

Feeling Blocked or Stuck: Avoidance, Conflict, and Restoring Action

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Narrative Clinical Review

Abstract—The same outward inactivity may reflect anxious avoidance, threat-related freezing, rumination, perfectionism, conflicting values, depression, executive dysfunction, fatigue, illness, trauma, environmental constraint, or a task that is unsafe or no longer wanted. This narrative clinical review offers a differential and functional approach to blocked action. Assessment begins by defining the action that is not occurring, its context and time course, the predicted consequences of acting and not acting, the relief supplied by delay, and relevant medical, psychiatric, neurodevelopmental, sleep, substance, relational, and social factors. Intervention should then match the likely mechanism: stabilization and safety planning, treatment of an underlying disorder, exposure, behavioral activation, task decomposition, environmental redesign, decision boundaries, acceptance of uncertainty, practical support, or clearer communication. Small steps are helpful when they create information, contact with reinforcement, or movement toward a chosen value; productivity alone is not the goal. A communication-focused formulation can supplement established methods by translating diffuse internal signals and unspoken interpersonal concerns into specific observations, meanings, boundaries, and requests. Prompt assessment is required when there is persistent loss of basic self-care, marked psychomotor change, mania, psychosis, suicidal intent, new neurological symptoms, or coercive control. Restoring action means widening the patient's capacity to act, pause, revise, or decline with greater safety and choice.

Index Terms—feeling stuck, avoidance, freezing, rumination, uncertainty, executive function, behavioral activation, psychotherapy

I. INTRODUCTION

People use “stuck,” “blocked,” “frozen,” “paralyzed,” and “unable to start” to describe a wide range of experiences. A person may sit before an email for hours, remain in an unsatisfying job, avoid a telephone call, postpone leaving an

unsafe relationship, or be unable to begin ordinary self-care. What these experiences share is a gap between an intended action and what actually occurs, although the mechanisms behind that gap vary.

Treating the experience as laziness is clinically poor reasoning. So is treating it as proof of a single hidden conflict. Anxiety, depression, trauma, ADHD, OCD, sleep loss, pain, medication effects, realistic danger, ambiguous priorities, and lack of resources can all impair action. At times, not acting is prudent. The central task is differential formulation: what process is active here, what does inaction accomplish now, what does it cost later, and what would make the next action possible and worthwhile?

Earlier JPPC discussions of social anxiety and persistent anxiety described how fear of evaluation, avoidance, and uncertainty can restrict communication and behavior (Haverkamp, 2013; Haverkamp, 2017a, 2017b). Those mechanisms are important, but they do not explain every block. The present review integrates stress neurobiology, behavioral learning, rumination research, behavioral activation, acceptance-based models, and communication-oriented clinical formulation.

II. SCOPE AND METHOD

This narrative review considers literature available through 30 August 2025 on avoidance, freezing, acute stress, rumination, indecision, intolerance of uncertainty, experiential avoidance, behavioral activation, and goal-directed action. Priority was given to reviews, influential theoretical work, controlled clinical research, and diagnostic guidance. Earlier JPPC articles were read before citation. Because “feeling stuck” is not a standardized diagnosis, direct trials are limited; the framework synthesizes evidence from adjacent constructs and labels interpretation accordingly.

III. DEFINE THE BLOCK BEHAVIORALLY

Vague language can preserve the block. “I cannot move forward” contains no observable target. A behavioral

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description might be “I open the application form, reread the first question, and close it within five minutes,” or “I think about ending the relationship but have not arranged a safe private conversation.” Specificity does not trivialize emotion. It reveals where the sequence can be studied.

The clinician asks when the difficulty occurs and when it does not. A person unable to start administrative tasks may initiate creative work easily. Someone who feels immobilized at home may function under externally structured deadlines. Variation points toward task features, cues, reinforcement, attention, or relationship context. Global self-judgments such as “I am a person who never follows through” obscure this information.

