Graduate thesis

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Norwegian University of Science and Technology
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How Do People Stop Worrying

Graduate thesis in Clinical Psychology
Supervisor: Stian Solem
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Abstract

Introduction: This study aims to answer the question "how do people stop worrying?". Worrying is the core symptom of generalized anxiety disorder and answering this question could lead to improved treatment opportunities for these patients and others who struggle with excessive worry. The recommended psychological therapies for generalized anxiety disorder are Cognitive Behavioral therapy (CBT), the Intolerance of Uncertainty model (IU), Acceptance and Commitment therapy (ACT), and Metacognitive therapy (MCT), which all differ in their recommended strategies for how to stop worrying. Classical CBT argues for logical reasoning and relaxation; IU for learning to tolerate uncertainty; ACT for defusing cognition and acceptance of worry thoughts; and MCT for detached mindfulness and dysfunctional metacognitions about worry.

Method: To research the question of how we stop worrying we created the Stop Worry Questionnaire (SWQ) with 23 items concerning ways of stopping worry. The SWQ was distributed to two samples, recruited from online forums and groups regarding mental health issues. A factor analysis was conducted on the SWQ in sample 1 (n = 371). The measures Cognitive Fusion Questionnaire (CFQ) and Intolerance of Uncertainty Scale (IUS) were included in sample 2 (n = 110) to test if the SWQ factors were unique predictors of worry.

Results: The factor analysis identified three factors: (1) *a feeling of safety*, (2) *a sense of too much time spent worrying*, and (3) *(meta)cognitive strategies*. *(Meta)cognitive strategies* (3) had a positive correlation with low worry, and it showed a significant relationship with worry, even when controlling for cognitive fusion (CFQ) and intolerance of uncertainty (IUS). The helpful *(meta)cognitive strategies* involved a conscious decision to stop worrying, not engaging with the worries, putting things into perspective, and figuring out that worrying is unhelpful. *A sense of too much time spent worrying* (2) had items describing stopping worry when realising that they had spent too much time on it. It had a positive correlation with high worry, and it was a unique predictor of worry in both samples when CFQ and IUS were not present. *A feeling of safety* (1) was characterised by people being able to stop worrying from a feeling of safety or calm. It had a positive correlation with low worry. Results were clear for *(meta)cognitive strategies*, though not as coherent for the two factors *a sense of too much time spent worrying* and *a feeling of safety*.

Discussion: Some *(meta)cognitive strategies* might be essential for stopping worry. The strategies have a resemblance to detached mindfulness in MCT, cognitive de-fusion in ACT, and tolerance of uncertainty in the IU. On the one hand, *a feeling of safety* can resemble a trait-like feeling of safety, while on the other hand, it can resemble the skill-goal of treatment within CBT and IU. *A sense of too much time spent worrying* is discussed as having less significant results because of how individual we view how much time we spend worrying. In conclusion, people use various strategies to stop worrying, but the *(meta)cognitive strategies* are shown to be of relevance to therapies trying to help people stop worrying.

Keywords: worry, coping, uncertainty

Norwegian summary

Abstrakt

Innledning: Denne studien ønsker å svare på spørsmålet "hvordan slutter folk å bekymre seg?". Bekymring er kjernesymptomet i generalisert angstlidelse, og ved å svare på dette spørsmålet kan det føre til bedre behandlingsmuligheter for disse pasientene og andre som sliter med bekymring. De anbefalte psykologiske terapiene for generalisert angstlidelse er Kognitiv atferdsterapi (KAT), Intoleranse for usikkerhetsmodellen (IU), Aksept- og engasjementsterapi (ACT) og Metakognitiv terapi (MCT). Alle svarer ulikt på spørsmålet om hvordan man slutter å bekymre seg. Klassisk KAT argumenterer for logisk resonnement og avslapning; IU for å lære å tolerere usikkerhet; ACT for kognitiv defusjon og aksept av bekymringstanker; og MCT for frakoblet mindfulness og dysfunksjonelle metakognisjoner til bekymring.

Metode: For å undersøke spørsmålet om hvordan vi slutter å bekymre oss har vi laget Stop Worry Questionnaire (SWQ) med 23 spørsmål om måter å stoppe bekymringer på. SWQ ble distribuert til to utvalg, rekruttert fra nettforumer og grupper på psykiske helseproblemer. En faktoranalyse ble utført på SWQ i utvalg 1 (n = 371), mens målene Cognitive Fusion Questionnaire (CFQ) og Intolerance of Uncertainty Scale (IUS) ble inkludert i utvalg 2 (n = 110) for å teste om SWQ-faktorene var unike prediktorer for bekymring.

Resultater: Faktoranalysen identifiserte tre faktorer: (1) *en følelse av trygghet*, (2) *en følelse av å bruke for mye tid på bekymring*, og (3) *(meta)kognitive strategier*. *(Meta)kognitive strategier* (3) hadde en positiv korrelasjon med lav bekymring og viste et signifikant forhold til bekymring selv etter å ha kontrollert for kognitiv fusjon (CFQ) og intoleranse for usikkerhet (IUS). (*Meta)kognitive strategier* inneholdt spørsmål som beskrev en bevisst beslutning om å slutte å bekymre seg, ikke engasjere seg med bekymringene, sette ting i perspektiv og det å finne ut at bekymring ikke hjelper. *En følelse av å bruke for mye tid på bekymring* (2) hadde spørsmål som beskrev måter å slutte å bekymre seg når man fikk en følelse av at man hadde brukt for mye tid på det. Den korrelerte svakt med høy bekymring, og var en unik prediktor for bekymring i begge prøvene da CFQ og IUS ikke var til stede. *En følelse av trygghet* (1) beskrev måter å slutte og bekymre seg på gjennom en følelse av trygghet eller ro. Den korrelerte positivt med lav bekymring. Resultatene var klare for *(meta)kognitive strategier*, mens de ikke var like sammenhengende for de to andre faktorene, *en følelse av trygghet* og *en følelse av å bruke for mye tid på bekymring.*

Diskusjon: Noen *(meta)kognitive strategier* kan være spesielt viktige for å stoppe bekymring. Strategiene ligner på frakoblet mindfulness i MCT, kognitiv defusjon i ACT samt toleranse for usikkerhet i IU. *En følelse av trygghet* kan på den ene siden minne om en egenskapslignende trygghetsfølelse, mens den på den andre siden ligne på ferdighetsmålet for behandling innen CBT og IU. *En følelse av å bruke for mye tid på bekymring* sine mindre signifikante resultater blir diskutert opp mot hvor individuelt vi bedømmer hvor mye tid vi bruker på bekymring. Vi bruker en rekke forskjellige strategier for å slutte å bekymre oss, men *(meta)kognitive strategier* har vist seg å være av spesiell relevans for terapier som prøver å hjelpe folk som vil slutte å bekymre seg.

Nøkkelord: bekymring, mestring, usikkerhet

Introduction

Worry is defined as a chain of negative thoughts and images aimed at solving upcoming problems (Borkovec, Robinson, Pruzinsky, & DePree, 1983). It is a primary characteristic in anxiety disorders and a common tendency in all people (Wells & Graham, 2006). The persistence of worry in patients with anxiety disorders, especially generalized anxiety disorder (GAD), has raised the question; "how do people stop worrying?" The psychological treatments considered as effective treatments for worry and excessive worry in patients with generalized anxiety disorders are: Cognitive Behaviour therapy (CBT: (Newman & Borkovec, 2002)), Intolerance of Uncertainty (IU: (Dugas, Gagnon, Ladouceur, & Freeston, 1997)), Acceptance and Commitment therapy (ACT: (Hayes, Strosahl, & Wilson, 2011)) and Metacognitive therapy (MCT: (Wells, 2009)). These treatments aim to help patients stop using worry as a problem-solving strategy but differ in what they consider as helpful strategies for stopping worry. This research aims to explore how people stop worrying and if this relates to the severity of worry.

