

When Worry Becomes the Price of Caring

Anxiety, shame, prediction, and the possibility of being less alone

Brian Kennedy, MA, LMFT

For therapists · 18 October 2026

Imagine a client who has checked the message, considered the possibilities, and prepared what to say. Nothing more can usefully be done tonight. Yet putting the phone down feels strangely difficult. We suggest rest, perhaps a little too quickly, and the client looks away. “I know. I should be able to stop this.”

Something has happened between our intention and its reception. We offered permission. The client heard another standard they cannot meet. Worry is now accompanied by shame, and the person who hoped we might understand has begun explaining why they are failing.

Before helping someone worry less, it can be useful to understand what stopping would mean. Would it feel careless? Would it expose a wish they cannot bear to have disappointed? Would they have to encounter anger about carrying too much, or the sadness of recognizing that carefulness cannot keep everyone safe?

The client companion, [When Worry Becomes a Way of Caring](#), begins with the dignity of this effort. The therapist's task includes understanding how care becomes entangled with anticipation, self-criticism, and a responsibility no person can completely fulfill. AEDP offers a particularly useful lens: what happens when anxiety and shame inhibit emotional experience, and what becomes possible when that experience can emerge with company?

The fear of what might happen, and the fear of feeling

We need several distinctions. Fear can respond adaptively to danger. Anxiety can prepare us for uncertain threat. Worry is a form of thinking, usually oriented toward possible future problems. Shame concerns how we experience ourselves in relation to an actual or imagined other's regard. They can occur together without being interchangeable.

Within AEDP's clinical framework, anxiety and shame can function as inhibitory affects: they interfere with access to emotional experience, needs, and impulses that have become difficult to tolerate or express. Fosha's four-state model maps a possible movement from this constriction toward fuller emotional contact and integration. [1, 2]

In **State 1**, the therapist attends to distress, defenses, and inhibitory affects while also noticing capacities and wishes for healing already present. The work begins with enough relational safety and regulation for the client to approach experience without becoming overwhelmed or having to push it away. [1, 9]

In **State 2**, the client can more fully experience an emotion, need, or relational encounter with the therapist's accompaniment. Anger may become a recognizable protest; sadness may become grief that can be felt and shared. The aim is to let the experience unfold and its meaning and possible response become available. [1, 9]

In **State 3**, attention turns toward the experience of change itself: what is it like to feel grief without being alone, or to express anger without losing the relationship? This exploration, called metaprocessing, can bring tenderness, pride, gratitude, or mourning for what was missing. [9]

State 4, called core state, describes a more integrated experience of clarity, openness, self-compassion, and contact with oneself and another. These states orient the therapist's attention; they are not four assignments a client must complete in order. A session may move between them. Anxiety and shame are understood by what they do in that movement, rather than treated as inherently unhealthy feelings. [1, 9]

Consider the person who begins to register anger when a partner changes an agreement. Almost immediately, their stomach tightens: *Do not make this worse*. Then comes self-attack: *You are too demanding*. Instead of saying what hurt, they spend the evening anticipating the partner's reaction. The practical issue remains, but contact with their own protest becomes harder.

Here, worry might help manage the anxiety associated with having anger. Shame might constrain the expression of a need. These are hypotheses to explore with the client. We could discover that the partner has repeatedly retaliated, that the agreement was genuinely unclear, or that exhaustion better explains the difficulty. The same visible sequence can require very different responses.

Calling anxiety inhibitory should make us more attentive to what the person needs in order to participate. It should not make anxiety an obstacle we impatiently clear away on our route to a supposedly more authentic feeling.

When the inner critic keeps the alarm going

The critical voice often speaks in predictions with moral consequences: *If you stop checking, you will miss something. If you miss something, people will see what you are really like*. A manageable uncertainty becomes an examination of character.