Time course also matters. Lifelong difficulty organizing multistep tasks suggests a different assessment from abrupt slowing after infection, medication change, bereavement, or a mood shift. Episodic inability to act accompanied by reduced need for sleep and racing plans may occur in a bipolar-spectrum presentation even if output is inconsistent. Sudden weakness, speech change, severe confusion, or altered consciousness is a medical concern, not a motivation problem.

Table 1. From a global sense of being stuck to a functional description (author-developed clinical synthesis; not a validated instrument)

Question	Example of useful detail	Clinical value
What action is absent?	Send one message, leave bed, choose between offers, begin a meal, attend an appointment	Defines a measurable target
What is the immediate cue?	Opening the document, seeing a name, bodily fatigue, uncertainty, criticism	Locates the beginning of the sequence
What is predicted?	Failure, shame, regret, conflict, danger, endless effort, loss of identity	Identifies threat or cost
What happens in the body?	Numbness, tension, agitation, sleepiness, pain, breathlessness	Guides differential and regulation needs
What replaces the action?	Scrolling, planning, checking, sleeping, helping others, another task	Reveals avoidance and reinforcement
What changes immediately?	Anxiety falls, conflict is delayed, uncertainty remains unopened	Shows the short-term function
What is the delayed cost?	Deadline, shame, dependence, missed care, narrowed life	Establishes why change matters
Where does action still occur?	At work, with another person present, under a deadline, on preferred tasks	Identifies usable conditions and exceptions

IV. THREAT, AVOIDANCE, AND REPETITIVE THINKING

Freezing is an adaptive defensive response, not merely a metaphor. In animals and humans, threat can produce bodily immobility accompanied by heightened information gathering and preparation for action. Roelofs (2017) described freezing as “freezing for action,” emphasizing its dynamic role in defense. The subjective experience of being stuck, however, should not automatically be mapped onto a laboratory measure of immobility. The term may describe several processes.

Under acute uncontrollable stress, prefrontal functions supporting working memory, flexible planning, and inhibition can be impaired while more habitual or reflexive responding dominates (Arnsten, 2009). Clinically, a person may know several options but be unable to hold and compare them when aroused. More analysis at peak activation can then worsen overload. Initial intervention may involve orienting to safety, reducing immediate demands, grounding, or postponing a nonurgent decision until cognitive capacity returns.

Trauma-related freezing may occur in response to cues that are only partly recognized. The body can become still, speech can be difficult, and later self-blame can arise: “Why did I not act?” A survival response is not consent. Trauma-informed care validates the involuntary component while gradually restoring present-day choice. Exposure or activation should not be imposed without attention to dissociation, actual danger, pacing, and consent.

Freezing also differs from tonic immobility, catatonia, psychomotor retardation, neurological impairment, and medication-related slowing. Marked immobility, mutism, posturing, inability to eat or drink, or rapidly changing responsiveness requires urgent clinical assessment. A popular nervous-system label is not a substitute for examination. Defensive reactions and conscious fear or anxiety are related but dissociable, so immobility should be formulated in context rather than read as direct evidence of a particular subjective state (LeDoux & Pine, 2016).

Many blocks persist because not acting changes emotion immediately. Avoiding a call reduces fear of criticism. Closing a form reduces uncertainty. Remaining in bed postpones contact with a difficult day. This short-term relief negatively reinforces avoidance: the probability of the same response rises the next time the cue appears. Hayes et al. (1996) described experiential avoidance as attempts to alter or escape unwanted internal experiences even when doing so creates behavioral harm.

Avoidance is not defined by outward inactivity alone. Excessive research, endlessly preparing, seeking reassurance, and switching to lower-priority tasks can all function as

avoidance. They feel productive and may be useful in moderation, which makes the boundary difficult to detect. A functional question helps: is the behavior producing new information and moving toward a decision, or mainly preventing contact with uncertainty and evaluation?