CBT teaches coping techniques to help patients during stressful situations and worrisome thoughts (Newman & Borkovec, 2002). Patients are taught to use cognitive exposure (a process of reducing fear and anxiety by exposure through imagining) combined with relaxation techniques (Applied Relaxation: (Öst, 1987)) to feel calm in anxiety-provoking situations. Patients reduce their anxiety as they imagine coping effectively with the situation (Borkovec & Costello, 1993). They learn the stimulus control method, which is a way to reduce the association between internal and external cues and their anxiety. Lastly, they are taught how to treat their thoughts as hypothesis rather than facts, which invites for contradicting facts. Gathering contradicting evidence allows for a stronger sense of control of the situation and the ability to see it in a new perspective (Newman & Borkovec, 2002). Therefore, possible strategies for stopping worry based upon CBT models would involve relaxation and feeling calm, having thought through all possible scenarios, replacing thoughts of concern with positive thoughts, and reaching a conclusion.

The coping techniques that patients develop in CBT resemble that of Intolerance of Uncertainty treatment (IU). The goal of the IU is for patients to judge a situation more clearly and feeling safe despite uncertainty (Dugas, Gagnon, Ladouceur, & Freeston, 1997). In IU therapy, patients are introduced to awareness training, identifying worry and its triggers, and testing their beliefs about uncertain situations through behavioral experiments. Accepting uncertainty, distancing from unhelpful thoughts, and eliminating cognitive avoidance are all

highlighted by the therapist (Hebert & Dugas, 2019). The problem orientation training in IU helps patients compromise between avoiding the problem and gathering excessive information, both of which interfere with problem-solving and prolong worry (Dugas & Robichaud, 2007). For worries concerning situations that are not amenable to problem-solving, the IU therapist seeks to reduce the perceived possibility of these events occurring by having the patient habituate to these threatening events (Dugas, Gagnon, Ladouceur, & Freeston, 1997). Possible strategies taught in the IU for stopping worry is leaving things you cannot influence, thinking you will be fine, being sure something wrong won't happen, or having the feeling that you have done everything you can to prevent something bad from happening.

ACT aims to foster more flexible and mindful ways of relating to anxiety. It is built on the problems of cognitive fusion, which occurs when people firmly believe the contents of their minds to be facts, and experiential avoidance, which is when people try to suppress, control, or eliminate experiences expected to be distressing. The constructive alternative to cognitive fusion is de-fusion, and the preferred option to experiential avoidance is acceptance (Hayes, et al., 2004; Hayes, Strosahl, & Wilson, 2011). An ACT therapist seeks to create an acceptance-based outlook on patients' worry. Patients learn to let go of the suppression and controlling of worry and instead stay with the discomfort and look at it from a de-fused mindful observer's perspective. According to ACT, an acceptance-based outlook on thoughts is through values. The ACT therapist and patient identify cherished life goals and values, e.g., "I want to be the best parent I possibly can". Following that example, the patient and therapist explore whether the patient's worry fits with their understanding of how a good parent should be. During an exposure exercise, framed in the context of their values, patients learn to practice de-fusing skills in the presence of discomfort (Eifert & Forsyth, 2005). The assumption is that people stop worrying when defusing and achieve a sense of acceptance of their thoughts. The therapist seeks to broaden the patient's mind by helping them keep a distanced view of their thoughts, accepting them, and reacting to them according to their values (Hayes, Strosahl, & Wilson, 2011). Possible strategies for stopping worry deduced from ACT could be to leave things you cannot influence, put things in perspective and accept the worrisome thoughts.

The metacognitive treatment is built on two main metacognitive principles. MCT teaches patients to "detach" from their thoughts; this is termed "Detached Mindfulness" (DM), which is an awareness of thoughts as events separate from facts. If you can

comprehend thoughts as events going through the mind without a solitary focus, nor trying to avoid them, you have detached mindfulness (Wells & Matthews, 1996). The second principle of the metacognitive model is the different metacognitive beliefs that uphold worrying. The positive beliefs maintain worrying by thinking they are helpful. Negative beliefs strengthen worry by adding a new type of worry: worry about worry (e.g., "I worry so much I think it will hurt me" or "I cannot control worry") (Wells, 1995). Combining the knowledge and practice of DM and metacognitive beliefs, patients train to detach from their worry, altering the beliefs by looking at counterevidence and consequently stopping worry by finding new plans of processing. Whenever the patient experience a trigger, they are to apply detached mindfulness and process the situation in a way that keeps them feeling safe and happy instead of worried (e.g., "I must ban checking for danger" instead of "I must check for groups of youths to feel safe") (Wells, 2009). Possible strategies for stopping worry deduced from this approach could be leaving thoughts alone, deciding not to think about the worries, putting worries in perspective or finding out that worrying is not helpful.

To summarize, the CBT and IU models involve helping patients utilize logical reasoning, problem-solving, and cognitive exposure when worrying (Newman & Borkovec, 2002; Dugas & Robichaud, 2007). IU places value on the intolerance of uncertainty in excessive worriers and teaches patients to find the middle way between overanalyzing and avoiding a problem (Dugas, Gagnon, Ladouceur, & Freeston, 1997). CBT is a broader framework and in further detail explains how they utilize relaxation techniques, stimulus control methods, and cognitive therapy (Newman & Borkovec, 2002). MCT and ACT, have a meta-cognitive nature. They seek to help patients "defuse" (ACT) or "detach" (MCT) from their thoughts and see them more as events of the mind (MCT) or accept them as is (ACT). This allows patients to react to their thoughts differently than before (Hayes, Strosahl, & Wilson, 2011; Wells, 2009). All four share similarities in teaching patients that using worry as a strategy is not helpful, and through different techniques you can stop worrying.

There has not been a study researching how people stop worrying. However, there is related research on emotion regulation, thought control, stop signals, and neuroticism. Theories on emotion regulation refers to how individuals try to influence their emotions (Gross, 1998). Similar research on thought control identifies factors we use to suppress or control thoughts (Wells & Davies, 1994). Stop signals refer to the internal or external stimuli or strategy that terminates a cognitive process (Wells, 2000). Finally, research on neuroticism explains how some can stop worrying while others have more difficulties controlling it

(Steimer, 2002). All these theories contribute to the topic of discussion, namely how we stop worrying.

In the process model of emotion regulation by Gross (1998), there are five influencing points during a generative emotion process:

1. Selection of the situation.

2. Situation modification.

3. Deployment of attention.

4. Change of cognition (reappraisal).

5. Modulation of experiential, behavioral, or physiological responses (suppression).

When people want to regulate their emotions, they select the situations they want to interact with. A way to avoid worrying, would be to choose situations that are not distressing, thus do not require worrying. Once in a stressfull position, we modify the circumstances to avoid the stress. If someone talks about something worrying you, you may ask them to stop, change the subject or leave. Roughly the same applies to the deployment of attention. You select where your attention lies in a situation, as a way to downregulate the worry created by some aspects. Once focused on a particular part of a situation, we assign meaning to the circumstances (reappraisal). For example, you think that "it is just a test" rather than "a sign of my worth," and by putting things in perspective it makes it easier for you to stop worrying. Reappraisal has proven to be effective in decreasing emotional experience and behavioral expression. By contrast, we sometimes act to modulate our responses by suppressing them, but suppression fails to reduce emotional experience (Gross, 2002). Based on the research from Gross (2002), the suggested ways of trying to stop worrying are deploying your attention elsewhere, putting things in perspective, or trying to think differently. Some may also try to suppress the emotional response from worry (e.g., "I get fed up with how much I think about this, and I think that enough is enough").