Sometimes the critic seems to have two incompatible assignments. It demands more preparation and condemns the person for being anxious. *Be ready. Why are you so weak?* The client cannot satisfy both demands. Rest becomes negligence; distress becomes incompetence. Even our invitation to self-compassion can be recruited into the same arrangement: *Now I am failing at being kind to myself*.

Schwartz's IFS account invites curiosity about protective roles, including those of inner critics, and about what they might do if their present methods were no longer necessary. [3] In this lens, criticism may attempt to prevent exposure, rejection, or mistakes. That possibility can soften our approach without establishing the critic's motive in advance. Some clients recognize a protective intention; others experience internalized contempt, habit, or something they cannot yet describe.

We might ask, “When that voice says you should have known, what happens next?” The answer may reveal more than an early request to appreciate the critic. Does the person check, go numb, apologize, become angry, or lose the thread of what they wanted to say?

Understanding a possible protective function does not require endorsing the attack. We can respect the wish to avoid harm while noticing that humiliation is making it harder to think, ask for help, or take proportionate responsibility. The capacity we hope to preserve is discernment. The person does not need contempt in order to have a conscience.

A mind trying to arrive before the hurt

Anticipation belongs to ordinary intelligence. We use past experience, present information, and bodily cues to prepare for what may happen. Grupe and Nitschke's account of uncertainty and anxiety examines how expectations of threat, attention, safety learning, and avoidance can contribute to persistent anticipatory distress. [4]

Predictive approaches add a useful question: what does this person expect the present moment to become? Paulus and Stein's account of interoception in anxiety and depression considers interactions between bodily information and belief-based expectations. [5] In clinical terms, an uneasy sensation can acquire meaning through what the person already expects, while that interpretation can make the sensation more alarming.

A brief “Can we talk?” may therefore arrive as impending criticism before its meaning is known. The person does not necessarily choose that interpretation after a calm comparison of alternatives. Their body may already be preparing an explanation. The prediction is being lived before it is clearly available to examine.

This is a conceptual bridge between anticipatory models and experiential work, not proof that AEDP and predictive processing describe identical mechanisms. Nor can we identify a person's neural predictions from a tight chest or a sentence. What we can explore is the expectation: *What did you suddenly feel sure was about to happen? What seemed likely to happen to you if it did?*

Sometimes the second answer matters most. The prediction is not simply *I might make a mistake*. It is *A mistake will leave me alone with someone else's contempt*. A probability estimate may change while that relational expectation remains untouched.

History arrives in a present context

For someone whose uncertainty once met ridicule, anticipation may have offered a little influence. Reading the room, preparing the explanation, and avoiding the wrong need could make a difficult environment more navigable. A history of dependable help can support different expectations about what happens when an answer is unavailable.

We should discover these histories through the person's account. A worried adult is not evidence of a particular childhood. Present-day instability, illness, financial pressure, discrimination, temperament, sleep loss, and repeated failures of support may each matter. A nervous system does not become irrational because it notices circumstances the therapist has underestimated.

Context can also change the meaning of an apparently familiar cue. A delayed reply from a generally dependable friend differs from a delayed reply in a relationship where silence has repeatedly preceded punishment. The sensation may resemble an old alarm; the current evidence still needs examination.

In therapy, the room itself becomes part of the context. Are we rushed? Have we forgotten something the client told us? Are we describing their concerns as excessive before understanding their obligations? If we treat all uncertainty as a private tolerance problem, we may ask the client to adapt to an arrangement that needs changing.

An inquiry worth keeping open is: *What belongs to remembered danger, what belongs to this situation, and what remains unknown?* More than one answer can be true. Sometimes the most regulating intervention is practical: clarify an agreement, address an unpaid obligation, arrange support, or acknowledge that the load cannot reasonably be carried by one person.

What continued worrying may spare us

Borkovec and Roemer's study of perceived functions of worry found that participants described preparation and prevention among its purposes; those meeting self-reported GAD criteria particularly endorsed distraction from more emotional topics. [6] This was a limited self-report study, not a way to infer an individual client's hidden motive. It nevertheless helps us ask what repeated thinking provides after useful planning is finished.