Exposure can address avoidance when fear is central. In a safe, collaboratively chosen situation, the person approaches the feared uncertainty while reducing protective maneuvers that would prevent a useful test. In this author-developed application, the aim is to compare a specific prediction with what occurs rather than to require anxiety to fall during every exercise. A small step is useful when it preserves the relevant uncertainty: drafting an imperfect opening sentence may test fear of inadequacy, whereas spending another hour selecting the perfect font may not. Delay often provides immediate relief while transferring cost to the future self, and longitudinal and meta-analytic work links this pattern to stress, poorer performance, and self-regulatory difficulty (Tice & Baumeister, 1997; Steel, 2007; Sirois & Pychyl, 2013). Experiential avoidance and uncertainty can intensify the loop without explaining every case (Hayes et al., 1996; Grupe & Nitschke, 2013; Wong et al., 2023).

Rumination is repetitive thinking about causes, meanings, and consequences of distress. Worry is commonly future-oriented and verbal. Both can masquerade as problem solving. Watkins (2008) distinguished constructive and unconstructive repetitive thought by factors such as concreteness, context, and function. Abstract questions—"Why am I like this?" or "What if every option is wrong?"—rarely identify an action. Concrete processing asks what happened, what information is missing, and what can be done next.

Nolen-Hoeksema et al. (2008) reviewed evidence linking rumination with multiple forms of psychopathology. Rumination consumes attention, strengthens negative mood, and delays behavior, but it is not simply excessive thought. Some repeated thought is reflection, rehearsal, or grief. The clinician examines whether the process changes with new evidence and ends in action.

A practical intervention is to separate solvable problems from uncertainty that cannot be resolved now. Solvable problems receive a defined next step and time. Unresolvable questions are acknowledged and approached through acceptance, attention shifting, or values-based action. Scheduled reflection can help, but it should not become a ritual promising the correct answer if enough thinking occurs.

Choices can block action when options are numerous, consequences seem identity-defining, or regret is treated as intolerable. The person may seek a decision that guarantees no loss. Yet meaningful choices often close alternatives. A decision procedure can identify criteria, minimum acceptable

information, a deadline, reversible and irreversible components, and the cost of not choosing.

Intolerance of uncertainty is relevant across anxiety presentations (Carleton, 2016). The aim is not careless decision making. It is proportionality: gather information with material value, then decide under the uncertainty that remains. Repeatedly revisiting a settled choice can be a reassurance or checking process, particularly in OCD, and may require disorder-specific treatment.

V. PERFECTIONISM AND CONFLICT

Perfectionistic rules make action conditional: begin only when fully prepared, submit only when no error is possible, speak only when the response is guaranteed. The person avoids both failure and the information that comes from an imperfect attempt. Standards are not themselves pathological. The problem is an inflexible rule whose cost exceeds its value.

The therapist can elicit the exact threshold and test it. What counts as good enough for this purpose? Which errors are correctable? What would a competent colleague reasonably produce in the available time? A deliberately limited draft separates creating from editing. The intervention should not ask a surgeon or engineer to ignore safety standards; it calibrates quality to consequence.

Perfectionism often protects identity. If a task is never completed, ability is never conclusively tested. "I could have succeeded if I had started" may feel safer than an imperfect result. Compassionate formulation reduces shame while preserving responsibility. The person did not choose the fear, but can participate in experiments that weaken its rule.

Sometimes the block is not a deficit of motivation but simultaneous motivation in opposing directions. A promotion offers status and financial security but threatens family time. Ending a relationship offers autonomy but risks loneliness and harm. Publishing offers contribution and exposure to criticism. No amount of productivity technique resolves a conflict that has not been named.

A values exercise can distinguish chosen directions from obligations, social comparison, and avoidance. The question is not "What should a successful person do?" but "Which consequences am I willing to accept in service of what matters?" Values do not eliminate grief or risk. They organize action when no option is cost-free.