Like emotion suppression, thought suppression also has the paradoxical effect of heightening the person's unwanted feelings, or now thoughts. Trying not to think about a distressing topic results in a rebound of unwanted and uncomfortable thoughts (Wegner, Schneider, Carter, & White, 1987). This paradoxical effect plays a key role in cognitive-behavioral and metacognitive models of several emotional disorders (Abramovitz, Tolin, & Street, 2001). Wells & Davies (1994) researched people's strategies to control their thoughts

in the Thought Control Questionnaire (TCQ). The study resulted in five dimensions of thought control strategies: distraction (e.g., "I think pleasant thoughts instead"); social control (e.g., "I talk to a friend about the thought); worry (e.g., "I dwell on other worries"); punishment (e.g., "I punish myself for having the thought") and reappraisal (e.g., "I try a different way of thinking about it"). Patients who scored high on worry reported significantly greater use of worry and punishment strategies, and less use of distraction and social control strategies. They try to control their worrying by shifting through different negative thoughts or punishing themselves verbally or physically for having negative thoughts. Distraction strategies were to do or think about something pleasant (e.g., thinking more positively), and social control was to seek out friends for advice and help (Wells & Davies, 1994). Possible ways of stopping worry based on this research may be to punish yourself (e.g., self-harming), stop worry with other worries, discuss it with somebody else (e.g., "Others say I have to stop worrying so much"), distract yourself, or reappraise (e.g., "I put things in perspective").

Possible stop signals for worry have previously not been explored. Stop signals for worry would be any internal or external stimuli or strategy to stop the worry process (Wells, 2000). Related research in other areas does, however, exist. Myers, Fisher & Wells (2009) researched the contribution of stop signals for patients with obsessive-compulsive disorder. According to the metacognitive model, individuals with o-c symptoms determine the cessation of rituals based on internal criteria or idiosyncratic rules. These rules or criteria may worsen the symptoms of OCD, because they prevent the development of a more flexible and functional relationship to thoughts and feelings. Examples of included stop signals were having a strong sense of certainty, performing rituals in a certain order, having an internal feeling that signals it is safe to stop, having no worries that bad things will happen, and being reassured by others that it is ok to stop. Results from the study found support for the role of maladaptive stop signals, both in maintaining and worsening symptoms in OC patients (Myers, Fisher, & Wells, 2009). Indications of different stop signals also exist in other problem areas such as rumination (Kolubinski, Nikcevic, Lawrence, & Spada, 2015), gambling (Spada, Giustina, Rolandi, Fernie, & Caselli, 2015), alcohol abuse (Spada & Wells, 2006), binge eating (Palmieri, Gentile, Da Ros, & Spada, 2020) and smoking (Nikcevic & Spada, 2010).

While emotion regulation, thought control, and stop signals may be teachable skills, there is evidence of people having an innate predisposition for excessive worry, especially those with high scores on the personality trait neuroticism (Widiger & Oltmanns, 2017).

Individuals high on neuroticism tend to use maladaptive strategies, such as worry and thought suppression, and be less engaged in reappraisal to regulate their mood (Haga, Kraft, & Corby, 2007). As a result, they report more worry in their daily life, and they generate more worry-related thoughts after a worry-inducing sentence (Servaas, Riese, Ormel, & Aleman, 2014). People with GAD, a disorder highly etiologically interrelated with neuroticism, may spend 310 minutes daily worrying compared to 55 minutes in the non-clinical group (Dupuy, Beaudoin, Rhéaume, Ladouceur, & Dugas, 2001). People with high levels of neuroticism tend to make threatening interpretations and direct their attention to potential adverse outcomes. In other words, they have an emotional processing bias, where ambiguous situations are being interpreted as threatening (Hirsch & Mathews, 2012). Twin studies report a high genetic correlation (0.80) between GAD and neuroticism (Hettema, Prescott, & Kendler, 2004), and further studies indicate that approximately one-third of genetic influences on GAD were in common with genetic influence on neuroticism (Mackintosh, Gatz, Wetherell, & Pedersen, 2006). Excessive worrying may result from predisposing traits, making an individual high on neuroticism more susceptible to being alert of danger and having a negative appraisal of events. This trait may correlate with ways of stopping that resemble thought- or emotion suppression (e.g., "I have been thinking for so long I can't take it anymore").

As reviewed above, there are different perspectives on how people stop worrying. Therefore, this study aimed to explore how people stop worrying, and relate these strategies to the severity of worry. To test the potential validity of these strategies further, we wanted to explore possible incremental validity of this questionnaire by controlling for established explanatory models of worry such as the Intolerance of Uncertainty Scale (Buhr & Dugas, 2002) and the Cognitive Fusion Questionnaire (Gillanders, et al., 2014). The main hypothesis is that people will utilize different strategies to stop worrying, and the use of these will be related to the severity of worry (study 1). In addition, if the strategies are of any importance to worry, they will explain variance beyond the established models for worry (study 2). Outlining the helpful and unhelpful strategies across the established treatments for worry may positively influence the goals and techniques practiced in therapy for anxiety disorders.

Method

An anonymous online survey was presented on multiple social media forums for people interested in mental health, in addition to being open to everyone who wanted to participate. The first invitation went out in July 2020 on the front page of Mental Health Norway. Then every four days, the survey was presented on different social media forums on Facebook. The survey was sent to forums for anxiety issues, depression, PTSD, and general mental health concerns to ensure that a higher-than-normal percentage of respondents had a significant worry.

Sample 1 consisted of 372 respondents, where 90.3% were female with a mean age of 39 (SD = 11.83), ranging between ages 18 and 80. Regarding employment status, 14.2% were students, 49.2% had a job, and 36.3% were unemployed. Respondents were recruited between 27.07.2020 and 26.08.2020. Sample 1 included the following Facebook groups: "Mental health Norway", "Anxiety forum", "Life with PTSD", "Mental health", "Mental health youth", and "Psychologists and psychology students."

Sample 2 consisted of 110 respondents, where 89.3% were female with a mean age of 39 (SD = 12.40), ranging between ages 18 and 75. In the sample, 26.8% were students, 25.9% were employed, and 46.4% were unemployed. Respondents from sample 2 were recruited between 05.01.2021 and 17.01.2021. Sample 2 included the following Facebook groups: "Anxiety and depression", "Life with anxiety", "Mental health Group" and "The community for anxiety".

A description of both samples' demographics is provided in Table 1. It also includes the rate of low, moderate, and high worries on PSWQ in both samples and sample 2's mean scores on IUS and CFQ. Respondents were distributed into three groups of low, moderate, and high worry based on their scores on PSWQ. The distribution of worry severity in sample 1 was: low worry (n = 69, 19%), moderate worry (n = 121, 32,6%) and high worry (n = 181, 49%), in sample 2: low worry (n = 14, 12,7%), moderate worry (n = 30, 27,3%), and high worry (n = 66, 60%). Looking at the distribution of respondents in sample 1 (N = 371) and sample 2 (N = 110), the mean score on PSWQ was somewhere between moderate anxiety and people with GAD.

Table 1. Descriptive statistics

	Sample 1 (N = 372)		Sample 2 (N = 112)	
	M/%	SD/n	M/%	SD/n
Female gender	90.3%	335	89.9%	98
Age	38.5%	11.73	36.4%	12.34
Employment status				
Work	49.3%	183	26.4%	29
Student	14.3%	53	26.4%	29
Other	36.1%	134	47.3%	52
PSWQ	55.81	15.60	59.46	15.33
Low (16-39)	18.6%	69	12.7%	14
Moderate (40-59)	32.6%	121	27.3%	30
High (60-80)	48.8%	181	60.0%	66
IUS			36.83	13.03
CFQ			33.76	9.66

PSWQ = Penn State Worry Questionnaire; CFQ = Cognitive Fusion Questionnaire; IUS = Intolerance of Uncertainty Scale.

