this safe place.* Other patients use their smart phones as these can carry pictures and music that distract and remind them of their strengths, connectedness and safety etc.

Again, it is important to stress that once you have encouraged patients to use grounding strategies, you must debrief and discover what they conclude from the successful application of the techniques. You need to establish as soon as possible if a technique is being used as a safety behavior rather than a coping strategy and deal with this so that the patient properly benefits from the strategy.

**Additional reading:**

- Kennerley, H. (1996). Cognitive therapy of dissociative symptoms associated with trauma. *British Journal of Clinical Psychology*, 35, 325–340.
- Koller, D., & Goldman, R.D. (2012) Distraction techniques for children undergoing procedures: a clinical review of paediatric research. *Journal of Paediatric Nursing*, 27, 652-681
- Nolan-Hoeksema, S. (1991) Responses to depression and their effects on the duration of depressive episodes *Journal of Abnormal Psychology*, 100, 569-582.
- Wenzlaff, R.M., & Bates, D.E. (2000). The relative efficacy of concentration and suppression strategies of mental control. *Personality and Social Psychology Bulletin*, 26, 1200–1212.
- Wenzlaff, R.M., Wegner, D.M., & Klein, F.B. (1991). The role of thought suppression in the bonding of thought and mood. *Journal of Personality and Social Psychology*, 60, 500–508.