Communication may be blocked because speaking changes a relationship. Silence can preserve belonging, hierarchy, or plausible deniability. A patient may be fully capable of writing an email yet unable to send it because the message establishes a boundary. Here, task decomposition alone is insufficient. Therapy addresses the feared relational consequence, safety, wording, and the person's right to choose. Measures of meaning and experimental work on psychological-flexibility

components can help operationalize values and willingness, although neither identifies a single correct life direction (Steger et al., 2006; Levin et al., 2012).

VI. MOOD, EXECUTIVE FUNCTION, AND PHYSICAL CAPACITY

Depression can reduce energy, initiation, pleasure, hope, concentration, and psychomotor speed. Telling a severely depressed person to “just take a small step” can sound dismissive unless the symptom burden and risk are recognized. Assessment includes mood, anhedonia, sleep, appetite, guilt, cognition, psychomotor change, functioning, suicidal thinking, prior episodes, and bipolar history.

Behavioral activation is an evidence-based treatment for depression. In one randomized trial, it was comparable with antidepressant medication and outperformed cognitive therapy among more severely depressed participants; treatment selection nevertheless remains individualized (Dimidjian et al., 2006). The approach is not indiscriminate busyness. It uses monitoring and planned action to increase contact with meaningful or stabilizing consequences.

When motivation is low, action may precede motivation. This does not mean emotion is irrelevant. A five-minute shower, one prepared meal, or brief daylight exposure may be chosen because it supports survival and provides data. Success is completion of the agreed behavior, not immediate pleasure. If even minimal self-care remains impossible, intensity of support and diagnosis should be reviewed rather than multiplying tasks.

Initiation requires representing a goal, sequencing steps, holding information, selecting a starting point, inhibiting alternatives, estimating time, and sustaining attention. ADHD and other neurodevelopmental conditions can impair these functions. Anxiety may coexist and sometimes compensate through urgency and overcontrol. When external deadlines disappear, the compensatory system may fail and the person may feel newly stuck.

Assessment considers childhood onset, cross-situational pattern, school and work history, distractibility, impulsivity, time blindness, organization, and collateral information where appropriate. A sudden adult onset should not be attributed to ADHD without examining mood, sleep, substance use, medical illness, and environment. Diagnosis is not made from a productivity complaint alone.

Executive supports can be considered when the formulation suggests overload; specific examples are discussed below. Their effect should be reviewed against the hypothesized mechanism and any burden. A helpful response supplies clinical information but does not establish a diagnosis, and

medication decisions still require full assessment and monitoring.

Physical capacity constrains action. Anemia, endocrine disease, infection, neurological conditions, post-viral illness, pain, sleep disorders, medication effects, and many other conditions can produce fatigue or slowing. The person's prediction “I will crash if I start” may be exaggerated, accurate, or both in different circumstances. Graded activity should not be prescribed without understanding post-exertional symptoms and medical guidance.

Medication review includes sedatives, antihistamines, antipsychotics, some anticonvulsants, analgesics, and recent changes. Substance intoxication or withdrawal can impair initiation and judgment. The purpose is not to stop medication abruptly but to identify temporal associations and coordinate care.

Disability-aware formulation distinguishes inability, high cost, and lack of support from avoidance. Adaptation—assistive technology, rest, task redistribution, or benefits advice—may restore action more effectively than cognitive intervention. Psychological care should increase agency within reality, not demand performance that ignores it.

Some patients feel stuck because their options are materially constrained. Money, housing, immigration status, discrimination, caregiving, inaccessible services, and coercive relationships can make a proposed step unsafe or impossible. Individual therapy cannot substitute for legal, social, occupational, or medical intervention. A sound formulation distinguishes what is internal, interpersonal, and structural.

Leaving an abusive relationship is a clear example. Delay may reflect danger, financial dependence, surveillance, concern for children, or risk escalation, not pathological avoidance. Safety planning with appropriate specialist services is more relevant than exposure to confrontation. The clinician should not communicate that decisive action is simple when consequences are not borne by the clinician.