Measures

The Stop Worry Questionnaire (SWQ) is a 23 item self-report measure assessing how people stop worrying. When the questionnaire was created, a list of 23 different strategies on how to stop worrying was constructed inspired by cognitive therapies for GAD (Dugas & Robichaud, 2007; Newman & Borkovec, 2002), Metacognitive- and Acceptance and Commitment therapy (Hayes, Strosahl, & Wilson, 2011; Wells, 1995), research done on worry related to thought control (Davey & Wells, 2005; Wells & Davies, 1994), research on emotion regulation (Gross, 1998), and research done on stop signals in OCD (Myers, Fisher, & Wells, 2009; Solem, Myers, Fisher, Vogel, & Wells, 2010). The items begin with the stem "I can stop worrying when…", and example items are "I put things in perspective" or "I get frustrated by how much time I spend thinking about this and decide that enough is enough." Items are rated on a 4-point scale (1 = disagree and 4 = agree). Also included is an open text box for comments and other ways to stop worrying not included in the questionnaire, but it was removed in the study because of anonymity concerns. The SWQ is included in Appendix A.

The Penn-State Worry Questionnaire (PSWQ) was included to measure participants' degree of worry (Meyer, Miller, Metzger, & Borkovec, 1990). PSWQ is a self-report inventory with questions concerning different characteristics of worry. It contains 16

questions about worry: periods, thoughts on uncontrollability, and the associated stress (Stöber, 2000). Each item is rated on a 1 (“Not at all typical of me”) to 5 (“Very typical of me”) Likert scale. PSWQ has demonstrated high levels of internal consistency ($\alpha > .90$), high test-retest reliability with scores between .75-.93 (Stöber, 2000), and highly convergent correlations with other measures of worry (Meyer, Miller, Metzger, & Borkovec, 1990; Stöber, 2000). Results show that PSWQ measures degrees of worry (Pallesen, Nordhus, Carlstedt, Thayer, & Johnsen, 2006).

The Cognitive Fusion questionnaire was introduced in sample 2 as an established measure on cognitive fusion strongly related to worry. CFQ is a 7-item self-report inventory with questions concerning rigidity, mindfulness, rumination, stress, exhaustion, and frequency of automatic thoughts (Gillanders et al., 2014). Respondents are asked on a Likert scale from 1 (“never true”) to 7 (“always true”). Cognitive fusion is a verbal process whereby individuals become entangled in their thinking and evaluations. When experiences are aversive, fusion leads to experiential avoidance strategies like worry to reduce this discomfort. Other studies have found a strong positive correlation between CFQ and PSWQ: ($r = .71$, $p < .001$), (Zorn, Abdoun, Sonié, & Lutz); ($r = .58$, $p < .001$), (Quintero, Biglieri, Etchezehar, & Gillanders, 2020). CFQ demonstrates good internal consistency and test-retest reliability (Gillanders et al., 2014).

The Intolerance of Uncertainty Scale - Short Form (IUS-12) was introduced in sample 2 as an established measure on uncertainty strongly related to worry. IUS-12 measures the tendency to interpret uncertain situations negatively (Dugas & Robichaud, 2007). The IUS-12 is a short version of the original 27-item Intolerance of Uncertainty Scale. The 12 items are rated on a 5-point Likert scale ranging from 1 (“Not at all characteristically of me”) to 5 (“Entirely characteristically of me”). Studies have found strong correlations between IUS and worry; ($r = .63$, $p < .001$ (Freeston, Rhéaume, Dugas, & Ladouceur, 1994); ($r = .60$, $p < .001$ (Buhr & Dugas, 2002), and IUS is suggested as one of the most contributing factors to degrees of worry (Dugas, Freeston, & Ladouceur, 1997; Ladouceur, Talbot, & Dugas, 1997). IUS has a good internal consistency ($\alpha = 0.91$) and test-retest reliability over five weeks ($r = 0.78$) (Dugas, Freeston, & Ladouceur, 1997).

Overview of data analyses

An exploratory principal axis factoring, rotated using Promax with Kaiser normalization, was used on the SWQ items in sample 1. Principal-axis factoring zeros in on the common variance among the items and delineates the latent factors underlying the data (Matsunaga, 2010).

In both samples, a one-way ANOVA was conducted to compare the difference between people with low, moderate, and high worry and the factors from the SWQ. More, we did further multiple comparisons with Tukey HSD to see if there were significant differences within the groups low, moderate, and high worry and the SWQ factors. The strength of relationship between measures was determined as weak being $.02 < r < .05$, moderate being $0.5 < r < 0.7$ and strong being $r > 0.70$.

Correlation analyses were conducted in both samples. In sample 1, the correlation was between the independent measure PSWQ and the SWQ factors. CFQ and IUS were included in sample 2. A regression analysis was done in sample 1 with PSWQ as the dependent variable. Sex, age, and employment (demographics) were included in step 1 and SWQ factors in step 2. To test whether the items in SWQ explain additional variance, beyond the measures CFQ and IUS, another regression analysis was carried out on sample 2. The dependent variable was PSWQ, and the predictors in step 1 were demographics, step 2 included CFQ and IUS, and step 3 included SWQ factors.

In sample 1, five respondents did not report age, and one left out an answer on employment, leaving the number of respondents in the regression slightly less. In sample 2, one respondent left out sex and one left out age. None of the above were replaced. Four respondents were missing one answer on the IUS; they received a sum score based on the score from the other eleven items. The amount of missing data in total was small, and only the IUS scores were replaced.

Results

An exploratory principal component factoring with principal axis factoring, and Promax rotation with Kaiser normalization, gave three factors with a requirement of factor loading above .50, and a difference between items loading on different factors over .20.

1) *A feeling of safety* (e.g., "I'm certain everything will turn out fine"). The scale consisted of seven items with a high internal consistency (see table 3) in both samples.

2) *A sense of too much time spent worrying* (e.g., "I realize that I have spent way too much time on it"). The scale consisted of five items and had a high internal consistency (see table 3) in both samples.

3) *(Meta)cognitive strategies* (e.g., "I find that the worries are not helpful"). The scale consisted of four items and had a high internal consistency (see table 3) in both samples.

Factor loadings and descriptive statistics are found in table 2. The requirement for item loading was set to greater than .50. Items 1, 4, 5, 6, 8, 10, and 23 loaded strongly into factor 1. Items in the factor all described stopping worry when having a feeling of safety. For factor 2, items 2, 3, 13, 14, and 21 were included. All five items described how to stop worrying when realizing you had spent too much time on it. Lastly, factor 3 had four items: 9, 17, 19 and 20 20. Items in the factor resembled metacognitive strategies for stopping worrying (e.g., "I put things in perspective"). Summarized, the factoring of items in the SWQ resulted in three factors: *a feeling of safety*, *a sense of too much time spent worrying*, and *(meta)cognitive strategies* (see table 2).