Dugas and colleagues' preliminary model gave intolerance of uncertainty a central place alongside beliefs about worry, cognitive avoidance, and problem orientation. [7] A client may recognize that further checking offers little new information while remaining convinced that stopping would be irresponsible. The difficulty is partly what uncertainty means, including what it would mean to be the person who allowed it.

Newman and Llera's contrast-avoidance model offers a related but distinct possibility: sustained worry may maintain negative emotion to avoid the abrupt shift into distress that an unexpected event could bring. [8] Remaining braced can feel less vulnerable than being caught at ease. Worry need not eliminate feeling to serve an avoidant function.

These accounts can inform an AEDP inquiry without being absorbed into it. What happens when thinking briefly pauses? A client may encounter fear, helplessness, longing, anger, or grief. Another may simply feel tired. There is no requirement that a more important emotion be discovered underneath.

For some, the painful recognition is that they cannot guarantee a loved one's wellbeing. Continuing to think preserves an activity in the face of that limit. Pausing allows the limit to be felt. The therapist's presence matters because an explanation of limited control does not, by itself, make the sorrow of loving someone bearable.

Enough company to remain in contact

Fosha's writing places dyadic affect regulation and the undoing of emotional aloneness at the center of experiential work. The task includes attending to whether the client can receive the therapist's presence while approaching difficult experience. [1, 9] Our caring intention is a beginning; its actual effect needs to be discovered.

Jerry Lamagna describes how intense pathogenic distress can compromise a person's capacity to take in relational help. His intra-relational approach offers another route toward compassionate engagement with distress when direct interpersonal support is difficult to receive. [10] This is a useful corrective to assuming that sufficient warmth will always reach the client immediately.

We can make the next invitation smaller. “Would it help if I slowed down?” “Would you rather stay with what happened than look inside right now?” “When I say you do not have to explain yourself to me, does that feel believable, irritating, or something else?” The client's answer should change our response.

The window of tolerance is useful here as a clinical description of enough capacity to remain present, connected, and able to choose. It is not a demand for quiet. A client may cry and remain engaged; another may become very still while losing contact. Bodily attention, ordinary orientation to the room, a pause, or practical conversation may each be appropriate. We need not turn regulation into another performance. [9]

Schore's account of implicit relational communication directs attention to voice, rhythm, expression, and the exchange beneath explicit explanation. [11] A slower pace can give the client time to discover what our words actually evoke. This does not mean abandoning thought or dividing the session into an emotional right brain and a rational left brain. It means allowing language and lived contact to inform one another.

Heralding affects: noticing what is beginning

Heralding affects belong in this discussion because the first movement toward feeling may be small and easily overtaken by another explanation. In Fosha's four-state formulation, they are “glimmers of core affective experience,” appearing around the transition toward more accessible emotional experiencing. [2] They are not synonymous with feeling better.

Imagine a client describing repeated checking. For a moment their voice changes: “I am just so tired of having to think of everything.” The sentence could carry exhaustion, anger, sorrow, or several experiences together. We do not yet know. Instead of interpreting it quickly, we might ask whether something happened inside as they said it, and whether they want to stay with that briefly.

A moment of tenderness toward the frightened self could also be significant. So could a newly felt wish to ask for help. These are proposed clinical examples, not a checklist of signs. Tears, a sigh, or a softened face cannot tell us by themselves what the person is experiencing.

Fosha's diagram distinguishes heralding affects from green signal affects, which announce openness and readiness, and from later transformational affects associated with processing change. [2] This prevents us from calling every welcome moment a breakthrough. A glimmer invites curiosity about what is becoming possible; it does not authorize us to press further.

The critical voice may return immediately: *You are making too much of this*. We can notice that return without treating it as sabotage. What made the emerging experience difficult to have? Did we lean forward too quickly, sound pleased, or inadvertently make the client feel responsible for giving us a meaningful session?