VII. A STRUCTURED CLINICAL ASSESSMENT

Assessment can proceed in layers: determine urgency and the person's ability to meet basic needs and care responsibilities; establish time course and impairment; assess psychiatric, medical, sleep, medication, substance, and neurodevelopmental contributors; map one recent episode behaviorally; and ask whether the proposed action is chosen, safe, and feasible. Diagnostic categories structure the differential, but ‘feeling stuck’ is not itself a DSM diagnosis and should remain a descriptive phrase unless a syndrome is established separately (American Psychiatric Association, 2022).

The patient's explanation is important but not final. ‘I am lazy’ may be a learned moral judgment; ‘my nervous system is

frozen' may capture bodily experience while obscuring depression or practical danger; and 'I need motivation' may hide fear of evaluation. The clinician holds several hypotheses and tests them against the pattern. Standardized measures can support assessment of depression, anxiety, ADHD symptoms, disability, or rumination, but there is no universal scale for feeling stuck. A behavioral baseline—such as days out of bed by noon, applications submitted, minutes spent reviewing without progress, or meals prepared—may be more useful and should not become another perfectionistic project.

Table 2. Differential formulation for feeling stuck (author-developed clinical synthesis; not a validated instrument)

Possible process	Indicators, response, and caution
Threat freezing	Indicators: Sudden immobility, narrowed attention, bodily alarm, cue dependence; Response: Safety, orienting, regulation, graded restoration of choice; Caution: Differentiate dissociation, catatonia, neurological or medical events
Anxious avoidance	Indicators: Anticipated threat, immediate relief after delay, narrowing behavior; Response: Exposure, safety-behavior reduction, uncertainty tolerance; Caution: Do not expose to actual danger
Rumination or worry	Indicators: Repetitive abstract thought without new data or action; Response: Concrete processing, scheduled problem solving, attention shift; Caution: Allow genuine reflection and grief
Perfectionism	Indicators: Conditional permission, excessive checking, fear of evaluative error; Response: Good-enough criteria, limited drafts, behavioral experiments; Caution: Preserve real quality and safety standards
Depression	Indicators: Low mood or anhedonia, hopelessness, slowing, self-neglect; Response: Risk assessment, behavioral activation, depression treatment; Caution: Screen bipolar history and medical contributors
Executive dysfunction	Indicators: Sequencing, time, working-memory, and initiation problems across contexts; Response: External structure, cues, task simplification, diagnostic assessment; Caution: Do not infer ADHD from one adult complaint

Possible process	Indicators, response, and caution
Value conflict	Indicators: Two meaningful, incompatible consequences; action feels identity-laden; Response: Clarify values, losses, reversibility, and chosen trade-offs; Caution: Technique cannot remove unavoidable grief
Fatigue, pain, or illness	Indicators: Capacity varies with symptoms, exertion, sleep, medication; Response: Medical review, pacing or rehabilitation as indicated, accommodation; Caution: Avoid attributing physical limitation to avoidance
Environmental constraint	Indicators: Money, access, care duties, discrimination, coercion, danger; Response: Practical, social, legal, or safeguarding support; Caution: Do not individualize structural problems

VIII. RESTORING ACTION

Intervention begins with an explicit hypothesis. If the proposed mechanism is avoidance, the plan should create contact with feared but safe information. If it is low reinforcement, the plan should increase meaningful activity. If it is executive overload, the plan should reduce steps visible at one time. If it is value conflict, the plan should clarify a trade-off. Using the same “five-minute task” for every mechanism may produce motion without understanding.

A project is not an action. “Write the article” contains planning, reading, drafting, revising, formatting, and submitting. A complete next action might be “open the outline and write three provisional headings.” It has a beginning and an observable end. The action should be within current control and should not depend on feeling ready.