Table 2. Factor loadings and descriptive statistics

SWQ items	*Safety*	*Time*	*(M)cog.strat*	Mean (SD)
4. I'm certain everything will turn out fine	**.870**			2.51(1.24)
8. I have peace of mind	**.715**			2.40(1.16)
10. I have no more worries that bad things will happen	**.673**			2.42(1.02)
1. I'm certain that something wrong won't happen	**.628**			2.44(1.22)
23. The bodily distress disappears	**.614**			2.29(1.02)
5. I have an internal feeling signalling that it is safe to stop	**.582**			2.25(1.06)
6. I have reached a conclusion	**.523**			2.20(1.13)
12. I am reassured by others	.426			2.06(0.97)
7. I have replaced the worries with positive thoughts	.423		.347	2.30(1.00)
11. I have the feeling that I have done everything I can to prevent something bad from happening.	.418	.361		2.28(0.93)
13. I get fed up with how much I think about this and think that enough is enough.		**.769**		2.39(1.01)
14. I realise that I have spent way too much time on it		**.734**		2.42(1.00)
16. I get exhausted from thinking so much and can't do it anymore		.596	-.555	2.51(0.94)
21. Others say I must stop worrying so much		**.594**		2.57(0.83)
3. I have been thinking for so long that I can't take it anymore		**.590**		2.47(0.87)
2. I have thought through all possible scenarios		**.508**		2.32(0.98)
22. I remind myself that I worry too much and should put this aside		.498	.359	2.29(0.91)
18. I become distracted by something else		.322		2.07(1.06)
20. I come to discover that the worries are not helpful			**.805**	2.40(0.99)
17. If there is something I cannot influence, I leave it at that			**.754**	2.41(0.89)
9. I decide to			**.681**	2.34(0.93)
19. I put things into perspective			**.576**	2.24(1.09)
15. I never stop worrying, but I get a break when I fall asleep			-.453	2.40(0.94)

Extraction method: Principal Axis Factoring. Rotation method: Promax with Kaiser normalization. Required factor loading >.50, factors marked in bold, and all >.30 is included in the table. *A feeling of safety = Safety*; *A sense of too much time spent worrying = Time*; *(meta)cognitive strategies = (M)cog.strat.*

Three factors were identified from the analysis. The descriptive statistics of the three factors can be found in table 3. The respondents scored highest in both samples on *safety* (1 = 2.56 and 2 = 2.40) and lowest on *(meta)cognitive strategies* (1 = 2.11 and 2 = 2.12).

Table 3. Descriptive statistics and internal consistency of the three factors

	Sample 1			Sample 2		
	M	SD	α	M	SD	α
Safety	2.56	.75	.86	2.40	.79	.88
Time	2.22	.82	.77	2.31	.80	.84
(Meta)cognitive strategies	2.11	.73	.84	2.12	.80	.83

A feeling of safety = Safety; *A sense of too much time spent worrying = Time*; *(meta)cognitive strategies = (Meta)cognitive strategies*. Scores range from 1 to 4.

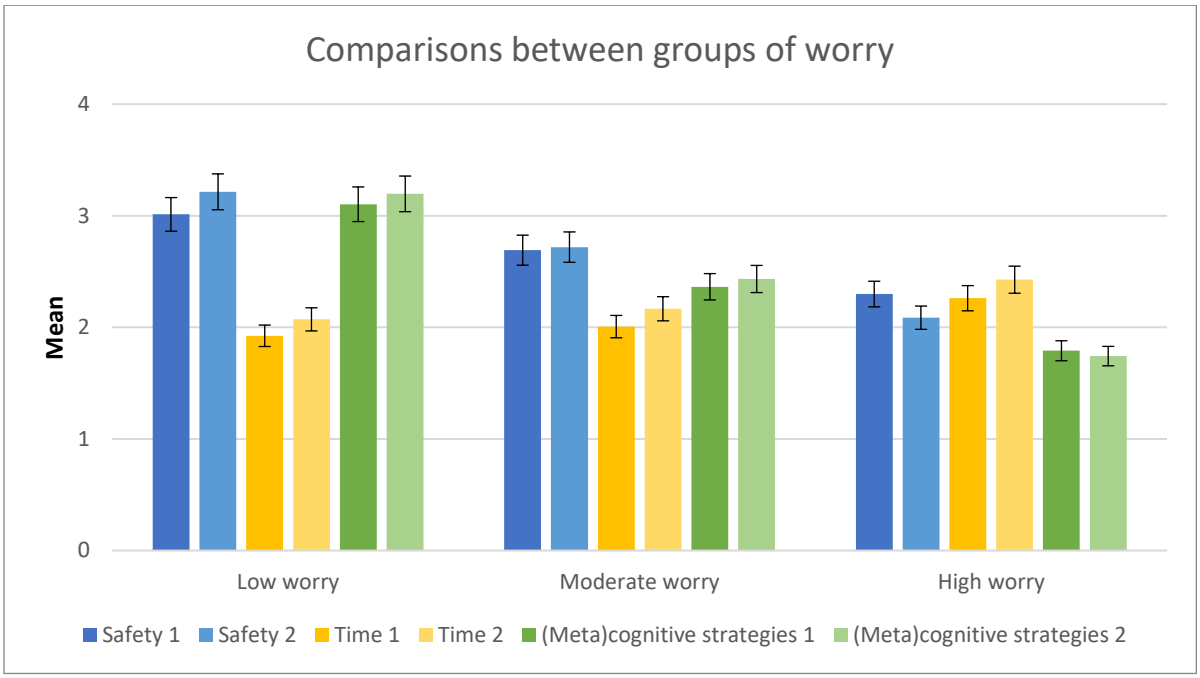
Relationship between strategies for stopping worry and severity of worry

A one-way, between subjects, ANOVA was conducted to compare the correlation with degrees of worry to the three factors: *A feeling of safety (safety), a sense of too much time spent worrying (time)* and *(meta)cognitive strategies*. In sample 1, there was a significant effect of degrees of worry for *safety* [F (2, 368) = 29.36, $p < .001$], *time* [F (2, 367) = 7.51, $p = .001$], and *(meta)cognitive strategies* [F (2, 366) = 103.58, $p < .001$]. In sample 2, a significant difference continued in *safety* [F (2, 109) = 20, 74, $p < .001$] and *(meta)cognitive strategies* [F (2,109) = 36,61, $p < .001$] while *time* was not significant [F (2,109) = 1.85, $p = .162$]. Respondents scoring higher on lower levels of worry (in the PSWQ) had the tendency to also score higher on *a sense of safety* and *(meta)cognitive strategies* according to results from both samples. Scoring high on *a sense of too much time spent worrying* had a correlation with high worry only in sample 1.

Tukey's range test was done post hoc to assess the significance of the differences in low worry, moderate worry, and high worry within each SWQ-factor (see figure 1). For *a feeling of safety*, differences between the scores of the three worry groups were significant only between high worry and moderate worry, and high worry and low worry ($p<.001$). *A sense of too much time spent worrying* had its highest means within the high worry group (2.43). There was, however, no significant differences between groups of worry. *(Meta)cognitive strategies* was the only factor with every mean difference between groups of

worry being highly significant ($p < .001$).

Figure 1. Comparisons between groups of worry in sample 1 and 2, on the three factors: *a feeling of safety*, *a sense of too much time spent worrying* and *(meta)cognitive strategies*.



*A feeling of safety (*Safety sample 1 and sample 2) = high > moderate, low; *a sense of too much time spent worrying (*Time 1 and 2) = high, moderate, low; *(meta)cognitive strategies* (1 and 2) = high > moderate > low.

Correlation between the SWQ factors and the measures of cognitive fusion, intolerance of uncertainty and worry.

The correlation analyses (see table 4) suggest that cognitive fusion (CFQ) and intolerance of uncertainty (IUS) almost measures the same construct as PSWQ, judging from their strong correlations with the worry measure (.82 and .77). *A feeling of safety* and *(meta)cognitive strategies* correlated moderately with PSWQ, suggesting that they are significantly and negatively associated with worry symptoms (sample 1= -.42 & -.65 and sample 2 = -.59 & -.70). In sample 1, *a sense of too much time spent worrying* had a significantly weak correlation with PSWQ (.22), suggesting it's association to higher levels of worry. In sample 2, however, it did not have a significant correlation.

A feeling of safety had a moderate negative correlation with CFQ and IUS, suggesting an association with cognitive de-fusion (psychological flexibility) and tolerance of uncertainty. *A sense of too much time spent worrying* correlated weakly, but significantly with CFQ (p <.01), implying that respondents scoring high on *a sense of too much time spent worrying* may experience more cognitive fusion. *(Meta)cognitive strategies* correlated significantly with all measures at the (p < .01) level, except for with *a sense of too much time spent worrying* (p <.05) (see table 4). The moderate correlations with CFQ, IUS, and *a feeling of safety* suggests that respondents scoring high on the *(meta)cognitive strategies* factor, also scores high on psychological flexibility, tolerance of uncertainty, and a feeling of safety.