A fictional encounter: keeping care while relinquishing the impossible task

Consider a fictional client, Alex, whose mother has an upcoming appointment. Alex has confirmed transport and written down the questions but repeatedly checks the arrangements at night. “If something goes wrong and I haven't thought of it, that is on me.”

The therapist initially wonders whether this is mostly an old expectation of blame. Alex corrects the account: a transport service recently failed to arrive. Further preparation is reasonable. They distinguish that unresolved practical issue from the additional promise Alex is demanding of themselves: that nothing upsetting will happen.

Once a backup arrangement is identified, the therapist asks what putting the list down might feel like. Alex's eyes fill. “Like leaving her.” The therapist does not answer that thought away. They ask whether Alex would like company with what has just appeared. Alex describes sadness about their mother's increasing needs, then adds, “And I am angry that my brother assumes I will handle it.”

These moments offer possible openings into grief and protest. Their meaning comes from Alex's account. The therapist helps Alex remain in contact without requiring a deeper childhood explanation or an extended emotional experience. Alex wants to discuss asking the brother to take responsibility for one specific task.

Alex predicts that, after the backup is confirmed, it may be possible to leave the list alone during dinner. The trial is modest and optional. It preserves necessary care and includes a reason to review the plan if new information arrives. Alex still checks once during dinner and later feels guilty. The brother agrees to the task but needs a reminder.

The next session therefore includes a mixed result. The plan helped somewhat; the duty was only partly shared; uncertainty and guilt remained. “I did not have to solve everything” begins to coexist with “I still wanted to.” The therapist lets these observations revise the formulation rather than declaring the experiment successful because it fits the theory.

The therapist's own prediction of failure

Persistent worry can stir our own alarm. We explain carefully and the client remains afraid. We offer reassurance and it does not last. An inner verdict appears: *I am not helping. I should know what to do.* Our anxiety may then narrow the session in much the same way we are trying to understand in the client.

We may talk faster, search for the right interpretation, offer another practice, or become unusually certain about what the client is avoiding. Sometimes we retreat behind neutrality. The client may experience the change as impatience or withdrawal and become more ashamed of needing us. Both people can end up trying to protect the relationship through increased performance.

Aponte and Kissil's Person-of-the-Therapist approach emphasizes the purposeful use of the therapist's present self, including awareness of personal emotional struggles. [12] It offers a disciplined question here: can I recognize what this client's uncertainty evokes in me without making the client resolve it?

Our own therapy, reflection, and supervision can help us encounter the shame of not knowing, the wish to be useful, and the limits of our influence. This is ongoing work. We need enough access to our reactions to distinguish the next clinically useful step from an effort to escape feeling inadequate.

Repair can be simple and specific: “I think I moved toward a solution before understanding what stopping would mean for you. What was that like?” The answer may be uncomfortable. Making room for it gives the client a present experience of their account affecting what happens between us.

Bringing the work back to the pathway

The five modules in [Fear, Worry, and Uncertainty](#) offer ordinary encounters through which these themes can become recognizable. The first separates an event from its predicted meaning. In therapy, we can also notice how quickly a prediction becomes self-condemnation, while retaining evidence of real danger or responsibility.

The second distinguishes useful preparation from a loop without a dependable stopping point. The third explores making room for uncertainty without abandoning care. A client's resistance to these invitations may reveal an unshared duty, a feared feeling, an inaccessible resource, or a poor fit with the exercise. It deserves inquiry rather than a compliance judgment.

The fourth invites a meaningful step with fear present. The fifth reviews what actually happened and identifies usable support. Neither requires calm as evidence of learning. A client may return still worried but better able to ask clearly, acknowledge sadness, or refuse responsibility for another adult's every response. Another may discover that self-directed learning is insufficient and want more clinical help.

If something has helped, AEDP's attention to metaprocessing offers a further invitation: what was it like to receive that help, and what made it usable? [9] Perhaps the person felt less judged. Perhaps their correction was welcomed. Perhaps a practical arrangement finally became dependable. Naming the condition gives the experience somewhere to go beyond the session.