Decomposition should stop once it supports action; building a perfect task system can become another delay. The clinician can cap planning time and test the smallest version in session. If initiation occurs with another person present but not alone, a temporary co-working arrangement tests whether social structure, rather than task ability, is the relevant variable. Other options include placing materials where the action occurs, removing extra logins, preparing the first step in advance, scheduling with a named person, keeping a phone elsewhere, or using a website blocker that may reduce decision load during a protected interval. These changes should be proportionate, chosen, and reviewed; rigid controls may be difficult to sustain or may themselves become counterproductive.

An undefined task can feel endless. A short, fixed interval with permission to stop changes the predicted cost: the patient commits to the interval, not to completing the project, and afterward reviews whether starting was possible, how anxiety changed, and how the task compared with the prediction. Time limits can also constrain rumination. A decision session ends at a chosen time by deciding, naming the specific missing information and how to obtain it, or deferring deliberately until a stated date; ‘keep thinking’ is not an outcome.

Many blocks combine incompatible cognitive modes. Generating ideas requires tolerance of error, whereas editing requires selection; evaluating continuously during generation interrupts production. A first pass can therefore be provisional and private, with later review against preselected criteria. Information gathering and deciding can be separated in the same way. Define in advance what evidence could change the decision; once that threshold is met, further searching is treated as possible certainty seeking unless the stakes or available facts change.

Practical technique is insufficient when the task evokes shame, grief, anger, or fear. The clinician helps name the emotion, locate its bodily expression, and identify the predicted meaning. Acceptance-based work emphasizes willingness to experience internal discomfort in the service of chosen action. Hayes et al. (1996) framed this as reducing experiential avoidance, not suppressing emotion.

A compassionate formulation may reduce self-attack sufficiently to support an agreed action, but it is not exemption from responsibility or a treatment claim by itself. A patient might say, ‘This task activates fear of judgment, which helps explain the delay. I can acknowledge that fear and write one provisional paragraph.’ The statement links context, accountability, and action without promising that distress will disappear.

When the block is maintained by a prediction, the next step should test it. A person who predicts that starting will create six hours of uncontrollable work can set a ten-minute interval and stop deliberately. Someone who predicts that asking for clarification will expose incompetence can ask one focused question. Record the predicted probability of the feared outcome and compare it with what actually occurs. Learning is stronger when the test concerns the feared consequence rather than merely proving that a task was completed. Implementation intentions translate a chosen goal into a cue-linked response, while treatment research on procrastination supports structured psychological methods rather than exhortation alone (Gollwitzer & Sheeran, 2006; Rozental et al., 2018).

Illustrative next-action protocol (author-developed clinical synthesis; not a validated treatment protocol)

- Name one observable action and why it matters.
- State the feared or costly outcome of doing it.
- Identify the protective behavior that usually interrupts it.
- Choose an interval, place, cue, and any temporary support.
- Preserve the relevant uncertainty while maintaining actual safety.
- Complete the action or collect precise information about where it stopped.
- Review learning without converting the exercise into a verdict on character.
- Decide the next step from the data, not from a demand for perfect confidence.

IX. WHEN THE ACTION SHOULD CHANGE

Persistence is not always adaptive. New information may show that the goal is unattainable, harmful, or no longer valued. A person may discover that the career, relationship, or project belonged to an earlier identity or to someone else's expectation. Abandoning it can be a decision rather than avoidance.

The distinction rests on process, not whether the clinician approves the outcome. Was the choice made with adequate information and capacity? Were important emotions and consequences allowed? Is the decision revisited compulsively? Does it reflect a stable value or an acute mood state? A deliberate “no” can restore action elsewhere.

Grief follows many choices. Selecting one future means losing alternatives. Therapy should not promise that the right choice feels entirely good. The capacity to act while acknowledging loss is often more realistic than achieving certainty.