Table 4. Correlations between worry symptoms, intolerance of uncertainty, cognitive fusion and *safety*, *time* and *(meta)cognitive strategies*

	Sample 1			Sample 2				
	4	5	6	2	3	4	5	6
1. PSWQ	-.42**	.22**	-.65**	.82**	.77**	-.59*	.18	-.70**
2. CFQ					.75**	-.52**	.31**	-.59**
3. IUS						-.50**	.21*	-.52**
4. *Safety*		-.05	.51**				-.17	.51**
5. *Time*			.17**					.21*
6. *(Meta)cogn. strategies*								

PSWQ = Penn State Worry Questionnaire; CFQ = Cognitive Fusion Questionnaire; IUS = Intolerance of Uncertainty Scale; *A feeling of safety = Safety*; *A sense of too much time spent worrying = Time*; *(meta)cognitive strategies = (Meta)cogn. strategies.*

*p < .05. **p < .01.

Predictors of worry

The results from the regression (see table 5) with PSWQ as the dependent variable were as follows: in sample 1, entering demographic data in step 1 (ΔR^2 = .13, p < .001) accounted for 13% of the variance. Sex did not explain any significant variance. Older age was associated with low worry (t = -2.97, p <.01), and being employed or studying had a lower mean worry than unemployed/not studying (t = -3.89, p <.001). When SWQ was

entered in sample 1 in step 2 (ΔR^2 = .43 p < .001), *a sense of too much time spent worrying* (t = 8.48, p < .001) and *(meta)cognitive strategies* (t = -14.58, p < .001) explained significant variance (see table 5).

In sample 2, with PSWQ being the dependent variable, demographic data was included in step 1 (ΔR^2 = 0.9, p < .05). It did not significantly explain any variance except for a moderate significance for sex (t = -2.25, p < .05). While in step 2 (ΔR^2 = .63, p < .001): CFQ (t = 4.55, p < .001) and IUS (t = 3.19, p < .01) significantly explained additional variance. In step 3 (ΔR^2 = .07, p < .001), SWQ explained additional 7.3% of the variance, with *(meta)cognitive strategies* being the only significant factor (t = -4.71, p < .001) (see table 5).

In the correlation analysis in sample 2, the measures CFQ, IUS, and PSWQ correlated strongly. CFQ and IUS had a VIF score of 3.3, suggesting possible issues with multicollinearity, which undermines the statistical significance of the independent variables (Allen, 1997). Based on this, there was conducted a third regression without CFQ and IUS.

Because of the multicollinearity problem, the second regression in sample 2 did not include the strongly correlated independent measures IUS and CFQ. The regression results gave reason to believe that all three factors in the SWQ was important for worry. In step 1 (ΔR^2 = .12, p < .01) demographics explained additional significance, with sex being the only unique predictor (t = -3.03, p < .01). Including the SWQ in step 2 (ΔR^2 = .64, p < .001), now all the three factors were unique predictors of worry: *a feeling of safety* (t = -2.73, p < .01), *a sense of too much time spent worrying* (t = 4.13, p < .001) and *(meta)cognitive strategies* (t = -9.03, p < .001). *(Meta)cognitive strategies* was the most unique predictor through all three regressions (t = -14.58 (1), -4.71 (2), -9.03 (2.2), p < .001: see table 5). When CFQ and IUS was removed all three factors were of importance. Results from both samples give evidence of reliability in predicting worry from *a sense of too much time spent worrying* and *(meta)cognitive strategies.* While *a feeling of safety* was not significant in the regression in sample 1, implying that the factor is not reliable when testing it in different samples.

Table 5. Predictors of worry

Steps	**Sample 1**			**Sample 2**			**Sample 2 – model 2**		
	R^2	$_{Adj}\ R^2$	R^2_{cha}	R^2	$_{Adj}\ R^2$	R^2_{cha}	R^2	$_{Adj}\ R^2$	R^2_{cha}
1. Demographics	.13	.12	.13***	.09	.07	.09*	.12	.09	.12**
2. CFQ & IUS				.72	.71	.63***			
3. SWQ	.56	.55	.43***	.80	.78	.07***	.66	.64	.54***
Final step	*B* (*SE*)	*β*	*t*	*B*(*SE*)	*β*	*t*	*B*(*SE*)	*β*	*t*
Sex	-3.2 (1.84)	-.03	-0.93	-5.36 (2.38)	-.11	-2.25*	-8.92 (2.95)	-.18	-3.03**
Age	-0.23 (.05)	-.16	-2.97**	0.08 (.07)	.07	1.19	0.09 (0.10)	.07	0.93
Employment	-10.89 (1.21)	-.20	-3.89***	1.14 (1.78)	.04	0.64		-.09	-1.05
CFQ				0.59 (.13)	.37	4.55***			
IUS				0.27 (.09)	.23	3.19**			
Safety	-0.18 (.13)	-.06	-1.38	-1.70 (1.14)	-.09	-1.50	-3.84 (1.41)	-.20	-2.73**
Time	1.33 (.16)	.32	8.48***	0.89 (1.12)	.05	0.80	5.14 (1.25)	.26	4.13***
(Meta)cognitive strategies	-3.02 (.21)	-.64	-14.58***	-6.26 (1.35)	-.33	-4.71***	-12.88 (1.43)	-.68	-9.03***

CFQ = Cognitive Fusion Questionnaire; IUS: Intolerance of Uncertainty Scale; SWQ = Stop Worry Questionnaire; Sex = 1 – woman, 2 – man. Employment = 0 – unemployed/not studying, 1 – employed or studying. *Safety* = Stop Worry Questionnaire factor 1; *Time* = Stop Worry Questionnaire factor 2; *(Meta)cognitive strategies* = Stop Worry Questionnaire factor 3.

*p < .05. **p < .01. ***p <.001

Discussion

This study set out to explore ways of stopping worry and if those relate to severity of worry. Factor analysis suggested three factors for stopping worry. The first was *a feeling of safety*, the second was *a sense of too much time spent worrying*, and the third was *(meta)cognitive strategies*. The results showed that people low on worry can be characterised by using more (meta)cognitive strategies to stop worrying. In other words, they could detach from their thoughts, beneficially assess them, and decide to stop worrying. In the regression analyses, *(meta)cognitive strategies* showed a significant relationship with worry even when controlling for Cognitive Fusion and Intolerance of Uncertainty. This suggested that people with few worries tend to report that they don't find worrying to be helpful, they leave worry thoughts alone, make a conscious decision not to worry, and tend to put things into perspective.

Further, the other two factors had more ambiguous results. *A feeling of safety* was significantly correlated with low worry. However, it had incoherent results in the group comparisons nor was it a significant predictor in sample 1 and the first regression in sample 2. Presumably, the factor tells us something about people prone to less worry by being able to stop worry from a feeling of safety. *A sense of too much time spent worrying* showed a weak correlation with high worry in sample 1, but no significant correlation in sample 2. The factor was a unique predictor in the regression analysis in sample 1 and the second regression in sample 2. This factor may be influenced by the subjectiveness of time, which possibly makes the results unclear.

The *(meta)cognitive strategies* factor showed a highly significant correlation with lower levels of worry. The fact that it could explain additional variance in worry after including the established measures IUS and CFQ, suggested that these *(meta)cognitive strategies* are important for stopping worry. All items in the factor showed a thematic tendency towards a detached way of relating to thoughts. The first item among the *(meta)cognitive strategies* is finding worry not to be helpful. This is an understanding all the therapies want the patient to acquire. It speaks of a healthy interpretation, or a beneficial metacognitive knowledge, of worry (Newman & Borkovec, 2002; Wells, 2009). The opposite is what metacognitive therapy and acceptance and commitment therapy call positive or negative metacognitions, or positive beliefs in IU, which upholds worry (Dugas, Gagnon, Ladouceur, & Freeston, 1997; Hayes, Strosahl, & Wilson, 2011; Wells, 2009). The second item in the factor is the act of leaving things you can't influence. Within CBT and IU, this is applied when worrying about situations not amenable to problem-solving. The patient is

encouraged to understand that worry creates an anxious experience merely by thinking worrisome thoughts and imagining a catastrophe (Dugas, Gagnon, Ladouceur, & Freeston, 1997; Newman & Borkovec, 2002).