The companion articles [A Presence That Helps Without Taking Over](#) and [When Another Person's Feelings Stir Our Own](#) deepen the relational and therapist self-inquiry dimensions of this work. Here, the continuing question is how a person can care, prepare, feel, and participate without being required to foresee everything. Sometimes the next change begins when uncertainty remains, but self-attack no longer has the whole room.

References and further reading

1. Fosha, D. (2021). Introduction: AEDP after 20 years. In D. Fosha (Ed.), *Undoing Aloneness and the Transformation of Suffering Into Flourishing: AEDP 2.0*. American Psychological Association. [Publisher's sample chapter](#). Relational and experiential clinical framework.
2. Fosha, D. (2020). *The phenomenology of the four-state transformational process in AEDP* (Figure 1.1 and Appendix Figure 1; accompanying the 2021 volume above). [Publisher-hosted diagram](#). The quoted definition of heralding affects and distinctions among inhibitory, transitional, green signal, and transformational phenomena.
3. Schwartz, R. C. (2021). *No Bad Parts: Healing Trauma and Restoring Wholeness with the Internal Family Systems Model*. Sounds True. [Official chapter-one excerpt](#). Protective roles and another relationship with self-criticism; a clinical lens rather than a required description of every client's mind.
4. Grupe, D. W., & Nitschke, J. B. (2013). Uncertainty and anticipation in anxiety: An integrated neurobiological and psychological perspective. *Nature Reviews Neuroscience*, 14, 488-501. [Article](#). A research-informed model of anticipatory anxiety.
5. Paulus, M. P., & Stein, M. B. (2010). Interoception in anxiety and depression. *Brain Structure and Function*, 214, 451-463. [Article](#). A theoretical review of bodily signals, beliefs, and prediction; its application to the encounters here is interpretive.
6. Borkovec, T. D., & Roemer, L. (1995). Perceived functions of worry among generalized anxiety disorder subjects: Distraction from more emotionally distressing topics? *Journal of Behavior Therapy and Experimental Psychiatry*, 26(1), 25-30. [Abstract and publication record](#). A self-report study of perceived functions, not proof of an individual's motive.
7. Dugas, M. J., Gagnon, F., Ladouceur, R., & Freeston, M. H. (1998). Generalized anxiety disorder: A preliminary test of a conceptual model. *Behaviour Research and Therapy*, 36(2), 215-226. [Abstract and publication record](#). A small preliminary study concerning uncertainty, worry beliefs, avoidance, and problem orientation.
8. Newman, M. G., & Llera, S. J. (2011). A novel theory of experiential avoidance in generalized anxiety disorder: A review and synthesis of research supporting a contrast avoidance model of worry. *Clinical Psychology Review*, 31(3), 371-382. [Article](#). Maintaining distress to avoid an abrupt negative emotional contrast; distinct from avoiding all emotion.
9. Fosha, D. (2009). Positive affects and the transformation of suffering into flourishing. *Annals of the New York Academy of Sciences*, 1172, 252-262. [Author manuscript](#). AEDP's regulation, state transitions, and experiential exploration of change.
10. Lamagna, J. (2015). Making good use of suffering: Intra-relational work with pathogenic affects. *Transformance: The AEDP Journal*, 6(1). [Author's article](#). Clinical discussion of inhibitory distress, receiving help, and intra-relational work.
11. Schore, A. (2022). Right brain-to-right brain psychotherapy: Recent scientific and clinical advances. *Annals of General Psychiatry*, 21, Article 46. [Article](#). A neuroscience-informed clinical synthesis concerning implicit communication and affect regulation.
12. Aponte, H. J., & Kissil, K. (2014). "If I can grapple with this I can truly be of use in the therapy room": Using the therapist's own emotional struggles to facilitate effective therapy. *Journal of Marital and Family Therapy*, 40(2), 152-164. [Article](#). The Person-of-the-Therapist approach to knowing and using one's present self.