X. COMMUNICATION, SUPPORT, AND HABIT

Blocked action may reflect information that has not been translated into a usable message. Anxiety signals possible threat, but the signal may be experienced only as diffuse tension. A conflict signals incompatible aims, but the person may hear only “I am incapable.” Communication-Focused Therapy was proposed by Haverkamp (2017a) as an author-developed framework for examining internal and interpersonal communication in anxiety. Its evidence base is not equivalent to established treatments, and it should be used to generate testable formulations.

One method separates sender, message, channel, recipient, and response. Internally, a bodily signal may communicate overload; its recipient is the person's interpretive system, which labels it failure; the response is withdrawal. Interpersonally, an unspoken boundary may emerge as delay; another person interprets delay as indifference; criticism increases the original block. Reconstructing the sequence can reveal alternatives.

A clearer message joins observation, emotion, value, and request. "I have postponed the meeting because I fear I will agree under pressure. I value the relationship and need the agenda in advance." The message does not guarantee compliance. It turns an opaque block into information and a boundary that can be answered.

Communication work becomes speculative when it assumes every symptom contains one true message. Some blocks are strongly biological, executive, or environmental. The model must remain subordinate to evidence, safety, and observed outcome.

Support can reduce executive and emotional load when its purpose is explicit. A trusted person may help define a first step, provide a workable setting, rehearse a message, accompany a safe exposure, or acknowledge completion; visible cues, fewer competing choices, a protected interval, or an if-then plan can make the intended response easier at the relevant cue (Gollwitzer & Sheeran, 2006). The form should follow the mechanism, and the plan should state who does what, for how long, and what will be reviewed. Rescue can maintain avoidance when another person repeatedly supplies certainty or takes over decisions, whereas continuing assistance may be an appropriate accommodation. A supporter should not conceal risk or decide something consequential that belongs to the patient; any move toward independence should be graded and chosen.

Habit-focused work examines the moment at which an intended action is displaced. Repetition can link a desk, device, room, or message cue to automatic checking or withdrawal even when emotion is not intense. Changing location can provide a temporary bridge, but permanent escape may preserve the difficulty when the original setting must eventually be used. Insight and rehearsal are therefore complementary: understanding the sequence identifies what to practice, while practice at the relevant cue tests whether the alternative is usable.

XI. INTERPERSONAL AND ORGANIZATIONAL APPLICATIONS

At work, blocked action may reflect unclear ownership, contradictory priorities, depleted capacity, or punishment for asking questions. A concise role map can identify the decision owner, required information, deadline, and escalation path. When instructions conflict, a specific request for prioritization communicates the constraint more accurately than treating the employee's delay as an individual motivation problem. Burnout or illness may instead require workload change, leave, accommodation, collective problem solving, or medical care.

In close relationships, silence may postpone conflict while allowing resentment and uncertainty to accumulate. A

bounded conversation can address one observable issue, each person's perspective, available options, and a named return time if arousal requires a pause. Rehearsal may improve clarity, but it cannot guarantee the other person's response. Where there is coercive control, surveillance, violence, or fear of retaliation, joint communication practice or confrontation may be unsafe; confidential assessment and specialist safeguarding support take priority.

Organizational decisions can also become stalled. Meetings may recur because the decision rule, authority, or cost of each option remains implicit. A facilitator can separate information, preference, authority, and accountability, then record the decision, owner, next action, and review point. This is a communication intervention at the system level and should not be recast automatically as one employee's avoidance or executive dysfunction.

As an author-developed communication formulation, relationship work can distinguish a preference, a boundary, and an attempt to control another person. A preference can be negotiated; a boundary states what the speaker will do to protect wellbeing; a demand seeks compliance from the other. The clinician can help formulate an observable concern, its meaning, and a specific request while preserving the person's right to pause or decline. The quality of the response supplies information about the relationship but does not determine whether the original need was legitimate.