The third item is making a conscious decision not to worry, and, like its predecessors, it shows an ability to detach or defuse from your thoughts (Hayes, Strosahl, & Wilson, 2011; Wells, 2009). The ability to decide to quit worrying, is evidence of a person not fused with their thoughts, who can tolerate the uncertainty of life and have few upholding negative or positive metacognitions (Buhr & Dugas, 2002; Gillanders, et al., 2014; Wells, 2009). The fourth and last item is putting things in perspective. This may resemble many of the suggested ways of stopping worry in the therapies. ACT may refer to placing worry in the perspective of chosen values. CBT and IU may say the perspective would be a reasoning of plausibility. At the same time, MCT might argue that the perspective is a more detached way of viewing the worries as just incidents of an unreasonable mind (Dugas & Robichaud, 2007; Hayes, Strosahl, & Wilson, 2011; Newman & Borkovec, 2002; Wells, 2009). The results indicate that the *(meta)cognitive strategies* are important for stopping worry, and the items in the factor match with the different strategies proposed by the recognized treatments for worry.

A feeling of safety moderately correlated with lower levels of worry. It is an experience-based factor with items that describes feeling safe or being confident that things will be all right (e.g., item 8: “I have peace of mind” or item 1: “I’m certain that something wrong won’t happen”). On the one hand, the items in the factor resemble the goal of CBT and IU. Where patients are being trained to acquire feelings of safety and calm when faced with uncertain situations and worrisome thoughts (Dugas & Robichaud, 2007; Newman & Borkovec, 2002; Öst & Breitholtz, 2000). On the other hand, it may be come close to a trait-like description of those less worry-prone having it easier when trying to stop worrying. The moderate correlations between a feeling of safety and CFQ, IUS and low worry points to a group of respondents feeling safe, having high psychological flexibility, and being tolerant of uncertainty. Being either a skill that helps people worry less or a trait associated with low worry may explain why it had some incoherent results. When CFQ and IUS were removed in sample 2, it was a unique predictor, presumably from this factor's multicollinearity with these constructs. Improvements of the questionnaire, through follow-up questions concerning how one acquires a feeling of safety and research into individual differences in difficulty to achieve it, would benefit the understanding of this factor.

A sense of too much time spent worrying contained items that described stopping worry when realizing that they worried too much (e.g., item 3: "I have been thinking for so long I can't take it anymore"). Worrying longer and not being able to stop may be associated with the research on neuroticism. The predisposed to higher levels of neuroticism worried five times more than the control group (Dupuy, Beaudoin, Rhéaume, Ladouceur, & Dugas, 2001), and were less likely to use reappraisal for regulating emotion (Haga, Kraft, & Corby, 2007). This suggests that the high worry group would correlate strongly with *a sense of too much time spent worrying*, seeing that many of the items in the factor describe excessive worry. In the regression analysis, the factor was a unique predictor in both sample 1 and the second regression in sample 2 when removing CFQ and IUS. However, it had a weak correlation (.22, $p < .01$) in sample 1 and no significant correlation in sample 2. The factor in its whole was incoherent, and in-group comparisons showed a weak distribution among groups of worry. Presumably, this may be caused by the subjectivity of time experience. Worry-prone individuals have a habitual bias in attention (Hirsch & Mathews, 2012), possibly making them susceptible to analysing their time spent worrying differently than others. Following that argument, two respondents - one from the low worry group and another from the high worry group - may benefit from the strategy ("I can stop worrying when I see I have spent way too much time on it"). This could be fifty minutes for the respondent with high worry, whilst five minutes for the one in the low worry group, making it highly individual what one answers on the different items in the *time* factor. Improvements of the questionnaire, through follow-up questions concerning time usage and a measure of individual differences in subjective experience, would be beneficial for the understanding of this factor.

This study is the first to research the matter of how we stop worrying. It is a cross-sectional study with two big and independent samples. The study does however contain some limitations, like having unthought-of items, self-report, no control groups, no qualitative methods, no treatment group, and no differentiation in cultural differences. Since the SWQ is the first of its kind, there may also have been items left out in the making of the questionnaire. Looking back at the theory that was used for the SWQ, some items were difficult to operationalize, some were not highlighted as necessary, and some were overlooked.

From the field of cognitive behavioural therapy, the techniques of logical reasoning and imagery exposure is something which could be included in greater detail in the questionnaire. Firstly, imagery exposure concerns the process of confronting worries as to worry less (Newman & Borkovec, 2002); nothing in the SWQ resembles this as a way of

stopping worry. Secondly, logical reasoning is mentioned partly through “I have come to a conclusion” and “I have thought through all possible scenarios”, but not quite to the extent that CBT wants. Instead of just reaching a conclusion or thinking through all scenarios, CBT advises patients to logically reason their worrisome thoughts to discover if their worries are plausible and then realize that worrying is futile (Newman & Borkovec, 2002).

The mindfulness strategies mentioned in the acceptance and commitment therapy refer to a process of experiencing situations fully without resorting to suppression or excessive preoccupation (Hayes, Strosahl, & Wilson, 2011). No item in the SWQ resembles the act of experiencing worry mindfully to stop worrying. The same applies to the importance of personal values in ACT, which was not included in detail in SWQ. It was impossible to operationalize all the different values that may be important in ACT for stopping worry (e.g., “I can stop worrying when realising it collides with being a good parent”).

The research on the thought control questionnaire, explaining how people try to control their thoughts, contains the five categories: Reappraisal, Social Control, Distraction, Worry, and Punishment. All except Punishment had a resemblance to items in the SWQ. Punishment involved ways of controlling thoughts through punishment (e.g., “I punish myself for thinking the thought”). Stopping worry though punishment is plausible and should be included in a review of the SWQ.

Within the research on emotion regulation (Gross, 2002) and thought control (Wells & Davies, 1994), reappraisal is emphasized as an efficient method for reducing negative affect. Although three of the four items in (meta)cognitive strategies resemble the act of reappraisal, there are possibilities of variating and developing the items. There is room for different reappraisals of worry other than helpful (item 20), uninfluenceable (item 17), or in perspective (item 19) (see table 2). Other reappraisals of worry containing different adjectives, read: beliefs (Wells & Matthews, 1996), could be: (e.g., “harmful”, “uncontrollable”, “trivial” or “hindering”). Further, the item “If there is something I cannot influence, I leave it at that” points to worries about problems not amenable to problem-solving. Unsolvable problems are a subjective view, and further questioning how one categorizes problems would improve this item. This would, in all likeliness, be influenced by habitual responses (Hirsch & Mathews, 2012), beliefs (Wells & Davies, 1994), and personality (Haga, Kraft, & Corby, 2007). Lastly, the item “I put things in perspective” is, to some degree, intangible. Further review into which perspectives makes people stop worrying would be clarifying for this item.

A limitation is the lack of a control group. A control group comparing people with a generalized anxiety disorder to groups of people with, e.g., social anxiety disorder, OC-disorder, or PTSD, would allow one to compare if there exist different strategies for stopping worry in different clinical subgroups. Still, there is a possibility that it would be similar across subgroups.

Another possibility would be to include qualitative methods. To discover if there were apparent items left out of the questionnaire, originally there was an open text box in the questionnaire, but it was removed because of privacy reasons. This could have provided insight into how the respondents understood the questionnaire and possibly supplied the questionnaire with more strategies for stopping worry. A central argument in the preliminary feedback from other colleagues was that if one did not fully understand the questionnaire, respondents would risk marking items they thought could stop worrying independent of their experiences with stopping worry. The results indicate otherwise.

There is also no clear answer as to if the suggested ways of stopping worry would benefit a population of patients. If the study had included a treatment group, we could have researched the benefits of the different ways of stopping before and after treatment. Possibly, this would provide results showing the causality between low worry and *(meta)cognitive strategies.* Researching the relationship between low worry and *(meta)cognitive strategies* is necessary for further use of these in therapy.

Conclusion

Researching efficient ways of stopping worry is crucial to the treatment of anxiety disorders. With the Stop Worry Questionnaire, one can further explore the relationship between how people stop worrying and their degree of worry. The SWQ was a unique predictor of worry in all three regressions in the study. The factor *a feeling of safety* is highly correlated with lower levels of CFQ, PSWQ, and IUS, which suggests that cultivating feelings of safety in therapy may be effective in stopping worry. This supports Cognitive Behavioural therapy for stopping worry. The question is still if this factor is more a trait description than an acquirable skill. *A sense of too much time spent worrying* had incoherent results throughout, presumably due to the subjective view of time. Most important was the *(meta)cognitive strategies* that explained additional variance within the construct of worry, even when controlling for CFQ and IUS. This gives reason to assume that these four

strategies are important for stopping worry. Therapies should seek to include knowledge on how we stop worrying, and in addition build upon these seemingly efficient strategies, when treating worry. Further research is needed into the causality between *(meta)cognitive strategies* and low worry through longitudinal research on treatment groups, further elaboration into the four items in the *(meta)cognitive strategies*, and extension of the SWQ to cover more of the strategies we use to stop worrying.

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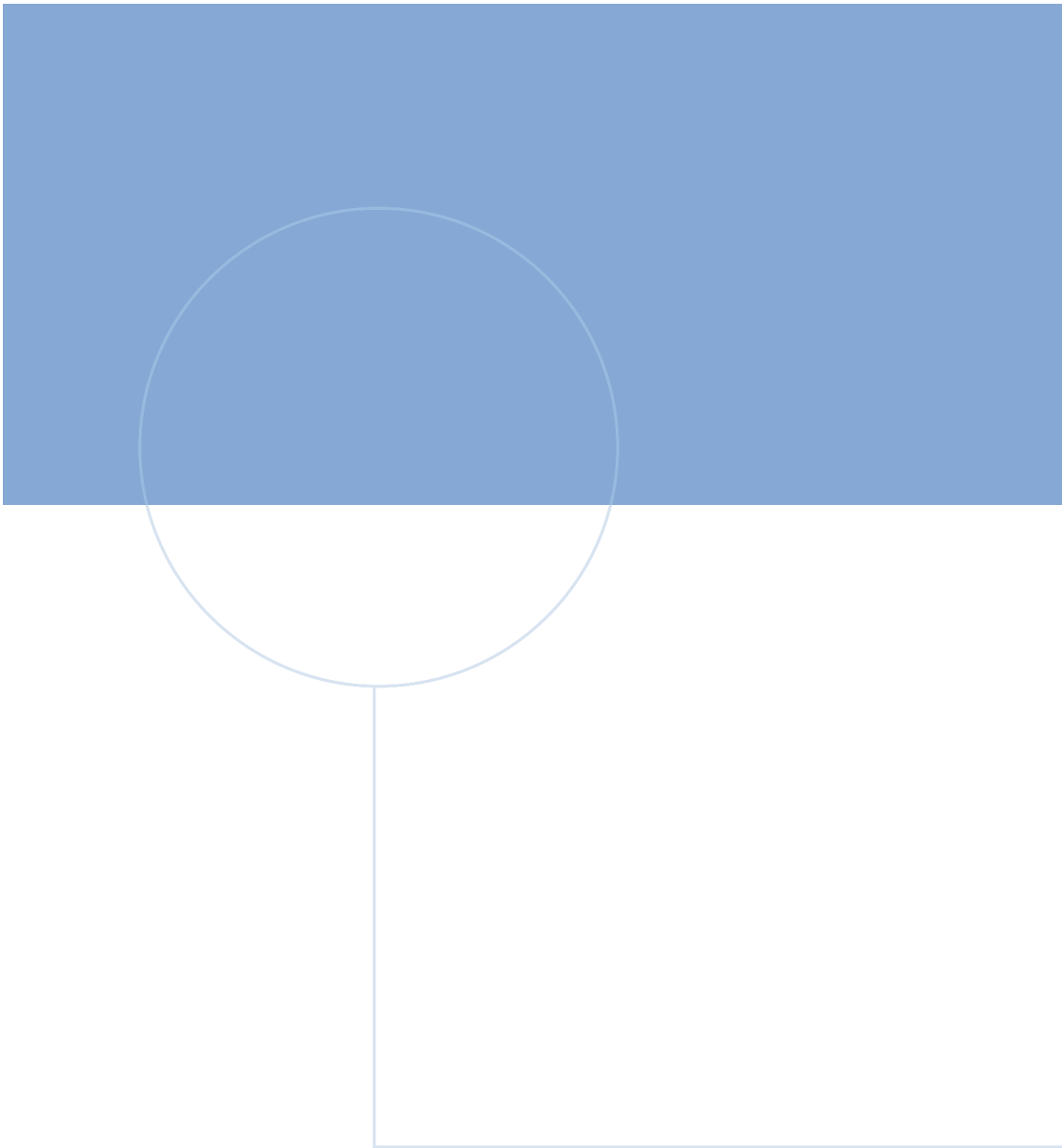
Appendix A

Stopp Bekymring Spørreskjemaet (SWQ)

Jeg kan slutte å bekymre meg når…

	Uenig	Litt enig	Ganske enig	Veldig enig
1. Jeg er sikker på at noe galt ikke vil skje	1	2	3	4
2. Jeg har tenkt gjennom alle mulige scenarioer	1	2	3	4
3. Jeg har tenkt så lenge at jeg ikke orker mer	1	2	3	4
4. Jeg er trygg på at det vil gå bra	1	2	3	4
5. Jeg har en indre følelse som signaliserer at det er trygt å stoppe	1	2	3	4
6. Jeg har kommet frem til en konklusjon	1	2	3	4
7. Jeg har erstattet bekymringstankene med positive tanker	1	2	3	4
8. Jeg føler sinnsro	1	2	3	4
9. Jeg bestemmer meg for det	1	2	3	4
10. Jeg ikke har flere bekymringer om at dårlige ting vil skje	1	2	3	4
11. Jeg har følelsen av at jeg har gjort alt jeg kan for å unngå at noe fælt skal skje	1	2	3	4
12. Jeg blir beroliget av andre	1	2	3	4
13. Jeg blir oppgitt over hvor mye jeg tenker på dette og tenker at nå er det nok	1	2	3	4
14. Jeg ser at jeg har brukt alt for mye tid på det	1	2	3	4
15. Jeg slutter aldri å bekymre meg, men får pause når jeg sovner	1	2	3	4
16. Jeg blir utslitt av å tenke så mye og klarer ikke mer	1	2	3	4
17. Hvis det er noe jeg ikke kan påvirke, så lar jeg det ligge	1	2	3	4
18. Jeg blir distrahert av noe	1	2	3	4
19. Jeg setter ting inn i perspektiv	1	2	3	4
20. Jeg finner ut at bekymringene ikke er hjelpsomme	1	2	3	4
21. Andre sier at jeg må slutte å bekymre meg så mye	1	2	3	4
22. Jeg påminner meg selv om at jeg bekymrer meg for mye og bør legge dette til side	1	2	3	4
23. Den kroppslige uroen forsvinner				

Hvilke andre måter bruker du eventuelt når du kan slutte å bekymre deg?



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