XII. SAFETY AND ESCALATION

Prompt assessment is required when blocked action includes inability to eat, drink, maintain basic hygiene, obtain essential medication, care for dependents, or leave immediate danger. Marked psychomotor slowing, stupor, mutism, posturing, delirium, new neurological signs, rapidly changing consciousness, reduced need for sleep with escalating activity, psychosis, severe intoxication or withdrawal, or suicidal intent changes the priority from action coaching to urgent medical or psychiatric care. Clinicians should ask directly about risk and coercion and use the appropriate local crisis or safeguarding pathway. Apparent indecision under financial control, surveillance, or threats may be a survival strategy rather than avoidance.

Risk assessment should include the consequences already produced by prolonged inaction, including hopelessness, escalating debt or housing instability, missed essential care, unsafe substance use, and loss of support. The response should be proportionate to current risk and local responsibility. Safety intervention takes precedence over the original productivity target, but the patient should be told what will happen next and which choices remain available; clear communication can reduce avoidable shame and disengagement.

XIII. COMMON CLINICAL ERRORS

The table summarizes recurrent errors without implying that every case follows one sequence. Its questions are intended to reopen observation: whether distress has been confused with danger, assistance with dependency, action with wellness, or interpretation with evidence. When a small step does not occur, the appropriate response is to locate the stopping point and reconsider capacity, cue, safety, meaning, and ownership rather than simply increasing the demand.

Table 3. Correcting common errors (author-developed clinical synthesis; not a validated instrument)

Error	Corrective question
Assuming one hidden cause	Which competing hypotheses fit the time course and exceptions?
Treating distress as the outcome	Did safe, chosen action and learning increase?
Escalating demand after noncompletion	At which observable point did the sequence stop?
Removing all support	Is the support a bridge, a safety behavior, or an appropriate accommodation?
Remaining only in insight	What behavior can be rehearsed at the relevant cue?
Equating action with wellness	What happened to sleep, pain, relationships, quality, and choice?

XIV. OUTCOME AND RELAPSE PREVENTION

Outcome is increased flexible action, not maximal output. The person can begin, stop, persist, revise, or decline according to context and value. Measures include latency to start, number of avoidance switches, completed next actions, recovered self-care, and ability to tolerate uncertainty. Mood or anxiety may lag behind behavior.

Relapse planning identifies vulnerable conditions: sleep loss, unstructured time, criticism, too many simultaneous goals, illness, or loss of external accountability. The plan restores a known cue, reduces the action to its tested first step, and reviews the differential if the pattern has changed. A return of difficulty is not evidence of character failure.

XV. LIMITATIONS AND RESEARCH NEEDS

“Feeling stuck” spans constructs that are usually studied separately. Evidence for freezing, avoidance, rumination, behavioral activation, and executive function cannot be combined into one proven mechanism. Laboratory stress effects do not diagnose an individual, and treatment trials often exclude complex medical or social constraints. The proposed framework is therefore a clinical map rather than a validated algorithm.

Research should examine how patients use the term, which functional subtypes predict treatment response, and when task-focused interventions help or harm. More inclusive work is needed in disability, chronic illness, coercive environments, and culturally diverse concepts of action and obligation.

XVI. CONCLUSION

Feeling blocked or stuck is a useful starting description, but it does not explain why action has stopped. Inactivity may reflect threat freezing, avoidance reinforced by relief, rumination, perfectionism, depression, executive dysfunction, physical limitation, value conflict, or structural constraint. Assessment defines the absent action, sequence, prediction, function, capacity, context, and safety. Intervention then matches mechanism: stabilization, treatment of a disorder, exposure, behavioral activation, task redesign, decision structure, practical support, or clearer communication. Small steps are useful when they create meaningful action or new evidence, not because productivity is an unquestioned good. The therapeutic objective is restored flexibility—the ability to act, pause, revise, or say no with greater awareness and choice.

XVII. DISCLOSURES

Conflicts of interest—The author developed Communication-Focused Therapy and has related publications. It is identified here as an author-developed supplementary framework and is not presented as a replacement for established evidence-based treatment. No other conflicts were reported.

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